

# **The Global Fund to Fight AIDS, Tuberculosis and Malaria: Strategic Review 2023 (SR2023)**

Final Report Appendix

GF/ ELO/2024/01/03  
4 July 2024  
Geneva, Switzerland

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# The Global Fund to Fight AIDS, Tuberculosis and Malaria: Strategic Review 2023 (SR2023)

## **FINAL REPORT APPENDIX**

19 January 2024

**Submitted by CEPA in  
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## Contents

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<b>i) Bibliography</b>	<b>5</b>
<b>ii) Consultee list</b>	<b>13</b>
<b>iii) Evaluation methodology</b>	<b>18</b>
<b>i) Evaluation matrix</b>	<b>42</b>
<b>ii) Mapping of strategy operational objectives to evaluation workstreams</b>	<b>53</b>
<b>iii) WS1: budget analysis</b>	<b>53</b>
<b>i) WS2: grant performance rating analysis</b>	<b>70</b>
<b>ii) WS2: analysis of 2017-2022 kpis</b>	<b>74</b>
<b>iii) WS2: descriptive statistics</b>	<b>116</b>
<b>iv) WS2: statistical and regression analysis</b>	<b>145</b>
<b>ii) WS2: Summary of country-specific enablers and barriers</b>	<b>171</b>
<b>iii) WS3: Sustainability and co-financing</b>	<b>186</b>
<b>iv) WS3: M&amp;E</b>	<b>188</b>
<b>v) WS3: Progress made against SR2020 recommendations</b>	<b>193</b>
<b>vi) WS4: C19RM</b>	<b>197</b>
<b>vii) WS5: Progress against CI terg recommendations</b>	<b>197</b>
<b>viii) WS5: Matching funds analysis</b>	<b>206</b>
<b>ix) WS6: Partnerships appendix</b>	<b>221</b>
<b>x) WS7: Gender, human rights, equity and communities</b>	<b>223</b>

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## ii) Consultee list

Section B.1 presents a list of consultations held during the Inception Phase of the evaluation, and Section B.2 presents a list of all core-phase consultees.

### a. Inception phase meetings

Table B.1 present the list of participants involved across all inception phase meetings. Some participants were involved in multiple meetings during this inception phase as required.

*Table B.1: List of Secretariat members consulted in the Inception Phase (Geneva, 7-9 June and select follow up meetings by phone)*

Position	Department, Division
Head of Strategy and Policy Hub	SPH
Senior Policy Advisor	SPH
Senior Strategy, Policy and Allocation Consultant	SPH
Strategy and Policy Advisor	SPH
Chief Risk Officer	PMRD
Head, Risk Department	PMRD
Senior Advisor, COVID-19 response	TAP, SIID
Senior Manager	C19RM Secretariat, PMRD
Head, Health Finance	Health Finance, SIID
Senior Advisor, Value for Money, Health Finance	Health Finance, SIID

Position	Department, Division
Manager, Health Finance Strategy and Value for Money	Health Finance, SIID
Head of Grant Portfolio Solutions & Support	Grant Portfolio Solutions, GMD
Manager, CCM Hub	Grant Portfolio Solutions, GMD
Head of TAP	TAP, SIID
Specialist, Partnerships and Technical Cooperation	TAP, SIID
Manager, Programmatic Results and Impact	PMRD
Manager, Data and Analytics	Grant Portfolio Solutions, GMD

b. Core phase meetings

Table B.2 present the list of stakeholders interviewed during the core phase, split across the following categories: Global Fund Secretariat, Technical Review Panel, Strategy Committee, Technical Partners, Comparators, Donors, and CBO/ CSO and Community representatives.

*Table B.2: List of stakeholders consulted in the core phase*

Stakeholder group	Organisation	Title
Global Fund Secretariat	ED	Executive Director
	Management Executive Committee	Chief Financial Officer
	Management Executive Committee	Head, Strategy & Policy Hub
	Management Executive Committee	Head, Supply Operations Department
	Management Executive Committee	Head, Strategic Investment and Impact Division
	Management Executive Committee	Chief Risk Office and Head of Programmatic Monitoring and Risk Division
	Grant Management Directorate	Head, GMD
	Grant Management Directorate	Head, Grant Portfolio Solutions & Support
	Grant Management Directorate	Head, Africa & Middle East Department
	Grant Management Directorate	Head, High Impact Africa 2 Department
	Grant Management Directorate	Head, High Impact Africa 1 Department

Stakeholder group	Organisation	Title
	Grant Management Directorate	Head, High Impact Asia Department
	Grant Management Directorate	Senior Fund Portfolio Manager, South East Asia (previously RSSH, TAP)
	Grant Management Directorate	Head of Asia, Europe, Latin America and the Caribbean
	Grant Management Directorate	Regional Manager, Latin America & Caribbean Team
	Access to Funding	Head, Access to Funding
	Community Rights & Gender	Head, Community Rights & Gender Department
	Community Rights & Gender	Senior Technical Coordinator, Policy & Strategy, CRG
	Community Rights & Gender	Technical Advisor, Community Systems and Responses
	Community Rights & Gender	Senior Technical Coordinator, Human Rights
	Community Rights & Gender	Senior Technical Advisor, Gender, Gender and Equity
	Community Rights & Gender	Senior Technical Coordinator, Investment Support & Key Populations
	Community Rights & Gender	Lead, Community Engagement
	External Relations & Communications	Head, Donor Relations & Deputy Director of Ext Relations & Communications
	Finance	Head of Programme Finance
	Finance	Senior Specialist. Secretariat Financial Process Optimisation and C19RM
	Health Finance	Head, Health Finance Department
	Health Finance	Senior Advisor, Value for Money
	MECA	Senior Specialist, M&E
	Programmatic Monitoring Department	Manager, Programmatic Results & Impact
	Programmatic Monitoring Department	Programme Officer, Programmatic Results & Impact

Stakeholder group	Organisation	Title
	Programmatic Monitoring Department	Programme Officer, Programmatic Results & Impact
	Programmatic Monitoring Department	Specialist, Information and Investment Management, C19RM Secretariat
	Risk Department	Head, Risk Department
	Strategic Investment & Impact Division	Manager, Catalytic Investments
	Strategic Investment & Impact Division	M&E Specialist, Strategic Initiatives
	Strategy and Policy Hub	Senior Strategy, Policy and Allocation Consultant
	Strategy and Policy Hub	Senior Strategy and Policy Advisor
	Strategy and Policy Hub	Manager, KPI Reporting
	Technical Advisory & Partnerships	Head, Technical Advice & Partnerships
	Technical Advisory & Partnerships	Specialist, Partnerships & Technical Cooperation
	Technical Advisory & Partnerships	Head of Malaria
	Technical Advisory & Partnerships	Head of HIV/ AIDS
	Technical Advisory & Partnerships	Head of Tuberculosis
	Technical Advisory & Partnerships	Head of RSSH
	Technical Advisory & Partnerships	Senior Specialist, Measurement, Monitoring and Evaluation, RSSH
	Technical Advisory & Partnerships	Specialist, Strategy Pandemic Preparedness and Response
	Technical Advisory & Partnerships	Senior Specialist, Infection Prevention and Control, C19RM
	Technical Advisory & Partnerships	C19RM Secretariat, Specialist
Technical Review Panel (TRP)	TRP	TRP Chair
	TRP	TRP Vice Char
Strategy Committee	PEPFAR	Chair Strategy Committee, Senior Health Advisor & U.S. Representative to the Global Fund
		Western Pacific Region Representative
		Communities Representative

Stakeholder group	Organisation	Title
	AusAID	Health Advisor, AusAID
	UNICEF	Senior Malaria Office, Unicef/ ALMA
	FCDO	Head of International Directors Office
Technical Partners	WHO	ABM-WHO
	WHO	Director for Strategy, Programmes and Partnerships, WHO Emergencies Programme
	Unitaid	Executive Director
	STOP TB	Executive Director
	Roll Back Malaria	Data Analyst
	Roll Back Malaria	Country/ Regional Support, Partners Committee Manager
	Expertise France	Technical director of the 'Major Pandemics' unit, Health Department of Expertise France
Comparators	Gavi	Chief Programme Strategy Officer
Donors	PMI	Chief, Malaria Supply Chain Branch
	PMI	Deputy, Malaria Division
	PMI	Malaria Technical Advisor (Counterpart for PMI 5%)
	PMI	Global Fund Liaison (new)
	PMI	Team Lead, Informatics
	PMI	Co-Team Lead, Community Health
	Bill and Melinda Gates Foundation	Consultant
	Bill and Melinda Gates Foundation	Advisor to BMGF on the Global Fund
	Bill and Melinda Gates Foundation	Deputy Director, Health Department
	USAID	Multilateral Team Leader
	USAID	Multilateral Advisor
Civil society representatives	Global Fund for Women	Former Global Coordinator - W4GF
	INPUD (International Network of People who Use Drugs)	Executive Director
	Via Libre	Technical Coordinator of the LAC Regional Platform (CRG SI)



### *iii) Evaluation methodology*

This Appendix complements Section 1.2 of the report, which describes the evaluation methodology and approach for SR2023. Section C.1 describes in detail the management and quality assurance approaches employed for the evaluation methods, and key limitations by method. Section C.2 presents interview guides, used for global consultations and country case studies. Appendix D presents the evaluation matrix.

#### *a. Management and quality assurance of evaluation methods*

This describes in detail the management and quality assurance approaches that were employed across evaluation methods as well as key limitations by evaluation method. As described in Section 1.2.3, review methods include: (i) document review; (ii) data analysis; (iii) key informant interviews; (iv) country case studies; and (v) comparator case studies.

#### *i. Document review*

### **Identification of key documents and review method**

The document review included materials from the Global Fund and select external materials from other stakeholders as well as based on the evaluation team's proactive, yet targeted review of the landscape (refer to Appendix A for the list of key documents referred to over the course of the evaluation).

The desk-based review of Global Fund documentation was the first step of the core phase, building on the review conducted in the inception phase, though continued throughout the core phase as more documentation became available. Content analysis of documents was a key method to collate evidence on the various SRQs. The evaluation team pulled out relevant material and evidence by SRQ using a standardised template. The document analysis was also used to guide specific lines of enquiry for the consultations.

### **Strengths, limitations and mitigations**

The strengths of the document review as a source of evidence for the evaluation are that it represents an open, transparent (where not confidential) and validated (to the extent that these are publicly available and published) source. However, there is a degree of subjectivity in the interpretation of the language in specific documents and some documents are more judgement/ opinion-based than others (e.g., previous reviews to some extent, progress reports to a lesser extent where they present factual progress). Further, there was fewer documentary evidence available for some workstreams, particularly the workstream on C19RM owing to its relative newness. For these workstreams, consultations took on greater relative importance as a source of evidence.

A second challenge of the document review is the extent of evidence available in line with the scope of our SRQs. As such, documentation evidence for each SRQ needed to be corroborated to lesser or greater extents with data available from other evidence sources such as key informant interviews.

The evaluation team's systematic approach to reviewing documentation in relation to the SRQs helped ensure most effective use of this method for the purposes of this evaluation.

#### *ii. Quantitative data analysis*

### **Identification of key data sources and review method**

Data sources included Global Fund databases (on funding allocations, absorption, results, etc.) and external databases (e.g., on health outcomes, health expenditure, etc.). Standard quantitative data analysis alongside statistical analysis were conducted. Appendix F-I and Q present data analyses conducted (budgetary analysis, KPI analysis, descriptive statistical analysis, analysis of

grant performance ratings and analysis of catalytic investments). Appendix J presents the statistical and regression analysis.

### **Strengths, limitations and mitigations**

Appendix F-I, J and Q provide detailed on data quality issues as well as caveats to analysis.

#### *iii. Key informant interviews*

All stakeholder interviews (global level and for country case studies) and use of interview data adhered to the UNEG guiding ethical principles for evaluation.<sup>1</sup> The management and quality assurance of key informant interviews are described below.

### **Identification of key informants**

CEPA developed an initial list of stakeholder categories that we planned to consult with for SR2023. In the first half of the core phase, the ELO helped to populate this list with specific names of individuals in respective teams and areas of work within the Secretariat, other Global Fund stakeholders, and external stakeholders. Once the stakeholder list was finalised, the evaluation team reviewed the stakeholder list closely to ensure: i) there were no gaps across the workstreams and SRQs; ii) fair representation of stakeholders with diverse perspectives (e.g. representation across Global Fund stakeholder groups and diversity within these groups, for example the voices of diverse community-led organisations), and proposed additional organisations and/ or names to facilitate an independent and balanced evaluation. As relevant, the evaluation team contacted Secretariat teams for additional stakeholder recommendations.

A matrix of stakeholders against each workstream was used for the purpose of identifying any gaps, informing lines of enquiry for consultations, and allocating interviews to team members primarily based on their workstream roles within the review and time zones, as well as their availability in line with stakeholders' availability, recognising the tight timeframe for the evaluation. The interview list was reviewed closely by the evaluation team, and interview allocation was discussed and agreed over initial team meetings (and subsequently, as the list evolved). Due to the cross-cutting nature of several workstreams and complexity and breadth of this review, most team members conducted enquiry across all workstreams of the review, including and beyond their workstream of focus. This supported the cross-fertilisation of reflections and findings across workstreams, important for the generation of suitably contextualised, quality findings within workstreams, as well as a basis for an effective triangulation effort drawing across data sources and the generation of useful conclusions and recommendations across the team.

### **Conduct of semi-structured interviews**

Stakeholder interviews were supported by interview guides developed by the evaluation team. The interview guides were discussed at a team meeting at the start of the evaluation and all team members appraised of the scope of the interview questions, background, sub-questions, etc. This approach ensured consistency in interviews whilst supporting a semi-structured, adaptive approach to ensure relevance. Bespoke interview guides were developed by stakeholder group (or in some instance by key informant, as appropriate). Section D.2 presents an example interview guide for global level consultations and country case studies. Interview guides were further

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<sup>1</sup> The four UNEG guiding ethical principles for evaluation are: Integrity, Accountability, Respect, and Beneficence.

elaborated for each stakeholder to maximise the utility of the consultation and to explore relevant topics based on specific consultee expertise and knowledge.

Interviews were conducted using a semi-structured interview approach, based on the agreed interview guide but also enabling flexibility in the enquiry according to relevant emerging points. All interviews utilised good interview practice (e.g., providing relevant background information, respecting anonymity, avoiding use of leading questions etc). In certain instances, focus group discussions (FGDs) were used where it made sense to combine individuals and/ or organisations.

To ensure quality control, each interview was conducted (wherever possible) by a minimum of two members of the evaluation team, with a lead and support in each interview. The lead interviewer posed questions based on the interview guide, whilst the support took notes. At times more than two members of the evaluation team attended an interview in circumstances where the interviewee had multiple roles and would speak to a variety of key topic areas, or the interviewee was a significant informant for the Review (e.g., CEO and senior leadership team).

We maintained a record of interviews by person, role and organisation. Notes were structured by workstream and SRQ, as well as key issue/ theme within this. File notes were updated on a regular basis and kept confidential for the use of the evaluation team only.

All notes were reviewed by all attending members of the evaluation team, and any gaps, inconsistencies or missed information addressed through either subsequent interviews, follow up with specific consultees and/or verification via other data sources. All interview notes were read and reviewed by the full review team to ensure collective insight across the emerging evidence. In addition, the review team met approximately on a weekly basis and reviewed feedback from interviews and cross shared learnings and emerging findings during the course of the evaluation. This also helped ensure a similar approach was taken during interviews.

A mix of in-person and remote interviews were conducted, with a majority of in-person interviews with Global Fund Secretariat staff in late July. This was followed by external consultations and the balance of Secretariat consultations.

Pertaining to protection of interviewees, several aspects were applied:

- All interviewees were informed of the interview context and background upfront, as well as provided the opportunity to provide open and frank responses as the interviews were kept confidential (as described above);
- SR2023 involved interviews across a range of stakeholder groups but did not involve direct beneficiary interviews. Where representatives of beneficiary groups were interviewed (e.g., CSOs), adherence to appropriate and respectful standards as well as the experience of the evaluation team ensured protection of the interviewees.

Finally, during the inception phase, the evaluation team was made aware of a concurrent OIG audit on the effectiveness of the Global Fund model in delivering the new Strategy, which entails consultations with some Global Fund stakeholders overlapping with those consulted for this Review. To facilitate synergies between the OIG audit and SR2023 and further inform lines of enquiry in SR2023 consultations, notes from OIG meetings were shared with the evaluation team and recordings made available. The OIG also audited select SR2023 interviews.

## Qualitative analysis and coding of key informant interviews

As this Review included a substantial amount of qualitative data collected through the stakeholder interviews, the Review involved a robust and pragmatic analysis of the data through the use of a structured note-taking approach, and coding framework linked to the various SRQs and key issues/ themes. The interview notes were coded by SRQ, as well as specific issues/ themes within each SRQ. This coding effort was done at the same time as the write up of interview notes, as part of a systematic coding approach which was adopted throughout. This evidence then fed into the evidence matrices for analysis and triangulation, described in Section 1.2.

## Strengths, limitations and mitigations

Key informant interviews (KIIs) were an important source of information to gather a range of perspectives and insights. KIIs were particularly critical for review aspects where there was less documentary evidence, such as on C19RM as noted above, as well as where documentary evidence may not be evaluative in nature (e.g., in success of partnerships).

The above-described approach to key stakeholder identification, selection and prioritisation helped to ensure a balanced stakeholder list. Pre-determined interview guides (Appendix D.2) conducted in a semi-structured, adaptive approach supported the relevance of the interviews and uniformity in the approach to evidence gathering.

There are a number of limitations that the review team was cognisant of during SR2023 and sought to mitigate any possible bias – these are listed in Table D.1.

*Table D.1: Key limitations and mitigating measures pertaining to consultations*

Limitations	Mitigating measures
Possible respondent bias – particularly when internal to the Global Fund or representative of specific stakeholder interest groups	<ul style="list-style-type: none"> <li>• Coverage of a wide range of stakeholders and triangulation of perspectives and findings within and across stakeholder groups, including proposing additional organisations and/ or names to facilitate an independent and balanced evaluation.</li> <li>• The review team systematically asked for specific examples and objective evidence to support stakeholder views as far these were available (e.g., published or internal reports etc).</li> <li>• Expertise and expert judgment of the review team applied in interview delivery and interpretation of feedback.</li> </ul>
Non-availability of key consultees in a relatively condensed time frame for SR2023	<ul style="list-style-type: none"> <li>• Early planning and engagement with the most relevant consultees.</li> <li>• Finding alternate consultees in consultation with the ELO when primary target consultees were not available.</li> <li>• Given the strong country emphasis of SR2023, country case studies have also served to provide country-level evidence for SRQs for which relevant global level stakeholders were not available.</li> </ul>

### b. Country case studies

14 country case studies were conducted for this review: 12 detailed (Nigeria, Kenya, Zambia, South Africa, Mozambique, Cote D'Ivoire, Sierra Leone, Chad, Kyrgyzstan, Bolivia, the Philippines and Pakistan) and 2 high level (South Sudan and India, which are desk-based due to the limited availability of stakeholders).

Country case studies were selected using a methodology developed in collaboration with the ELO with the objective to follow a structured selection approach that ensured: (i) a higher weight was given to countries that receive more Global Fund funding; (ii) countries were selected that offer relevant insights across evaluation workstreams and SRQs; (iii) there was a representation across key country characteristics; and (iv) it was feasible for the country to have a case study and the country was not overly burdened by the case study given any ongoing events in the country. A five-step approach was applied to consider the above factors:

- Stratification of Global Fund eligible countries by portfolio categorisation;
- Weighting of strata by total Global Fund allocation, to determine the number of countries to be selected in each country category;
- Ranking of selected countries according to identified measures using a ‘preference score’<sup>2</sup>;
- Purposeful selection of countries to ensure that preference was given to countries with high scores, while maintaining representation across key country characteristics<sup>3</sup>;
- Confirmation by GMD of the country list, and selection of replacement countries as needed.

The country case studies were conducted using a mixed method approach including document review, quantitative data analysis and around 10-15 interviews with national stakeholders, in-country partners, and Global Fund staff, with overall methods tailored to country context (many of these are FGDs). The document and data review were conducted first and prior to the in-country stakeholder consultations. This sequencing ensured that the evaluator/(s) arrived with a strong understanding of the country contexts and could tailor questions to confirm and corroborate any early insights from the document and data review. Consistent with the methods described above for global level evidence, the case studies pull out relevant material and evidence by SRQ using a standardized template and data collection tools. An overview of each method used is provided below:

Country case studies were led by a mix of either a single country expert, a team of international experts, or a hybrid team of international and local experts. The choice of approach for the country case study was based on the qualifications of the country expert and the complexity of the Global Fund country portfolio.

## **Data analysis**

The country case studies leverage existing analysis conducted by the Global Fund Secretariat. In particular, they use the “country factbooks” provided by the Global Fund DASH unit which provide an overview and key trend analysis of (i) key country characteristics; (ii) Global Fund allocation and expenditure and (iii) key performance, outcome and impact indicators.

Additionally, country case study leads are also provided with key insights from the wider data analysis conducted as part of the review. This includes information on whether the country has performed relatively well / less well across disease areas / RSSH when compared to other

<sup>2</sup> Key factors included high disease burden of HTM, high share total of C19RM allocation for 2021 and 2020 C19RM cycles, high share of matching funds, human rights focus, AGYW focus, standalone RSSH grant and/or above average allocation to RSSH, Challenging Operating Environment, above average share of domestic health financing, transition process, existence of previous reviews that could be leveraged for this evaluation.

<sup>3</sup> Country characteristics considered included Global Fund Regions, languages, World Bank income classification, and country/ grant performance.

countries in the same income classification This information was shared with case study leads to ensure targeted questions on key barriers / enablers and to ensure triangulation across different evidence bases.

## **Document review**

The document review includes a review of the following key documents:

- Global Fund documentation: (i) funding requests and related grant documents; (ii) performance updates and logframes; (iii) Secretariat Briefing Notes written by the Global Fund country teams and TRP reports;
- National documentation: (i) national plans and strategies; (ii) reports on performance / progress; (iii) implementation guidance for specific interventions;
- Key partner documentation: (i) reports on plans and activities conducted in the countries by key partners (E.g. PEPFAR, PMI, UN partners); (ii) assessment of status of HTM in-country etc.; (iii) wider literature relevant to the country case study (e.g. pertaining to sustainable health financing).

## **In-country stakeholder consultations:**

A launch meeting was held in country with the CCM and others as appropriate to explain evaluation objectives and scope and plan for interviews. For most case studies, this was done virtually in advance of the in-person consultations.

In order to identify the most relevant stakeholders and ensure fair representation of different voices and perspectives, a template of stakeholder categories relevant to the previous **Global Fund Strategy and C19RM** was developed by the evaluation team in consultation with the ELO. For each country, a stakeholder list was then developed and tailored to country context based on this template, with input from the Global Fund Country Team, the CCM and Principal Recipients. Key stakeholders included the following:

- CCM chair and vice chair plus CCM Secretariat (and on occasion past chair/ vice chair)
- Ministry of Health representatives including HTM, HSS, finance and data departments
- Global Fund-related program implementation units within MOH
- Ministry of Finance representatives, including those involved in external donor funding and overall government budgeting and expenditure management
- Sub-national government representatives, as appropriate
- Technical partners at country level - WHO RO/ CO, other UN partners, CHAI, etc
- Donor partners at country level - US government and other bilaterals, World Bank
- Community and civil society organisations
- Country PRs and SRs (presumably covered in the above)
- Local Fund Agents

Related to C19-RM component, we included the following stakeholders:

- Incidence Manager, National Public Health Agency and/or Epidemiology Unit
- Case Management, Surveillance and Laboratory Services heads and/or relevant Committees



- C19-RM Committee or equivalent (Specifically to explore absorption rates by the various C19-RM components).

While the majority of consultations were conducted in person, some interviews were conducted virtually to ensure the perspectives of informants not based in capital cities were captured (as the majority of case studies were conducted in the capital). This also allowed for flexibility for stakeholders not available for an in person consultation.

The same methodological and analytical approach used at the global level was followed for consultations at the country level.

#### **Validation workshop with emerging findings**

The review team offered to present an overview of early observations at the end of the five-day country case study. These were high-level and included key emerging themes and ensured key country stakeholders (e.g., PRs, CCM representatives) could provide feedback and verify results and also gain insights from the conducted case study. Global Fund FPMs will also review the draft report and provide feedback on the country case study findings.

The case study reports follow a standardised template. Across the 14 country case studies, there is quality control by a core team member and copy-editing of reports.

#### **Strengths, limitations and mitigations**

The main strength of country case studies which form a critical aspect of this review, is to provide an evidence-based assessment of Global Fund performance and key issues across a diversity of contexts supported by the Global Fund. These permit a 'deep dive' into specific workstreams and SRQs and provide more nuanced evidence of reasons for stronger and weaker performance across the different aspects covered in this review.

The limitation is the extent of generalisability of findings given the range of different contexts the Global Fund supports. To mitigate this, the review has triangulated case study findings against other evidence (such as global consultations, document review) and highlighted specific context / factors within case studies which limit ability to generalise findings.

- c. Case studies of comparator organisations

#### **Identification of comparator case study**

We conducted a case study of Gavi as a comparator organisation where we thought there was value in drawing in learnings from their approaches. The comparator case study was applied to SRQ 1.1 on relevance of country investments where to explore other organisation approaches to VFM; SRQ3.3. on sustainability to review other funder approaches to co-financing and transition; and SRQ 6.1 on partnerships to gather learnings from Gavi's approach to managing partnerships. The selection of the organisation was purposive, mainly to select organisations that are large funders of country programmes like the Global Fund (and Gavi is an obvious selection in this regard).

#### **Review method**

The comparator case study followed the above described methods for document review as well as consultations. As has been flagged, the comparator case study was based primarily on document review and entailed one focused consultation as well.

## Strengths, limitations and mitigations

The main strength of using a topic-specific case study is that they will enhance the findings for certain areas, drawing in comparator organisation experience.

The limitation is extent of applicability to the Global Fund. We have considered any caveats to this effect in our analysis.

### d. Additional aspects pertaining to data

The following additional aspects pertaining to data also applied for this review:

- Data quality was ensured by correctly reflecting any limitations and caveats to any databases and related analysis;
- Safe data storage was ensured through CEPA's robust IT systems as described in CEPA's Quality Assurance policy;
- As noted above, confidentiality of data collection has been maintained at all costs, as was promised to all informants for interviews at the global and country levels. File notes and recordings of interviews were kept confidential for access by the evaluation team only and have not been made available to the client or other stakeholders.

### e. Interview guides

The example interview guides below provide an overview of the scope of consultations for SR2023. As described above these were tailored to consultee (and C.5.2 also to country context) prior to the interview.

#### i. Global consultation interview guide

#### *Country programmes and progress/ results*

1. **Overall results:** Looking back at the historical timeline of the Global Fund, what do you view as the main achievements over the 2017-22 Strategy period and where do you think progress has fallen short of expectations? What are the big "events" and aspects that have impacted Global Fund supported performance over the 2017-22 Strategy period? COVID-19 is a key aspect, but what other external and internal facilitating and hindering factors do you view as key?
2. **Relevance of grants:** In your assessment, were Global Fund resources invested in addressing key epidemiological and country needs to advance progress on HTM? Aspects for comment may include adequate focus on current and emerging disease priorities, RSSH funding as supporting or strengthening health and community systems, gender and human rights issues, funding of innovations versus standard programmes, etc.

#### *Global Fund strategic levers contributing to achievements*

3. **Strategic levers:** What do you view as the main "strategic levers" of the Global Fund to impact country-level results and what levers have worked well and less well?
4. **Funding model/ business model:** Looking at the full suite of Global Fund funding model and business processes and approaches, what do you think has reached "steady state" in terms of working well for the next Strategy period and what might be key areas of further development/ reform? Was there anything specific that you think the Global Fund should have done differently to support better results (noting specifically the range of issues highlighted for RSSH and HRG in particular)?



5. **Policies and processes:** Does the Global Fund policy framework developed for the 2017-22 Strategy work well (e.g. allocation, STC, COE, Operations Manual, etc)? What are key gaps/ learnings for the next strategy period?
6. **Sustainability:** In view of tightening budgets all around, how well do you think the Global Fund has supported an increase in domestic financing for HTM and health and community systems strengthening over the 2017-22 Strategy period, and did it have the right mechanisms in place to do so (particularly in terms of effectiveness of the STC policy)?
7. **Risk management:** To what extent have risk trade-off decisions impacted effective implementation of Global Fund programs and initiatives?
8. **M&E:** To what extent did the Global Fund's approach to M&E meet the decision-making needs of stakeholders responsible for delivering on strategy objectives?
9. **C19RM:** What worked well and less well with regards to the Global Fund C19RM, especially post 2021 changes, and observed progress/ results until the end of the last Strategy period 2017-22?
10. **Catalytic Investments:** What are key learnings from the 2017-22 Strategy period on the design and implementation of Catalytic Investments (Strategic Initiatives, Multi Country Grants and Matching Funds)? How effective have the various catalytic investments been in driving catalytic change, including through incentivising enhanced resources, innovation and prioritisation of key issues, over the 2017-2022 strategy period? How could SIs, MCGs and MFs be better utilised to optimise future gains?
11. **Partnerships:** What are key learnings from the 2017-22 Strategy period in terms of effective working with partners, specifically technical partners and bilateral and multilateral funders? How has the experience from the Global Fund's participation in global coordination mechanisms such as ACT-A and SDG GAP over the 2017-22 Strategy period contributed to coordination and effectiveness in delivery of the Global Fund Strategy?

#### *Forward looking/ recommendations*

12. **Recommendations:** What would be your main recommendations for the Global Fund for the next strategy period and Grant Cycle 8, based on learnings from the 2017-22 Strategy period?

#### *ii. Country case study consultation guides*

##### *(ii) CCS master interview guide*

*The master interview guide should be used as feasible as is a comprehensive coverage of topics.*

*It should be suitable for the CCM Secretariat in country (ideally should be the first interview as they have crosscutting knowledge of Global Fund investments across HTM/ RSSH/ C19RM/ etc. and are more familiar with Global Fund parlance).*

*It should also be applicable for the CCM Co-Chairs, government disease programmes in country i.e. NACs / National TB Program/ National Malaria Program (where the guide should be tailored to focus on the specific disease) and PRs (where the guide should be tailored to specific investments being implemented by the respective PRs). Qs 9 and 10 below on C19RM and Qs 11 below on catalytic investments may not be relevant for these stakeholders, unless they have been directly involved in this funding.*

#### *Background on Global Fund funding in country*

1. Could you describe the HTM situation in your country and key progress areas and gaps?

2. Could you describe the Global Fund grants in country across HTM/ RSSH/ C19RM and main implementers (PRs, SRs) involved? What are key aspects funded by Global Fund in relation to what is funded by government and other donors?

#### *Relevance of country programmes and progress/ results*

3. **Relevance of investments:** Looking back at Grant Cycles 5 and 6, to what extent have Global Fund investments in [country name] been relevant to country needs and priorities with regards to HTM? To what extent have Global Fund investments in country focused on interventions that deliver the most impact and best value for money? *Probe for:*
  - a. *Consideration of contextual factors (HTM epidemiological profile, socio-economic context etc.)*
  - b. *Appropriate and balanced funding of current and emerging disease priorities (e.g., emerging TB and malaria drug resistance, HIV prevention vs treatment programs)*
  - c. *Adequate consideration of health and community systems needs through RSSH grants*
  - d. *Adequate consideration of systems issues, integration, people centred approaches*
  - e. *Incorporation of key considerations for key, vulnerable and underserved populations, including with regards to human rights and gender*
  - f. *Consideration for balance between funding innovative products and approaches vs. already established products and approaches*
  - g. *Consideration of Global Fund support in relation to what others are funding in the country (government and other donors)*
4. **Investment results in country:** Over Grant Cycle 5 and 6, what do you view as the biggest areas of progress achieved through Global Fund support and what are the key gaps? *Probe for:*
  - a. *Key programmatic results across HTM diseases including during COVID-19*
  - b. *Reasons for over and under performance*
  - c. *Degree of contribution of Global Fund interventions to country progress and change in key disease indicators (e.g., incidence)*
  - d. *Have there been any challenges with regard to the grant performance target setting and did this in any way drive performance (e.g., targets set too low / too high)*

#### *Funding model/ business model*

5. **Funding model and business processes:** How well does the Global Fund funding model<sup>4</sup> support effective prioritisation and implementation of country programs and interventions to deliver against targets? *Probe for:*
  - a. *Adequacy and effectiveness of Global Fund funding cycle to country applications (including efficacy of country dialogues and Funding Request prioritisation and development, CCM representation and engagement by members (and especially health systems stakeholders beyond HTM and CSO/ CBOs), adequacy of guidelines, forms and templates, TRP review process, efficacy of grant making, support received through Global Fund Secretariat and technical partners, etc.)*
  - b. *Adequacy and effectiveness of grant implementation processes in country including PR reporting, grant financial management processes, and other key processes including disbursements, revisions and grant closure.*
  - c. *Aspects that work well and less well with regards to funding model for RSSH investments in country.*

<sup>4</sup> The Global Fund funding model pertains to the funding cycle stages and processes (including application, implementation, closure), structures involved (e.g. CCM, TRP, PRs, LFAs) and key characteristics such as differentiation, three-year funding cycles, continuity of programme funding.

- d. *Funding model contribution or hinderance towards reduction of human rights related barriers (including those related to key, vulnerable and underserved populations) and advancement of gender equality in country.*
- e. *Is the model sufficiently tailored for your country and flexible in relation to your needs?*
- f. *What are key areas that you would propose be reformed by the Global Fund going forward?*

6. **Sustainability** What are positive achievements and/ or key issues with regards to country take over of aspects funded through the Global Fund? What do you view as helpful aspects of the Global Fund model as a whole that foster long run sustainability? *Probe for:*
- a. *Effective engagement of key country stakeholders from the onset of country investments (i.e., grant design) to ensure financial and programmatic sustainability*
  - b. *Availability and use of quality health financing strategies, sustainability plans and transition readiness assessments in country*
  - c. *Access to data/ trends in domestic financing for health and HTM specific funding where possible (ideally beyond commitments to also cover expenditures) and Global Fund's contribution to observed progress.*
  - d. *Views on the relevance/ appropriateness of Global Fund's approach to country co-financing and transition*
  - e. *[if possible, interviewer to validate domestic funding analysis that came from the document review, as documentation may not be up to date/comprehensive]*
7. **Risk management:** What is your view on whether the Global Fund appropriately manages risks for its funding in relation to supporting the most needed/ impactful programmes in country? *Probe for:*
- a. *Would you like to share specific instances where you thought the Global Fund was focusing too much on financial risk at the cost of programme suitability?*
  - b. *What is your perception on how Global Fund approaches the C19RM pandemic response in terms of being more (or adequately) risk prone given the circumstances?*
  - c. *Do you think the Global Fund's approach to risk impedes participation of CSO/ CBOs in grant implementation? Could you highlight aspects that support their participation and those that hinder?*

**M&E:** What works well & less well with regards to the Global Fund's M&E requirements on countries? Is the process to set grant performance targets effective and leads to the right selection of indicators and targets? *Probe for:*

- a. *Are the M&E requirements adequately aligned with country systems?*
- b. *Have there been any challenges with regard to the grant performance target setting (e.g., selected indicators do not match supported interventions, data quality concerns, targets considered to be too ambitious / not ambitious enough)*
- c. *In your assessment, does the M&E support funding decision-making and progress assessment adequately?*
- d. *Does the Global Fund adequately support innovations in M&E to improve efficiency (e.g. digitalisation, performance-based funding, where relevant)?*

8. **C19RM:** For any applications your country has made for C19RM post 2021, can you share views on aspects that have worked well and less well with regards to the requirements and processes instituted by the Global Fund? *Probe for:*

- a. *Adequacy of C19RM processes to country context, needs and operations, including C19RM allocation, technical guidance, timelines for approvals, review process, in-country requirements in terms of relevant bodies that need engagement and sign-off, etc*
  - b. *Effectiveness of post 2021 C19RM changes in supporting country programs adaptations and agility needs during COVID-19*
9. **C19RM:** To what extent have C19RM interventions contributed to mitigating the effect of COVID-19 on the three disease program outcomes in country? *Probe for:*
  - a. *Contribution of C19RM to mitigating the impact of COVID-19 on HTM in country*
  - b. *Contribution of C19RM to RSSH and community systems strengthening in country*
  - c. *Please provide some examples of interventions that have supported (or hindered) results*
10. **Catalytic Investments:** We understand that [country] has benefitted from the following funding over and above what is delivered through the Global Fund country allocation: [list SI, MCC, MF for the country] *Probe for:*
  - a. *What do you view as the value add of this funding? (e.g. additional to allocation funding, not funded by other partners, support needed for priorities that would otherwise be unfunded, supports TA needs, incentivises other partners' investments etc.)*
  - b. *What was your experience in accessing this funding?*
  - c. *To what extent has this funding been coordinated with the core allocation funding from the Global Fund?*
  - d. *To what extent and how do you think this funding has been "catalytic"?*
  - e. *To what extent is any 'catalytic effect' also sustainable, and what does this require?*
  - f. *Do you have any views on how the catalytic effect of this funding has been or could be best measured?*
  - g. *For MFs in particular, does this support increase government spending in the area?*
  - h. *How could we better utilise Catalytic Investments to optimise future gains?*
11. **Partnerships:** What has worked well and less well in terms of support from international technical partners in country (WHO, UN partners, etc.) for Global Fund investments? To what extent is there adequate coordination between Global Fund and other donors of HTM (US government in particular)? What are key aspects to improve on both of these areas?
12. **Gender, human rights, equity & communities (crosscutting):** What aspects of the Global Fund funding model have facilitated and hindered efforts to reduce human rights related barriers, advance gender equality, enhance health equity and promote communities' needs and responses in country? *Probe for:*
  - a. *Evidence of Global Fund contribution to reducing human rights related barriers (including those related to key, vulnerable and underserved populations) and advancing gender equality, health equity and responsiveness to communities' needs at country level.*
  - b. *How are these outcomes being assessed / measured? And what are the strengths and challenges related to this?*
  - c. *What were the key enabling factors (internal / Global Fund or external) of these outcomes?*
  - d. *What, if any, factors (internal / Global Fund or external) have hindered efforts to reduce human rights related barriers (including those related to key, vulnerable and underserved populations) and advance gender equality, health equity and responsiveness to communities' needs at country level?*

*Forward looking/ recommendations*



13. **Recommendations:** Please provide your top 3-4 suggestions for the Global Fund's support to your country in the future?

*(iii) Global Fund Secretariat country team/ FPM*

1. **Understanding Global Fund funding in [country]:**

- i. *Could you describe the main aspects funded by the Global Fund in [country] for HTM and RSSH (including CSS)?*
- ii. *To what extent have Global Fund investments in country focused on interventions that deliver the most impact and best value for money?*
- iii. *How does this relate to the aspects funded by the government and other donors?*
- iv. *Who are the main PRs and SRs? Is there any history/ context we should be aware of?*
- v. *Who are the main technical partners and donors of relevance to Global Fund funding in Nigeria? Is there any history/ context we should be aware of?*
- vi. *What do you view as the main areas of progress and gaps on HTM and RSSH in [country] over the last Strategy period? What are supporting and hindering factors?*

2. **Funding model and business processes:** How well does the Global Fund funding model support effective prioritisation and implementation of country programs and interventions to deliver against targets? Any lessons learned / suggestions for improvement?

- i. *What is your view on whether the Global Fund appropriately manages risks for its funding in relation to supporting the most needed/ impactful programmes in country?*
- ii. *What works well and less well with regards to the Global Fund's M&E requirements on countries?*

3. **Sustainability** What are positive achievements and/ or key issues with regards to country takeover of aspects funded through the Global Fund? What do you view as helpful aspects of the Global Fund model as a whole that foster long run sustainability?

4. **C19RM:** What has been [country]'s experience with C19RM (funding requests, key stakeholders in country, etc.)?

- i. *For any applications your country has made for C19RM post 2021, can you share views on aspects that have worked well and less well with regards to the requirements and processes instituted by the Global Fund?*
- ii. *To what extent have C19RM interventions contributed to mitigating the effect of COVID-19 on the three disease program outcomes in country?*

5. **Catalytic investments:** What have been the main CI funding for [country]? How effective has been the catalytic investment in HTM and RSSH over the 2017-22 period? Any lessons learned / suggestions for improvement?

6. **Partnerships:** What has worked well and less well in terms of support from international technical partners in country (WHO, UN partners, etc.) for Global Fund investments? To what extent is there adequate coordination between Global Fund and other donors of HTM (US government in particular)? What are key aspects to improve on both of these areas?

7. **Gender, human rights, equity & communities:** What aspects of the Global Fund funding model have facilitated and hindered efforts to reduce human rights related barriers, advance gender equality, enhance health equity and promote communities' needs and responses in country?

8. **Recommendations:** What would be your main recommendations for the Global Fund for the next strategy period and Grant Cycle 8, based on learnings from the 2017-22 Strategy period?  
(iv) *C19 Stakeholders*

*Please use this guide for implementers of C19RM funds in country and any other C19RM stakeholders.*

1. Please share your views on the value of Global Fund funding through the C19RM to support response to the pandemic in your country?
  2. For any applications your country has made for C19RM post 2021, can you share views on aspects that have worked well and less well with regards to the requirements and processes instituted by the Global Fund? *Probe for:*
    - a. *Adequacy of C19RM processes to country context, needs and operations, including C19RM allocation, technical guidance, timelines for approvals, review process, in-country requirements in terms of relevant bodies that need engagement and sign-off, etc*
    - b. *Effectiveness of post 2021 C19RM changes in supporting country programs adaptations and agility needs during COVID-19*
  3. To what extent have C19RM interventions contributed to mitigating the effect of COVID-19 on the three disease program outcomes in country? *Probe for:*
    - a. *Contribution of C19RM to mitigating the impact of COVID-19 on HTM in country*
    - b. *Contribution of C19RM to RSSH and community systems strengthening in country*
    - c. *Please provide some examples of interventions that have supported (or hindered) results*
- (v) *Technical Partners: WHO, UNAIDS, etc*

*Please use this guide for TA partners in country, focusing on Qs 1-3, and where they are able to comment on the standard questions included in the master interview guide (Qs 4 onwards). Please note that it is expected that WHO in particular will be able to cover most questions here, but for other partners you may focus on Qs 1-6 + Qs 14.*

1. **Introduction:** What has been your role in supporting or collaborating with Global Fund investments in-country?
2. **Partnerships – TA:** What has worked well and less well in terms of technical assistance (TA) support for Global Fund investments in country? What are key aspects for improvement?
3. **Partnerships – donor funding:** To what extent is there adequate coordination between Global Fund and other donors of HTM (US government in particular)? What are key aspects for improvement?
4. **Relevance of investments:** Looking back at Grant Cycles 5 and 6, to what extent have Global Fund investments in [country name] been relevant to country needs and priorities with regards to HTM? To what extent have Global Fund investments in country focused on interventions that deliver the most impact and best value for money? *Probe for:*
  - a. *Consideration of contextual factors (HTM epidemiological profile, socio-economic context etc.)*
  - b. *Appropriate and balanced funding of current and emerging disease priorities (e.g., emerging TB and malaria drug resistance, HIV prevention vs treatment programs)*

- c. *Adequate consideration of health and community systems needs through RSSH grants*
  - d. *Adequate consideration of systems issues, integration, people centred approaches*
  - e. *Incorporation of key considerations for key, vulnerable and underserved populations, including with regards to human rights and gender*
  - f. *Consideration for balance between funding innovative products and approaches vs. already established products and approaches*
  - g. *Consideration of Global Fund support in relation to what others are funding in the country (government and other donors)*
5. **Investment results in country:** Over Grant Cycle 5 and 6, what do you view as the biggest areas of progress achieved through Global Fund support? *Probe for:*
- a. *Key programmatic results across HTM diseases including during COVID-19*
  - b. *Reasons for over and under performance*
  - c. *Degree of contribution of Global Fund interventions to country progress and change in key disease indicators (e.g., incidence)*
  - d. *Grant performance framework efficacy in measuring and managing country progress against diseases and targets.*
6. **Funding model and business processes:** How well does the Global Fund funding model<sup>5</sup> support effective prioritisation and implementation of country programs and interventions to deliver against targets? *Probe for:*
- a. *Adequacy and effectiveness of Global Fund funding cycle to country applications (including efficacy of country dialogues and Funding Request prioritisation and development, CCM representation and engagement by members (and especially health systems stakeholders beyond HTM and CSO/ CBOs), adequacy of guidelines forms and templates, TRP review process, efficacy of grant making, support received through Global Fund Secretariat and technical partners, etc.)*
  - b. *Adequacy and effectiveness of grant implementation processes in country including PR reporting, grant financial management processes, and other key processes including disbursements, revisions and grant closure.*
  - c. *Aspects that work well and less well with regards to funding model for RSSH investments in country.*
  - d. *Funding model contribution or hinderance towards reduction of human rights related barriers (including those related to key, vulnerable and underserved populations) and advancement of gender equality in country.*
  - e. *Is the model sufficiently tailored for your country and flexible in relation to your needs?*
  - f. *What are key areas that you would propose be reformed by the Global Fund going forward?*
7. **Sustainability** What are positive achievements and/ or key issues with regards to country takeover of aspects funded through the Global Fund? What do you view as helpful aspects of the Global Fund model as a whole that foster long run sustainability? *Probe for:*
- a. *Effective engagement of key country stakeholders from the onset of country investments (i.e., grant design) to ensure financial and programmatic sustainability*
  - b. *Availability and use of quality health financing strategies, sustainability plans and transition readiness assessments in country*

<sup>5</sup> The Global Fund funding model pertains to the funding cycle stages and processes (including application, implementation, closure), structures involved (e.g. CCM, TRP, PRs, LFAs) and key characteristics such as differentiation, three-year funding cycles, continuity of programme funding.

- c. *Access to data/ trends in domestic financing for health and HTM specific funding where possible (ideally beyond commitments to also cover expenditures) and Global Fund's contribution to observed progress.*
  - d. *Views on the relevance/ appropriateness of Global Fund's approach to country co-financing and transition*
  - e. *[if possible, interviewer to validate domestic funding analysis that came from the document review, as documentation may not be up to date/comprehensive]*
8. **Risk management:** What is your view on whether the Global Fund appropriately manages risks for its funding in relation to supporting the most needed/ impactful programmes in country? *Probe for:*
  - a. *Would you like to share specific instances where you thought the Global Fund was focusing too much on financial risk at the cost of programme suitability?*
  - b. *What is your perception on how Global Fund approaches the C19RM pandemic response in terms of being more (or adequately) risk prone given the circumstances?*
  - c. *Do you think the Global Fund's approach to risk impedes participation of CSO/ CBOs in grant implementation? Could you highlight aspects that support their participation and those that hinder?*
9. **M&E:** What works well & less well with regards to the Global Fund's M&E requirements on countries? *Probe for:*
  - a. *In your assessment, does the M&E support funding decision-making and progress assessment adequately?*
  - b. *Are the M&E requirements adequately aligned with country systems?*
  - c. *Does the Global Fund adequately support innovations in M&E to improve efficiency (e.g. digitalisation, performance-based funding, where relevant)?*
10. **C19RM:** For any applications your country has made for C19RM post 2021, can you share views on aspects that have worked well and less well with regards to the requirements and processes instituted by the Global Fund? *Probe for:*
  - a. *Adequacy of C19RM processes to country context, needs and operations, including C19RM allocation, technical guidance, timelines for approvals, review process, in-country requirements in terms of relevant bodies that need engagement and sign-off, etc*
  - b. *Effectiveness of post 2021 C19RM changes in supporting country programs adaptations and agility needs during COVID-19*
11. **C19RM:** To what extent have C19RM interventions contributed to mitigating the effect of COVID-19 on the three disease program outcomes in country? *Probe for:*
  - a. *Contribution of C19RM to mitigating the impact of COVID-19 on HTM in country*
  - b. *Contribution of C19RM to RSSH and community systems strengthening in country*
  - c. *Please provide some examples of interventions that have supported (or hindered) results*
12. **Catalytic Investments:** We understand that [country] has benefitted from the following funding over and above what is delivered through the Global Fund country allocation: [list SI, MCC, MF for the country] *Probe for:*



- a. *What do you view as the value add of this funding? (e.g. additional to allocation funding, not funded by other partners, support needed for priorities that would otherwise be unfunded, supports TA needs, incentivises other partners' investments etc.)*
- b. *What was your experience in accessing this funding?*
- c. *To what extent has this funding been coordinated with the core allocation funding from the Global Fund?*
- d. *To what extent and how do you think this funding has been "catalytic"?*
- e. *To what extent is any 'catalytic effect' also sustainable, and what does this require?*
- f. *Do you have any views on how the catalytic effect of this funding has been or could be best measured?*
- g. *For MFs in particular, does this support increase government spending in the area?*
- h. *How could we better utilise Catalytic Investments to optimise future gains?*

**13. Gender, human rights, equity & communities (crosscutting):** What aspects of the Global Fund funding model have facilitated and hindered efforts to reduce human rights related barriers, advance gender equality, enhance health equity and promote communities' needs and responses in country? *Probe for:*

- a. *Evidence of Global Fund contribution to reducing human rights related barriers and advancing gender equality, health equity and responsiveness to communities' needs at country level.*
- b. *What are supporting and hindering (internal or external) factors?*

#### *Forward looking/ recommendations*

**14. Recommendations:** Please provide your top 3-4 suggestions for the Global Fund's support to your country in the future?

(vi) **Donors:** USAID, PEPFAR, PMI, BMGF, Other Bilateral Donors, etc.

1. **Partnerships – donor funding:** To what extent is there adequate coordination between Global Fund and other donors of HTM (US government in particular)? What are key aspects for improvement?
2. **Partnerships – TA:** What has worked well and less well in terms of technical assistance (TA) support for Global Fund investments in country? What are key aspects for improvement?
3. **Relevance of investments:** Looking back at Grant Cycles 5 and 6, to what extent have Global Fund investments in [country name] been relevant to country needs and priorities with regards to HTM? To what extent have Global Fund investments in country focused on interventions that deliver the most impact and best value for money? *Probe for:*
  - a. *Consideration of contextual factors (HTM epidemiological profile, socio-economic context etc.)*
  - b. *Appropriate and balanced funding of current and emerging disease priorities (e.g., emerging TB and malaria drug resistance, HIV prevention vs treatment programs)*
  - c. *Adequate consideration of health and community systems needs through RSSH grants*
  - d. *Adequate consideration of systems issues, integration, people centred approaches*
  - e. *Incorporation of key considerations for key, vulnerable and underserved populations, including with regards to human rights and gender*
  - f. *Consideration for balance between funding innovative products and approaches vs. already established products and approaches*

- g. Consideration of Global Fund support in relation to what others are funding in the country (government and other donors)*
4. **Investment results in country:** Over Grant Cycle 5 and 6, what do you view as the biggest areas of progress achieved through Global Fund support? *Probe for:*
- a. Key programmatic results across HTM diseases including during COVID-19*
  - b. Reasons for over and under performance*
  - c. Degree of contribution of Global Fund interventions to country progress and change in key disease indicators (e.g., incidence)*
  - d. Grant performance framework efficacy in measuring and managing country progress against diseases and targets.*
5. **Funding model and business processes:** How well does the Global Fund funding model<sup>6</sup> support effective prioritisation and implementation of country programs and interventions to deliver against targets? *Probe for:*
- a. Adequacy and effectiveness of Global Fund funding cycle to country applications (including efficacy of country dialogues and Funding Request prioritisation and development, CCM representation and engagement by members (and especially health systems stakeholders beyond HTM and CSO/ CBOs), adequacy of guidelines forms and templates, TRP review process, efficacy of grant making, support received through Global Fund Secretariat and technical partners, etc.)*
  - b. Adequacy and effectiveness of grant implementation processes in country including PR reporting, grant financial management processes, and other key processes including disbursements, revisions and grant closure.*
  - c. Aspects that work well and less well with regards to funding model for RSSH investments in country.*
  - d. Funding model contribution or hinderance towards reduction of human rights related barriers (including those related to key, vulnerable and underserved populations) and advancement of gender equality in country.*
  - e. Is the model sufficiently tailored for your country and flexible in relation to your needs?*
  - f. What are key areas that you would propose be reformed by the Global Fund going forward?*
6. **C19RM:** To what extent have C19RM interventions contributed to mitigating the effect of COVID-19 on the three disease program outcomes in country? *Probe for:*
- a. Contribution of C19RM to mitigating the impact of COVID-19 on HTM in country*
  - b. Contribution of C19RM to RSSH and community systems strengthening in country*
  - c. Please provide some examples of interventions that have supported (or hindered) results*
7. **Recommendations:** Please provide your top 3-4 suggestions for the Global Fund's support to your country in the future?
- (vii) Health systems stakeholders*

*This guide would be relevant for RSSH PRs/ SRs and other government departments covering health systems functions (e.g. procurement, data, etc.)*

<sup>6</sup> The Global Fund funding model pertains to the funding cycle stages and processes (including application, implementation, closure), structures involved (e.g. CCM, TRP, PRs, LFAs) and key characteristics such as differentiation, three-year funding cycles, continuity of programme funding.

### *Background*

1. Could you describe the health systems situation in your country in terms of key progress areas and gaps?

### *Relevance of RSSH investments*

2. What are the main areas of funding for health systems through the Global Fund grants? Do you view these as adequate in relation to the needs and priorities for health systems development in your country?
3. What is your assessment on what aspects of the health system the Global Fund should be funding in your country and why? Please comment based on your understanding of the added value of the Global Fund in country, and what others such as the government and other donors are funding in country.

### *Results from RSSH grants*

4. What are the main results achieved in country through RSSH investments? Could you comment on key reasons for over and under performance?
5. Do you view the HTM focused grants as supporting health systems overall? Do you think Global fund investments in country adequately support people-centred and integrated approaches? What more could be done to support these objectives?
6. Do you view the Global Fund investments as “strengthening” health systems or mainly funding recurrent operational costs?

### *Funding model*

7. What aspects of the Global Fund funding model work well and less well with regards to supporting RSSH investments in country? *(including efficacy of country dialogues and Funding Request prioritisation and development, CCM representation and engagement by members (and especially health systems stakeholders beyond HTM and CSO/ CBOs), adequacy of guidelines forms and templates, TRP review process, efficacy of grant making, support received through Global Fund Secretariat and technical partners, PR reporting, grant financial management processes, and other key processes including disbursements, revisions and grant closure, etc.)*
8. Does the design of Global Fund RSSH investments adequately consider sustainability? Please explain how or how not?
9. What is your view on whether the Global Fund appropriately manages risks for its funding in relation to supporting the most needed/ impactful programmes in country? *Probe for:*
  - a. *Would you like to share specific instances where you thought the Global Fund was focusing too much on financial risk at the cost of programme suitability?*
10. What works well & less well with regards to the Global Fund’s M&E requirements on countries? *Probe for:*

- a. *In your assessment, does the M&E support funding decision-making and progress assessment adequately?*
- b. *Are the M&E requirements adequately aligned with country systems?*
- c. *Does the Global Fund adequately support innovations in M&E to improve efficiency (e.g. digitalisation, performance-based funding, where relevant)?*

### *Partnerships*

11. What has worked well and less well in terms of technical assistance (TA) support for Global Fund investments in RSSH in country? What are key aspects for improvement?
12. To what extent is there adequate coordination between Global Fund and other donors for health systems (US government in particular)? What are key aspects for improvement?

### *Recommendations*

13. Please provide your top 3-4 suggestions for the Global Fund's support to your country in the future?

*(viii) Civil society and communities (PRs and SRs only)*

1. **Background:** Please describe the investment/ activities that you are responsible for implementing?
2. **Gender, human rights, equity & communities (crosscutting):** What aspects of the Global Fund funding model have facilitated and hindered efforts to reduce human rights related barriers, advance gender equality, enhance health equity and promote communities' needs and responses in country? *Probe for:*
  - a. *Evidence of Global Fund contribution to reducing human rights related barriers (including those related to key, vulnerable and underserved populations) and advancing gender equality, health equity and responsiveness to communities' needs at country level.*
  - b. *How are these outcomes being assessed / measured? And what are the strengths and challenges related to this?*
  - c. *What were the key enabling factors (internal / Global Fund or external) of these outcomes?*
  - d. *What, if any, factors (internal / Global Fund or external) have hindered efforts to reduce human rights related barriers (including those related to key, vulnerable and underserved populations) and advance gender equality, health equity and responsiveness to communities' needs at country level?*
3. **Funding model:** What has been your experience in contributing to the design of the investment/ activities through engagement in the country dialogue with the CCM and grant making? Do you have any specific suggestions to improve this process from your perspective?
4. **Funding model:** What has been your experience in implementing the investment/ activities in terms of key issues faced in country during implementation as well as in terms of responding to Global Fund requirements (e.g. M&E and financial reporting)? Do you have any specific suggestions to improve this process from your perspective?
5. **Relevance of investments:** Do you view the Global Fund as adequately funding the key needs and priorities for key, vulnerable and underserved populations, including with regards to human rights and gender as well as overall community systems strengthening in your

country? Please provide a response that is also cognizant of what else is being funded by the government and other donors?

6. **Progress/ results:** What have been key results and progress supported through your investment/ activities? *Probe for:*
  - i. *Key programmatic results across HTM diseases including during COVID-19*
  - j. *Reasons for over and under performance*
  - k. *Have there been any challenges with regard to the grant performance target setting (e.g., selected indicators do not match supported interventions, data quality concerns, targets considered to be too ambitious / not ambitious enough)*
  - l. *Extent to which Global Fund M&E requirements capture the right results?*
7. **Sustainability** What are positive achievements and/ or key issues with regards to country takeover of aspects funded through the Global Fund? What do you view as helpful aspects of the Global Fund model as a whole that foster long run sustainability? *Probe for:*
  - a. *Effective engagement of key country stakeholders from the onset of country investments (i.e., grant design) to ensure financial and programmatic sustainability*
  - b. *Availability and use of quality health financing strategies, sustainability plans and transition readiness assessments in country*
  - c. *Access to data/ trends in domestic financing for health and HTM specific funding where possible (ideally beyond commitments to also cover expenditures) and Global Fund's contribution to observed progress.*
  - d. *Views on the relevance/ appropriateness of Global Fund's approach to country co-financing and transition*
8. **Recommendations:** Please provide your top 3-4 suggestions for the Global Fund's support to your country in the future to better support key needs and priorities for key, vulnerable and underserved populations, including with regards to human rights and gender?  
*(ix) Civil society and communities (Non-PRs)*
  1. Please describe the main areas of your work in country in relation to HTM and health and community systems development?
  2. Have you been approached for funding through Global Fund grants previously? If not, why not? If yes, why didn't the funding go through?
  3. Do you view the Global Fund as adequately funding the key needs and priorities for key, vulnerable and underserved populations, including with regards to human rights and gender as well as overall community systems strengthening in your country? Please provide a response that is also cognizant of what else is being funded by the government and other donors?
  4. What aspects of the Global Fund funding model have facilitated and hindered efforts to reduce human rights related barriers, advance gender equality, enhance health equity and promote communities' needs and responses in country? *Probe for:*
    - a. *Evidence of Global Fund contribution to reducing human rights related barriers (including those related to key, vulnerable and underserved populations) and advancing gender equality, health equity and responsiveness to communities' needs at country level.*
    - b. *What were the key enabling factors (internal / Global Fund or external) of these outcomes?*



- c. *What, if any, factors (internal / Global Fund or external) have hindered efforts to reduce human rights related barriers (including those related to key, vulnerable and underserved populations) and advance gender equality, health equity and responsiveness to communities' needs at country level?*
5. Please provide your top 3-4 suggestions for the Global Fund's support to your country in the future to better support key needs and priorities for key, vulnerable and underserved populations, including with regards to human rights and gender?  
(x) *Local Fund Agent (LFA)*
1. What has been your experience as LFA in [country name] in terms of key issues in the implementation of Global Fund grants in country by the range of implementers/ PRs/ SRs?
2. **Investment results in country:** Over Grant Cycle 5 and 6, what do you view as the biggest areas of progress achieved through Global Fund support? *Probe for:*
  - a. *Key programmatic results across HTM diseases including during COVID-19*
  - b. *Reasons for over and under performance*
  - c. *Degree of contribution of Global Fund interventions to country progress and change in key disease indicators (e.g., incidence)*
  - d. *Grant performance framework efficacy in measuring and managing country progress against diseases and targets.*
3. **Risk management:** What is your view on whether the Global Fund appropriately manages risks for its funding in relation to supporting the most needed/ impactful programmes in country? *Probe for:*
  - a. *Would you like to share specific instances where you thought the Global Fund was focusing too much on financial risk at the cost of programme suitability?*
  - b. *What is your perception on how Global Fund approaches the C19RM pandemic response in terms of being more (or adequately) risk prone given the circumstances?*
  - c. *Do you think the Global Fund's approach to risk impedes participation of CSO/ CBOs in grant implementation? Could you highlight aspects that support their participation and those that hinder?*
4. **M&E:** What works well & less well with regards to the Global Fund's M&E requirements on countries? Is the process to set grant performance targets effective and leads to the right selection of indicators and targets? *Probe for:*
  - a. *Are the M&E requirements adequately aligned with country systems?*
  - b. *Have there been any challenges with regard to the grant performance target setting (e.g., selected indicators do not match supported interventions, data quality concerns, targets considered to be too ambitious / not ambitious enough)*
  - c. *In your assessment, does the M&E support funding decision-making and progress assessment adequately?*
  - d. *Does the Global Fund adequately support innovations in M&E to improve efficiency (e.g. digitalisation, performance-based funding, where relevant)?*
5. **Funding model and business processes:** How well does the Global Fund funding model<sup>7</sup> support effective prioritisation and implementation of country programs and interventions to deliver against targets? *Probe for:*

<sup>7</sup> The Global Fund funding model pertains to the funding cycle stages and processes (including application, implementation, closure), structures involved (e.g. CCM, TRP, PRs, LFAs) and key characteristics such as differentiation, three-year funding cycles, continuity of programme funding.

- a. *Adequacy and effectiveness of Global Fund funding cycle to country applications (including efficacy of country dialogues and Funding Request prioritisation and development, CCM representation and engagement by members (and especially health systems stakeholders beyond HTM and CSO/ CBOs), adequacy of guidelines forms and templates, TRP review process, efficacy of grant making, support received through Global Fund Secretariat and technical partners, etc.)*
  - b. *Adequacy and effectiveness of grant implementation processes in country including PR reporting, grant financial management processes, and other key processes including disbursements, revisions and grant closure.*
  - c. *Aspects that work well and less well with regards to funding model for RSSH investments in country.*
  - d. *Funding model contribution or hinderance towards reduction of human rights related barriers (including those related to key, vulnerable and underserved populations) and advancement of gender equality in country.*
  - e. *Is the model sufficiently tailored for your country and flexible in relation to your needs?*
  - f. *What are key areas that you would propose be reformed by the Global Fund going forward?*
6. **Sustainability** What are positive achievements and/ or key issues with regards to country takeover of aspects funded through the Global Fund? What do you view as helpful aspects of the Global Fund model as a whole that foster long run sustainability? *Probe for:*
- a. *Effective engagement of key country stakeholders from the onset of country investments (i.e., grant design) to ensure financial and programmatic sustainability*
  - b. *Availability and use of quality health financing strategies, sustainability plans and transition readiness assessments in country*
  - c. *Access to data/ trends in domestic financing for health and HTM specific funding where possible (ideally beyond commitments to also cover expenditures) and Global Fund's contribution to observed progress.*
  - d. *Views on the relevance/ appropriateness of Global Fund's approach to country co-financing and transition*
  - e. *[if possible, interviewer to validate domestic funding analysis that came from the document review, as documentation may not be up to date/comprehensive]*
7. **C19RM:** For any applications your country has made for C19RM post 2021, can you share views on aspects that have worked well and less well with regards to the requirements and processes instituted by the Global Fund? *Probe for:*
- a. *Adequacy of C19RM processes to country context, needs and operations, including C19RM allocation, technical guidance, timelines for approvals, review process, in-country requirements in terms of relevant bodies that need engagement and sign-off, etc*
  - b. *Effectiveness of post 2021 C19RM changes in supporting country programs adaptations and agility needs during COVID-19*
8. **C19RM:** To what extent have C19RM interventions contributed to mitigating the effect of COVID-19 on the three disease program outcomes in country? *Probe for:*
- a. *Contribution of C19RM to mitigating the impact of COVID-19 on HTM in country*
  - b. *Contribution of C19RM to RSSH and community systems strengthening in country*
  - c. *Please provide some examples of interventions that have supported (or hindered) results*



9. **Catalytic Investments:** We understand that [country] has benefitted from the following funding over and above what is delivered through the Global Fund country allocation: [list SI, MCC, MF for the country] Probe for:
- m. What do you view as the value add of this funding? (e.g. additional to allocation funding, not funded by other partners, support needed for priorities that would otherwise be unfunded, supports TA needs, incentivises other partners' investments etc.)*
  - n. What was your experience in accessing this funding?*
  - o. To what extent has this funding been coordinated with the core allocation funding from the Global Fund?*
  - p. To what extent and how do you think this funding has been "catalytic"?*
  - q. To what extent is any 'catalytic effect' also sustainable, and what does this require?*
  - r. Do you have any views on how the catalytic effect of this funding has been or could be best measured?*
  - s. For MFs in particular, does this support increase government spending in the area?*
  - t. How could we better utilise Catalytic Investments to optimise future gains?*
10. **Gender, human rights, equity & communities (crosscutting):** What aspects of the Global Fund funding model have facilitated and hindered efforts to reduce human rights related barriers, advance gender equality, enhance health equity and promote communities' needs and responses in country? Probe for:
- a. Evidence of Global Fund contribution to reducing human rights related barriers (including those related to key, vulnerable and underserved populations) and advancing gender equality, health equity and responsiveness to communities' needs at country level.*
  - b. How are these outcomes being assessed / measured? And what are the strengths and challenges related to this?*
  - c. What were the key enabling factors (internal / Global Fund or external) of these outcomes?*
  - d. What, if any, factors (internal / Global Fund or external) have hindered efforts to reduce human rights related barriers (including those related to key, vulnerable and underserved populations) and advance gender equality, health equity and responsiveness to communities' needs at country level?*
11. **Recommendations:** Please provide your top 3-4 suggestions for the Global Fund's support to your country in the future?

### i) Evaluation matrix

The evaluation matrix is presented in Table D.1. This provides an overview of all evaluation objectives, workstreams, SRQs, key issues and methods that will be employed. Methods are colour shaded to reflect the degree of importance to the SRQ (green=critical use, orange=significant/ moderate use, red=limited/no use). The evaluation matrix should be considered alongside Appendix C which describes the evaluation methodology in detail, and complements Section 1.2 in the main report.

Table D.1 Evaluation matrix

WS	Strategic Review Question	Key issues	Methods				
			Document review	KIIs	Quantitative data analysis	Country case studies	Topic-specific case studies
Objective 1: Achievement of SOs	WS1: Relevance	<b>SRQ1.1:</b> To what extent are the programmes and activities supported by the Global Fund addressing the key epidemiological and country needs and priorities to advance progress on HIV, TB and malaria? To what extent were Global Fund investments funding programmes and activities which are the most impactful and provide the most value for money? <ul style="list-style-type: none"> <li>Alignment to country needs, country plans and health systems</li> <li>Extent of support for current and emerging disease priorities</li> <li>Relevance and appropriateness of RSSH funding</li> <li>Relevance and appropriateness of funding for KPs and HR&amp;GE more generally</li> <li>Extent of VfM considerations</li> </ul>	Review of multiple Global Fund documents including the Strategy, country guidance documents and previous evaluations Particular emphasis on the TRP reports over the strategy period	Interviews with the range of stakeholders and particularly the Global Fund Secretariat country facing teams (e.g., GMD), TRP members and technical partners	Review of Global Fund funding data to analyse funding of priority interventions and how this is distributed by portfolio (high impact, core, focus), region and disease Review of segmented RSSH funding and expenditure data over time Review of key Global Fund KPIs Segmentation analysis or stratification analysis to compare different sub-groups	Key source of information, analysed country funding requests and engaged with country stakeholders to understand if the most relevant and VfM aspects are being funded, as well as enabling and impeding factors to the selection of interventions Systematic review of country findings, organised by key theme/ factor driving performance and assessment of key country characteristics to	Light-touch review of Gavi's approach to prioritising interventions which provide the most VfM to derive any lessons for the Global Fund

WS	Strategic Review Question	Key issues	Methods				
			Document review	KIIs	Quantitative data analysis	Country case studies	Topic-specific case studies
						attempt to explain these trends	
WS2: Results	<b>SRQ2.1:</b> To what extent has the Global Fund met its Strategic Objectives for 2017-22? How and why has performance varied by region and high impact countries?	<ul style="list-style-type: none"> <li>• Performance against KPIs and significance of progress achieved given global disease plans, SDGs, etc.</li> <li>• Variations in performance</li> <li>• Enabling and hindering factors</li> <li>• Process of country target setting</li> </ul>	<p>Review of multiple Global Fund documents with a focus on the KPI framework and results reporting alongside global disease strategies (outlining plans, targets, results)</p> <p>External reviews of the Global Fund (e.g., MOPAN review)</p> <p>Previous Global Fund evaluations for evidence on progress and trend variations</p>	Interviews with the range of stakeholders, particularly partners to interpret significance of results and country focused consultees (Secretariat, partners) to understand variations in trends	<p>Review of country progress data to understand trends in KPIs and grant performance – by portfolio (high impact, core, focus), region, disease burden, absorption levels, grant performance, country funding levels, etc.</p> <p>Analysis of available coverage, incidence and mortality statistics which are publicly available (e.g., WHO, UNAIDS data)</p> <p>Segmentation analysis or stratification analysis to compare different sub-groups</p> <p>Statistical (including regression) analysis to understand</p>	<p>Feedback from country stakeholders on progress across key outcome and impact indicators and identification of enabling and hindering factors with regards to performance</p> <p>Systematic review of country findings, organised by key theme/ factor driving performance and assessment of key country characteristics to attempt to explain these trends</p>	n/a

WS	Strategic Review Question	Key issues	Methods				
			Document review	KIs	Quantitative data analysis	Country case studies	Topic-specific case studies
					drivers of results (see Appendix J)		
Objective 2: Role of strategic levers	WS3: Funding model and business processes	<b>SRQ3.1:</b> To what extent did the funding model support prioritization and implementation to support the achievement of the strategy targets? <ul style="list-style-type: none"> <li>• Adequacy and effectiveness of the funding cycle (all key processes, structures involved)</li> <li>• Effectiveness in supporting investment prioritisation, implementation</li> <li>• What works well/less well for RSSH and HR&amp;G</li> </ul>	Funding model description based on Global Fund documentation  Funding model reviews – SR2020, TERG reviews, OIG audits as well as external reviews such as MOPAN 2022	Interviews with the range of Secretariat teams engaged in different aspects of the funding model (A2F and TAP on design, GMD on implementation, PMD on monitoring, etc.) as well as users/ observers such as technical partners, donors and CSOs/ CBOs	n/a (to our understanding timeliness of grant cycle steps has been analysed adequately previously)	Interviews with country stakeholders to understand outstanding issues and best practice with regards to the funding model	n/a
		<b>SRQ3.2:</b> How did the Global Fund policies and related processes support country disease program planning, prioritisation and implementation? <ul style="list-style-type: none"> <li>• What works well/less well in supporting country planning, prioritisation in terms of both the formal Board approved policies and the information included in the Operations Manual</li> <li>• Awareness and understanding of policy framework and perceptions of formal/informal policies</li> <li>• Extent of progress on recommendations made in previous TERG and OIG</li> </ul>	Review of policy documents and previous evaluations of policies	Consultations with Global Fund Secretariat staff familiar with the policies (SPH, TAP, GMD) and wider consultations to understand the interaction between formal and informal policies (e.g., partners)	n/a (document review will cover the results of policies such as the Eligibility Policy and Allocation Methodology and we would not review the underlying data)	Limited consultations to understand implications of the policies, based on stakeholder awareness/ understanding	n/a

WS		Strategic Review Question	Key issues	Methods				
				Document review	KIIs	Quantitative data analysis	Country case studies	Topic-specific case studies
			reviews on Global Fund policies and processes					
		<b>SRQ3.3:</b> To what extent has the implementation of the Global Fund’s Sustainability, Transition and Co-financing (STC) policy and other aspects of its business model facilitated prioritisation and actual increased domestic investments in national responses to the three diseases and RSSH?	<ul style="list-style-type: none"><li>• Extent factored into grant design and engagement of key stakeholders</li><li>• Adequacy of tools and support</li><li>• Co-financing and incentives</li><li>• Progress on recommendations from TERG review of STC policy</li></ul>	Review of several Global Fund documents including funding model related documents that cover sustainability issues, the STC policy, and reviews in the area by the TERG and OIG	Consultations with Secretariat health financing and country teams primarily, but also wider funding model and policy teams Consultations with technical partners and donors (PEPFAR, PMI, World Bank, WHO etc.)	Review of the performance against KPI 11 on domestic health financing including an assessment of the quality of the underlying data Analysis of high-level trends in domestic health expenditure using WHO / World Bank data, where available; builds on existing analyses conducted by the Global Fund health financing team Review of domestic funding analysis specifically for the three diseases which have been conducted by the Global Fund health financing team Segmentation analysis or	Feedback from country stakeholders on sustainability drivers within the Global Fund business model and country specific factors Systematic review of country findings, organised by key theme/ factor driving performance and assessment of key country characteristics to attempt to explain these trends	Review of Gavi approaches to co-financing and transition to identify key lessons on offer for the Global Fund

WS	Strategic Review Question	Key issues	Methods				
			Document review	KIIs	Quantitative data analysis	Country case studies	Topic-specific case studies
WS3: Funding model and business processes					stratification analysis to compare different sub-groups		
	<b>SRQ3.4:</b> How has the Global Fund leveraged the Risk Management Framework and Board approved Risk Appetite and to what extent have risk trade-off decisions impacted effective implementation of Global Fund programs and initiatives?	<ul style="list-style-type: none"> <li>• How applied in practice and any challenges for program implementation and impact</li> <li>• Management of risk-related trade-offs</li> <li>• Implications of C19RM, performance-based financing, CSOs/ CBOs as implementing organisations in country</li> </ul>	Review of Global Fund key risk-related documents (Risk Management Framework, Risk Appetite, annual report)	Consultation with risk management team at the Secretariat	n/a	Feedback from country stakeholders—specifically views on whether C19 response was well balanced from a risk perspective as well as Global Fund factors impacting inclusion of CSOs/ CBOs in country implementation arrangements	
	<b>SRQ3.5:</b> To what extent did the Global Fund's approach to M&E meet the decision-making needs of stakeholders responsible for delivering on strategy objectives? How has the Global Fund M&E evolved since the SR2020?	<ul style="list-style-type: none"> <li>• Challenges with the previous M&amp;E framework and the extent to which the new approach could potentially address these</li> <li>• Innovations in M&amp;E</li> <li>• Alignment of M&amp;E to country systems. quality assurance, use of data in practise</li> <li>• Extent is supporting strategic decision making and assessment of programmatic performance</li> </ul>	Review of key documents on 2017-22 Strategy M&E such as the KPI framework and modular framework Review of new M&E framework for the 2023-28 Strategy	<p>Focused consultations with Secretariat M&amp;E teams (PMD as a whole, but also M&amp;E managers within GMD)</p> <p>Consultations with key technical partners (WHO, UNAIDS, Stop TB, RBM)</p>	n/a	Analysis of country M&E frameworks and reporting, and any issues thereof, supplemented by soliciting feedback from country stakeholders on what works well and less well with Global Fund's approach to M&E	n/a

	WS	Strategic Review Question	Key issues	Methods				
				Document review	KIs	Quantitative data analysis	Country case studies	Topic-specific case studies
Objective 2: Role of strategic levers			<ul style="list-style-type: none"> <li>Build on 2023 TERG Evaluation on Data Driven Decision Making</li> </ul>					
		<b>SRQ3.6:</b> To what extent have the recommendations from SR2020, related to the focus areas of SR2023, been incorporated into 1) policies and processes for the second half of the 2017-2022 Strategy period, and 2) 2023-2028 Strategy, and to what extent has this enabled coherence, agility and flexibility in the transition across strategy periods? ?	<ul style="list-style-type: none"> <li>Extent of follow up/ implementation of SR2020 recommendations over the second half of the 2017-22 Strategy period and in the new 2023-28 Strategy</li> </ul>	Review of SR2020 and Secretariat response and TERG position paper Review of any Global Fund documents covering improvements since SR2020 Review of new Global Fund Strategy 2023-28 Review of OIG audit report on Global Fund readiness to implement the new strategy (including drafts before finalization to allow integration with SR2023 report timelines)	Consultations with Secretariat and external partners on specific aspects regarding key SR2020 recommendations and progress against them	n/a	n/a	n/a
	WS4: C19RM	<b>SRQ4.1:</b> To what extent have the post 2021 changes to C19RM contributed or hindered effective implementation of	<ul style="list-style-type: none"> <li>Adequacy of changes introduced since 2021</li> <li>Lessons in terms of agility/ speed and variations from standard GF model</li> </ul>	Review of key Global Fund documents on C19RM, including Board documents, guidance	Consultations with Secretariat staff involved in C19RM alongside key partners (e.g.,	Data analysis of C19RM approved funding, disbursement and absorption by category (e.g.,	Country stakeholder consultations to solicit feedback on what works well and	n/a



WS	Strategic Review Question	Key issues	Methods				
			Document review	KIIs	Quantitative data analysis	Country case studies	Topic-specific case studies
	Global Fund C19RM investments?		documents, progress reports, etc.  Review of previous reviews conducted through the TERG and OIG  Review of ACT-A and other partner material as relevant	within the ACT-A framework)	mitigation, health products and community & RSSH)  Segmentation analysis or stratification analysis to compare different sub-groups	less well with the C19RM design  Expand consultee list beyond HTM stakeholders to cover those directly relevant to COVID e.g., Incident Manager, Emergency Centre, COVID-19 Response Coordinating Body, Working Groups	
	<b>WS4: C19RM</b>  <b>SRQ4.2:</b> How effectively have the interventions supported by C19RM contributed to mitigating the effect of COVID-19 on the three disease program outcomes? How and to what extent were they leveraged for health and community systems strengthening?	<ul style="list-style-type: none"> <li>• Contribution of C19RM in mitigating effects of Covid-19 on HTM</li> <li>• Contribution to, and extent C19RM was leveraged for RSSH and CSS</li> </ul>	Review of previous reviews conducted through the TERG and OIG  Monthly Board updates on C19RM (e.g., where country case studies are included such as April 2022)	Consultations with Secretariat staff involved in C19RM alongside key partners (e.g., within the ACT-A framework)	Data analysis of C19RM approved funding, disbursement and absorption by category (e.g., mitigation, health products and CSS & RSSH)  Analysis of the share of C19RM funding to RSSH and CSS compared to regular HTM funding allocations to these areas  Review of impact figures from the Global Fund Secretariat (e.g.,	Country stakeholder consultations to solicit feedback on key areas of progress on HTM, RSSH and CSS  Expand consultee list beyond HTM stakeholders to cover those directly relevant to COVID e.g., Incident Manager, emergency Centre, COVID-19 Response Coordinating Body, Working Groups  Systematic review of country findings,	n/a

WS	Strategic Review Question	Key issues	Methods				
			Document review	KIIs	Quantitative data analysis	Country case studies	Topic-specific case studies
					work commissioned to Imperial estimating health impact of interventions) Segmentation analysis or stratification analysis to compare different sub-groups Statistical (including regression) analysis to understand whether there is a positive association between C19RM funding and grant achievement (see Appendix J)	organised by key theme/ factor driving performance and assessment of key country characteristics to attempt to explain these trends	
	<b>WS5:</b> Catalytic investments	<b>SRQ5.1:</b> How did the Global Fund advance findings and recommendations of the thematic evaluations on Strategic Initiatives and Catalytic Multi-Country Grants of 2021-22?  <ul style="list-style-type: none"> <li>• Progress on findings and recommendations from TERG evaluations of CI and MCGs and linkage with new Strategy work</li> <li>• Definition of 'catalytic'</li> <li>• Harmonisation across CI and between CIs and broader GF portfolio</li> <li>• Prioritisation of areas for CIs</li> </ul>	Key evaluation documents (TERG reviews and management responses) Relevant policies, guidelines and tools Current MCG and SI design and implementation documents	Consultations with Secretariat teams (SPH, GMD) Consultations with technical partners involved in CIs	Funding analysis of catalytic investments by thematic area over time	Insights obtained from the country case studies where they received MCGs or SIs.	n/a

WS	Strategic Review Question	Key issues	Methods					
			Document review	KIIs	Quantitative data analysis	Country case studies	Topic-specific case studies	
		<b>SRQ5.2:</b> To what extent has the catalytic effect of matching funds been effective in driving focus in intended areas?	<ul style="list-style-type: none"><li>• MF deep dive</li><li>• Extent MF have been catalytic and how this is measured</li><li>• Linkage of MF with co-financing (per STC policy) and PfR</li><li>• Extent MF have leveraged additional financing</li></ul>	Relevant policies, guidelines and tools Current Matching Fund design and implementation documents	Consultations with Secretariat teams (SPH, GMD) Consultations with technical partners involved in MFs	Funding analysis of Matching Funds by area and over time Outcome analysis for country grants with Matching Funds, as available	Deep-dive analyses to explore specific MFs across specific countries, which will also highlight cross-cutting processes, issues, influencing factors etc.	n/a
	WS6: Partnerships	<b>SRQ6.1:</b> How have partnerships with technical, bilateral and multilateral partners facilitated the design and implementation of Global Fund supported programs aligned to the Strategy?	<ul style="list-style-type: none"><li>• Effectiveness of cooperation and coordination efforts, including coordination in practice</li><li>• Adequacy of mechanisms and approaches to strengthen partnerships. What works well/less well</li><li>• Bilateral partners, set asides</li><li>• Partner capacity</li><li>• Partnerships for C19</li></ul>	Key Global Fund documents on partnerships, including previous reviews	Interviews with Global Fund Secretariat and key representatives of partners (e.g., WHO, Unitaids, WHO, PEPFAR, PMI, UNAIDS, RBM, Stop TB)	n/a	Interviews with country stakeholders to understand partnerships that work well and less well with regards to technical assistance as well as donor coordination	Comparison with Gavi
		<b>SRQ6.2:</b> How has the experience from the Global Fund’s participation in global coordination mechanisms such as ACT-A and SDG GAP contributed to coordination and effectiveness in delivery of the Global Fund Strategy?	<ul style="list-style-type: none"><li>• Lessons from Global coordination: ACT-A, UHC2030, SDG-GAP</li></ul>	Key reviews of global coordination mechanisms including the ACT-A Rapid Review (Dalberg 2021), the External Evaluation of the Act-A (Open Consultants 2022)	Interviews with Global Fund Secretariat and key partners under ACT-A and SDG-GAP	n/a	n/a limited visibility of global partnerships at the country level	n/a

		WS	Strategic Review Question	Key issues	Methods				
					Document review	KIIs	Quantitative data analysis	Country case studies	Topic-specific case studies
Cross-cutting	WS7: Gender, HR, equity & communities	SRQ7.1: What aspects of the Global Fund funding model have facilitated and hindered efforts to reduce human rights related barriers, advance gender equality and the rights of key, vulnerable and underserved populations, enhance health equity, and promote communities' needs and responses?	<ul style="list-style-type: none"><li>• Extent GF promoted and protected HR and GE</li><li>• Key achievements and challenges drawn from WS</li><li>• Enablers and barrier, acknowledging GF control</li><li>• Good practice examples</li><li>• Key lessons learnt</li><li>• A Gendered Political Economy Analysis (GEPA) approach will be applied</li></ul>	Key Global Fund documents including the 2017-2022 and 2023 – 2028 Strategies, country guidance relevant for HR, GE and KPs, previous evaluations and TRP reports, external publications in the area	Consultations with the Secretariat CRG team as well as technical disease leads and country facing staff (GMD).  Technical support partners (UN Women, UNFPA, UNICEF, WHO, UNAIDS, Stop TB) and CSOs / CBOs (recipients and sub-recipients)	Bringing together data analysis conducted under other WS, including:  Review of Global Fund funding data with regard to funding trends / priority interventions concerning GE, HR and KPs  Review of performance against KPI 8 and 9  Analysis of catalytic investments (across all three modalities) to identify level of support of HR, GE and KP interventions	Feedback on relevant issues from country stakeholders  HR and AGYW focus of countries considered in selection of country case studies. Case studies provided insights into what interventions have worked well / not well, in which context; and what were the key contributing factors and actors (GF and other) - as well as barriers - to the achievement of HR and GESI. Learnings extracted, and recommendations formulated on this basis. For example, case study selection included countries that have participated in the Breaking Down Barriers and/or Community, Rights	n/a	

WS	Strategic Review Question	Key issues	Methods				
			Document review	Kills	Quantitative data analysis	Country case studies	Topic-specific case studies
						and Gender Strategic initiatives (CRG SI) and the extent to which additional funding and technical support has enabled GE, HR and KP-related outcomes was assessed	

## ii) Mapping of strategy operational objectives to evaluation workstreams

Table E.1: Mapping of strategic operational objectives to evaluation workstreams

Strategic objective	Operational objective	Mapping to WS
SO1. Maximize Impact against HIV, Tuberculosis and Malaria	1. Scale-up evidence-based interventions with a focus on the highest burden countries with the lowest economic capacity and on key and vulnerable populations disproportionately affected by the three diseases	WS1
	2. Evolve the allocation model and processes for greater impact, including innovative approaches differentiated to country needs	WS3
	3. Support grant implementation success based on impact, effectiveness, risk analysis and value-for-money	WS2, 3
	4. Improve effectiveness in challenging operating environments through innovation, increased flexibility and partnerships	WS1, 2, 3, 6
	5. Support sustainable responses for epidemic control and successful transitions	WS1, 3
SO2. Build resilient and sustainable systems for health	1. Strengthen community responses and systems	WS1, 7
	2. Support reproductive, women's, children's, and adolescent health, and platforms for integrated service delivery	WS1
	3. Strengthen global and in-country procurement and supply chain systems	WS1
	4. Leverage critical investments in human resources for health	WS1
	5. Strengthen data systems for health and countries' capacities for analysis and use	WS1
	6. Strengthen and align to robust national health strategies and national disease specific strategic plans	WS1
	7. Strengthen financial management and oversight	WS1
SO3. Promote and protect human rights and gender equality	1. Scale up programs to support women and girls, including programs to advance sexual and reproductive health and rights	WS1, 2, 7
	2. Invest to reduce health inequities including gender- and age-related disparities	WS1, 2, 7
	3. Introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria services	WS1, 2, 7
	4. Support meaningful participation of key and vulnerable populations and networks in Global Fund-related processes	WS3, 7
	5. Integrate human rights considerations throughout the grant cycle and in policies and policy-making processes	WS3, 7
SO4. Mobilize increased resources	1. Attract additional financial and programmatic resources for health from current and new public and private sources	Not in scope
	2. Support countries to use existing resources more efficiently and to increase domestic resource mobilization	WS3
	3. Implement and partner on market shaping efforts that increase access to affordable, quality-assured key medicines and technologies	Not in scope
	4. Support efforts to stimulate innovation and facilitate the rapid introduction and scale-up of cost effective health technologies and implementation models	WS1

## iii) WS1: budget analysis

This Appendix sets out data analysis conducted on budget data from the Global Fund. The appendix is structured as follows: (i) Section F.1 sets out the analysis approach and limitations; (ii) Section F.2 presents overarching trends in Global Fund budgets; (iii) Section F.3 presents trends in HIV funding composition; (iv) Section F.4 presents trends in TB funding composition; (v) Section F.5 presents trends in malaria funding composition; (vi) Section F.6 presents trends in RSSH funding; and (vii) Section F.7 presents trends in funding for HRG.

a. Approach and limitations

This Section provides the analysis of the budget data which has been provided by the Global Fund Finance Team and is coded against the various Modular Frameworks over successive grant cycles.<sup>8</sup> The budget data includes the funding approved in the grant making process as well as any updates that have been made through reprogramming and grant optimisation since grant making. The budget data includes funding from (i) the within allocation funding for countries; (ii) matching funding and (iii) additional funding received for Unfunded Quality Demand. The analysis is conducted across three grant cycles, including grant cycle 4 (2014-16), grant cycle 5 (2017-19) and grant cycle 6 (2020-22) to identify key trends in Global Fund funding to countries over the last nine years.<sup>9</sup>

Comparison across disease groupings were conducted based on allocating modules to specific diseases (TB/HIV was allocated to HIV funding following discussion with the Global Fund Finance team). Programme management costs and payment for results were not included in the disease specific funding allocations. For RSSH, only those interventions were included that were coded as RSSH interventions against the respective modular frameworks. Due to these decisions in the methodology, presented numbers in the Appendix may differ to reported results from other sources.

There are a range of limitations with regard to the analysis including:

- **Differences across time periods:** there have been different approaches with regard to the coding of Global Fund funding data such as the use of a different modular framework.<sup>10</sup>
- **Contextual background:** it was not within the scope of the analysis to set the Global Fund investments into the specific context for each country with regard to investments from domestic sources.
- **Changes due to C19RM:** Global Fund country budget data includes C19RM funding. As such comparison of HTM and RSSH related funding across periods can be best analysed when excluding the C19RM budget.
- **No Strategic Initiative funding included:** Funding from Strategic Initiatives is not included in the Global Fund budget database (as it is not directly allocated and disbursed to countries).

b. Overarching trend in Global Fund budgets

(xi) Overall trends and disease burden split

**The Global Fund budget has increased over the grant periods with US\$ 11,990 million in GC4, US\$ 12,346 million in GC5 and US\$ 17,156 million in GC6.** Figure F.1 below shows that a key contributing factor to the large increase in GC6 has been the increase in C19RM funding in GC6 (increase by 74% compared to C19RM funding in GC5) but also the traditional HTM allocation increased by 16% across cycles. The budget for HTM between GC4 and GC5 decreased slightly predominately due to grant flexibilities which has meant that some HTM funding was repurposed for COVID-19 in GC5.

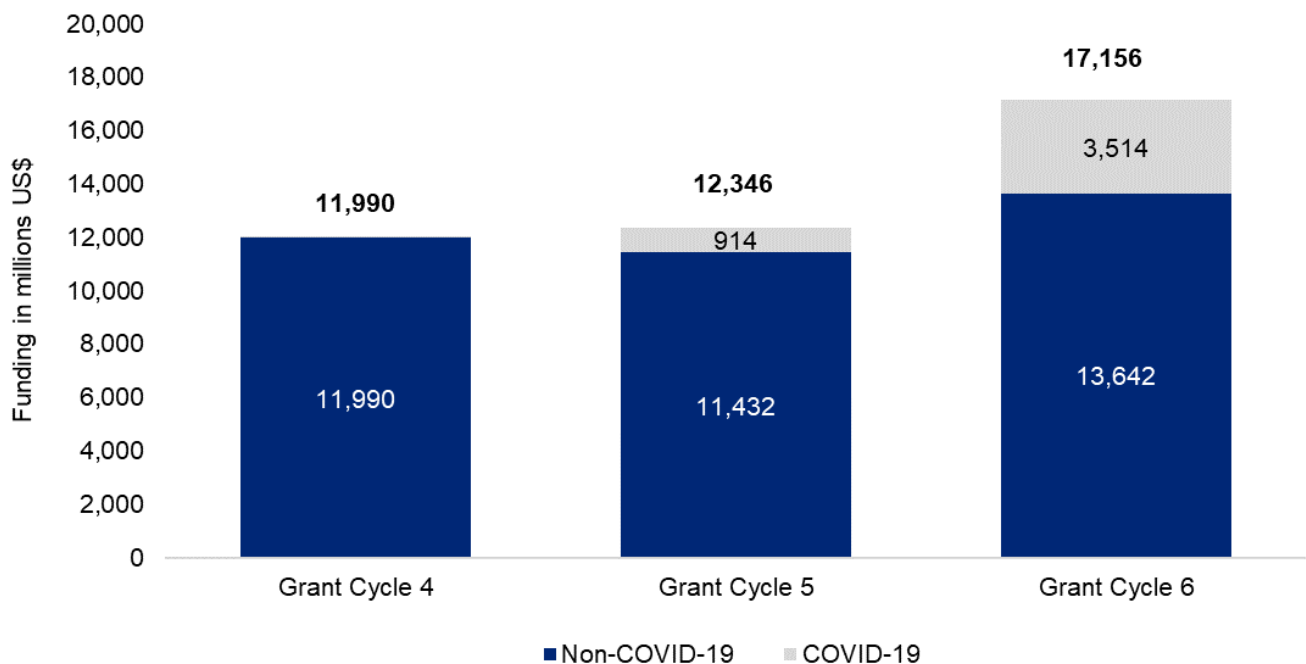
Figure F.1: Global Fund funding to countries by grant cycle and COVID vs non-COVID investments

<sup>8</sup> The budget data for GC5 and GC6 was extracted and shared on the 25<sup>th</sup> of May 2023. The budget data for GC4 (2014-2016) was shared on August 25<sup>th</sup> 2023.

<sup>9</sup> A comparison across the full Strategic Period (2017-22) against the previous Strategic Period (2011-16) was not seen as appropriate due to key changes made in 2011-16 Strategy Period which included the switch to the New Funding Model as well as changes in reporting. As such, it was seen as most appropriate to compare budget data across the GC4, GC5 and GC6.

<sup>10</sup> Comparison with GC4 need to be taken with additional care as GC4 included the transition from the rounds to the allocation model.





The largest share of the Global Fund budget is for HIV (35% in GC6) followed by Malaria (23%) and then TB (13%), the largest increases across grant cycles can be observed for COVID-19 and Payment for Results (albeit from a much lower level). Figure F.2 below depicts changes in funding across grant cycles over time and shows that all funding areas received more funding in GC6 compared to GC4. Most areas experienced also increases in GC5 with the exception of HIV and RSSH that experienced a dip in GC5 before rebounding in GC6.

Figure F.2: Global Fund funding by disease area, RSSH and programme management by grant cycle in US\$

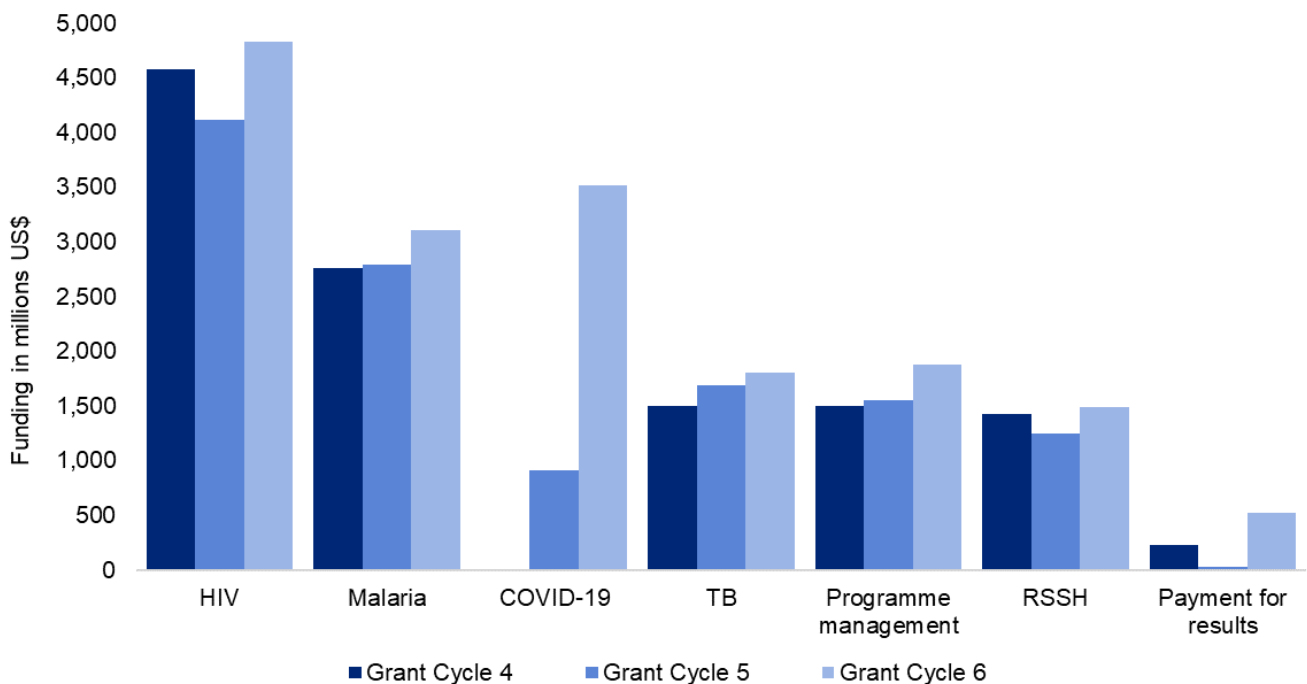
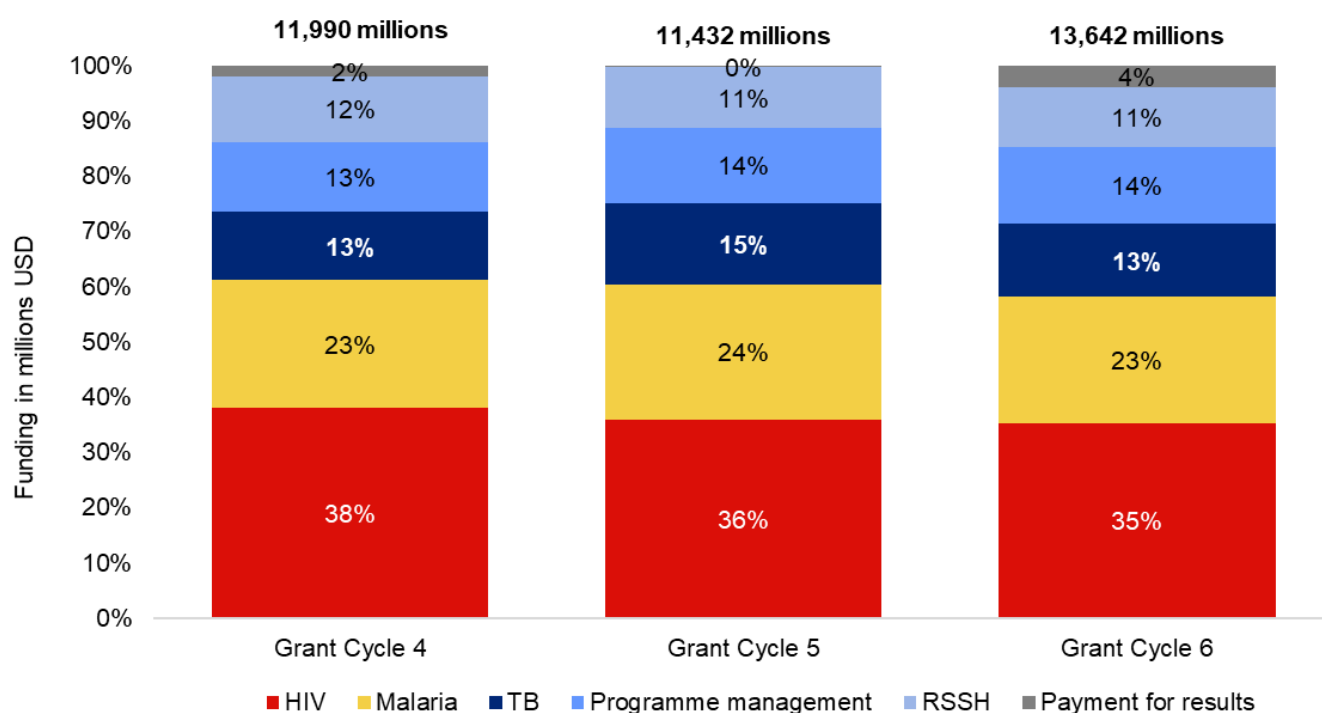


Figure F.3 provides an overview of proportion change across disease areas and RSSH, this excludes COVID-19 funding to adequately compare across grant cycles. The proportion for HIV has declined slightly over the years from 38% in GC4 to 35% in GC6. Malaria stayed largely stable at around 23% and TB funding dropped back to 13%

(after an increase to 15% in GC5).<sup>11</sup> Direct RSSH remained roughly at the same level of about 11% in GC5 and GC6 (a slight drop from 12% in GC4) and programme management costs increased slightly between GC4 to GC5 from 13% to 14% and then stayed stable. Payment for results has been used much more in GC6 reaching 4% (up from 2% in GC4 and 0% in GC5) this is driven by the usage of PfR in Rwanda and India in GC6.

Figure F.3: Global Fund funding by disease area, RSSH and programme management by grant cycle in % (excluding C19RM funding)

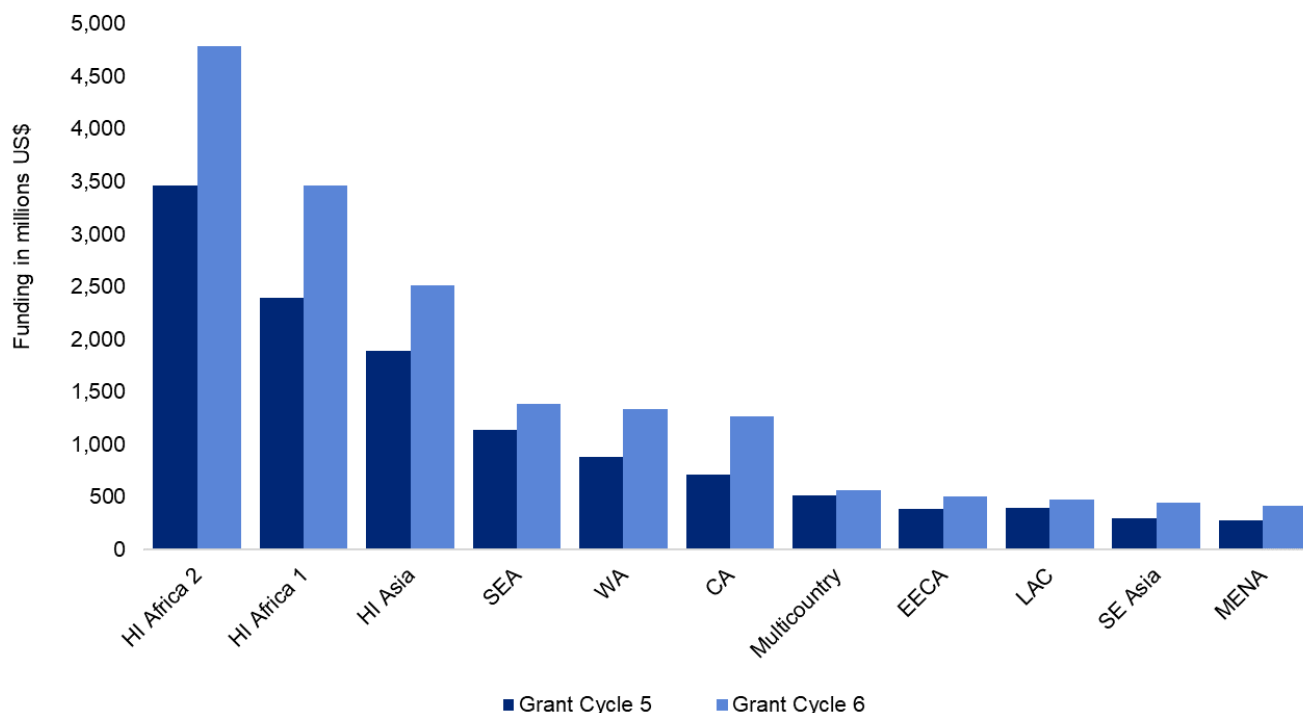


### (xii) Regional trends

**The majority of Global Fund funding is going to SSA and Asia with the largest increases observed in core West and Central African countries.** Figure F.4 shows that funding has increased across all regions between the GC4 and GC5 with CA and WA having the biggest increase (44% and 34% increase respectively). The high impact regions respectively increased in funding by 28% (HI Africa 2), 31% (HI Africa 1) and 25% (HI Asia) between the GC5 and GC6.

Figure F.4: Global Fund funding by region across grant cycle 5 and 6

<sup>11</sup> HIV/ TB interventions were included in HIV but they only account for around 0.9% of budget in GC5 and 1.1% in GC6 and, thus, even allocating these to TB would mean that funding remains relatively low for TB.

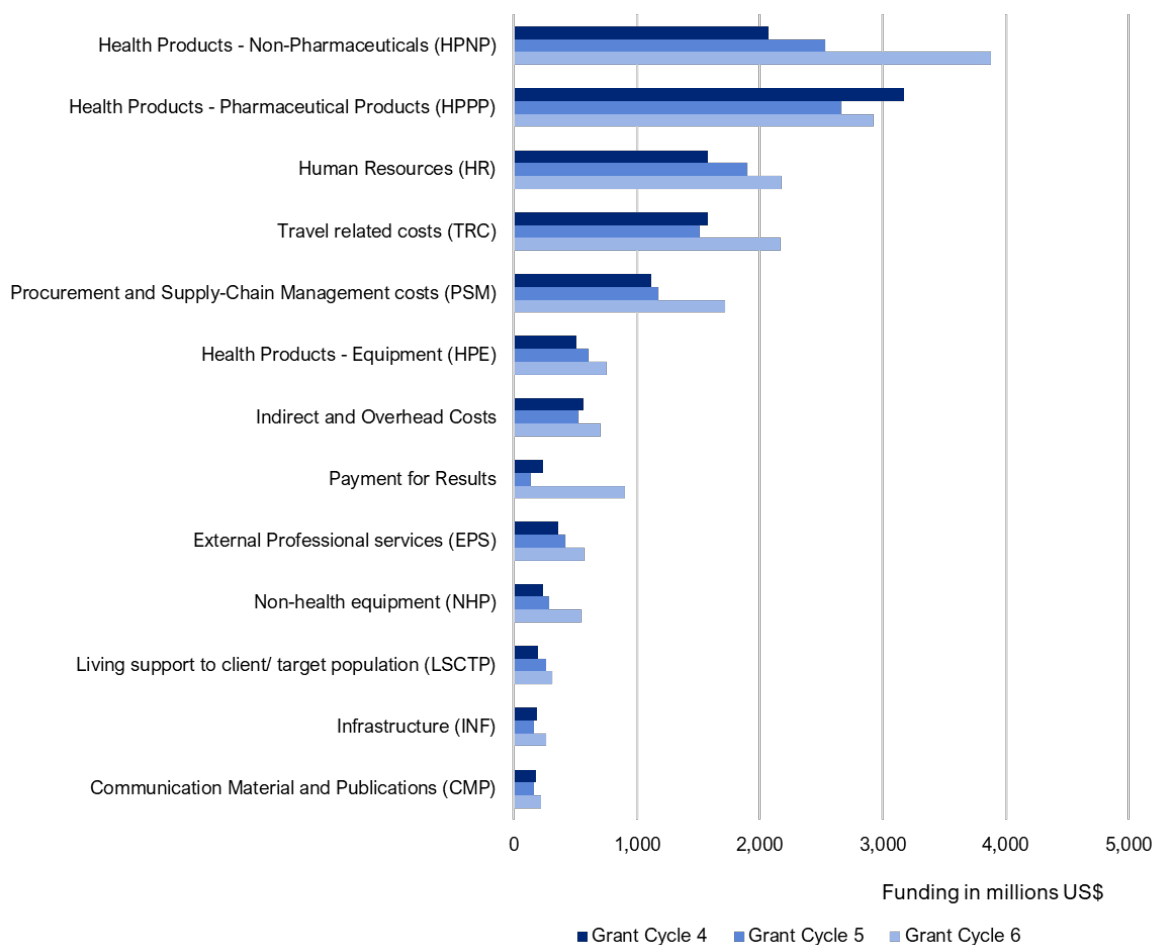


The composition of funding across regions varies with SSA countries (especially in HI Africa 2) having a higher proportion of their funding allocated to HIV and Malaria, whereas Asian countries (especially HI Asia) have a higher proportion of their funding allocated to TB. For example, the share of HIV was 49% in HI Africa 2 and TB was 7% whereas in High Impact Asia HIV was 7% and TB 44%.

### (xiii) Cost categories

Health products (pharma and non-pharma) are the highest cost categories and there has been a large increase in non-pharmaceutical health products during GC6 due to C19RM funding. Figure F.5 provides an overview of the funding across cost categories across the cycles. The third highest cost category is HR which has also seen a steady increase across the allocation cycles.

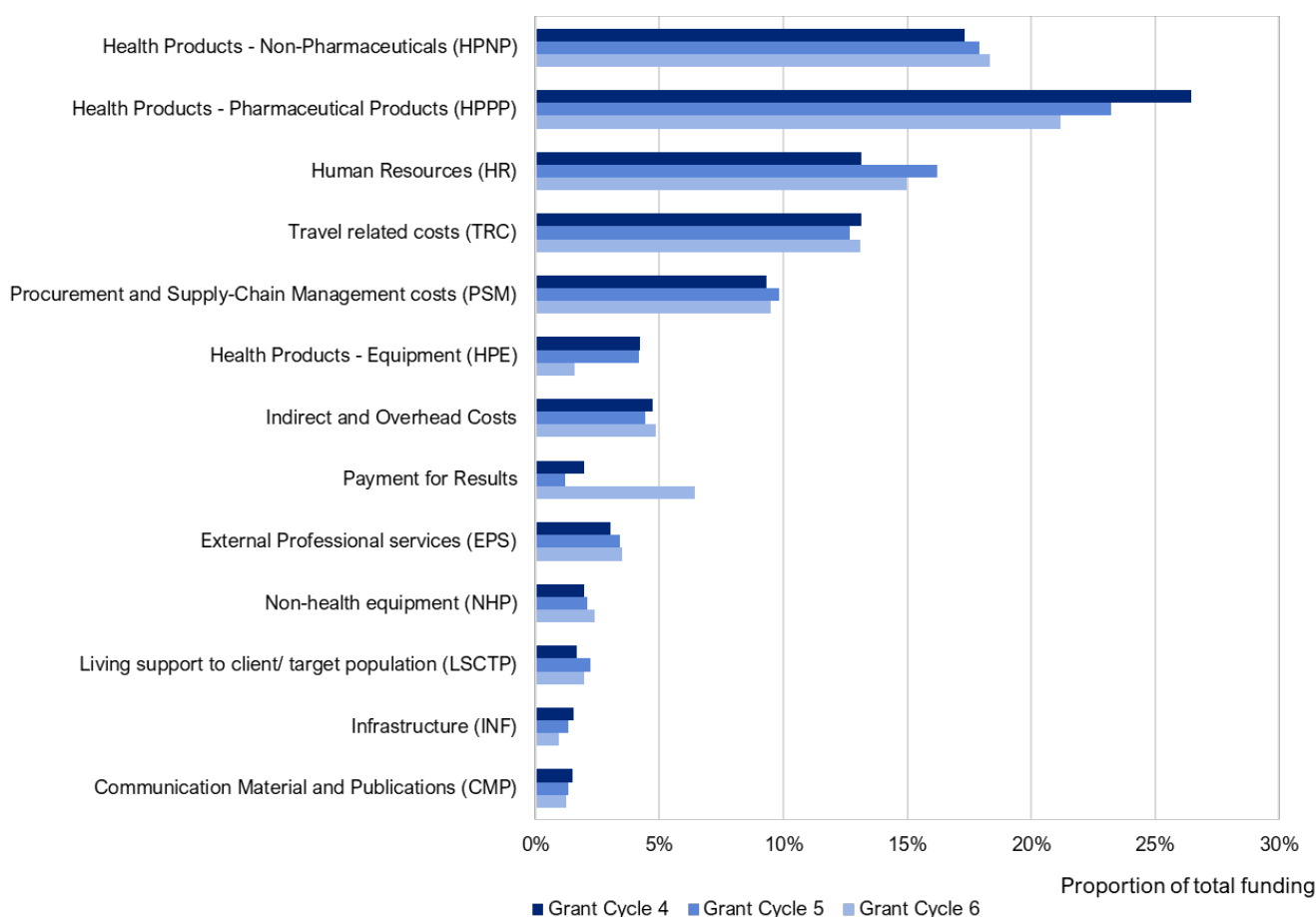
Figure F.5: Global Fund funding by cost category, including C19RM funding



**Without COVID-19, the cost composition has been relatively stable across cycles with health products continuing to be the largest cost categories however there has been a slow decline in the proportion of funding being used for pharmaceutical health products.** Health products (pharma) were still the largest cost category with 21% in GC6, but this decreased from 26.5% in GC4. Compared to GC4, there instead has been a slight increase in Human Resources (13% in GC4 vs 15% in GC6) and a large increase in payment for results.<sup>12</sup>

*Figure F.6: Global Fund funding by cost category as proportion of total budget, excluding C19RM funding*

<sup>12</sup> The reduction in health product equipment is likely driven by the fact that equipment funding was shifted to C19RM funding as this category remained stable when C19RM funding was included.



#### a. Trends in HIV funding composition

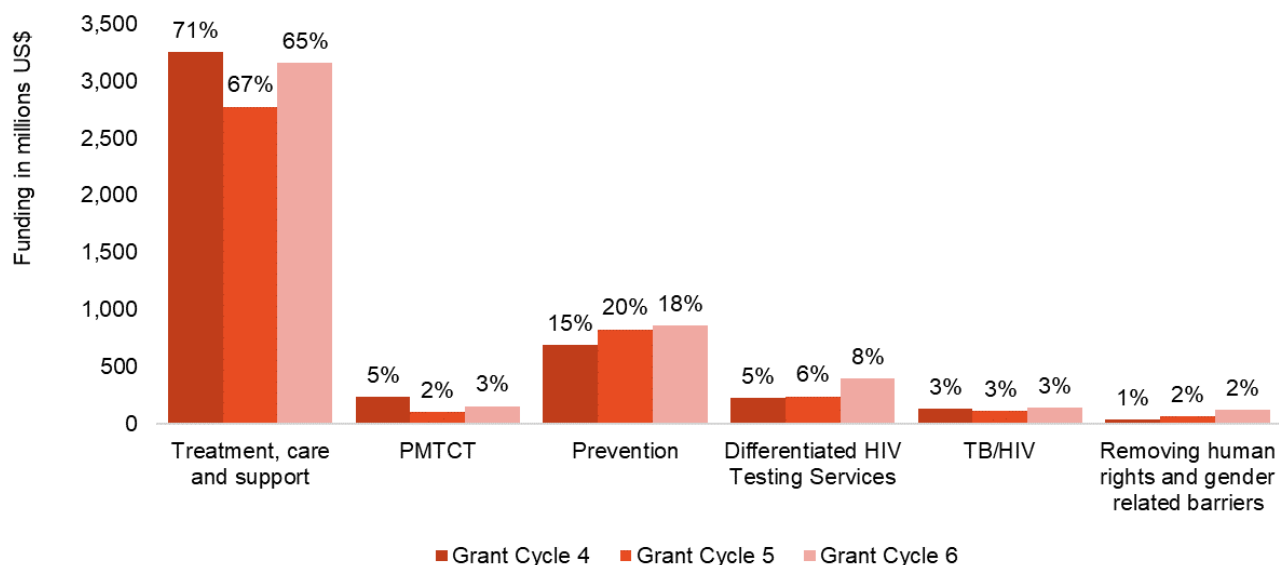
Figure F.7: provides an overview of the changes in HIV funding composition across the three grant cycles. Key takeaways include:

- **The majority of HIV funding continues to be provided for treatment, care and support although there has been a decline in the proportion from 71% in GC4 to 67% in GC5 to 65% in GC6.** This has been despite an increase in absolute funding for treatment between GC5 and GC6.
- **The funding for HIV primary prevention has increased over each of the cycles, but while the proportion increased from 15% in GC4<sup>13</sup> to 20% in GC5, it dropped back to 18% in GC6.** In absolute terms, there has been a slight increase from US\$ 827 million in GC5 to US\$ 857 in GC6
- **Differentiated HIV Testing Services has been the area with the highest increase in the proportion of funding under GC6 to a total of 8%.** This is likely to have been driven at least partially by the COVID-19 pandemic. In GC6, around 19% of this module was used for Self-testing, 32% for Community Testing and 49% for facility-based testing.<sup>14</sup>
- Removing human rights and gender related barriers also had a considerable increase over the three allocation cycles albeit from a very low level (doubling from under 1% in GC4 to over 2% in GC6)

Figure F.7: HIV funding per module area in US\$ (with proportion of module area of total funding)

<sup>13</sup> For GC4, HIV testing services were allocated within the HIV prevention module. To allow for accurate comparison with other cycles, the interventions related to testing were recoded and instead allocated to the "Differentiated HIV Testing Services" module.

<sup>14</sup> The structure of the modular framework does not provide this breakdown for GC5 and GC4.



Health products (pharma and non-pharma) made up 60% of HIV funding spent in GC5 and GC6 across costing categories followed by human resources (11%).

Figure F.8: HIV funding by costing categories across GC4 and GC5



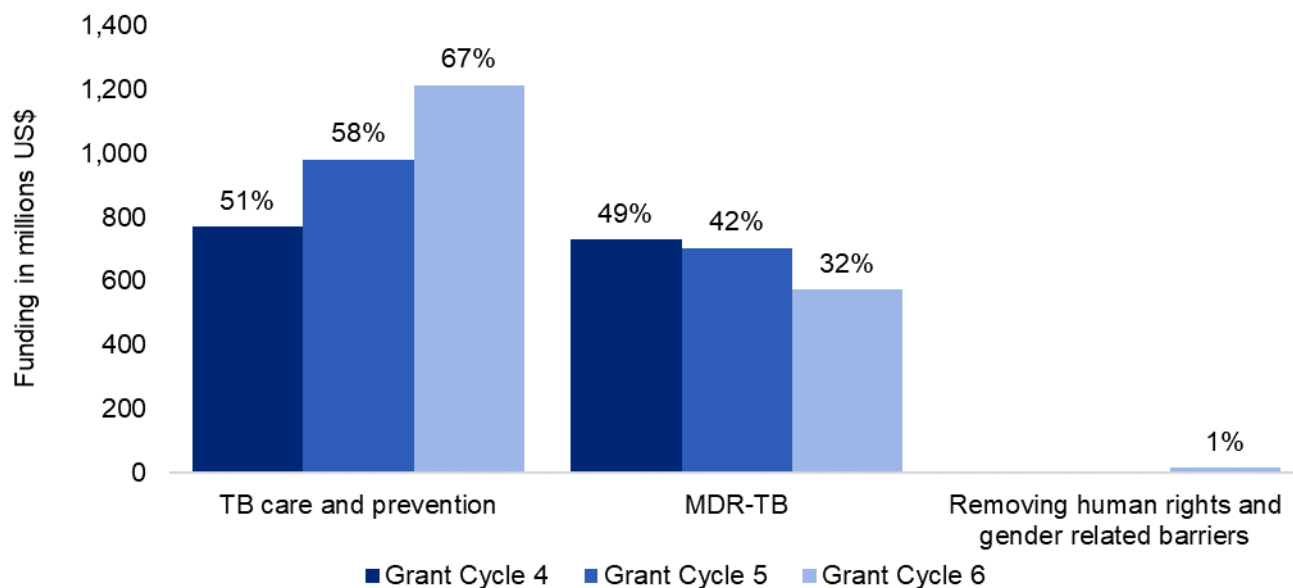
#### b. Trends in TB funding

Figure F.9: provides an overview of the changes in TB funding composition (excluding TB/HIV) across the three grant cycles. Key takeaways include:

- TB funding for TB care and prevention has increased in both absolute as well as relative terms.** The proportion increased from 51% in GC4 to 67% of all TB funding in GC6. The increase is driven in particular by increased funding on health products (non-pharmaceutical and pharmaceutical products) and is across treatment, case detection and diagnosis and prevention interventions.

- **TB funding for MDR-TB in contrast has declined in both absolute and relative terms.** The proportion dropped from 49% to 32% and absolute funding declined from US\$ 731 million in GC4 to US\$ 574 million in GC6. The decrease is driven in particular by a decline in spending on health products (pharmaceutical products).
- **There has been some dedicated funding for removing TB human rights and gender barriers, but this is at a low level representing 1% of total TB funding.**

Figure F.9: TB funding per modules

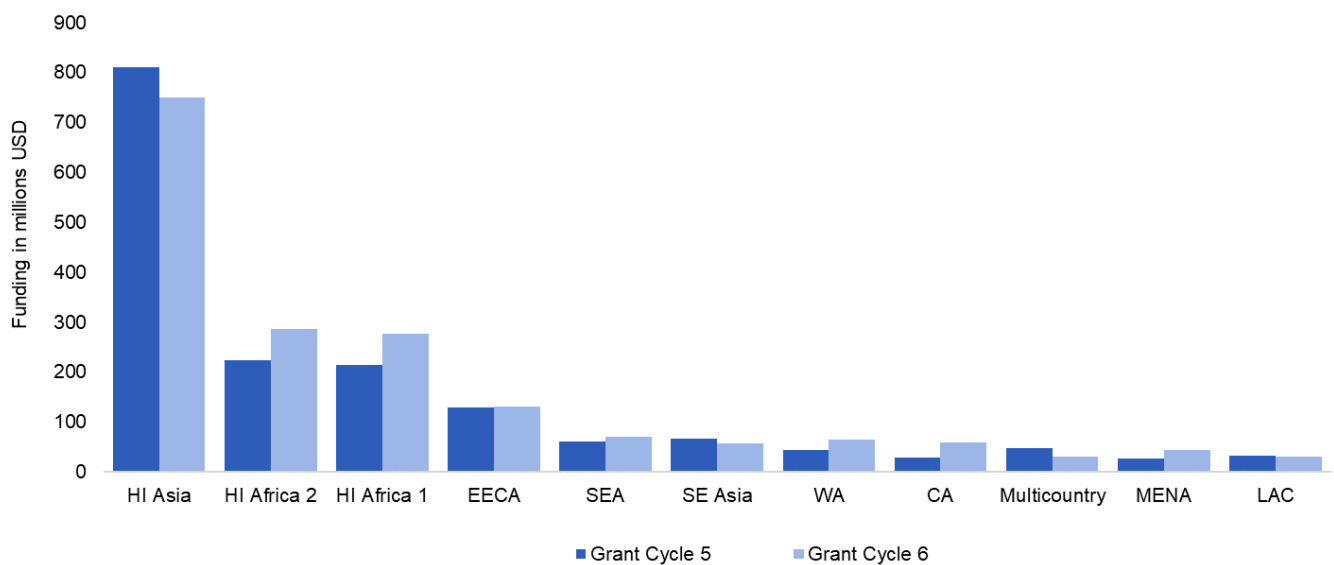


**Specific prevention within the TB funding remains relatively low but has been increasing from around 2% in GC4 and GC5 to around 5% of all TB funding in GC6.** This increase is driven by increased funding on the prevention module for DS-TB, with prevention expenditure for MDR-TB decreasing (similar to other interventions in this area).

**Most TB funding has gone to High Impact Asia countries although there has been a small decrease across GC5 and GC6 and an increase in funding for TB in SSA.**

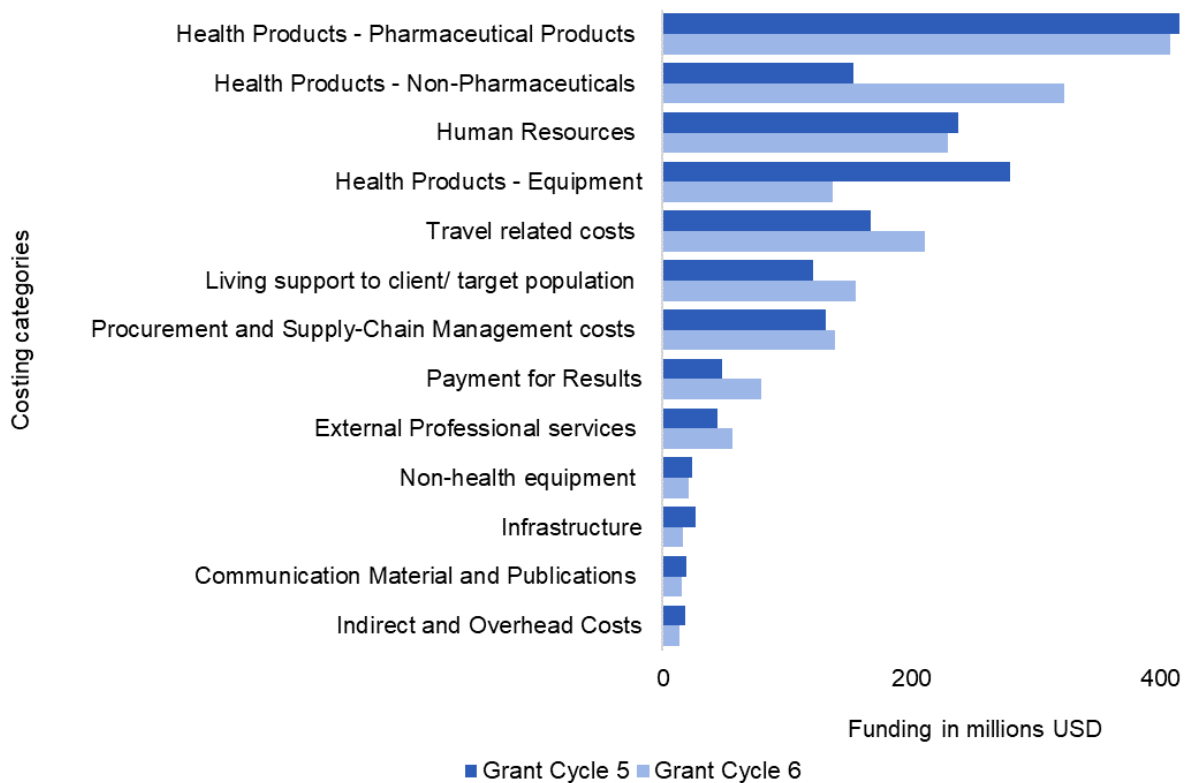
Figure F.10: TB funding by region





The health products (pharma, non-pharma and equipment) made up ~50% of all TB funding of all costing categories (23%, 14% and 12% respectively). There has been a large increase in non-pharma health products costing between GC5 and GC6 driven predominately by an increase in test kits.

Figure F.11: TB funding by costing categories

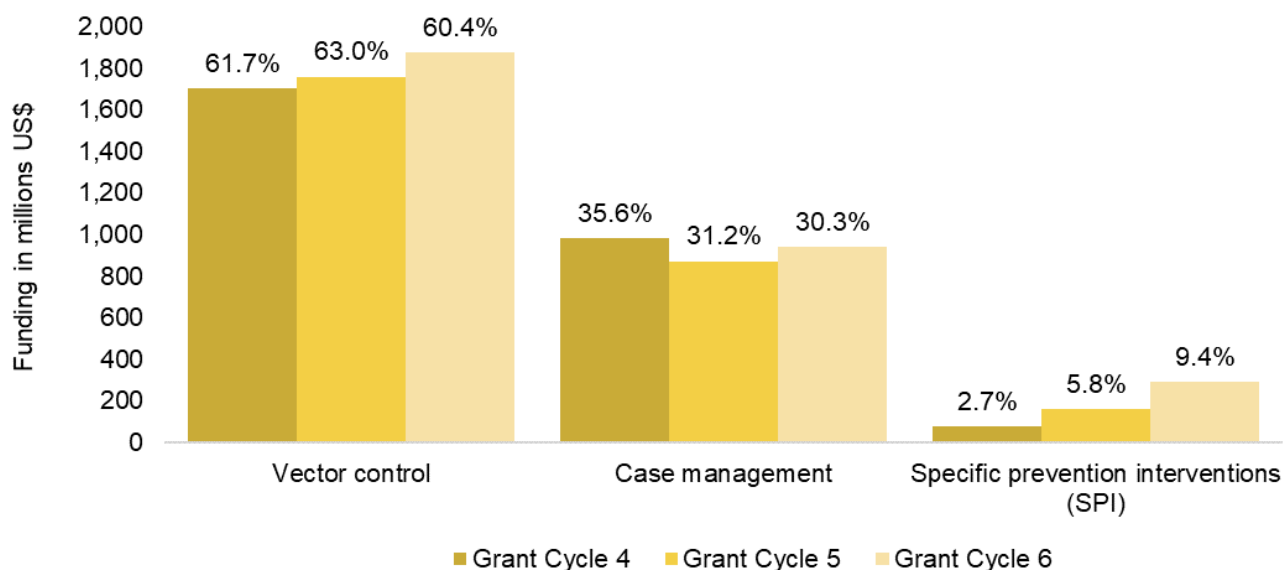


### c. Trends in Malaria funding

Figure F.12: provides an overview of the changes in malaria funding composition across the three grant cycles. Key takeaways include:

- **Vector control remains the largest funding area in malaria with 60% of all funding going to vector control in GC6 (slightly below the 62% in GC4).** There has been an increase in absolute funding for vector control each cycle. Within Vector control the majority of funding has been spent on mass campaigns for LLINs (72% in GC5 and GC6). The amount of funding going to continuous LLIN distribution slightly increased (11% in GC5 to 14% in GC6) and the proportion of funding going to IRS declined from 14% in GC5 to 12% in GC6.
- **Case management absolute funding remained constant between GC4 and GC6 and the proportion of funding dropped from 36% in GC4 to 30% in GC6.**
- **Specific prevention initiatives experienced the largest gains in absolute and relative terms increasing from 2.7% in GC4 to 9.4% in GC6.** The increase can be observed across all key interventions within this module. The largest funding has been going towards SMC (76% in GC5 and 78% in GC6).

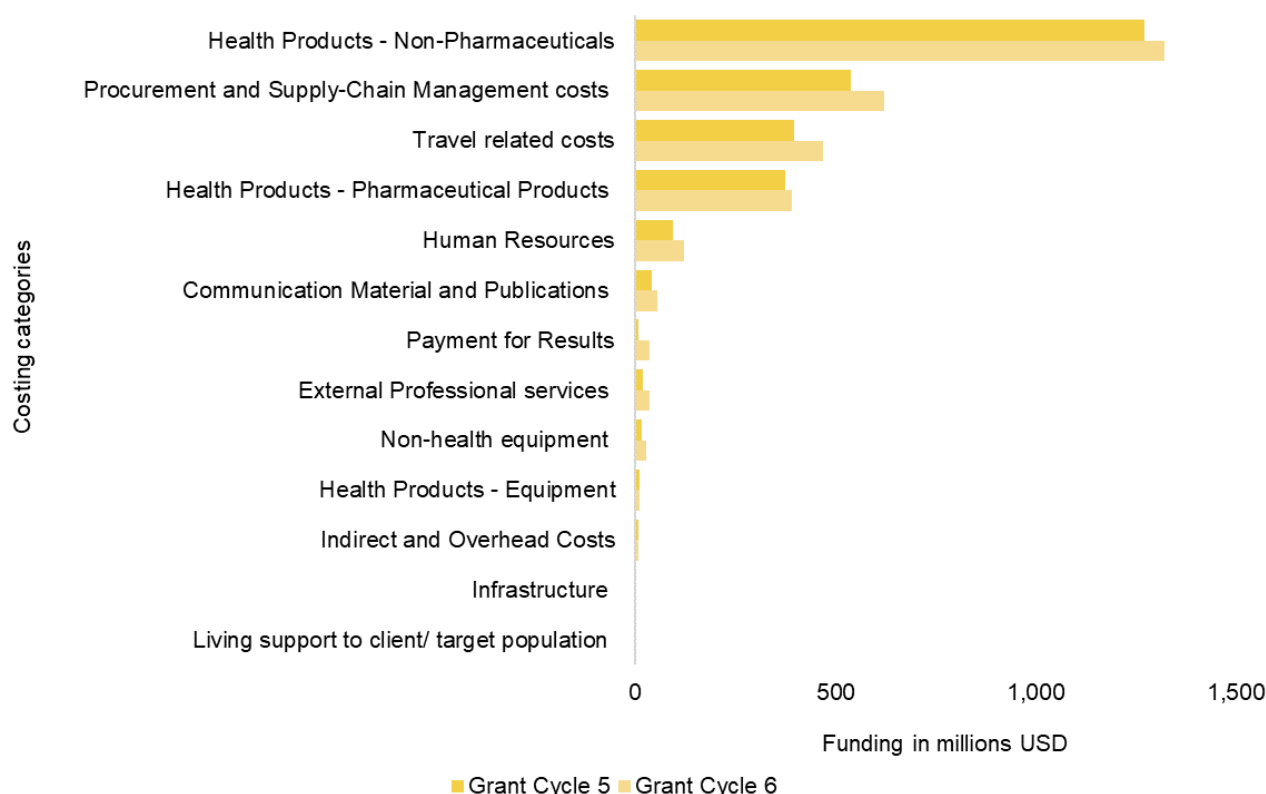
Figure F.12: Malaria funding per modules



**The majority of funding for malaria is budgeted for SSA which accounted for around 85% of all malaria funding in GC5 and GC6.**

**Health Products - Non-Pharmaceuticals remain the largest costing category in both allocation periods, accounting for nearly half of all funding (46% in GC5 and 43% in GC6).** This is driven by costs for vector control LLINs. Procurement and Supply-Chain Management costs, Travel related costs and Health Products - Pharmaceutical Products completed the top 4 costing categories, accounting for 20%, 15% and 13% of 2020-2022 costing categories respectively (with similar proportions for GC5).

Figure F.13: Malaria funding by costing categories



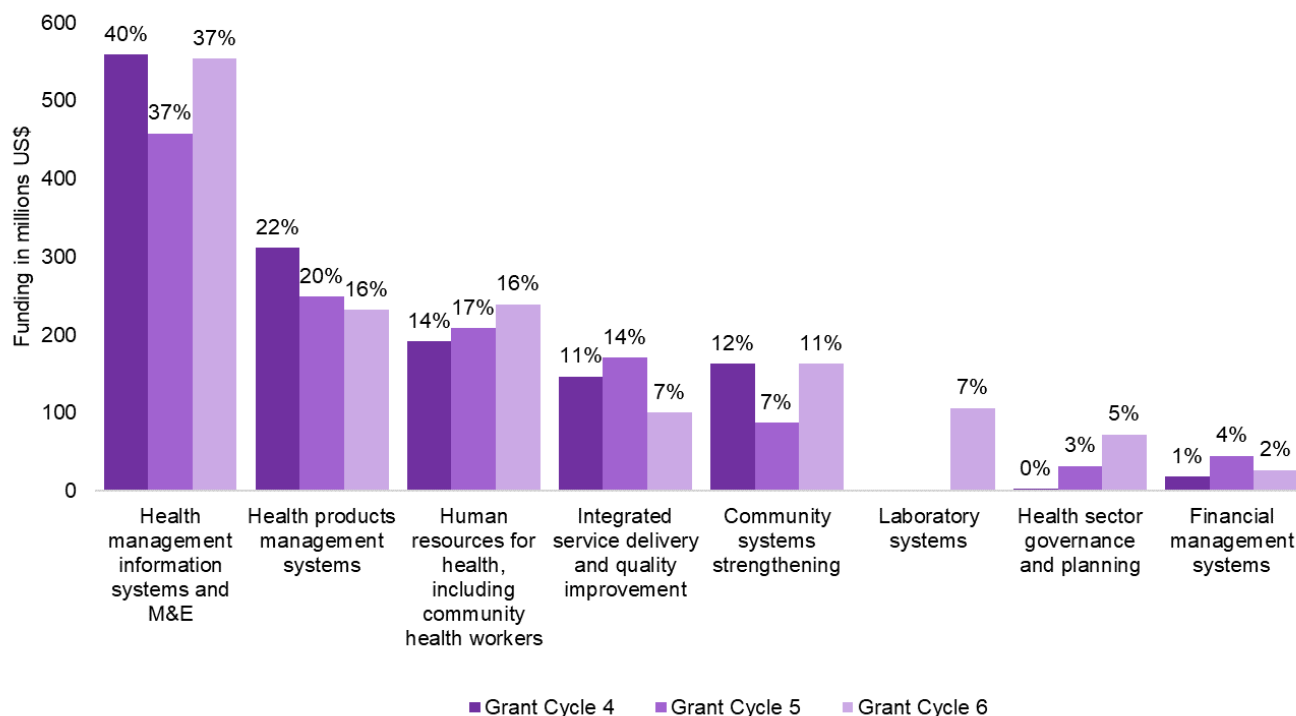
#### d. Trends in RSSH funding

Figure F.14: provides an overview of the changes in RSSH specific modules across the three grant cycles. The analysis only focuses on RSSH interventions directly included in RSSH modules and not any interventions in other disease areas that could also have a contributory effect on supporting the health system. It also does not include any investment for RSSH under the C19RM funding. Key takeaways for RSSH funding modules include:

- **Health management information systems and M&E are the largest module making up around 37% of direct RSSH budget in GC6 (slightly down from 40% in GC4<sup>15</sup>).**
- **The share of health product and management systems has steadily declined and dropped from 22% in GC4 to 16% in GC6.** Similarly, the funding share for integrated service delivery and quality improvement has dropped from GC4 to GC6 (after an initial increase in GC5).
- **The share of human resources for health including community workers has increased from 13% in GC4 to 16% in GC6.**
- **A new module was created in 2020-2022 for Laboratory systems accounting for 7% of total allocation for RSSH in GC6.**

Figure F.14: RSSH funding by modules and across grant cycles in US\$ millions (and proportion of funding)

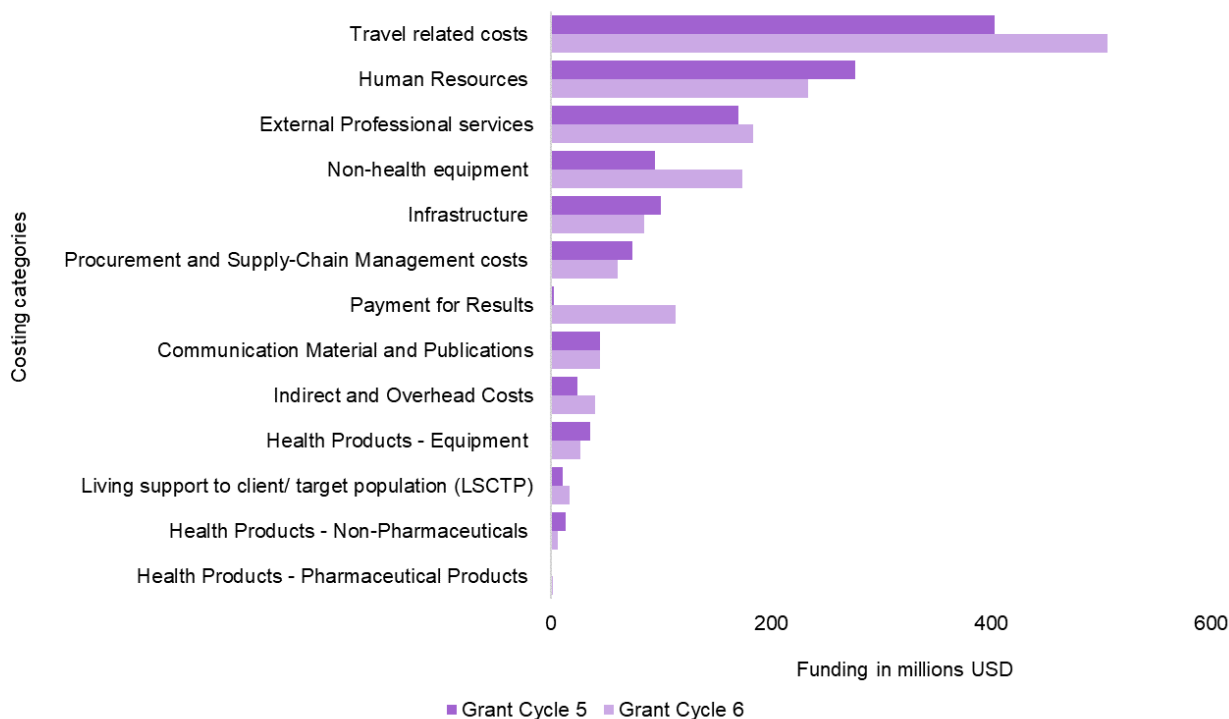
<sup>15</sup> For GC4, this category included all funding under "RSSH: Health management information systems and M&E" as well as "RSSH: Monitoring and Evaluation Systems". This is to ensure consistency when comparing with GC5 and GC6 that only have a single integrated module for HMIS and M&E.



**The use of RSSH standalone grants increased between GC5 and GC6.** The use of RSSH standalone grants increased from around US\$ 75 million (representing 6% of all RSSH modules) in GC5 to US\$ 194 million (representing 13% in GC6). The number of countries with standalone grants increased from 3 in GC5 to 11 in GC6.

**Travel related costs, Human Resources and External Professional services were the top 3 costing categories across both GC5 and GC6, accounting for 62% of overall funding in GC6 allocation period and 68% in GC5.** Funding for Payment for results and Non-health equipment had the largest increase across all RSSH costing categories.

Figure F.15: RSSH funding by costing categories



#### e. HRG

This section provides an overview of the HRG funding across the three allocation cycles. The following funding was included with regard to HRG:

- Funding for “Reducing human rights and gender-related barriers to HIV/TB services or TB services” modules which have been introduced in GC5
- Funding for HRG interventions which address stigma, discrimination and violence, gender-based violence as well as interventions aiming to improve laws, regulations and policies related to HIV and TB services.

Other interventions related to more widely to gender (e.g., malaria interventions focused on pregnant women) were not included in the analysis. The used methodology is different to the one employed by the Global Fund to calculate the KPI9b indicator. In particular, comparisons are made within disease spending categories rather than at the grant type level and therefore do not include programmatic spending.

The current framework data does not allow to differentiate robustly between reducing human rights and gender related barriers as this has been grouped within the same intervention in many instances.

#### (xiv) Overview of HRG funding

Figure F.16: provides an overview of the changes in HRG funding over time in US\$ terms and Figure F.17 provides an overview of the proportion of all HRG funding by disease areas. The following key findings emerge from the data:

- There has been a steady increase in HRG funding across the three grant cycles from US\$ 38 million in GC4 to US\$ 97 million in GC5 and increasing to US\$ 205 million in GC6.
- The majority of funding for HRG is in HIV (with 72% in GC6) – however, within GC6 there has been an increase in funding for TB as well as the use of C19RM funding to support HRG interventions.
- The proportion of HRG funding within disease areas has increased especially for HIV from 0.8% in GC4 to around 3.1% in GC6. TB also increased from 0.3% in GC5 to 0.9% in GC6. While this result is in

line with the findings under KPI9b for HIV (and would still reach the target of 3%), for TB the result is below the 2% target. This might be due to the difference in methodology employed.

- **There is variation in the funding for HRG across countries** – with countries without Breaking-Down Barriers reporting considerably lower proportion of funding. Additionally, LICs have lower funding for HRG in HIV and MICs have lower funding for TB for HRG (see KPI9b in Appendix H).

Figure F.16: HRG funding by disease area in US\$

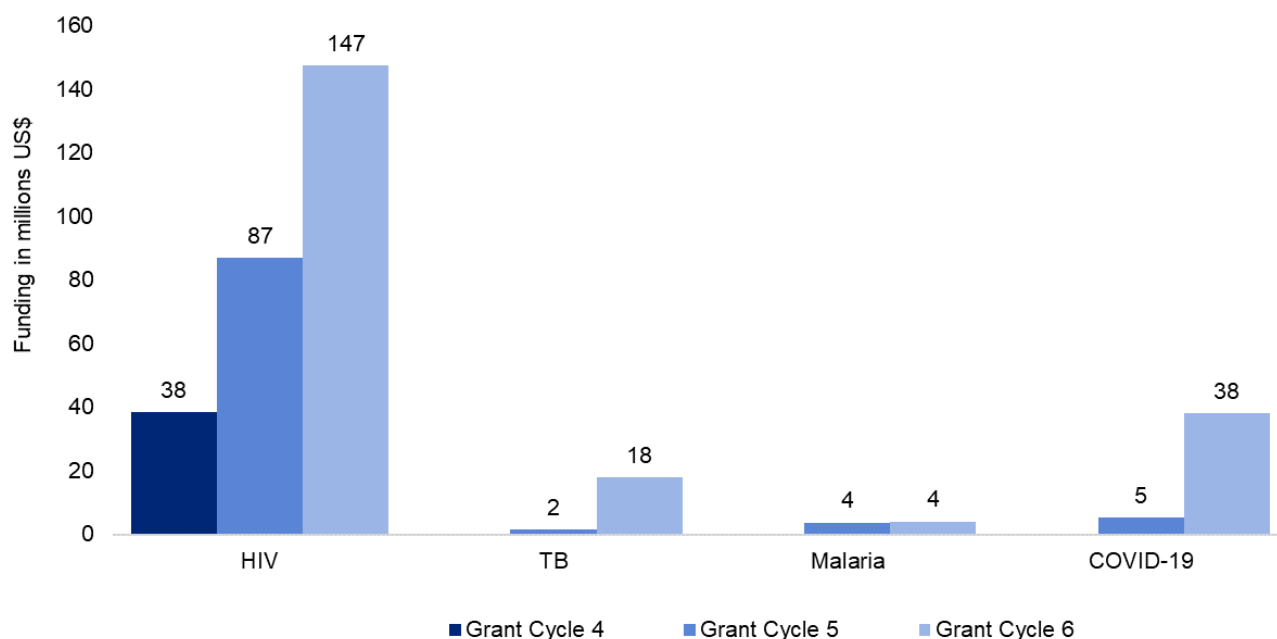
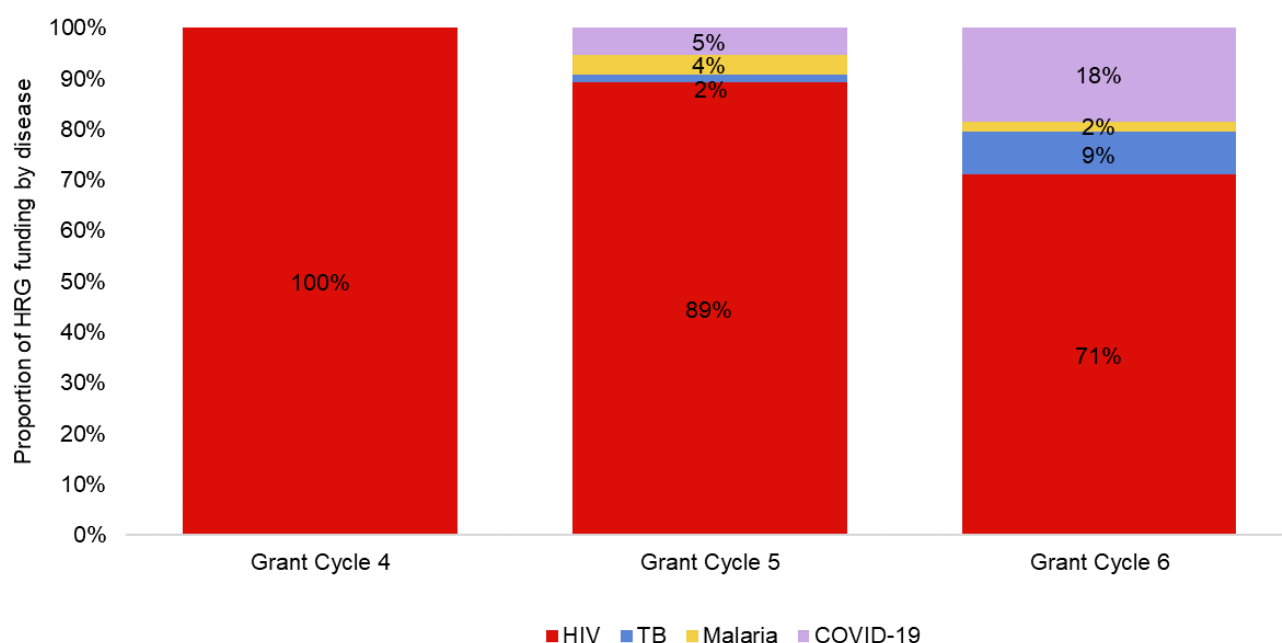


Figure F.17: Proportion of HRG funding over time by disease category

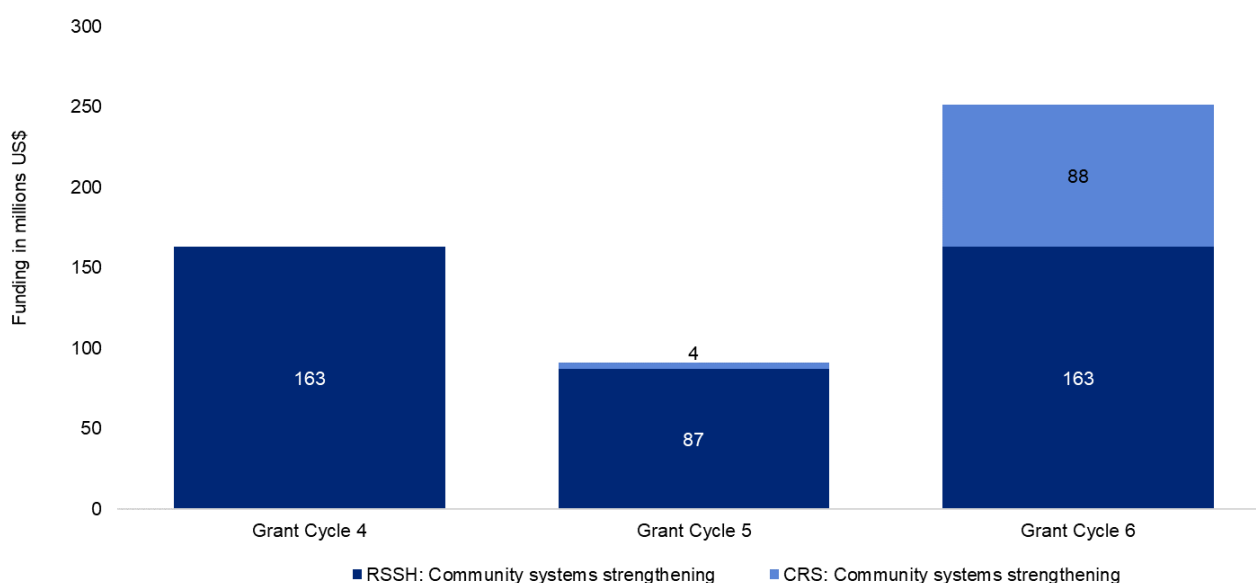


(xv) *Community Systems Strengthening*

Figure F.18: provides an overview of the changes in community system strengthening (CSS) funding over time in US\$ - including C19RM funding. Key takeaways include:

- **CSS funding as part of the RSSH modules has declined between GC4 and GC5 but recovered to the same absolute level of US\$ 163 million in GC6.** The proportion of all RSSH funding going to CSS also dropped from 12% in GC4, to 7% in GC5 and increasing again to 11% in GC6 (See section on RSSH above).
- **C19RM funding has provided an opportunity to expand on CSS with US\$ 88 million budgeted through C19RM increasing the total CCS funding in GC6 to US\$ 251 million** (an increase of over 50% compared to GC4 and more than double compared to GC5).<sup>16</sup>

Figure F.18: Changes in CSS funding over time in US\$ (includes C19RM funding)



It is difficult to compare the total funding on community activities within HIV, TB and Malaria modules due to the different ways in which these have been recorded over the allocation cycles. Within GC6, there is often a more detailed breakdown (e.g., whether testing is taking place at community or facility level). The takeaways for a few interventions include:

- **Integrated community case management (iCCM)** experienced a growth in funding from US\$ 125 million in GC4 (13% of call case management) to US\$ 167 million (18% of all case management) in GC6
- **Community TB care delivery** experienced a growth in absolute terms but declined in terms of proportion of call TB care and prevention. In GC4 around US\$ 70 million (9% of all TB care and prevention funding) has been spent on Community TB care, this increased to US\$ 90 million in G6 (7% of all TB care and prevention funding)

<sup>16</sup> C19RM funding for the CSS module also included GBV and HR interventions.





*i) WS2: grant performance rating analysis*

This appendix provides an overview of the evolution of grant performance ratings from 2018 to 2022, including a breakdown of performance by regions and grant types. The grant performance rating methodology has been updated for the first time in December 2021 since the creation of the Global Fund. A key change included moving away from a single grant rating to a separate programmatic rating and financial rating. Additionally, a separate PR performance rating is being rolled out for 2025. Based on Global Fund documentation, the approach to rating the programmatic results was kept pretty similar to the previous grant rating allowing for trend analysis over time.<sup>17</sup>

The grants are ratings are rated across A, B, C, D, E based on their programmatic performance, corresponding to the following performance: A= >100%; B= 90%-99%; C= 60%-89%; D= 30%-59% and E=<30%.<sup>18</sup>

*a. Overview*

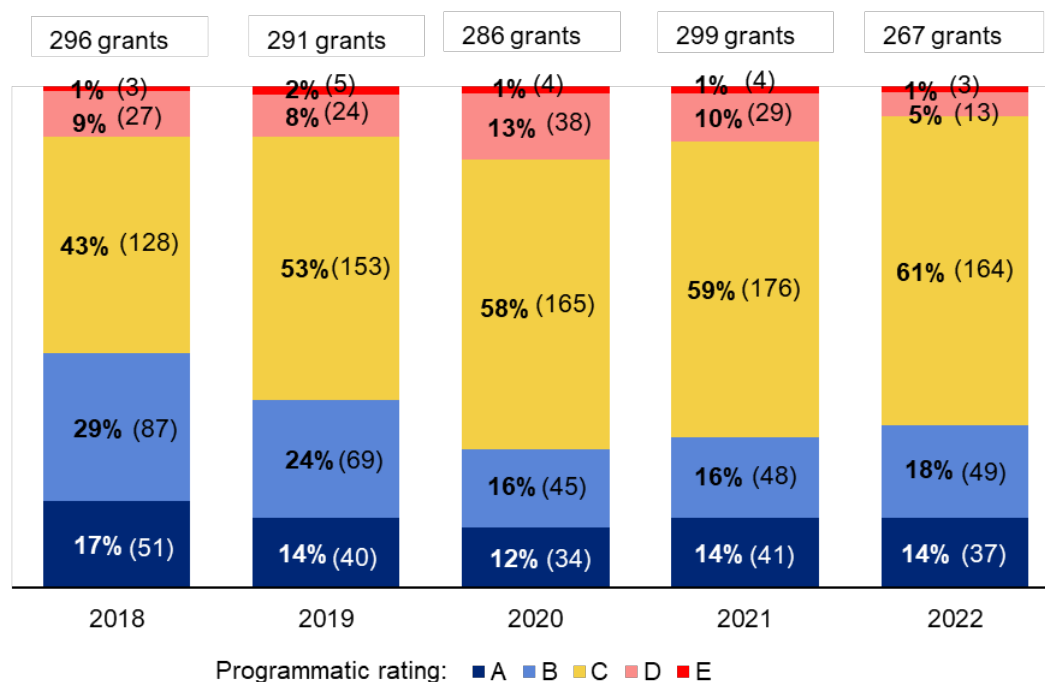
Figure G.1. below presents an overview of all rated grants across the years from 2018-2022. Key highlights from the analysis include:

- The proportion of grants rated A and B has declined from 2018 (46%) to only 28% in 2020. Since then, there has been a slight increase with 32% of grants achieving A and B rating in 2022.
- The proportion of grants rated D and E was 10% in 2018 and increased to 14% in 2020. This has improved dropping to 11% in 2021 and 6% in 2022.
- Corresponding to the two trends above, there has been an increase in grants in the mid-range from 43% of grants being rated C in 2018 to 61% in 2022.

*Figure G.1: Overview of programmatic rating across 2018-2022 (not all grant ratings were yet recorded for 2022)*

<sup>17</sup> Updates to the PU/DR Process and Performance Rating (2022)

<sup>18</sup> The Programmatic Rating from 2021 onwards uses A, B, C, D and E as metrics but these corresponds to the same quantitative scale as previously A1, A2, B1, B2, C under the Overall Grant Rating. To ensure comparability the Programmatic Rating Score was adjusted to the grant rating scale.

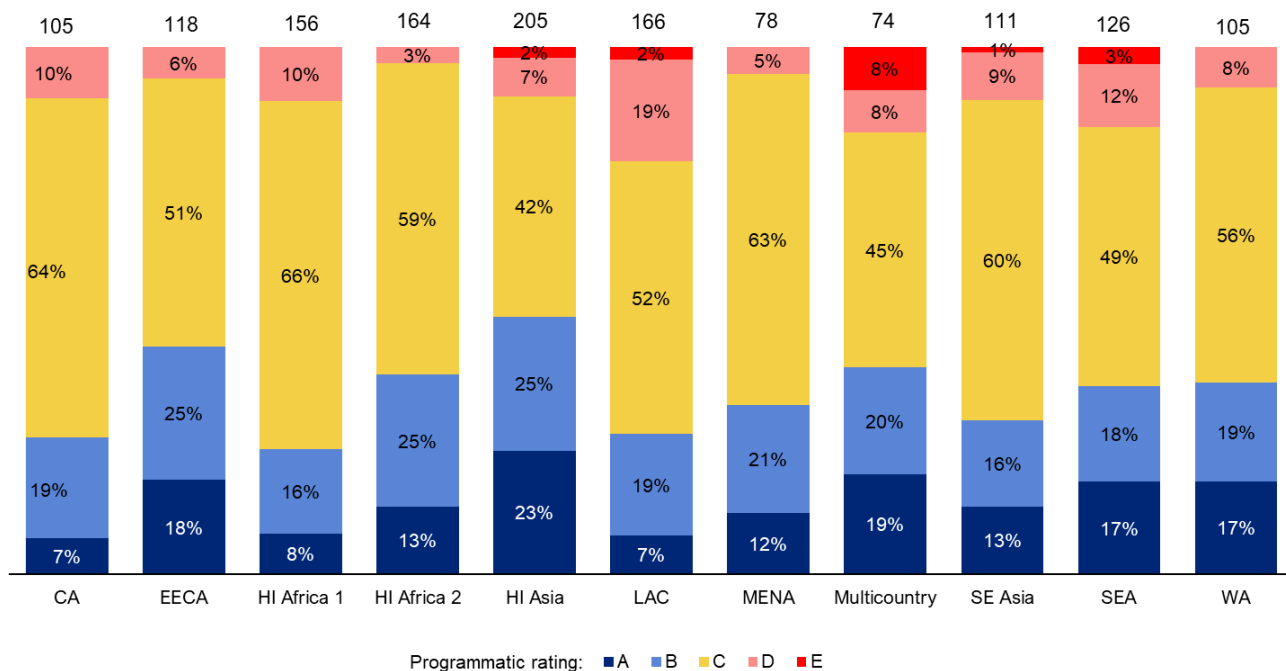


#### b. Regional Analysis

Figure G.2 presents an overview of programmatic rating per region for the whole 2018-2022 period. For the analysis each grant-year was counted as a single observation. Key highlights include:

- Regions with a high proportion of high performing grants included High Impact Asia which was the region with the highest percentage of grants rated A or B with 48%. This is followed by EECA with 43% and Multicounty grants with 39%. However, both HI Asia and EECA followed the overarching trend and had better results in 2018 (HI Asia had 67% of grants rated A and B and EECA 63%) then dropped in 2020 and had a slight recover by 2022 (High Asia had 44% and EECA 35%).
- Regions with a lower proportion of high performing grants include: High Impact Africa I (24%), Central Africa (26%), LAC (26%) and Southeast Asia (29%). All of these regions were performing better in 2018 compared with 2022.
- Regions with a high proportion of low performing grants include LAC (21%) and Multicounty grants (16) which also had by far the highest proportion of poor performing grants (rated E) with 8%. Multicounty grants were overrepresented in the lowest performing grants making up 32% of all E-rated grant-years compared to making up less than 5% of all grant-years.
- Regions with very few low performing grants include High Impact Africa 2 (3%), MENA (5%) and EECA (6%).

Figure G.2: Regional analysis of grant programmatic ratings (aggregated by grant-years) for 2018-2022

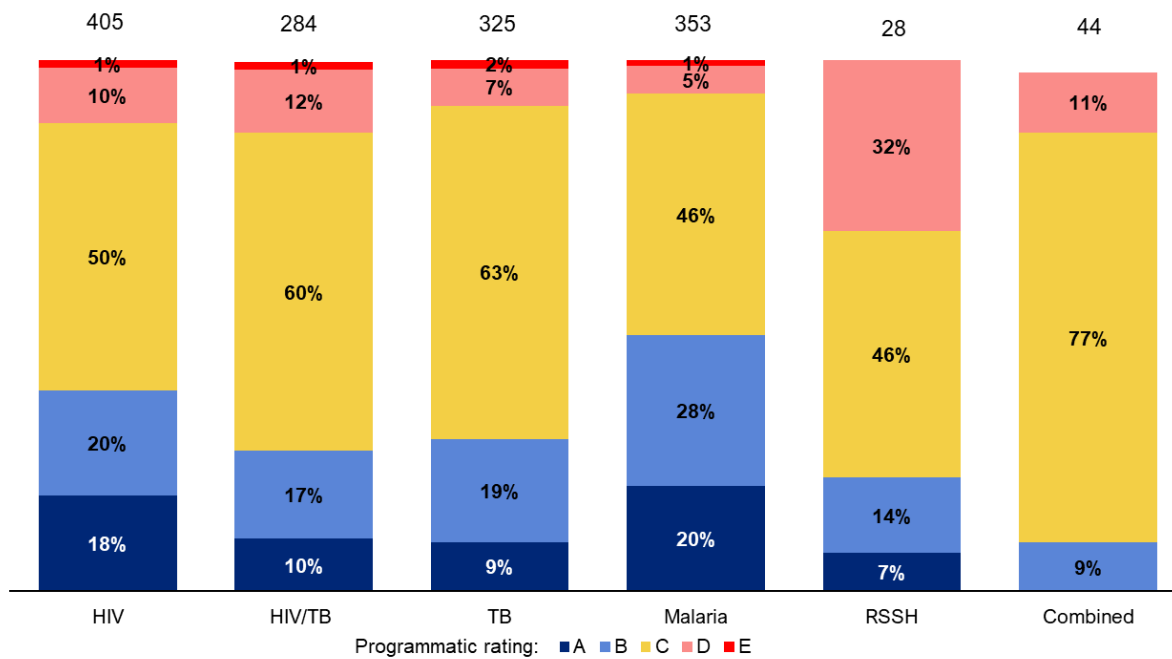


### c. Disease distribution

Figure G.3. provides an overview of programmatic rating across disease for the cumulative period 2018-2022. For the analysis each grant-year was counted as a single observation. Key highlights include:

- Malaria had the highest percentage of high rated grants, 48% of all its grants between 2018 and 2022 (20% A rated and 28% B rated). The trend of malaria grants was stable over time with 49% high rated in 2018 and 51% in 2022. Malaria grants also had the lowest proportion of low performing grants (6%).
- HIV had the second highest percentage of high rated grants with 38%. However, this has declined over the period with 47% being top rated in 2018 and dropping to 31% in 2022.
- HIV/TB had 27% of grants with high ratings on average, dropped from 43% in 2018 to 23% in 2019 and then stayed stable on that level.
- TB grants had an average of 28% dropping from 45% in 2018 to 14% in 2020, but since then have recovered to 27% in 2022. The drop in 2020 is likely driven by the challenges to the TB programme performance under COVID-19.
- RSSH grants had the highest proportion of poorly performing grants (32%).
- Combined grants (e.g., HTM grants) had no high achieving grants ratings and only 9% with a B rating.

Figure G.3. Overview of programmatic rating across disease (aggregated by grant-years) for 2018-2022



ii) *WS2: analysis of 2017-2022 kpis*

This appendix provides an overview of the key results against the KPIs of the 2017-22 Global Fund Strategy. The analysis is presented by KPI indicators and comments on the methodology, limitations, key results and changes under the KPI Framework. The analysis closely builds on the documentation provided by the Global Fund. Section H1-H12 provide an overview for each of the KPIs and H13 provides a brief overview of improvements made in the 2023-28 KPI Framework.

a. KPI 1 Public Health Impact

Area	KPI1a: Estimated number of lives saved
Definition	Estimated number of lives saved
Purpose	Measures the extent to which Strategic Objectives are achieving high level goals of lives saved and reduction of new infection/cases; strategic view towards maximizing portfolio impact.
Methodology	<p><b>Calculation Methodology:</b></p> <ul style="list-style-type: none"> <li>• HIV: lives saved from HIV-related prevention and treatment interventions is estimated by the UNAIDS Spectrum/Goals model and in the absence of calibrated model by the UNAIDS Spectrum/AIM model. The burden estimates underlying impact estimates are reviewed and signed off by countries during the UNAIDS regional workshops or annual updates.</li> <li>• TB: lives saved from TB-related interventions is estimated by the WHO Global TB Program and is derived by applying case fatality rate of untreated cases to the estimate of incidence and subtracting it from the estimate of TB deaths for the same years. The 'double-counting' of lives saved between TB and HIV is avoided by removing lives saved from treating HIV-positive TB patients from TB count.</li> <li>• Malaria: lives saved by the national malaria programs is estimated by the WHO Global Malaria Program and is derived by applying the estimate of malaria deaths rate in year 2000 as counterfactual (i.e. before scale up of malaria key interventions) to the population at risk over the following years and subtracting it from the actual malaria deaths for the same years.</li> </ul> <p><b>Data sources:</b> Various – see above</p> <p><b>Cohort:</b> Full portfolio of eligible countries</p>
Target	<p>29 million [28-30] million for the 2017-22 period aggregated across diseases</p> <p><b>Methodology:</b> The targets were modelled by the modelling teams who developed the 'Global Plan' targets using the same models in collaboration with the Global Fund Secretariat and the Global Fund modelling Secretariat at the Imperial College London under guidance of the Global Fund modelling Guidance Group which consisted of the technical partners including WHO and UNAIDS using a modelling framework. In this framework, the 'total envelope' of available resources for each disease for each country over the period of the strategy is the main input to the models. No distinction is made as to the origin of the monies (domestic or external, the Global Fund or other). The models then determine allocation of the money across program elements, and then project the impact that such a program would have on the epidemic. The overarching strategic direction for the allocation is set by the published guidance of the corresponding disease specific technical agency.</p>

Area	KPI1a: Estimated number of lives saved
Results - Overview	<p><b>On track (and always been on track)</b></p> <p><b>Results 2017-2021: 29.2 million</b></p> <p><i>In order to account for uncertainty in the modelling of the targets – the Global Fund considers the target to be achieved as long as results are within the target range (e.g., results need to be above lower bound, not mid-point).</i></p> <p><i>The next results will be released in spring 2024 - too late for inclusion in this review.</i></p>
Results – Deep dive	<ul style="list-style-type: none"> <li>• The Strategy Target for number of lives saved has already been met with 29.2 million lives have been saved by the GF Partnership across the portfolio over 2017-2021. Current projections indicate that the 2022 results will be in the range of 34.3 and 35.4 million lives saved – well above the Strategy target.</li> <li>• Overachieving lives saved targets is partly explained by a slower rate of decline in incidence rates which in turn resulted in the need to treat more patients.</li> </ul> <p><b>Disease insights</b></p> <ul style="list-style-type: none"> <li>• Although the Global Fund Board did not approve disease-specific impact targets, they were generated as part of the target setting exercise and are used for this analysis. Based on this <b>HIV and TB outperform whereas malaria is slightly below target:</b> <ul style="list-style-type: none"> <li>o HIV: “Projection Central Target”: 11.9m – Projection Results: 14.4-15.3m</li> <li>o TB: “Projection Central Target”: 10.7m – Projection Results: 14.3-14.4m</li> <li>o Malaria: “Projection Central Target”: 6.2m – Projection Results: 5.5 – 5.7m</li> </ul> </li> <li>• Looking at median mortality rate decline between 2015-2021 also shows most progress for HIV: 42% reduction for HIV; 1.6% reduction for TB and 9.5% reduction in Malaria</li> </ul> <p><b>Country and region insights:</b></p> <ul style="list-style-type: none"> <li>• Given the uncertainty with regard to specific country targets that have been modelled (e.g., use of standard assumptions including projection of available funding etc.), the specific performance against modelled targets on a country basis needs to be interpreted with care. It can however provide some guidance especially when complemented with trends in the mortality rate</li> <li>• Around half of the remaining gap is in Asia (52%) followed by West Central Africa (35%) and South-Eastern Africa (11%)</li> <li>• Poor performer: <ul style="list-style-type: none"> <li>o HIV: Nigeria and Mozambique have large gaps compared to Strategy target</li> <li>o TB: Philippines and India (and Indonesia) had an increase in TB mortality since 2015 and have a large gap to Strategy target</li> <li>o Malaria: Nigeria (and DR Congo and Angola) showed an increase in malaria mortality and have large gaps to Strategy targets</li> </ul> </li> <li>• Strong performer (within large countries) <ul style="list-style-type: none"> <li>o HIV: Zambia</li> <li>o TB: Kenya</li> <li>o Malaria: Mozambique performed relatively well (when compared for example to Nigeria)</li> </ul> </li> </ul>
Limitations	<p>Estimates produced by WHO/UNAIDS use standardized models and country-specific data collected through routine surveillance and survey in consultation with countries with variable quality and availability.</p> <p>There are also considerable assumptions that had to be made with regard to the Global Fund Secretariat modelling used to set the target. A key challenge includes the availability of robust country-specific service unit cost data for different interventions which were not available for all countries and</p>



Area	KPI1a: Estimated number of lives saved
	had to be borrowed from comparable countries or regions which makes it difficult to accurately model intervention costs and ultimately quantity of services at country level. Additionally, there are severe limitations in the estimated resource envelope for the Strategic period.
Changes under KPI Framework 2023-28	<b>This indicator has been changed.</b> Going forward the indicator will be measured against the reduction in the mortality rate rather than lives saved. The targets are still based on modelled targets which uses the same models as used by technical partners.
Evaluators comment	<ul style="list-style-type: none"> <li>The progress on KPI 1a needs to be interpreted with care as overachievement in this indicator is at least partly driven by the fact that incidence was not reduced as planned (or at least as predicted in the models used to set the targets).</li> <li>The breakdown of the results also shows that there are nuances across diseases, regions and countries – e.g., malaria not performing as well as projected at least in some settings</li> <li>The Global Fund should consider setting disease specific targets and report against these. To understand performance, it would be important to understand in which disease areas the results are worse / better than expected.</li> <li>The change to using mortality rates rather than lives saved is welcome. This was also included as a recommendation under SR2020. Major advantages include: (i) alignment across diseases and no longer needing to use different counterfactuals for estimating lives saved; (ii) addresses issues around the interdependency where lives saved increases if incidence reduction performs poorly; (iii) easier to interpret and more widely used.</li> </ul>

Area	KPI1b: Reduction in new infections / cases
Definition	Reduction in new infections / cases
Purpose	Measures the extent to which Strategic Objectives are achieving high level goals of lives saved and reduction of new infection/cases; strategic view towards maximizing portfolio impact.
Methodology	<p><b>Calculation Methodology:</b></p> <ul style="list-style-type: none"> <li>Step 1: calculate pooled incidence rate at the baseline and reporting year separately: <ul style="list-style-type: none"> <li>Calculate pooled incidence rate for the baseline year (2015) and reporting year (e.g. 2017) = sum of number of new infections (for HIV) or new cases (for TB and malaria) in year t / sum of population at risk across selected countries across eligible countries (e.g. 99 countries for HIV). Note: population at risk for HIV is the uninfected population in year t-1 (total population in year t-1 – people living with HIV in year t-1). For TB, it is total population in the same year (t). For malaria, total population at risk (defined by WHO) in the same year (t).</li> <li>Calculate % reduction between 2015 and year t in pooled incidence rate for each disease = (incidence rate in 2015 – incidence rate in year t)/incidence rate in year 2015</li> </ul> </li> <li>Step 2: calculate average reduction in incidence across 3 diseases as a simple arithmetic mean of three pooled % reductions from three diseases.</li> </ul> <p><b>Data sources:</b> Various – see under KPI1a for data sources</p> <p><b>Cohort:</b> Full portfolio of eligible countries</p>
Target	<p>38% [28-47] % reduction in incidence rate from 2015 to 2022 averaged across the three diseases</p> <p><b>Methodology:</b> The targets were modelled by the modelling teams who developed the ‘Global Plan’ targets using the same models in collaboration</p>

Area	KPI1b: Reduction in new infections / cases
	<p>with the Global Fund Secretariat and the Global Fund modelling Secretariat at the Imperial College London under guidance of the Global Fund modelling Guidance Group which consisted of technical partners including WHO and UNAIDS using a modelling framework. In this framework, the ‘total envelope’ of available resources for each disease for each country over the period of the strategy is the main input to the models. No distinction is made as to the origin of the monies (domestic or external, the Global Fund or other). The models then determine allocation of the money across program elements, and then project the impact that such a program would have on the epidemic. The overarching strategic direction for the allocation is set by the published guidance of the corresponding disease specific technical agency.</p>
Results - Overview	<p><b>Off track (been offtrack since 2022 before at risk)</b></p> <p><b>Results 2017-2021: 16.2 %</b></p> <p><i>In order to account for uncertainty in the modelling of the targets – the Global Fund considers the target to be achieved as long as results are within the target range (e.g., results need to be above lower bound, not mid-point).</i></p> <p><i>The next results will be released in spring 2024 - too late for inclusion in this review.</i></p>
Results – Deep dive	<ul style="list-style-type: none"> <li>Recent trends project results to be between 15.2% and 20.2% at end 2022 making it extremely unlikely that target will be met (more likely will be around 2/3 achievements against lower bounds or around half achievement against mid-point)</li> </ul> <p><b>Disease insights</b></p> <ul style="list-style-type: none"> <li>Although the Global Fund Board did not approve disease-specific impact targets, they were generated as part of the target setting exercise and are used for this analysis. Based on this, all diseases are significantly missing their targets – especially HIV and TB (when compared against lower bound target only): <ul style="list-style-type: none"> <li>HIV: “Projection Central Target”: -66% [59%-72%] – Projection Results: -38.2% to -38.8%</li> <li>TB: “Projection Central Target”: -35% [29%-37%] – Projection Results: -8.5% to -15.2%</li> <li>Malaria: “Projection Central Target”: -21% [5.4% - 35%] – Projection Results: 1.1% - 6.5%</li> </ul> </li> <li>Median reduction for HIV is 40%, for TB 2% and for malaria 4.7%. Thus, for HIV there has been significant reduction but just way below what was targeted whereas the progress for TB and malaria is overall limited.</li> </ul> <p><b>Country insights:</b></p> <ul style="list-style-type: none"> <li>Given the uncertainty with regard to specific country targets that have been modelled (e.g., use of standard assumptions including projection of available funding etc.), the specific performance against modelled targets on a country basis needs to be interpreted with care. It can however provide some guidance especially when complemented with trends in the incidence rate</li> <li>Around 80% of the Strategy gap is West Central Africa followed by South-Eastern Africa (11%)</li> <li>Poor performer: <ul style="list-style-type: none"> <li>HIV: Nigeria, South Africa and Mozambique have large gaps compared to Strategy target (despite reduction in incidence). Philippines also didn’t perform well against modelled target.</li> <li>TB: Philippines and Indonesia had an increase in TB incidence; there are also still a gap in India and Pakistan despite some progress</li> </ul> </li> </ul>

Area	KPI1b: Reduction in new infections / cases
	<ul style="list-style-type: none"> <li>o Malaria: Nigeria (and DR Congo and Angola) showed an increase in malaria incidence and drive gap in malaria</li> <li>• Strong performer <ul style="list-style-type: none"> <li>o HIV: Zambia and Cote d'Ivoire performed relatively well compared to targets</li> <li>o TB: South Africa had big improvements (though from very high levels)</li> <li>o Malaria: Mozambique performed relatively well</li> </ul> </li> </ul>
Limitations	<p>Estimates produced by WHO/UNAIDS use standardized models and country-specific data collected through routine surveillance and survey in consultation with countries with variable quality and availability.</p> <p>There are also considerable assumptions that had to be made with regard to the Global Fund Secretariat modelling used to set the target. A key challenge includes the availability of robust country-specific service unit cost data for different interventions which were not available for all countries and had to be borrowed from comparable countries or regions which makes it difficult to accurately model intervention costs and ultimately quantity of services at country level. Additionally, there are severe limitations in the estimated resource envelope for the Strategic period.</p>
Changes under KPI Framework 2023-28	<b>This indicator has been maintained.</b>
Evaluators comment	<ul style="list-style-type: none"> <li>• KPI 1b is an important indicator illustrating the challenges faced by the Global Fund with regard to incidence reduction.</li> <li>• The exact underlying reasons are harder to pinpoint but likely is a combination of: (i) changing external factors (including COVID-19); (ii) challenges with regard to prevention programmes especially for KPs; (iii) potentially modelling assumption that set too ambitious targets for prevention but also (iv) either underinvestment in prevention by GF and partners as well as challenges to successfully implement prevention programmes.</li> <li>• The Global Fund should consider setting disease specific targets and report against these. To understand performance, it would be important to understand in which disease areas the results are worse / better than expected.</li> </ul>

b. KPI 2 Service Delivery Indicators

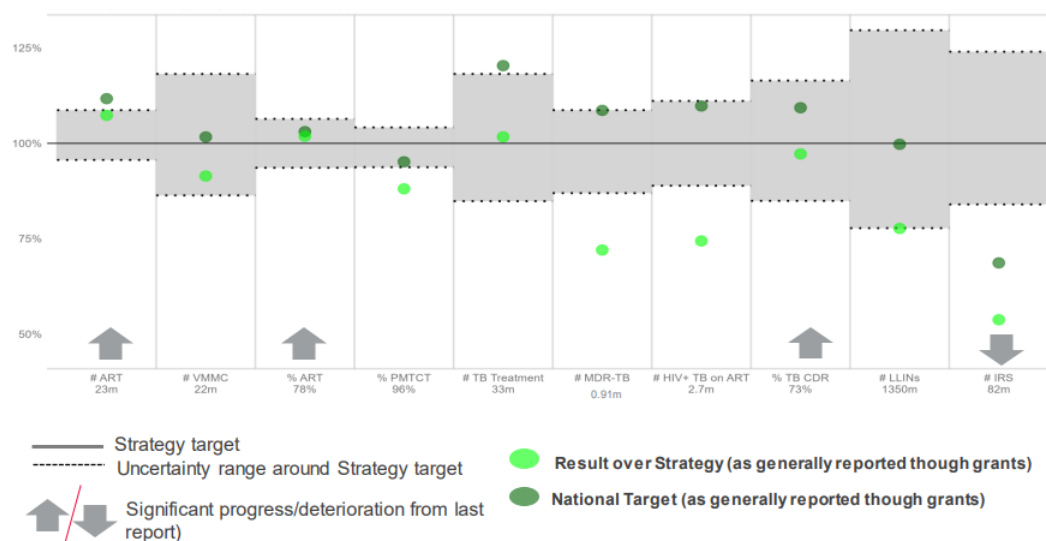
Area	KPI 2 Service Delivery Indicators
Definition	A total of 17 Service Delivery indicators (details below in the tables)
Purpose	<p>Measures extent to which the Strategic Objectives are achieving the high-level service delivery targets at levels of coverage and quality required to deliver impact. Measures have been reviewed and endorsed by technical partners.</p> <p>As projection methodology is strengthened and results forecast is institutionalized, the indicator will drive portfolio performance management in conjunction with work with partners.</p>
Methodology	<p><b>Calculation Methodology:</b> Various – see Tables with indicator details (below)</p> <p><b>Data sources:</b> Various – see Tables with indicator details (below)</p>

Area	KPI 2 Service Delivery Indicators
	<b>Cohort:</b> Various – see Tables with indicator details (below)
Target	<p><b>Methodology:</b> The targets for KPI2 indicators have been set in two ways – either modelled or non- modelled.</p> <p>For indicators with modelled targets, this was based on the same modelling framework also used under KPI 1. In this framework, the ‘total envelope’ of available resources for each disease for each country over the period of the strategy is the main input to the models. No distinction is made as to the origin of the monies (domestic or external, the Global Fund or other). The models then determine allocation of the money across program elements, and then project the impact that such a program would have on the epidemic. The overarching strategic direction for the allocation is set by the published guidance of the corresponding disease specific technical agency. The models used are the same as those agencies have used in their most recent ‘Global Plans’.</p> <p>Some of the KPI 2 indicators are not amenable to the same disease transmission model-based analysis because the data available are not sufficient to define a functional relationship between those indicators, costs and effects. Here, instead of using disease transmission models, targets are derived from a benchmarking exercise and using the Global Plan targets as the upper bound of the range. The lower bound is derived by analysing the distribution of performance against each indicator among the set of Global Fund eligible countries, and setting the lower bound to correspond, generally, to the 75th percentile value of that distribution. This lower bound represents the coverage or outcome that countries with better performance have managed to reach.</p>
Results - Overview	<p><b><i>Partially achieved (and always has been marked at risk)</i></b></p> <p>The performance against this indicator depends on the specific indicators (see Table below for more details)</p>
Results – Deep dive	<p><b>Overall:</b></p> <ul style="list-style-type: none"> <li>Indicators are in Strategy range for most indicators with modelled targets, but not those with non-modelled targets. For some services (e.g. MDR-TB, HIV+ TB on ART), the grant results are out of the target range for the reasons explained further down.</li> </ul>

## Area

## KPI 2 Service Delivery Indicators

Comparison between grant targets and modelled strategy targets at portfolio level over 2017-2022 (for #VMMC, #TB treated, #MDR-TB treated, #HIV+ TB on ART, #LLINs and #IRS) or at 2022 (for #ART, %ART, %PMTCT, %TB CDR)



Note: For IRS, since Global Fund is not the main supporter of this intervention, due to missing data for majority of countries, the alignment assessment presented above is not representative of the portfolio performance.

- Generally, grant performance, measured as achievement against national targets (delta between dark and light green above), has improved in 2022 and 2021 after there were severe disruption in 2020 due COVID-19.
- Very significant loss of progress was seen in 2020 in the context of COVID-19, with grant indicators performing at historically lowest level, with TB (detection, notification, MDR on treatment) and VMMC especially affected.

### HIV overview:

- ART indicators (# of patients and coverage) achieved the 2022 Strategy target. This can be attributed to strong sustained performance across the Strategy period and successful COVID-19 mitigation.
- PLHIV who know their status and Viral Load Suppression were considered partially achieved with 81% and 87% of countries in the cohort are in target range (with high results in HIV priority countries)
- VMMC results are within the Strategy target range, despite setbacks caused by the COVID-19 pandemic (though mostly funded through PEPFAR)
- PMTCT coverage (due to poor performance in a few key countries) and PLHIV who started TB preventative treatment (due to poor performance) did not achieve Strategy targets
- COVID-19 disruptions were largest on prevention indicators (VMMC and testing) and less on treatment in 2020. PMTCT and PLHIV who started TB preventative treatment less affected by COVID-19 but still underperforming.

### TB overview:

- TB notifications (number/ rate) are within target range despite significant negative impact of COVID-19 in 2020 and 2021
- Other KPIs did not achieve Strategy targets:
  - # of MDR-TB cases on treatment (due to poor national performance)
  - HIV/TB co-infections on ART (although the performance framework targets for HIV/TB co-infections on ART were largely aligned with the strategy targets, the strategy target was not met due to cascade effect, i.e. low TB case detection and low HIV case detection among the notified

Area	KPI 2 Service Delivery Indicators
	<p>TB cases, as well as significant updates in incidence estimates for South Africa, the largest country in cohort)</p> <ul style="list-style-type: none"> <li>o <i>DS-TB TSR and MDR-TB TSR</i> (due to ambitious strategy targets and challenges from COVID-19)</li> <li>o <i>COVID-19</i>: had a significant effect on TB in 2020, reversing some of the strong progress observed since the beginning of the strategy. This included a decrease in TB notifications as well as MDR-TB. However, there was a rebound in 2022 especially for TB case notifications.</li> </ul> <p><b>Malaria overview:</b></p> <ul style="list-style-type: none"> <li>• <i>% cases tested in public facilities</i> considered partially achieved as 88% of countries are within target</li> <li>• Ambitious <i>IPTp3</i> target was clearly not met due to historically very low national targets compounded by poor performance</li> <li>• <i>LLINs</i>– KPI is considered to be partially achieved, as there is less than a 5% relative difference to the lower bound (with current result also considered an underestimation as key country data, including India, is still only partially available)</li> <li>• <i>IRS</i>- KPI considered not achieved although results based on a cohort of 9 out of 36 original countries, i.e., those for which data was available, therefore usefulness of KPI limited</li> <li>• <i>COVID-19</i>: impacted programmes but performance was stable due to strong efforts in 2020.</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>• Time lag for the reporting results and data quality and availability for some indicators such as VMMC, knowing HIV status, viral load suppression, IPT coverage, IPTp3 coverage and IRS will remain a challenge.</li> <li>• There are also considerable assumptions that had to be made with regard to the Global Fund Secretariat modelling used to set the target. A key challenge includes the lack of accurate costing data for different interventions which makes it difficult to accurately model intervention costs and ultimately quantity. Additionally, there are severe challenges in estimating the resource envelope for the Strategic period.</li> </ul>
Changes under KPI Framework 2023-28	<p><b>This indicator has been maintained with updates to the methodology and addition of new indicators.</b> Key changes include: (i) all targets are set based on the grant performance targets rather than a separated model – the aim of this is to increase Global Fund accountability and actionability; (ii) new indicators have been added such as an indicator on SMC and TB contacts on preventative treatment</p>
Evaluators comment	<ul style="list-style-type: none"> <li>• KPI2 provides the outcomes of the key interventions supported by the Global Fund and as such is a key performance measure for the Global Fund.</li> <li>• Overarchingly, the KPI2 indicators have been well selected and designed. One weakness has been the way in which targets have been set. In particular, the non-modelled targets were understood to be overambitious and should be interpreted with care.</li> <li>• KPI2 was previously critiqued as being too far removed from the Global Fund accountability as it covers both grant and national level, and the Strategy targets were not directly linked to the grant performance target of the Global Fund. This has been addressed in the new updated KPI Framework. While this is generally a welcomed change, it also brings closer attention to the fact how grant targets are set – (e.g., how consistent they are, what guidance is provided) especially with regard to the level of ambition and how well they are targeted at areas supported by the Global Fund (e.g., are they at the national or sub-national level). The change towards using the grant performance framework has its advantages but comes with its own set of challenges (thus, good that modelled targets are still used as guidance and comparison points when grant performance targets are set).</li> </ul>

Area	KPI 2 Service Delivery Indicators
	<ul style="list-style-type: none"> <li>• The indicators also were weaker for prevention – e.g., there were no indicators on SMC / preventative TB which have now been added in the new Framework</li> <li>• Overall, the KPI are providing a sense of the direction and challenges of the Global Fund – e.g., strong performance around treatment but more challenges around prevention intervention. In that way, the results are aligned with KPI 1 that showed weaker performance on incidence.</li> <li>• There are some challenges with regard to the cohorts which differ considerable between indicators and diseases. And have also been set with different focus in mind – e.g., TB has been as inclusive as possible whereas HIV focused on select priority countries.</li> </ul>



Table H.1: Results of HIV indicators

Indicator	Methodology	Target	Results	Results deep dive and evaluator comments
# of adults and children currently receiving ART	<b>Calculation:</b> Sum of numerical result <b>Cohort:</b> 99 of 99 countries <b>Data:</b> Global Fund performance framework or UNAIDS/ WHO	23m [22-25] <b>Modelled</b>	<b>Achieved</b> 24.7 million in 2022	<ul style="list-style-type: none"> <li>Despite the COVID-19 disruption, grant performance against their own targets was maintained at acceptable level across portfolio</li> <li>Small drop in grant performance in 2020 (median 89%) compared to 2017-19 with 91% but then improvement to 94% in term</li> <li>Remaining gap mostly in Asia including Indonesia, Philippines and Pakistan but most countries performed well especially in SSA</li> </ul>
# of males circumcised	<b>Calculation:</b> Sum of numerical result <b>Cohort:</b> 14 priority countries selected with partners <b>Data:</b> Global Fund performance framework or UNAIDS/ WHO	22m [19-26] <b>Modelled</b>	<b>Achieved</b> 20.1. million by 2022	<ul style="list-style-type: none"> <li>Despite the COVID-19 impact, the final result of 20m is within the Strategy target range</li> <li>Large drop in grant performance from 2017-19 with median of 94%, to 31% in 2020 and recovery in 2021 of 38% and 2022 of 51%</li> <li>VMMC is predominantly funded by PEPFAR so only a few GF grants have corresponding performance data and GF has only limited leverage in driving performance</li> <li>Key gaps in case study countries: Mozambique, South Africa</li> </ul>
% of HIV+ pregnant women receiving ART for PMTCT	<b>Calculation:</b> # receiving PMTCT / # need PMTCT <b>Cohort:</b> 26 priority countries selected with partners <b>Data:</b> Global Fund performance framework or UNAIDS/ WHO	96% [90-100%] <b>Modelled</b>	<b>Not achieved</b> 84.6% in 2022	<ul style="list-style-type: none"> <li>Results have declined compared to 2019</li> <li>Aggregate PF targets low vs. Strategy targets for majority of countries. Even if all grants had achieved their PF targets, the Strategy target range would have been just in reach</li> <li>The gap is partly driven by Nigeria (both with low targets and suboptimal performance)</li> </ul>
% of adults and children currently receiving ART among all adults and children living with HIV	<b>Calculation:</b> # receiving ART / # need ART <b>Cohort:</b> 33 priority countries selected with partners <b>Data:</b> Global Fund performance framework or UNAIDS/ WHO	78% [73-83%] <b>Modelled</b>	<b>On target</b> 79.4% at end 2022	<ul style="list-style-type: none"> <li>Latest results of 79.4% ART coverage meet Strategy target</li> <li>Key remaining gaps in South Africa, Indonesia, Pakistan and Philippines</li> </ul>
% of people living with HIV who know their status	<b>Calculation:</b> % of countries meeting target performance level of over 80% <b>Cohort:</b> 33 priority countries selected with partners	33 countries with >80% <b>Non-modelled</b>	<b>Partially achieved</b> 26 countries in 2022 (results)	<ul style="list-style-type: none"> <li>81% of countries with data (26 countries) are within target range, therefore the target is considered to have been partially achieved (i.e. 67%-90% of countries in cohort are in target range)</li> </ul>

Indicator	Methodology	Target	Results	Results deep dive and evaluator comments
	<b>Data:</b> Global Fund performance framework or UNAIDS/ WHO		available for 32 countries)	<ul style="list-style-type: none"> <li>Results relatively high (over 80%) in most of the countries with largest incidence</li> <li>Country case study performance: <ul style="list-style-type: none"> <li>Met target: South Africa, Mozambique, Kenya, Nigeria, India, CIV, Zambia</li> <li>Did not meet target: Philippines, South Sudan, Pakistan</li> </ul> </li> </ul>
PLHIV newly enrolled in care that started preventative therapy for TB, after excluding active TB	<b>Calculation:</b> % of countries meeting target performance level of over 80% <b>Cohort:</b> 35 priority countries selected with partners <b>Data:</b> Global Fund performance framework or UNAIDS/ WHO	35 countries with >80% (but only data for 29) <b>Non-modelled</b>	<b>Not achieved</b> 26% of countries (i.e. 8 countries) in 2022	<ul style="list-style-type: none"> <li>At the end of 2022, 26% of cohort countries with data i.e. 8 countries were in the Strategy target range (data was not available for 4 countries)</li> <li>Country case study performance: <ul style="list-style-type: none"> <li>Met target: Mozambique, Nigeria, Cameroon, Philippines</li> <li>Did not meet target: Kenya, CIV, Pakistan</li> </ul> </li> </ul>
Adults and children on ART who are virologically suppressed	<b>Calculation:</b> % of people on ART with viral load suppression <b>Cohort:</b> 33 priority countries selected with partners <b>Data:</b> UNAIDS/ WHO	90% of adults and children in all 33 cohort countries	<b>Partially achieved</b> 27 countries in 2022	<ul style="list-style-type: none"> <li>87% of cohort countries for which data is available (27 countries) are within target range (data not available for 2 countries). Target considered partially achieved i.e. between 67%-90% of countries in cohort in target range</li> <li>Results high (over 90%) in all HIV priority countries especially countries with the largest number of patients on ART</li> </ul>

*Table H.2: Results of TB indicators*

Indicator	Methodology	Target	Results	Results deep dive and evaluator comments
<b># of notified cases</b> of all forms of TB - bacteriologically confirmed plus clinically diagnosed, new and relapses	<b>Calculation:</b> Sum of numerical result <b>Cohort:</b> Full portfolio of eligible countries (96 countries) <b>Data:</b> Global Fund performance frameworks (PF) or WHO	33m [28-39] <b>Modelled</b>	<b>Achieved</b> 33.6 million in 2021	<ul style="list-style-type: none"> <li>Despite the significant COVID-19 impact, the result is within target range, thanks to high pre-2020 achievements and successful mitigation of COVID-19</li> <li>Drop in grant performance in 2020 (median 73%) compared to 2017-19 with 85% but then improvement to 79% in 2021 and 87% in 2022</li> <li>Positive results driven by TB high burden countries in Asia (including India, Philippines) and Africa (including Nigeria, Mozambique) with very ambitious national / grant targets</li> <li>Gap to Strategy target driven by South Africa, partly due to very ambitious modelled projects not reflecting declining incidence</li> </ul>

Indicator	Methodology	Target	Results	Results deep dive and evaluator comments
<b>% of notified cases of all forms of TB -</b> bacteriologically confirmed plus clinically diagnosed, new and relapses among all estimated cases (all forms)	<b>Calculation:</b> # number of new and relapse cases notified / estimated number new TB cases <b>Cohort:</b> Full portfolio of eligible countries (96 countries) <b>Data:</b> Global Fund performance framework or WHO	73% [62-85%] <b>Modelled</b>	<b>Achieved</b> 71.2% in 2022	<ul style="list-style-type: none"> <li>Despite the significant COVID-19 impact, final result is within Strategy target range thanks to high pre-2020 achievements and successful mitigation of COVID-19.</li> <li>There was a drop from 2019 levels (~ 70%) which then dropped to 56% in 2020 mostly due to COVID-19</li> </ul>
<b># of cases with drug-resistant TB</b> (RR-TB and/or MDR-TB) that began second-line treatment	<b>Calculation:</b> Sum of numerical result <b>Cohort:</b> Cohort comprised of 87 countries <b>Data:</b> Global Fund performance frameworks (PF) or WHO	920k [800k-1,000k] <b>Modelled</b>	<b>Not achieved</b> 663k by 2022	<ul style="list-style-type: none"> <li>Aggregate PF targets exceed Strategy target, so achievement of 2022 target may have been possible assuming strong performance</li> <li>However, due to poor national performance and the impact of COVID-19, the final result is far below the target range</li> <li>The gap between the low and high projections is driven by South Africa (low targets) and Pakistan (low targets and poor performance)</li> </ul>
<b># of HIV-positive registered TB patients</b> (new and relapse) given anti-retroviral therapy during TB treatment	<b>Calculation:</b> Sum of numerical result <b>Cohort:</b> Cohort comprised of 93 countries <b>Data:</b> Global Fund performance frameworks (PF) or WHO	2.7m [2.4-3.0] <b>Modelled</b>	<b>Not achieved</b> 2.0m by 2022	<ul style="list-style-type: none"> <li>The targeted number of patients on ART was consistently not met through the Strategy period and the KPI target was not achieved</li> <li>Generally, underperformance caused by lower number of HIV/TB co-infections detected compared to modelling (caused by challenges in TB case detection and/or unrealistic modelled HIV-positive incidence)</li> <li>Country case study performance: Gap in South Africa (however mainly attributed to ambitious modelled projects, not reflecting declining incidence) and India and Nigeria (poor performance)</li> </ul>
<b>% of TB cases, all forms, bacteriologically confirmed plus clinically diagnosed, successfully treated</b> (cured plus treatment completed) among all notified TB cases (drug susceptible)	<b>Calculation:</b> New TB cases cured or completed treatment/New TB cases cohort. % of countries meeting target performance level <b>Cohort:</b> Cohort of 99 countries <b>Data:</b> Global Fund performance frameworks (PF) or WHO	90% [88% - 90%] <b>Non-modelled</b>	<b>Not achieved</b> 36% in 2021	<ul style="list-style-type: none"> <li>36% of cohort countries with data were within Strategy target range at the end of 2021, therefore the final result is not achieved</li> <li>As results for this indicator are from 2021, COVID-19 may have had an impact on results.</li> <li>Median portfolio results over Strategy period have consistently been 85-86%. Also TSR is relatively high (80% or more) for many countries with a large share of Strategy target in notifications.</li> <li>Country case study performance: relatively high (80%) or more in India, Mozambique, Pakistan, Nigeria and the Philippines. Gaps in Kyrgyzstan, South Africa, Bolivia, and CIV</li> </ul>

Indicator	Methodology	Target	Results	Results deep dive and evaluator comments
<b>% of bacteriologically-confirmed RR and/or MDR-TB cases successfully treated</b> (cured plus completed treatment) among those enrolled on second-line anti TB treatment*	<b>Calculation:</b> RR-TB and/or MDR-TB cases successfully treated / RR-TB and/or MDR-TB cohort. % of countries meeting target performance level <b>Cohort:</b> 33 priority countries selected with partners <b>Data:</b> Global Fund performance framework or UNAIDS/ WHO	33 countries with >85% <b>Non-modelled</b>	<b>Not achieved</b> 50% of cohort countries with data in range	<ul style="list-style-type: none"> <li>50% of countries with data (i.e. 14 countries) are within target range, therefore the final KPI result is not achieved</li> <li>Median results across the portfolio show that TSR is gradually improving over the Strategy period from 67% in 2017 to 75% in 2020, despite the use of longer regimens. Introduction and scale up of all-oral regimens for MDR-TB likely to improve outcomes.</li> </ul>

Table H.3: Results of Malaria indicators

Indicator	Methodology	Target	Results	Results deep dive and evaluator comments
<b># of LLINs</b> distributed to at-risk-populations	<b>Calculation:</b> Sum of numerical result <b>Cohort:</b> Full portfolio of eligible countries (63 countries) <b>Data:</b> Global Fund performance frameworks (PF)	1.350m [1.050-1.750]m <b>Modelled</b>	<b>Partially achieved</b> 1.049 million by 2022	<ul style="list-style-type: none"> <li>Despite the COVID-19 impact, national results were broadly sustained. Between 2017 and end 2022 at least 1,049 million bed nets were distributed, just below the lower bound of the target range. As there is less than a 5% relative difference to the lower bound, the KPI is considered partially achieved.</li> <li>Modelled projections defined nationally, but grant targets/ results sometimes subnational and therefore underestimate the actual number of nets distributed nationally (important issue for India)</li> <li>Key gaps in case study countries: India, Nigeria and Kenya</li> </ul>
<b># of households</b> in targeted areas that received IRS	<b>Calculation:</b> Sum of numerical result <b>Cohort:</b> Full portfolio of eligible countries (36 countries) <b>Data:</b> Global Fund performance frameworks (PF) or WHO	250m [210-310] <b>Modelled</b>	<b>Not achieved</b> 44 million in 2022 (based on 9 countries reporting reliable data)	<ul style="list-style-type: none"> <li>Even though the initial cohort for this KPI included 36 countries, only <b>9 of them</b> (representing approximately one third of the total 2022 Strategy Target) are providing reliable national data</li> <li>In the absence of relevant partners data, the performance of the KPI was assessed on the basis of this small cohort, i.e. against a recalibrated target of 81.9m instead of 250m</li> <li>Usefulness of this KPI result is therefore limited</li> </ul>
<b>% of suspected malaria cases</b> that receive a parasitological test	<b>Calculation:</b> # of suspected malaria cases that received a parasitological test in the public sector/ # of suspected malaria cases reported in the public sector. % of countries meeting target performance level	90% [85-100%] <b>Non-Modelled</b>	<b>Partially achieved</b> 88% of countries in target range in 2022	<ul style="list-style-type: none"> <li>Cohort of 80 countries, with data on results not available in 7 countries</li> <li>The majority of countries (88%) are within target, but the KPI is considered as partially achieved (i.e. between 67% and 90% of countries meet threshold)</li> </ul>

Indicator	Methodology	Target	Results	Results deep dive and evaluator comments
	<b>Cohort:</b> Full portfolio of eligible countries (80 countries) <b>Data:</b> Global Fund performance frameworks (PF) or WHO			
<b>% of women who received at least 3 doses of IPTp for malaria during ANC visits during their last pregnancy in selected countries*</b>	<b>Calculation:</b> # of pregnant women who received at least 3 doses of IPT/ # of pregnant women attending ANC. % of countries meeting target performance level <b>Cohort:</b> 36 countries <b>Data:</b> Global Fund performance frameworks (PF) or WHO	70% [60-80%] <b>Non-Modelled</b>	<b>Not achieved</b> 25% of countries in target range in 2022	<ul style="list-style-type: none"> <li>• Cohort of 36 countries, of which 32 have results</li> <li>• This indicator continues to show low national targets</li> <li>• Only 25% of countries with projections are expected to be within Strategy range, and most countries are far from meeting their national targets therefore this KPI is considered as not achieved</li> <li>• Key gaps in case study countries: including South Sudan, Nigeria, CIV</li> </ul>

c. KPI 3 Alignment of investment & need

Area	KPI3: Alignment of investment & need
<b>Definition</b>	Alignment between investment decisions and country “need”; with need defined in terms of disease burden and country economic capacity
<b>Purpose</b>	The measure tracks the extent to which the Global Fund is able to rebalance the grant portfolio to effectively invest funds in the countries where need is greatest. Performance is driven by the design of the allocation methodology and the ability of countries, particularly those with high burden and low economic capacity, to use allocated funds.
<b>Methodology</b>	<p>A: GF investment = country’s share of all funds <u>disbursed</u> over the current year plus previous 2 years</p> <p>B: Need = country’s share of allocation formula “Initial Calculated Amount”, i.e. disease burden and country economic capacity, adjusted for minimum/maximum shares &amp; external financing</p> <p>Result = Total of absolute values of (A minus B for each country)</p>
<b>Target</b>	Below 0.293 at the end-2022 (based on 2020-2022 allocation definition of need)
<b>Results – Overview</b>	<p><b>On track (and always been on track with exception of S2018)</b></p> <p><i>Results 2022: 0.231</i></p>
<b>Results – Deep dive</b>	<p>The deviation between needs and disbursements has been reducing in recent years.</p> <p><b>Country trends:</b></p> <ul style="list-style-type: none"> <li>• High-Impact countries with larger allocation amounts tend to have the largest gap between allocation and investment and these include Mozambique, South Africa and Zimbabwe (and in previous years India). But this is driven largely by the fact that High Impact countries have the highest share in need and investments.</li> <li>• Other countries such as Russia or Rwanda also show imperfect alignment.</li> </ul>
<b>Limitations</b>	<p>Country “need” is determined by the allocation methodology. It does not provide a measure of how investment relates to “need” within country.</p> <p>There are challenges with regard to the methodology as achievement is much more dependent on minor changes in High Impact countries rather than larger divergence of investment and allocation in focus and core countries.</p>
<b>Changes under KPI Framework 2023-28</b>	<b>This indicator has been dropped.</b> Reportedly as it was not considered to have a big value-add with regard to decision-making (and similar to indicator KPI7a on allocation utilisation) and was not really considered a suitable “performance” indicator for the GF Strategy. It was also considered hard to interpret.
<b>Evaluators comment</b>	The positive result of this KPI should not be over-interpreted as it has a narrow focus and essentially measures if portfolio optimisation moves funding away from countries compared to their original allocation under the allocation model.

<b>Area</b>	<b>KPI3: Alignment of investment &amp; need</b>
	The indicator <b>lacks actionability</b> for the Global Fund and it makes sense that the indicator has been dropped in the updated KPI Framework.
d. KPI 4 Investment efficiency	
<b>Area</b>	<b>KPI4: Investment efficiency</b>
<b>Definition</b>	Change in cost per life saved or infection/case averted from supported programs
<b>Purpose</b>	Maximizing impact of all available funding from national and international sources through mobilizing technical partners to support countries in applying disease transmission and costing models to inform development of NSP and funding requests to Global Fund. Increased use of models catalyses use of epidemiological and financial data to improve the design of country-level programming to increase value for money of grant investments – this indicator will track these gains.
<b>Methodology</b>	<p><b>Calculation methodology:</b> At least one of the two indicators (cost per life saved or cost per infection/case averted) show efficiency improvement: <math>IE\ improvement = (IES1 - IES2) / IES1</math></p> <p>Investment Efficiency (IE) = cost per life saved and cost per infection/case averted of the country program</p> <ul style="list-style-type: none"> <li>• Scenario 1 (S1), business as usual (had resources been allocated and utilized as they were during the last replenishment period)</li> <li>• Scenario 2 (S2), action scenario (resources are allocated and utilized under the current replenishment period)</li> </ul> <p><b>Data Source:</b> Results of the allocative efficiency models provided by the modelling teams through in-country process with country participation and ownership or desk exercise in the absence of in-country process</p> <p><b>Cohort:</b> High impact countries for all 3 diseases</p>
<b>Target</b>	90% of countries measured show a decrease or maintain existing levels of cost per life saved or infection/case averted for the current allocation period
<b>Results – Overview</b>	<p><b>On track (and always been since it started reporting in S19)</b></p> <p><i>Result 2022 – 98% of countries showing a high likelihood of efficiency improvements for 2020-22 Allocation period</i></p>
<b>Results – Deep dive</b>	<ul style="list-style-type: none"> <li>• Results of all 20 HIV national disease programs have been finalized with all but one country (95%) demonstrating a decrease in cost per life saved or infection/case averted over the 2020-2022 Allocation period, indicating improved grant design leading to efficiency improvement of national programs.</li> <li>• Results of 4 malaria national disease programs have been finalized with 4 countries (100%) demonstrating a decrease in cost per life saved or case averted over the 2020-2022 Allocation Period. Limited number of countries were assessed due to the unavailability of well calibrated model for countries in Asia and limited capacity of external teams in supporting the assessment.</li> <li>• Results for the 24 countries for TB have also all demonstrated a high likelihood of efficiency improvement for the 2020-22 Allocation Period.</li> <li>• There remain outstanding assessments due to data accuracy challenges which have been compound by the impact of COVID-19.</li> </ul>



Area	KPI4: Investment efficiency
<b>Limitations</b>	<p>Focus is on allocative efficiency of the national program/national strategic plan, not Global Fund-specific investment.</p> <p>Limited or weak data on past spending as a key input for this assessment.</p> <p>Limited capacity in some of the key countries to conduct this exercise.</p> <p>Limited partner capacity available to support country level modelling.</p> <p>Limitations of some of the modelling tools.</p>
<b>Changes under KPI Framework 2023-28</b>	<b>This indicator has been dropped.</b> Reportedly due to a number of reasons: (i) not closely related to GF performance (not accountable); (ii) results only available one or two years later (not actionable); (iii) uncertainty in modelling approaches especially TB; among others.
<b>Evaluators comment</b>	<ul style="list-style-type: none"> <li>• Targets were set reportedly very generously (e.g., countries only needed to show improvement in lives saved or infections averted). Additionally, limitations of the modelling approach mean that the KPI results should not be over-interpreted.</li> <li>• Reportedly, the insights from the modelling exercise were also not really used by the GMD (partly due to them coming quite late).</li> <li>• The decision to drop the indicator makes sense given the limitations with regard to the actionability and accountability.</li> <li>• While there are limitations to this indicator making it not suitable as KPI, there is a gap with regard to the measurement of VfM (and this was one of the few indicators attempting to cover at least part of this).</li> </ul>

e. KPI 5 Service Coverage for key populations

Area	KPI5a: Investment in prevention programmes for key Populations
<b>Definition</b>	Percentage of Global Fund investment in prevention programs for Key Populations
<b>Purpose</b>	Greater investments need to be established to ensure adequate scale up of comprehensive prevention programs for Key Populations This indicator measures this scale up.
<b>Methodology</b>	<p><b>Calculation methodology:</b> % of budget in signed HIV and HIV/TB grants dedicated to prevention programmes targeting Key populations<sup>19</sup></p> <p><b>Data Source:</b> Investment data from grant budgets</p> <p><b>Cohort:</b> Full portfolio</p>
<b>Target</b>	<p>Baseline: 8.1% in 2017-2019 budget period</p> <p>Target: 10% in 2020-2022 budget period</p>
<b>Results – Overview</b>	<b>Partially achieved (previously off track since added in 2021)</b> <b>Result 2022 (8.2%-10.6%)</b>
<b>Results – Deep dive</b>	<ul style="list-style-type: none"> <li>• Results are similar to those reported in Fall 2022 (8.4%-10.6%) but higher than reported in Spring 2022 (7.7%-9%)</li> </ul>

<sup>19</sup> Though the majority of investments in HIV prevention for Key Populations are in the five modules for men who have sex with men, sex workers, people who inject drugs, transgender individuals and people in prisons, sometimes either due to misclassification or to avoid stigmatization, some investments are noted under the prevention module for “Other vulnerable people”. To avoid both under and over-reporting of results, the KPI result will thus be reported as a range between the HIV prevention investment in Key Populations and investment in both Key Populations and “Other vulnerable people”.

Area	KPI5a: Investment in prevention programmes for key Populations
	<ul style="list-style-type: none"> <li>• Increase in proportion of HIV investment for HIV prevention for KPs is significant but less than expected and not sufficient to meet target for KP</li> </ul> <p><b>Disease and region insights</b></p> <ul style="list-style-type: none"> <li>• Investment aligned with epidemiology (e.g., higher in EECA (40%) and lower in Africa (11%))</li> <li>• The majority of funding goes to MSM (25%), PWIDs (23%), SW (22%) and other vulnerable populations (22%) with TG (4%) and prisoners (3%) playing a more minor role</li> </ul> <p><b>Country insights</b></p> <ul style="list-style-type: none"> <li>• Progress made is driven by a small number of large portfolios along with high proportion of investment in HIV prevention for KPs in smaller portfolio</li> <li>• Addition of South Africa (due to different grant cycle) impacted on KPs investment and improvement compared to Spring 2022 (impact of 1.2%)</li> <li>• Country case studies performed similar to income status and epi status – e.g., more advanced economies with focused GF investments had a higher share (e.g., India, South Africa and Philippines) in contrast large countries with very high investment had a lower share (e.g., Zambia, Nigeria and Mozambique)</li> </ul>
Limitations	Only reflects investment not actual results for KPs
Changes under KPI Framework 2023-28	<p><b>This indicator is dropped</b> but there is a KPI for KP prevention coverage: <i>portfolio performance for “% of Key Populations reached with HIV prevention programs -defined package of services”</i></p>
Evaluators comment	<ul style="list-style-type: none"> <li>• Reportedly indicator dropped as funding levels not considered a performance indicator as such as but rather capturing a trade-off. Instead, this is reported as complementary information to the HIV-related KPIs.</li> <li>• Generally, there is value in understanding how much the Global Fund is supporting different areas but agree that KPIs may not be the best way of doing this (e.g., usually also not much change between allocation cycles)</li> </ul>
Area	KPI5b: Reporting on comprehensive service packages for KPs
Definition	Percentage of countries currently reporting on comprehensive package of services for at least two Key Populations
Purpose	Sustained commitment and efforts to report and deliver on this sub-indicator is required as a prerequisite to the quality and reliability of a national service coverage-reporting
Methodology	<p><b>Calculation methodology:</b> % of target countries with data collection mechanisms in place to report on coverage of an evidence-informed package of services for at least two Key Populations</p> <p><b>Data Source:</b> Desk review reports, country-specific reports and studies, UNAIDS Global AIDS Monitoring (GAM), PEPFAR KP-PREV data; Country classification endorsed by joint review with technical partners</p> <p><b>Cohort:</b> Countries with adequate national Key Population size estimates that are supported by the Global Fund</p>
Target	<p>Baseline: 64% for end 2017-19 period</p> <p>Target: 75% for end 2020-2022 period</p>
Results – Overview	<p><b>Considered to be partially achieved by Global Fund</b></p> <p><i>End-2022 Results: 67%</i></p>

Area	KPI5b: Reporting on comprehensive service packages for KPs
<b>Results – Deep dive</b>	<ul style="list-style-type: none"> <li>• Cohort is fluid: The cohort was 55 countries at the time of the KPI's approval. In 2019 KPI reporting it was 60 but then decreased to 47 in 2020, 43 in 2021, 32 in 2022 and 33 in 2023.</li> <li>• Compared to previous reported results in FY2022, there is no real progress with a similar number of countries having up to-date PSEs and a slightly decreased percentage of countries being able to report on KP coverage.</li> <li>• The number of countries with quality, and nationally adequate PSEs has decreased by 26% between the FY2021 and FY2022 reporting period. This is due to a growing number of countries with PSEs that are out of date. The capacity to quantify the size of the population that is being targeted by GF HIV prevention resources is critical to HIV prevention</li> </ul>
<b>Limitations</b>	<ul style="list-style-type: none"> <li>• There is no current consensus on how to measure a comprehensive combination prevention service package. Therefore, the measure will assess coverage of an evidence-informed package of services appropriate to national epidemiological contexts. Positive discussions indicate that implementation issues can be successfully addressed. However, they also stress that it may take three years before data is available to detect change in coverage levels.</li> <li>• Indicator focuses on HIV only. New Global Plan for TB has a focus on key populations, but as of April 2016 work remains at an early stage of development.</li> </ul>
<b>Changes under KPI Framework 2023-28</b>	<p><b>This indicator has been replaced</b> by an indicator on KP reached with prevention programmes:</p> <p><i>Portfolio performance for “% of Key Populations reached with HIV prevention programs -defined package of services”</i></p> <p>Target: Achieve or sustain Global Fund grant portfolio performance at or above 90%, assessed annually</p>
<b>Evaluators comment</b>	<ul style="list-style-type: none"> <li>• There are key underlying challenges in the methodology of this indicator – e.g., the shifting reporting cohort made it difficult to assess progress for this indicator over time with performance being more reflective of underlying shifts in cohort than actual progress.</li> <li>• For the new KPI framework, this is addressed by focusing the assessment directly on GF performance frameworks and then to adjust the performance targets to make them relevant (e.g., geographic focus on KPs where GF is investing).</li> <li>• The issue around not having accurate national KP data will continue to be challenge in the new KPI period, but it is a challenge that goes beyond the Global Fund.</li> </ul>

Area	KPI5c: Achievement against service coverage targets
<b>Definition</b>	Achievement against service Coverage Targets for Key Populations in Global Fund grants
<b>Purpose</b>	Reporting on this sub-indicator is a prerequisite for sustaining commitment to improving quality and reliability of reporting on national service coverage for Key Populations
<b>Methodology</b>	<p><b>Calculation methodology:</b> Median achievement rate at end of year, with “achievement rate” defined as actual validated coverage at end of year divided by country coverage target as approved in Global Fund grants</p> <p><b>Data Source:</b> Programmatic data from grants’ performance frameworks and progress reports</p> <p><b>Cohort:</b> Countries with adequate national Key Population size estimates that are supported by the Global Fund</p>

Area	KPI5c: Achievement against service coverage targets
Target	<p>Baseline: 91% using mid-2020 data</p> <p>Target: 100% at end year (to be measured at end 2020, end 2021 and end 2022)</p>
Results – Overview	<p><b>Achieved (significant improvement since last year and 2021 when indicator was marked off-track)</b></p> <p><i>End-2022 Results: 94% median achievement rate</i></p>
Results – Deep dive	<p>Within the cohort under assessment, the median achievement rate is 94% which has been a significant improvement from last year's 78%. The 2022 median achievement rate is now catching up with the 2019 baseline of 99% for the same cohort, suggesting that countries are on the path to pre- COVID trends.</p> <p>The improvements were in particular driven by Asian countries recovering strongly since the COVID-19 related drop in 2022. In contrast, results have not rebounded for the Americas and remain considerably below the baseline.</p> <p>The significant drop in median achievement in 2020 and 2021 was driven by a drop in performance compared to the 2019 baseline, with COVID-19 being considered a strong contributing factor.</p> <p><b>Region insights:</b></p> <ul style="list-style-type: none"> <li>• Drop in results in Americas and MENA compared to 2019 baseline</li> <li>• Strong improvement in Asia and in South -Eastern Africa</li> </ul> <p><b>Component insights:</b></p> <ul style="list-style-type: none"> <li>• PWID had the highest average coverage mainly driven by EECA and MENA being the countries reporting</li> </ul>
	<p>Geographical regions based on UN geoscheme</p>
Limitations	<ul style="list-style-type: none"> <li>• Shifting KPI cohorts and biases on which countries are reporting</li> </ul>
Changes under KPI	<p><b>This indicator has been maintained</b> for KP reached with prevention programmes, but different weights have been used based on country targets (rather than using a median value as in the last strategy).</p>

Area	KPI5c: Achievement against service coverage targets
Framework 2023-28	Target: Achieve or sustain Global Fund grant portfolio performance at or above 90%, assessed annually
Evaluation comment	<ul style="list-style-type: none"> <li>• This is the most important of the KPI 5 indicators which actually focuses on achievements with regard to KPs. This is also reflected in the fact that it has been maintained (with some update to the methodology and targets).</li> <li>• There are issues in the data – with only 64 country / components being reported. This is something that should be strengthened for the upcoming period. The switch to using grant performance should help to address some of these shortcomings.</li> <li>• The indicator has illustrated the disruption of the COVID-19 pandemic as well as the successful rebounding of KP efforts in many countries. However, the fact that the recovery has not been consistent across all country settings points to the wider challenges faced by KP programmes in the last few years.</li> </ul>

f. KPI 6 RSSH Investments

Area	KPI6a: RSSH – Procurement prices
Definition	Improved outcomes for procurements conducted through countries' national systems, tracked via Product prices measured as % of prices (weighted average per country) at or below the Pooled Procurement Mechanism (PPM) reference price
Purpose	Ensures that procurement capacity is actually delivering improved outcomes in terms of prices
Methodology	<p><b>Calculation method:</b> Binary score for whether each combination of countries and products in the cohort was purchased at or below the PPM reference price for the measurement year, aggregated by product category and by country.</p> <p><b>Data source:</b> Global Fund Price &amp; Quality Reporting system (PQR)</p> <p><b>Cohort:</b> Core PPM products, compliant to the Global Fund Quality Assurance policy, for which prices are comparable (i.e., ARVs, bed nets, RDTs and ANTM) for country using a national procurement channel for these products that has either (a) a sufficiently high amount spent for these products; or (b) significant funding for RSSH-PSM in their grant</p>
Target	50% at end of 2022
Results – Overview	<p><b>Achieved (and been on track since reported in 2021)</b></p> <p><i>Results 2022: 66%</i></p>
Results – Deep dive	<ul style="list-style-type: none"> <li>• The results decreased from 51% in 2022 to 66% in 2023 (for transactions placed in 2021 and 2022 respectively)</li> <li>• In total 10 countries out of a cohort of 12 with 102 transactions worth \$64M of product met the criteria for the KPI. This cohort is reduced compared to last year 15 countries, 130 transactions, and \$111M. This lack of comparability makes it challenging to draw broader trends around domestic procurement 2021 respectively)</li> </ul>
Limitations	There is a risk that outcomes can be impacted by factors outside the procurer's control (e.g. changes in market conditions for active pharmaceutical ingredients can impact price)

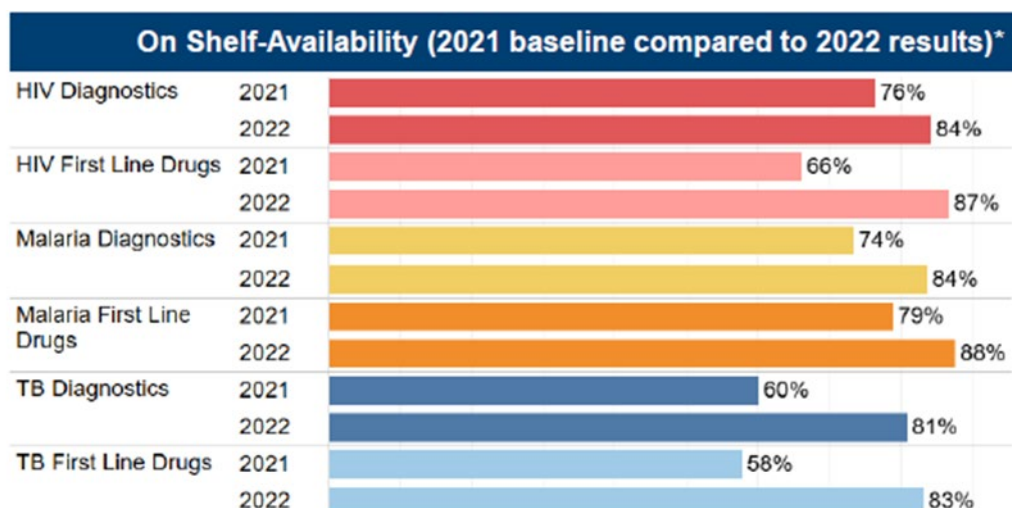
Area	KPI6a: RSSH – Procurement prices
	The structure of KPI 6a gives potentially too much importance to results of single orders in small countries (e.g., Albania, Azerbaijan, and Tunisia have only one order for Diagnostic Equipment or ARVs for the entire KPI).
Changes under KPI Framework 2023-28	<b>This indicator has been dropped.</b> Reportedly as it was not considered to not measure Global Fund performance – e.g., the Global Fund is not directly accountable for the procurement in countries outside of the PPM.
Evaluators comment	The indicator <b>lacks accountability</b> for the Global Fund – a criticism which has already been included in the SR2020. E.g., Procurement outside of the PPM was not a big investment area for the Global Fund under RSSH.  The performance of this indicator is also hard to interpret – e.g., performing well under this indicator could also be interpreted as the PPM not performing more strongly.

Area	KPI6b: RSSH – Supply chains
Definition	(i) Percentage of health facilities with tracer medicines available on the day of the visit or as per Logistics and Management Information System (LMIS) status (for medicines)  (ii) Percentage of health facilities providing diagnostic services with tracer items on the day of the visit
Purpose	Measures the extent to which investments in strengthening the different components of health product management systems contribute to the uninterrupted availability of essential health products at service delivery points
Methodology	<b>Calculation method:</b>  (i) Percentage of health facilities with tracer medicines available on the day of the visit; aligned to SARA methodology  (ii) Percentage of health facilities providing diagnostic services with tracer laboratory items on the day of the visit [represents diagnostic service readiness]  <b>Data source:</b> Publicly available Health Facility Assessment reports, complemented by Programmatic spot checks  <b>Cohort:</b> 16 Selected High Impact or Core countries
Target	15% reduction of non-availability when the on-shelf availability is at 90% or less, maintain current level otherwise
Results – Overview	<b>Achieved (has not been on track in 2021 after COVID-19)</b> <i>Results 2022:</i> All six sub-indicators met the target
Results – Deep dive	<ul style="list-style-type: none"> <li>Results achieved due to reduction in non-availability (e.g., due to improving from 2021 when the methodology was changed to improve on robustness and better capture COVID-19 response).</li> </ul>



Area	KPI6b: RSSH – Supply chains
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- Despite the progress, improvement is still required in select product categories and geographies. The major root causes for product non-availability included poor order fill rates and late deliveries pointing to a need to strengthen in-country distribution networks.
- Amongst product groups, Malaria FLD had the highest product availability with eight of the 16 cohort countries reporting greater than 90% OSA.



<b>Limitations</b>	Stock out on the day is a Yes/No measure, not a measure of stock-out days. Health facility assessments would only provide data every three years. Other systems may exist in country, but data quality is uncertain
<b>Changes under KPI Framework 2023-28</b>	As of Spring 2024, this <b>KPI will be replaced by KPI S8</b> that will be similar and continue to track OSA but with a different aggregation approach.
<b>Evaluators comment</b>	Generally, this has been a more useful RSSH indicator which relates to GF investment in supply chain strengthening. Changes to methodology in 2021 were a sensible improvement on the robustness of indicator.  The way the indicator target has been set (e.g., allowing for 15% improvement) has meant that once OSA really dropped (e.g., due to COVID-19) it is much easier to show gains in the following years. This has been addressed in the target setting under the new KPI which asks to achieve 90% by 2023 and then to maintain it.

Area	KPI6c: RSSH – Financial Management
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<b>Definition</b>	(i) Number of high priority countries completing public financial management transition efforts towards use of country PFM system  (ii) Number of countries with financial management systems meeting defined standards for optimal absorption & portfolio management
<b>Purpose</b>	Increased use of country financial management systems, and addressing routine financial management capacity gaps, is key to program sustainability and enables the delivery of impact from investments.



Area	KPI6c: RSSH – Financial Management
<b>Methodology</b>	<p><b>Calculation method:</b></p> <p>(i) Number of countries using at least 6 defined public financial management system components contributing to financial management sustainability, aid effectiveness, accountability &amp; transparency</p> <p>(ii) Number of countries with at least 80% implementation of agreed action plans for improving financial management</p> <p><b>Data source:</b> Monthly data collection from Secretariat teams based on country action plan items</p> <p><b>Cohort:</b> For (i) 8 countries; for (ii) Other High impact and Core countries (n = 46)</p>
<b>Target</b>	<p>i) 8 countries</p> <p>ii) 46 countries</p>
<b>Results – Overview</b>	<p><b>Partially achieved for indicator 6c (ii) achieved for indicator 6c (i)</b></p> <p><i>Results 2022 6c i): 8 countries</i></p> <p><i>Results 2022 6c ii): 34 countries</i></p>
<b>Results – Deep dive</b>	<p><b>Results for 6c i):</b></p> <ul style="list-style-type: none"> <li>As in the past two years all of the 8 countries in the cohort met the target. These countries are Ghana, Ethiopia, India, Senegal, Sierra Leone, Tanzania, Uganda, Zimbabwe.</li> <li>The most used components (observed in all 8 targeted countries) were: Operational Policy &amp; Procedures Manuals, Institutional Arrangements &amp; Management Oversight, and Chart of Accounts. Three other components were used in all except one country: Information System, Planning and Budgeting, and Internal Audit. The least used components are External Audit, and Treasury &amp; Funds Flow (two countries each missing).</li> </ul> <p><b>Results for 6c ii)</b></p> <ul style="list-style-type: none"> <li>The final result shows that the indicator partially met the target given that 12 countries failed to meet the target of 80% implementation of agreed action plans for improving financial management.</li> <li>Although over time there has always been an improvement against target, this was just not enough as the number of countries progressing has not kept pace with the expanding cohort.</li> <li>The causes of underperformance can be linked to i) C19RM supplementary funding requests priority-processing which impacted the responsiveness of implementers and CTs/FSs on action plan implementation and oversight/monitoring; ii) other competing but critical Secretariat finance processes (PUDR/FCR reviews and validations, corporate forecasting and recoveries validation) that negatively affected the KPI performance, especially when trying to finalize in time action plans for the countries newly integrated in the cohort</li> <li>Countries that have not completed the action plan include CAR, Angola, DRC and South Africa</li> </ul>
<b>Limitations</b>	<p>Part i) In-country capacity, ownership and co-ordination is a challenge for public financial management initiatives</p>
<b>Changes under KPI Framework 2023-28</b>	<p><b>This indicator has been dropped.</b></p>

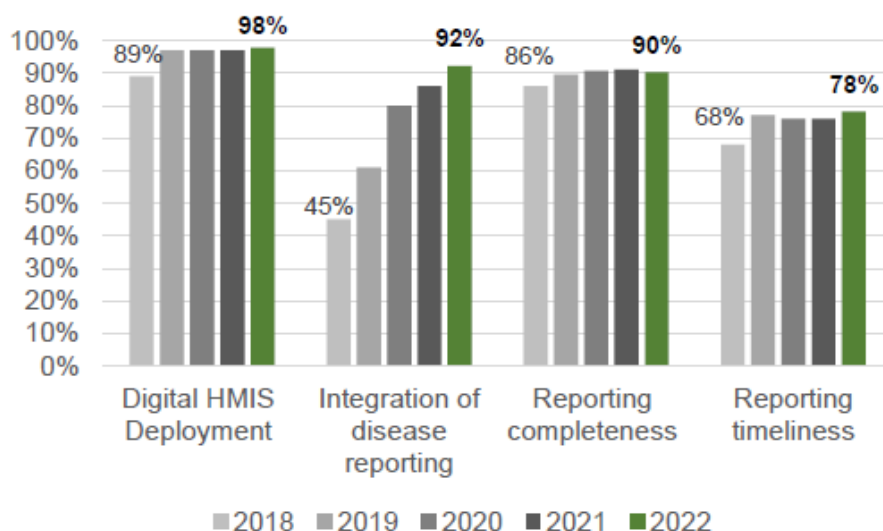
Area	KPI6c: RSSH – Financial Management
Evaluators comment	<p>The limited set of countries for 6c i) makes it hard to generalise this indicator. Additionally, the indicator is primarily a process indicator that does not capture the outcomes of improved financial management.</p> <p>The shift towards more encompassing indicators for RSSH under the new KPI framework makes sense. Additionally, the Global Fund will continue to track the capacity of in-country financial systems through updated KPI (KPI R2) situated under “mobilising resources”.</p>

Area	KPI6d: RSSH – HMIS Coverage
Definition	Percent of high impact countries with fully deployed (80% of facilities reporting for combined set of indicators), functional (good data quality per last assessment) HMIS
Purpose	<p>To truly be able to use data for program improvement, data need to be available routinely, rather than through surveys or global estimates. Significant investments are being made to build these routine HMIS and this indicator measures the success of these investments.</p> <p>The indicator is designed to measure two key aspects of an HMIS that have proven problematic in the past – coverage (fully deployed) and functional (defined in terms of data quality).</p>
Methodology	<p><b>Calculation method:</b> Based on formal DQR/HMIS assessments:</p> <ol style="list-style-type: none"> <li>1. HMIS coverage: 80%+ of health facilities submitting monthly/quarterly reports to electronic HMIS (national HMIS/disease specific system)</li> <li>2. Timeliness: 80%+ of reports from health facilities submitted to electronic HMIS received on time</li> <li>3. Completeness: 80%+ of reports from health facilities submitted to electronic HMIS are complete</li> <li>4. Disease data in the national HMIS: data for all relevant HIV, TB, and Malaria indicators is available in national HMIS</li> </ol> <p>Country included in numerator if all 4 elements achieve threshold</p> <p><b>Data source:</b> Global Fund M&amp;E dashboard</p> <p><b>Cohort:</b> High impact and Core countries (n = 54)</p>
Target	70% by 2022
Results – Overview	<p><b>Partially achieved</b></p> <p><i>Results 2022: 55% (28) countries</i></p>
Results – Deep dive	<ul style="list-style-type: none"> <li>• This year marks the last reporting period for KPI 6d showing that 28 countries have fully deployed and functional HMIS by the end of 2022. Despite a substantial improvement from the beginning of the strategy, this result is below the target of 35 countries (70%)</li> <li>• Individual sub-indicators of KPI 6d have performed well. In particular, there has been a significant improvement on the integration of disease reporting skyrocketing from 45% in 2018 to 92% in 2022 thanks to GF Data-SI and grant activities having directly supported a major reduction in siloed reporting of HIV, TB and malaria data. Nevertheless, a better</li> </ul>

Area	KPI6d: RSSH – HMIS Coverage
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performance on reporting timeliness would have been necessary to meet the target of the overall KPI 6d indicator

**Figure 2. KPI6d sub-indicator average results over time**



- The root causes of underperformance are challenges linked to systemic issues – including human resources availability and training; insufficient power; internet connectivity, or other infrastructure; funding gaps for maintenance of data systems – but also political instability in a few countries in the cohort and continuing COVID-19 effects.

<b>Limitations</b>	This indicator does not measure data are used to improve program outcomes, rather it tracks completeness and functionality of the information systems needed for facilities/districts to have access to the data.
<b>Changes under KPI Framework 2023-28</b>	The indicator is <b>updated and is replaced by KPI S6a</b> which looks at whether core and High Impact countries have a secure, maintained and interoperable HMIS system and been complemented by KPI S6b which looks at data use.
<b>Evaluators comment</b>	The indicator provided insights of Global Fund investment in HMIS and showed both improvements (e.g., integration of disease reporting) as well as challenges around reporting timeliness.

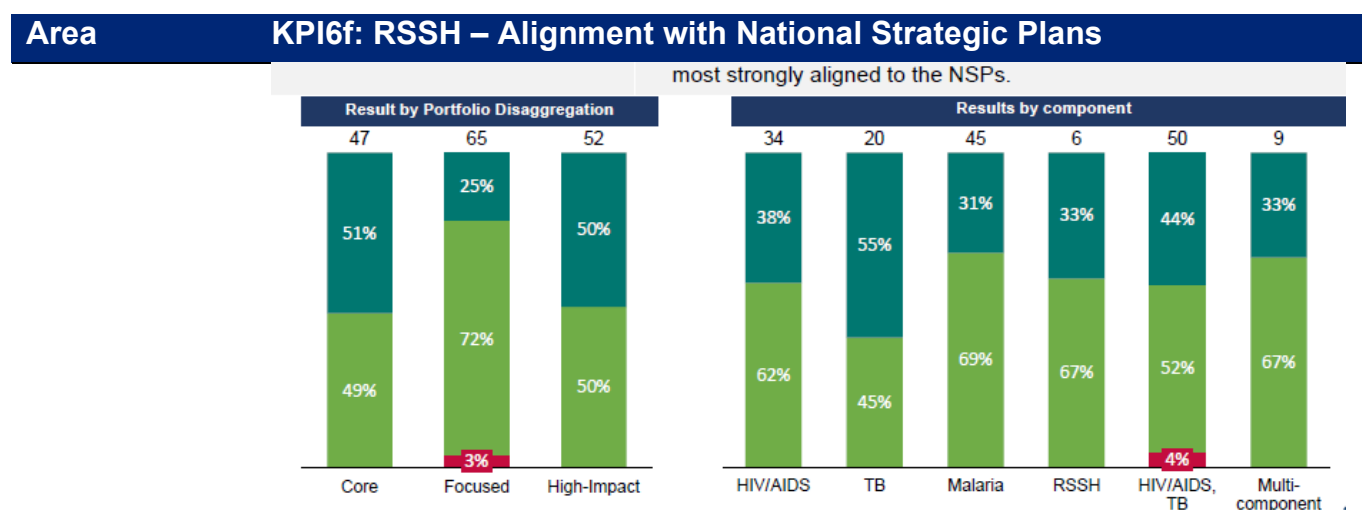
Area	KPI6e: RSSH – Results disaggregation
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<b>Definition</b>	Percentage of countries that have documented evidence of using disaggregated data to inform planning and programmatic decision making for priority populations in HIV, TB and malaria
<b>Purpose</b>	<p>A baseline for capacity to report disaggregated data has been established. The broader goal for this indicator is to determine whether supported countries are using disaggregated data to inform program design and management.</p> <p>The indicator measures whether countries have required disaggregated data facilitating identification of populations in need of health services (priority populations) and if available, whether disaggregated data is analysed and used to inform planning and ongoing implementation.</p>

Area	KPI6e: RSSH – Results disaggregation
<b>Methodology</b>	<p><b>Calculation method:</b> Survey results include score for each tracer indicator for each disease.</p> <p>Scores on “use” of disaggregated data are broken down in the categories as follows:</p> <ul style="list-style-type: none"> <li>• For use of disaggregated data in planning – check latest disease strategic plan or NSP for interventions and targets for priority populations/ required disaggregation</li> <li>• For use of disaggregated data to inform ongoing programmatic decision making – check quarterly/annual program/performance review report includes priority populations/ required disaggregation</li> </ul> <p>For each country, a “use” score (percent) is available for each tracer indicator for both categories noted above. An average score is calculated for all disease specific tracer indicators for both categories. A disease score is then determined by taking the higher of the two use scores across the two categories. A given country will then have one use score for each relevant disease. Finally, a country is given an aggregate “use” score taking an average across the relevant diseases (no weighting).</p> <p>This aggregate score for each country is then compared to a benchmark of 50% (applicable across all countries). Countries surpassing the benchmark are counted towards the KPI result.</p> <p><b>Data source:</b> Targeted, country-based survey conducted by an independent body with data collected in country and independently reviewed</p> <p><b>Cohort:</b> High impact excluding COEs</p>
<b>Target</b>	80% by 2022
<b>Results – Overview</b>	<p><b>Achieved (and always has been when reported – though updated in 2021)</b></p> <p><i>Results End-2022: 76% (within target range)</i></p>
<b>Results – Deep dive</b>	<ul style="list-style-type: none"> <li>• 76% (19 out of 25) of countries met the 50% threshold of having documented evidence of using required disaggregated data to inform planning or programmatic decision making for priority populations in HIV, TB, and Malaria programs.</li> <li>• This result improved in comparison to its baseline (2020) and last year’s result (2021) – both equal to 68%. 17 out of 25 countries registered an improvement compared to last year’s result.</li> <li>• From qualitative part of the survey, some key gaps in use of disaggregated data were identified as follows; lack of available disaggregated data in existing data source, lack of disaggregated targets and related interventions in strategic plans and organizational culture of focusing on aggregate data.</li> <li>• ART coverage tracer indicators had the greatest variance between availability of disaggregated data and use of disaggregated data for planning and programmatic decision making.</li> </ul> <p><b>Country case study performance:</b></p> <ul style="list-style-type: none"> <li>• Positive: India (82%), Nigeria (100%), CIV (89%)</li> <li>• Negative: Philippines (26%), Pakistan (11%), Mozambique (35%)</li> </ul>
<b>Limitations</b>	<p>As the interim indicator served to measuring the availability of disaggregated data, it follows that this measure should evolve to address the strategic goal to measure whether countries are using available disaggregated data for</p>

Area	KPI6e: RSSH – Results disaggregation
	planning and programmatic decision making. This has been addressed with the update of the indicator in 2021.
<b>Changes under KPI Framework 2023-28</b>	The indicator has been maintained by KPI S7 on the use of disaggregated data for planning or decision making
<b>Evaluators comment</b>	Given that the indicator has only been updated in 2021 it makes sense to maintain it under the new KPI Framework – although the target has not changed with 80% still being the target for 2028 (this was partly driven by the expansion of the cohort to Core countries with arguably lower capacity and thus the target itself was not increased)

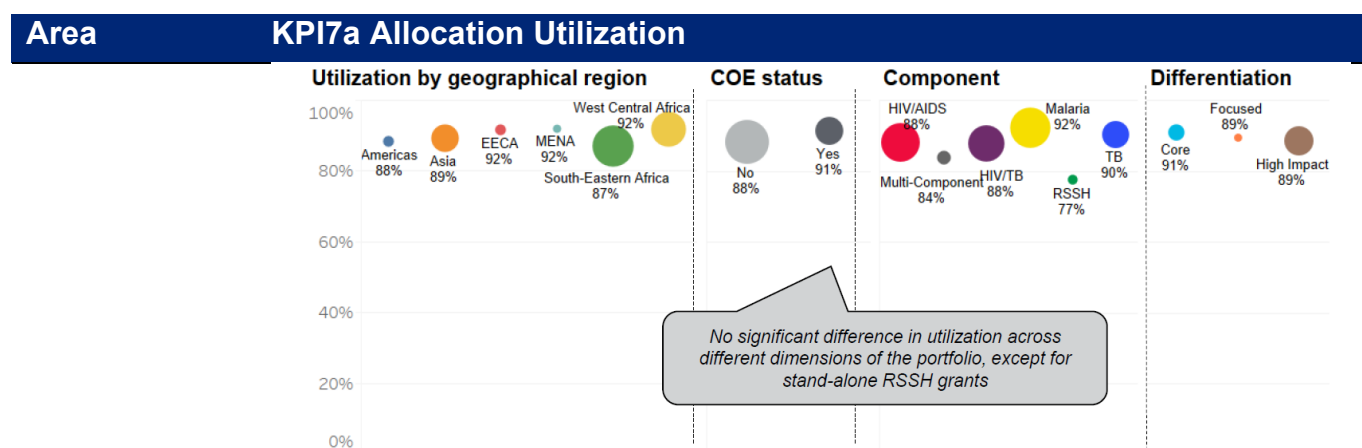
Area	KPI6f: RSSH – Alignment with National Strategic Plans
<b>Definition</b>	Percentage of funding requests rated by the TRP to be aligned with National Strategic Plans
<b>Purpose</b>	National health strategies and disease specific strategic plans will remain central to the Global Fund's next funding period. The indicator proposes to use the grant approval process to monitor and ensure alignment between funding requests and National Strategic Plans.
<b>Methodology</b>	<p><b>Calculation method:</b> Subjective survey of TRP members:  “The funding request aligns with national priorities as expressed in the National Strategic Plan (or an investment case for HIV)”</p> <p><b>Data source:</b> TRP survey</p> <p><b>Cohort:</b> All new funding requests submitted with NSP for TRP review</p>
<b>Target</b>	90% Strongly Agree/Agree over the 2020-22 period
<b>Results – Overview</b>	<p><b>Achieved (and always has been when reported)</b></p> <p><i>Results Mid-2022: 99% Strongly agree / agree</i></p>
<b>Results – Deep dive</b>	<ul style="list-style-type: none"> <li>As no more Funding Requests are expected for the 2020-2022 Allocation Period, assessment of 99% Funding Requests aligned</li> <li>Similar to the last cycle only 2 Funding Requests were rated as ‘Disagree’ on alignment with (both were Focused and HIV/TB funding requests)</li> <li>Similar to previous report, TB Funding Requests (55%) continue to be most strongly aligned to the NSPs.</li> </ul>



<b>Limitations</b>	<p>Ratings for this indicator are based on a subjective assessment by TRP members.</p> <p>Indicator measures only the Global Fund’s alignment with national strategic plan priorities. It does not track the rigor of those plans. Within the Global Fund’s partnership model, the primary responsibility for ensuring the rigor of national strategic plans rests with technical partners and countries.</p>
<b>Changes under KPI Framework 2023-28</b>	<b>The indicator has been dropped</b> as it was not considered to really reflect a performance measure for the GF.
<b>Evaluators comment</b>	The indicator does not offer much in terms of actionability (as vast majority aligned) and didn’t have high utility – as quality of NSPs is not considered and, thus, limits insights that can be derived from the quality of the provided requests. It would be better as suggested to continue to track and report on this indicator outside of the KPI structure.

g. KPI 7 Fund utilization

Area	KPI7a Allocation Utilization
<b>Definition</b>	Portion of allocation that has been disbursed or is forecast to be disbursed
<b>Purpose</b>	Allocation utilization provides high level view on the extent to which countries can use their allocation, and the Secretariat can optimize portfolio level investments
<b>Methodology</b>	<p><b>Calculation method:</b> Disbursed amount / allocation – aggregated to portfolio level</p> <p><b>Data source:</b> Global Fund grant finance system</p> <p><b>Cohort:</b> Entire portfolio</p>
<b>Target</b>	91-100% for the current allocation period
<b>Results – Overview</b>	<p><b>Achieved (and always been since reporting started)</b></p> <p><i>Result 2022 – 95% of allocation utilized</i></p>
<b>Results – Deep dive</b>	<ul style="list-style-type: none"> <li>Across all disaggregation’s (see below) utilization is strong with the exception of stand-alone RSSH grants – a trend that has carried over from past reporting</li> </ul>



Note: Reminder – disaggregation does not reflect portfolio level optimization hence lower values than overall KPI result.  
 Multicountry utilization excluded as the result is co-mingled with the amount applied for optimization

- Consistent with Financial Reporting to AFC, allocation utilization is based on Real Funds under Management which has an impact on the denominator of KPI 7a. This allows a more accurate consideration of Portfolio Optimization, not treating as new sources of funds when it really is pure recycling of existing sources of funds approved to maximize funds utilization. To avoid double-counting these in the KPI denominator (i.e., total allocation), adjustments are applied at the overall portfolio level – this means the overall KPI result will not match the average by region, component, differentiation status, etc.

<b>Limitations</b>	<p>The Allocation utilization indicator risks two negative incentives:</p> <ul style="list-style-type: none"> <li>• Over-commitment to meet allocation</li> <li>• Re-direction of funds through portfolio optimization from portfolios with the greatest “need” to portfolios better able to absorb funds – without dealing with underlying health system constraints</li> </ul> <p>These risks are controlled by other indicators tracking absorption, cash balance, and alignment between investments and “need” (KPI 3)</p>
<b>Changes under KPI Framework 2023-28</b>	<b>This indicator has been maintained</b> with an increase of the target (95%)
<b>Evaluators comment</b>	This is a key performance measure for the Global Fund and would point to key challenges in the model in case it would drop significantly. As such, it is good that the Global Fund has performed strongly and also has set a more ambitious target in the new KPI Framework.

Area	KPI7b Absorptive capacity
Definition	Portion of grant budgets that have been reported by country program as spent on services delivered
Purpose	Absorptive capacity measures whether programs can spend the budgeted funds
Methodology	<p><b>Calculation method:</b> Actual expenditure / Grant budget (for each grant aggregated to the portfolio level)</p> <p><b>Data source:</b> Global Fund grant operations system</p> <p><b>Cohort:</b> Entire portfolio</p>



Area	KPI7b Absorptive capacity
Target	75% by 2022
Results – Overview	<b>Achieved (and always been with the exception of S2018)</b> <i>Result 2022 – 80% of absorption capacity</i>
Results – Deep dive	<ul style="list-style-type: none"> <li>Grant absorption rate for 2020-22 calendar years stands at 80% but does not include COVID-19 funding which has a substantially lower absorption.</li> <li>For 2017-19 Allocation Period grants, absorption is at 89% and for 2020-22 Allocation Period grants absorption is 72% (driven by the fact that for those years only years 1 and 2 are included which traditionally have lower absorption than the final year).</li> <li>There is a lot of variation over years due to fact that absorption aligns with the grant cycle</li> </ul> <p><b>Absorption by component:</b></p> <ul style="list-style-type: none"> <li>Absorption was above target for HIV (82%), TB (78%), Malaria (82%), HIV/TB (80%) but below target for <b>multi-component (65%) and RSSH (52%)</b> and COVID-19 modules.</li> </ul> <p><b>Absorption by modules:</b></p> <ul style="list-style-type: none"> <li>There have been some recent decreases, absorption remains on or above target for most modules except for RSSH and Covid-19.</li> <li>The low COVID-19 absorption is due to a range of broad operational, execution and global challenges.</li> </ul> <p><b>Absorption by region:</b></p> <ul style="list-style-type: none"> <li>Strongest in South-Eastern Africa (84%), West Central Africa (79%) and EECA (83%) but lower for MENA (71%), Asia (74%) and Americas (66%)</li> </ul> <p><b>Absorption by analytical grouping:</b></p> <ul style="list-style-type: none"> <li>Absorption is higher for human resources and commodities. Lowest are infrastructure and non-health equipment as well as capacity building and technical assistance</li> <li>Health equipment is also below target of 75%</li> </ul>
Limitations	<p>Nothing noted in KPI Definitions document. However, some criticisms include:</p> <ul style="list-style-type: none"> <li>Focus on absorption can disadvantage areas that require longer time and instead provide funding for interventions that are less needed but have good absorption</li> <li>Increase in spending at the end of cycle to ensure high absorption</li> </ul>
Changes under KPI Framework 2023-28	<ul style="list-style-type: none"> <li><b>This indicator has been maintained.</b></li> <li>Included with an increase of the targets and by splitting targets by year (in-country absorption by end Y1: 75%, Y2: 80%, Y3: 85%, assessed annually)</li> </ul>
Evaluators comments	<ul style="list-style-type: none"> <li>This is a key performance measure for the Global Fund with high accountability and actionability.</li> <li>The updated targets under the new KPI Framework make sense given the different levels in absorption observed across grant years (and good to keep the target of 75% in Y1).</li> </ul>

h. KPI 8: Gender and Age equality

Area	KPI8: Gender and age equality
Definition	Reduction in HIV incidence in women aged 15-24 years old
Purpose	HIV infection rates among young women are twice as high as among young men in some regions. The indicator will track the extent to which an enhanced programmatic focus on women and girls results in a reduction in new infections in selected countries with large disparities in incident infections.

Area	KPI8: Gender and age equality
Methodology	<p><b>Calculation method:</b> Modelling informed by:</p> <ul style="list-style-type: none"> <li>• UNAIDS Global Progress Reporting on HIV incidence estimates, which should also be aligned with PEPFAR'S HIV incidence reporting</li> <li>• HIV incidence estimates for 15–24-year-old females from national, population based surveys (available currently in 3 of the selected countries)</li> <li>• Through PEPFAR funding, Population based Impact Assessments (PHIAs), also national, population-based surveys, are being conducted or are planned through 2018 in all the selected countries, except four (which will conduct their own incidence surveys)</li> </ul> <p><b>Data source:</b> HIV incidence estimates derived from the Goals model</p> <p><b>Cohort:</b> 13 countries selected from Sub-Saharan Africa with 1) highest estimated HIV incidence rates among 15–24-year-old females; 2) female-male ratio of new infections in 15-24 &gt;1. (Botswana, Cameroon, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, UR Tanzania, Uganda, Zambia, Zimbabwe)</p>
Target	58% (47-64%) from 2015 to 2022 (based on modelling also used for other KPI2s)
Results – Overview	<p><b>Achieved</b></p> <p><i>Result End- 2022: 55% from 2015 baseline</i></p>
Results – Deep dive	<ul style="list-style-type: none"> <li>• The decline in combined HIV incidence rate among females 15-24 years old across 13 priority countries from 2015 to 2022 is 55% which is within the target range of 58% (47%-64%)</li> <li>• Incidence continues to decline in all 13 countries between 2015-22 ranging from 29% to 72%. The decline is driven by expansion of HIV treatment but despite this progress there remain structural barriers on gender inequality, stigma and gender-based violence persist.</li> <li>• AGWY SI is fully implementing and has already supported countries to identify opportunities and challenges in SRHR and HIV prevention integration.</li> <li>• Greater alignment of AGYW investments with partners (PEPFAR) continues</li> </ul> <p><b>Countries:</b></p> <ul style="list-style-type: none"> <li>• Low performer in terms of 2015-2022 change: Namibia (-29%), Uganda (-36%), Mozambique (-44%) and South Africa (-46%)</li> <li>• Strong performer: Tanzania (-72%), Zimbabwe (-71%), Cameroon (-71%)</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>• Limitations with regard to setting model targets (see also KPI2 discussion)</li> <li>• Only includes a limited cohort (though selected countries represent majority of AGYW HIV incidence)</li> </ul>
Changes under KPI Framework 2023-28	<ul style="list-style-type: none"> <li>• <b>This indicator has been updated.</b> The updated indicator is now part of the HIV reporting and, similar to other KPI2s, the target is now set against the achievement of the grant performance targets and is also measuring prevention outcomes. The cohort remains small with only 12 countries. A range of new gender and equity indicators have also been added including on results (KPI E3b on performance of gender specific indicators as well as engagement in the grant cycle (KPI E3a) as well as equity indicators E2.</li> </ul>
Evaluators comments	<ul style="list-style-type: none"> <li>• The indicator itself offers insights into one specific area with regard to gender – it is now widely understood that gender needs to be addressed and measured at a much wider level than on select AGYW interventions in 13 priority countries.</li> <li>• Another challenge with regard to the indicator is how much it really provides for accountability of the Global Fund AGYW interventions. In particular, reportedly part of the reduction is due to a shift in cohort (e.g., women moving out of the 15-24 age bracket) and many of the Global Fund interventions have indeed focused on reaching that age bracket rather than any of the new cohort coming into the age group.</li> </ul>

i. KPI 9 Human Rights Investments in HIV, TB and HIV/TB grants

Area	KPI9a Reduce human rights barriers to services
Definition	# of priority countries with comprehensive programs aimed at reducing human rights barriers to services in operation
Purpose	With a focus on 20 priority countries, this indicator will measure the extent to which comprehensive programs are established to reduce human rights barriers to access.
Methodology	<p><b>Calculation method:</b> Number of countries that meet benchmark for implementation of partner recommended interventions</p> <p><b>Data source:</b> Baseline, mid-term &amp; end-term studies: Conducted in each of the 20 focus countries</p> <p><b>Cohort:</b> 20 countries (Benin, Botswana, Cameroon, Cote d'Ivoire, DRC (Province-Level), Ghana, Honduras, Indonesia, Jamaica, Kenya, Kyrgyzstan, Mozambique, Nepal, Philippines, Senegal, Sierra Leone, South Africa, Tunisia, Uganda, Ukraine)</p>
Target	<p>Baseline: 0 in 2016</p> <p>Target: 4 for HIV and 4 for TB by 2022</p>
Results – Overview	<p><b>Off track</b></p> <p><i>Final result only available in Spring 2024</i></p>
Results – Deep dive	<ul style="list-style-type: none"> <li>Final assessments for 2017-2022 Strategy period are currently underway with preliminary results available from 12 of the 20 BDB countries. Final results are presented in Spring 2024.</li> <li>Preliminary findings show progress since baseline toward comprehensive programs for HIV in all 12 countries. However, progress has not been linear and has slowed since the mid-term assessments.</li> <li>While overall TB scores remain lower than HIV scores, progress towards comprehensive programming for TB was more sustained since baseline (consistent with historic trends that progress is generally faster when starting from the baseline)</li> <li>Despite the progress being made, KPI 9a target is unlikely to be met. Factors contributing to underperformance include: <ul style="list-style-type: none"> <li>As part of the global anti-human rights movement, introduction of harmful and discriminatory laws &amp; practices against Key Populations, and a deteriorating environment for communities and civil society</li> <li>Ongoing political instability and insecurity across many BDB countries (notably Ukraine which was one of BDB's best performing countries)</li> <li>COVID-19 impact that diverted focus and capacity away from Human Rights</li> </ul> </li> </ul> <p><b>Country and disease insights</b></p> <ul style="list-style-type: none"> <li>HIV generally scoring higher, and every country improved in mid-term assessment. There would be a range of countries that would reach a score of 4 and above (needed to be counted towards target) if improvement is maintained (so far Ukraine scored above 4)</li> <li>For TB, the performance is lower overall than for HIV and reaching for 4 countries as per target will be a challenge. Some countries had lower improvement between baseline and mid-term assessment and the Philippines actually experienced a decline</li> <li>Well-performing countries for HIV: Ukraine, Ghana and Mozambique since mid-term assessment; for TB: Ukraine and Ghana; Philippines remains a low performer in HIV and TB despite some improvement since the mid-term assessment</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>Human rights interventions to reduce barriers to service are well defined for HIV, but more work is needed for TB &amp; Malaria</li> </ul>

Area	KPI9a Reduce human rights barriers to services
Changes under KPI Framework 2023-28	<ul style="list-style-type: none"> <li>• <b>Indicator has been maintained</b> but will focus on progress towards comprehensiveness, rather than a set # of countries attaining it. Additionally, the indicator was extended to also include Malaria.</li> <li>• <i>Percentage of countries with increases in scale of programs to reduce Human Rights-related barriers for a) HIV; b) TB; c) Malaria respectively</i></li> </ul>
Evaluators comment	<ul style="list-style-type: none"> <li>• The indicator is a useful performance measure of the Global Fund HR efforts and highlights some of the challenges that HR efforts are recently facing with this indicator not being met.</li> <li>• The measure only captures whether comprehensive HR services are put into place and not their outcomes, but this seems reasonable given the challenges to look into specific outcomes.</li> <li>• The indicator has only focused on the 20 focus countries – however, HR challenges extend beyond this but it makes sense to focus measure on those countries that have received specific GF support to keep the measure accountable to GF.</li> </ul>

Area	KPI9b Human Rights Investments
Definition	<p>Human Rights Investments in HIV, HIV/TB and TB grants (% of grant funds invested in human rights)</p> <p><i>Percentage of investment in signed HIV and HIV/TB grants dedicated to programs to reduce human rights barriers to access</i></p> <p><i>Percentage of investment in signed TB grants dedicated to programs to reduce human rights barriers to access</i></p>
Purpose	To ensure that programs to reduce human rights-related barriers to services are sufficiently funded, resulting in improved uptake of and adherence to treatment and preventions programs.
Methodology	<p><b>Calculation method:</b></p> <ul style="list-style-type: none"> <li>• HIV: % of investment in signed HIV and HIV/TB grants dedicated to programs to reduce human rights barriers to access</li> <li>• % of investment in signed TB grants dedicated to programs to reduce human rights barriers to access</li> </ul> <p><b>Data source:</b> Baseline, mid-term &amp; end-term studies: Conducted in each of the 20 focus countries</p> <p><b>Cohort:</b> HIV – all eligible countries; TB – Congo (Democratic Republic), Ghana, Nigeria, Ethiopia, Kenya, Mozambique, South Africa, Tanzania, Uganda, Bangladesh, Cambodia, Indonesia, India, Myanmar, Pakistan, Philippines, Vietnam, Cameroon, Ukraine, Zambia</p>
Target	Target: 3% for HIV and 2% for TB
Results – Overview	<p><b>Achieved (since 2021 after methodology changes)</b></p> <p><i>For HIV: 3.26% and for TB: 2.42%</i></p>
Results – Deep dive	<ul style="list-style-type: none"> <li>• HIV: The increase in absolute terms between 2017-2019 Allocation Period and 2020-2022 Allocation Period in the countries included in this reporting has almost doubled for HIV: \$197,835,849 in 2020-2022 compared to \$111,245,055 in 2017-2019 Allocation Period <ul style="list-style-type: none"> <li>o Human Rights Matching Funds have proven to be effective in stimulating increased investments, including from within allocation. The cross-cutting nature of Matching Funds in 2020-2022 Allocation Period has served as a significant lever to increase both HIV and TB investments in programs to reduce human rights-related barriers.</li> </ul> </li> </ul>

Area KPI9b Human Rights Investments	
	<ul style="list-style-type: none"> <li>o The level of investment in programs to reduce human rights-related barriers in the 99 countries in the cohort is at 3.26% compared to 3.45% reported previously in Fall 2022. The slight decrease in level of investment since last year could be explained by an increase in TB-related human rights investments but could also be a sign of reprogramming of funds away from Human Rights.</li> <li>• The indicator has been updated in 2020 and has been separated out between HIV and TB – since then it has always been on track.</li> </ul> <p><b>Disease specific results:</b></p> <ul style="list-style-type: none"> <li>• HIV: Although the target is largely met overall, <b>non-BDB</b> as well as <b>low-income countries</b> report a share of human right investments below 3%.</li> <li>• For TB: The level of investment in TB programs to remove human rights-related barriers in 20 countries in the cohort is at 2.42% against a target of 2%. This result represents a 100% increase compared to GC5 baseline (1.21%)</li> <li>• Although the target is also largely met for TB, <b>non-BDB as well as lower middle-income countries</b> report a share of human rights investments significantly below 2%.</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>• Only investment not outcome</li> </ul>
Changes under KPI Framework 2023-28	<ul style="list-style-type: none"> <li>• The new Global Fund Strategy has a significant focus on human rights, including as part of its ending HIV and TB objectives. Though KPI 9b is being discontinued as a KPI, regular investment analysis will have to be undertaken to continue to shine a light on the importance to invest significantly and consistently in programs to remove human rights-related barriers</li> </ul>
Evaluators comment	<ul style="list-style-type: none"> <li>• Understandable that this indicator is discontinued as a performance KPI and reported instead as part of the financing reporting.</li> <li>• The results show that non-BDB countries have performed significantly worse. Providing support for the fact that BDB has been at least somewhat successful in bringing in the necessary resources. At the same time, it shows the gap in countries that have not received specific support. This makes the selection of supported countries even more important.</li> </ul>

Area KPI9c Human Rights Domestic Investment	
<b>Definition</b>	<p>% of countries with domestic HIV expenditure allocated to</p> <p>(i) social enablers, including programs to reduce human rights-related barriers,</p> <p>(ii) prevention programs targeting key populations</p>
<b>Purpose</b>	<p>This indicator measures the extent to which, in key countries, governments recognize that supporting services for key populations and programs to reduce human rights-related barriers to services are essential, and increasingly take over responsibility for and funding of these services</p>
<b>Methodology</b>	<p><b>Calculation method:</b></p> <ul style="list-style-type: none"> <li>• Numerator: Number of countries in cohort that have reported in GAM at least once in previous 3 years, which are meeting a benchmark of percentage of domestic HIV expenditures allocated to (i) programs targeting social enablers and (ii) prevention in key populations within target range</li> <li>• Denominator: Number of countries that have reported in GAM at least once in previous 3 years that are reporting domestic HIV expenditures allocated to programs targeting social enablers and prevention in key populations (and have provided data on domestic public expenditure)</li> </ul>

Area	KPI9c Human Rights Domestic Investment
	<p><b>Data source:</b> UNAIDS Global AIDS Monitoring (GAM)</p> <p><b>Cohort:</b> 21 countries (Bangladesh, Belarus, Botswana, Cameroon, Costa Rica, Cote D'Ivoire, Dominican Republic, Ghana, Guatemala, India, Indonesia, Jamaica, Kazakhstan, Kenya, Kyrgyzstan, Malaysia, Mauritius, Mozambique, Ukraine, South Africa, Zimbabwe)</p>
Target	Target: Social enablers: 33% and Key populations: 33%
Results – Overview	<p><b>Not achieved for social enablers / achieved for KPs</b></p> <p><i>For Social enablers: 0% (6% in Fall 2022) and for KPs: 57% (25% in Fall 2022)</i></p>
Results – Deep dive	<ul style="list-style-type: none"> <li>14 countries in the cohort, 57% countries met the benchmarks for investment in prevention programs for KPs, whilst no country met the benchmarks for investment in programs to reduce human rights-related barriers.</li> <li>While more countries are reaching their low benchmarks for KP prevention, this does not fully translate in progress towards meeting the need. In 2022, UNAIDS estimated a 90% funding gap for prevention programmes for KPs, compared with the funding needed by 2025 in low- and middle-income countries.</li> <li>Underperformance of this KPI reflects a larger trend in decreases in domestic HIV spending. There are also ongoing challenges with data availability and quality</li> <li>As evidenced in this KPI, funding for HIV prevention among Key Populations still comprises very small proportions of total HIV spending in low and middle-income countries, even in regions where the vast majority of new HIV infections are occurring in these populations. The bulk of that funding—at least two thirds come from international sources.</li> </ul>
Changes under KPI Framework 2023-28	<ul style="list-style-type: none"> <li><b>This indicator has been dropped</b> due to issues with Global Fund accountability as well as data verification aspects.</li> </ul>
Evaluators comment	<ul style="list-style-type: none"> <li>The underlying data challenges make it very difficult to interpret this indicator accurately and the direct accountability for this indicator by the Global Fund is not given.</li> </ul>

j. KPI 10: Resource mobilisation

Area	KPI10: Resource mobilisation
Definition	<p>a) Actual pledges as a percentage of the replenishment target, with respect to the current replenishment period</p> <p>b) Pledge conversion rate. Actual replenishment contributions as a percentage of forecast contributions, with respect to the current replenishment</p>
Purpose	A key objective of the Global Fund is to mobilize resources for health from current and new public and private sources. This indicator directly measures the volume of new pledges made, and the extent to which these pledges are fulfilled as contributions.
Methodology	<p><b>Calculation method:</b></p> <p>a) Actual current replenishment pledges to date / replenishment target (all data at the current replenishment conference rate: 5-year simple moving average as of current replenishment conference)</p> <p>b) Actual current replenishment contributions to date plus forecast contributions to the current replenishment [cash received, contributions receivable plus outstanding pledges</p>



Area	KPI10: Resource mobilisation
	adjusted for technical assistance and risk adjustment] / forecast for current replenishment contributions (per the initial sources of funds approved by the AFC) <b>Data source:</b> Global Fund pledge & contribution database <b>Cohort:</b> All contributions, including earmarked contributions; Exclusions: Co-financing
Target	a) 100% of replenishment announced target pledges b) 100% of forecasted contributions actually received
Results – Overview	<b>Achieved</b> (and always been on track) <i>Results mid 2023: a) 100%; b) 99%</i>
Results – Deep dive	<b>KPI 10a</b> <ul style="list-style-type: none"> <li>For the 6<sup>th</sup> Replenishment period, the Replenishment target of \$14 bn was achieved. This result does not include additional pledges for C19RM as they were not included in the 6<sup>th</sup> Replenishment target.</li> <li>Results for 7<sup>th</sup> Replenishment period (to be formally reported from Spring 2024 as part of 2023-2028 KPI Framework), show that 87% of the target has currently been achieved.</li> </ul> <b>KPI 10b</b> <ul style="list-style-type: none"> <li>For the 6<sup>th</sup> Replenishment period, the current pledge conversion rate is at 99% (excluding C19RM). If C19RM is included in KPI 10b results, pledge conversion will increase to 133%.</li> </ul>
Limitations	
Changes under KPI Framework 2023-28	<ul style="list-style-type: none"> <li><b>This indicator has been maintained</b> (With slight change in methodology for KPI 10b. The new version will not compare contribution to forecast, but to predefined targets by year)</li> </ul>
Evaluators comment	<ul style="list-style-type: none"> <li>The indicator is a useful performance measure for the replenishment efforts by the Global Fund. While not included in this strategy period, the indicator highlighted the changing external funding environment post COVID-19.</li> </ul>

k. KPI 11: Domestic investments

Area	KPI11: Domestic investments
Definition	Percentage of domestic co-financing commitments to the health budget realized as government expenditures
Purpose	An increase in domestic investments in programs for HIV, TB and malaria are required to accelerate the end of the epidemics and to foster sustainable programs. The Global Fund directly supports these aims through advocacy and the Sustainability, Transition and Co-Financing policy. This indicator directly measures the extent to which domestic health co-financing commitments are fulfilled to meet this need.
Methodology	<b>Calculation method:</b> % of domestic co-financing requirements from the previous allocation period realized as government expenditures (inflation adjusted) <b>Data source:</b> Funding landscape data submitted as part of country funding requests <b>Cohort:</b> All country components accessing funding, except those exempted from co-financing



Area		KPI11: Domestic investments
Target	100% of policy stipulated requirements from previous allocation period realized. Measured over the current allocation period.	
Results – Overview	<b>Achieved</b> (and always been on track) <i>Result end-2022: 125%</i>	
Results – Deep dive	<ul style="list-style-type: none"> <li>• There was also a 34% increase in estimated co-financing in the implementation period of 2017-2019 allocation compared to previous (2014-2016) allocation period.</li> <li>• Percentage increase in estimated co-financing was greatest for Upper- LMI countries (65%) and lowest for UMI countries that just showed an increase of 13%.</li> <li>• While there has been a broad increase in co-financing across portfolio, only 84% of the total co-financing commitments were realized, with UMI countries having the lowest (78%) realization of co-financing commitments. This is not due to a reduction in overall domestic public health expenditure which increased over the 2018-20 period, but likely due to prioritisation for meeting emergency requirements and disruption of services due to Covid-19.</li> <li>• On average, of the total public expenditure on health, estimated co-financing of HTM programs for countries in KPI cohort was about 6.5% in 2018-2020, and combined HTM and RSSH co-financing averaged about 9.7%</li> </ul>	
Limitations	<ul style="list-style-type: none"> <li>• Data systems improvements to collect this information will be required.</li> <li>• The data provided as part of the funding requests is self-reported by countries and not additionally verified.</li> </ul>	
Changes under KPI Framework 2023-28	<ul style="list-style-type: none"> <li>• <b>This indicator has been maintained but the methodology has been updated.</b> In particular, this includes a move away from funding request reporting and tracks against country commitments and not the minimum requirements. Additionally, a new KPI has been created to measure the performance of the mitigation actions for countries at risk of not meeting co-financing commitments.</li> </ul>	
Evaluators comment	<ul style="list-style-type: none"> <li>• This indicator needs to be interpreted with care due to the uncertainty in the self-reported data and the lack of a strong verification mechanism in the past. The Global Fund Health Finance team has been focused on addressing some of these underlying data issues but have stressed the limitations of using this historic data.</li> <li>• To measure co-financing performance is useful, but the approach in collecting and verifying robust domestic health financing data used under this KPI was weak reducing the actionability for this indicator. This is also reflected in the fact that the indicator was always on track (e.g., countries would report that co-financing has been achieved and a clear verification mechanism has been missing). A key challenge is hereby that it is hard to follow actually expenditure for HTM in cases in which there is no separate budget line for disease programmes. The current approach is also not clear what type of RSSH expenditure is counted towards the co-financing commitment.</li> <li>• The changes to the new KPI Framework make sense to increase the robustness of the underlying data tracked and, the addition of the mitigation KPI also seems very timely given the financial situation in many LMICs after COVID-19.</li> </ul>	

I. KPI 12: Availability of affordable health technologies

Area		KPI12a: Supply continuity of health products:
Definition	For each of two defined product sets, percentage of a defined set of products with the desired number of suppliers that meet Quality Assurance requirements (i.e., four or more suppliers or two or more suppliers, depending on the product set)	

Area		KPI12a: Supply continuity of health products:
Purpose	This indicator aims to track availability of essential products via a measure of market health, and affordability via a measure of savings achieved.	
Methodology	<b>Calculation method:</b> Numerator: Number of products with four or more suppliers (for high volume products) or two or more suppliers (for lower volume products) that meet Quality Assurance requirements; Denominator: Number of products <b>Data source:</b> Global Fund product/supplier eligibility list <b>Cohort:</b> All Select products: WHO recommended 1 <sup>st</sup> & 2 <sup>nd</sup> line ARVs, ACTs, LLINs <ul style="list-style-type: none"> <li>• High Volume (for 2022: all 1<sup>st</sup> line adult ARVs; ACTs; LLINs)</li> <li>• Low Volume (for 2022: all 2<sup>nd</sup> line adult ARVs; all pediatric ARVs; specialized formulations)</li> </ul>	
Target	90% by 2022	
Results – Overview	<b>Achieved</b> (and has been in last 2 years, but not in 2018-2019 reporting periods when there was no differentiation between high and low volume products) <i>Results for end-2022: 93% and 100% respectively</i>	
Results – Deep dive	<ul style="list-style-type: none"> <li>• High Volume: 93% of products have 4 suppliers or more that meet QA requirements (against a target of 90% of products)</li> <li>• For Low Volume: 100% of products have 2 suppliers or more that meet QA requirements (against a target of 90% of products)</li> <li>• In 2022, only TLE 300/400mg, 30 tablet has not met the target of 4 suppliers</li> <li>• In 2018-19, there was only a single measure for this indicator and the KPI was off-track with only 69% meeting the threshold of having three suppliers in the market. This was then changed to have high volume and low volume products with different targets.</li> </ul>	
Limitations	<ul style="list-style-type: none"> <li>• It should be noted that even with more than three suppliers, manufacturing capacity may still be insufficient to meet demand, especially during peak times. Manufacturing capacity is estimated and self-reported by suppliers and therefore difficult to validate. The same is true for global demand.</li> <li>• Only includes Malaria and HIV products (given that TB procurement is led by GDF)</li> </ul>	
Changes under KPI Framework 2023-28	<ul style="list-style-type: none"> <li>• <b>This indicator has been maintained</b> with a similar methodology which now also includes TB products.</li> </ul>	
Evaluators comment	<ul style="list-style-type: none"> <li>• The methodology change in 2021 seems sensible to ensure that the number of suppliers better match the market size. The indicator is useful in providing a high-level overview of the health of the market of existing products.</li> <li>• It is welcomed that this indicator has been complemented with another KPI indicator in the new framework which tracks the introduction of new products into the market (an element which has been missing).</li> </ul>	

Area		KPI12b: Affordability of health products:
Definition	Annual savings achieved through the Pooled Procurement Mechanism on a defined set of key products (mature and new)	

Area		KPI12b: Affordability of health products:
Purpose	This indicator aims to track availability of essential products via a measure of market health, and affordability via a measure of savings achieved.	
Methodology	<b>Calculation method:</b> (Baseline price – current year price) x volume of current year Purchase Order confirmed Baseline price dependent on product maturity: Weighted average price during the previous contract/period, announced lowest market entry price, Spend avoidance, etc. <b>Data source:</b> Pooled procurement mechanism data <b>Cohort:</b> Key products covering: ARVs, ACTs, LLINs, RDT & Non-Core products; PSA Fees, Freight & logistics costs	
Target	USD 154m in 2021 (target varies on yearly basis) USD 136m in 2020 USD 115m in 2019	
Results – Overview	<b>No target was set for 2022</b> (as the target was seen to potentially impact on the ability of the Secretariat to negotiate on prices and due to transition of this indicator to more specific sourcing performance measures) <i>Results end 2022: US\$ 49.7 million</i>	
Results – Deep dive	<ul style="list-style-type: none"> <li>Pharmaceuticals products positive savings of USD 76M in 2022 (vs 2021 WAP) – mostly driven by price drops in 1<sup>st</sup> Line ARTs</li> <li>Health Technologies products have negative savings of USD -26.5M in 2022 (compared to USD -16M in 2021). This was due to higher costs for LLINs driven by an increase in raw materials</li> <li>In previous years, this indicator has always been on track.</li> </ul>	
Limitations	<ul style="list-style-type: none"> <li>Does not capture affordability of products in countries that do not access PPM framework agreements</li> <li>Only includes product prices which not necessarily reflect total costs of using products in countries</li> </ul>	
Changes under KPI Framework 2023-28	<ul style="list-style-type: none"> <li><b>This indicator has been dropped.</b> Instead, this measure has been integrated into sourcing, procurement and supply chain performance measures.</li> </ul>	
Evaluators comment	<ul style="list-style-type: none"> <li>Hard to disentangle through this indicator what would be an expected decrease in product prices (as usually observed in the market) and what has been achieved due to the GF procurement and market shaping approaches</li> <li>The sole focus on product prices also has the risk to miss out on actual total costs experienced by countries (e.g., service delivery costs or cost-effectiveness of different products)</li> </ul>	

m. Methodological challenges with 2017-2023 KPIs

Table H.4 summarises methodological challenges with each of the 2017-2023 KPIs, and the Global Fund response in the new Strategy Period.

Table H.4: Methodological challenges with 2017-23 SP KPIs

KPI	Issue	Response
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1a Estimated lives saved	Challenges of using lives saved rather than mortality rates (including strong feedback loop between lives saved incidence rate)	Updated to be measured against the reduction in the mortality rate
1b Reduction in incidence		Maintained
2 Service delivery	Time lag with reporting; data quality and availability; modelling assumptions, incl. lack of interventions costings data	Updated to be measured against grant performance. Additionally, a number of indicators have been dropped (on VMMC and IRS) and other indicators have been added including on malaria treatment, SMC and TB contacts on TPT.
3 Alignment	'Need' determined by allocation methodology; weighted to HI countries	Dropped (as it also had a strong overlap with KPI 7a)
4 Efficiency	Allocative efficiency of NSPs only; data, modelling problems	Dropped
5a KVP prevention budget	Reflects budgeted rather than KVP results	Dropped
5b KVP service reporting	Measurement of services ambiguous; HIV only	Updated to measure reach of KVP prevention
5c KVP service coverage	Shifting cohorts and every cohort counts the same regardless of burden or investment	Updated to expand cohort and an weighted average approach
6a Procurement prices	Affected by external factors; Global Fund investment was limited – thus lacking accountability and actionability	Dropped
6b Supply chains	Stockout duration not captured;	Updated to measure with different aggregation approach
6c Financial management	Limited cohort and indicator primarily process-level	Updated through the introduction of new financial management indicators at the outcome level
6d HMIS coverage	Does not measure data usage	Updated to dual KPIs, one measuring usage
6e Results disaggregation	(updated 2021)	Maintained (with an expanded cohort)
6f NSP alignment	Subjective TRP assessment; does not assess NSP quality	Dropped
7a Allocation utilisation	Incentivizes over-commitment to meet allocation, fund transfer from need towards absorption capability, increased spending at cycle end	Maintained
7b Absorptive capacity		Maintained
8 Gender, age equality	As with KPI 2 re modelling targets; limited cohort of 13 countries	Updated and a wider indicator was added on gender equality

9a Reduce HR barriers	Interventions better defined for HIV than TB, malaria	Updated to better capture malaria issues and with a focus on measuring progress
9b HR investments	Only expenditure not outcome	Dropped – but reported internally
9c HR domestic investment	Not GF accountable; data verification challenge	Dropped
10 Resource mobilisation	None	Maintained
11 Domestic investments	Data verification, Target set against minimum requirement not actual commitments	Changed to new methodology
12a Supply continuity of health products	TB excluded	Changed to include TB
12b Health product affordability	Not actionable; Not clearly measuring what is due to action from the Global Fund	Dropped

### iii) WS2: descriptive statistics

This appendix illustrates time trends in HTM incidence and mortality, and the performance of priority service delivery indicators against target (i.e., the difference between KPI2 results and targets) to inform the following review question:

- To what extent has the Global Fund met its Strategic Objectives for 2017-22? How and why has performance varied by region and high impact countries? [SRQ2.1]

...with a particular focus on **how** performance has varied by region, Global Fund country classifications and case study countries.

The priority service delivery indicators analysed were:<sup>20</sup>

- # of adults and children currently receiving ART (#ART);
- % HIV+ pregnant women receiving ART for PMTCT (%PMTCT);
- # of notified cases of all forms of TB – bacteriologically confirmed plus clinically diagnosed (#TB Notifs);
- # of cases with drug resistant TB (RR-TB and/or MDR-TB) that began second line treatment (#MDR-TB);
- # of LLINs distributed to at-risk-populations (#LLINs); and
- # of households in target areas that received IRS (#IRS).

To investigate how performance and disease burden have varied by region and high impact countries both the level changes and percentage changes over time were analysed, and the median was calculated for each group of countries. The median was calculated, as opposed to the mean, as it is more robust to outliers, which is particularly important when exploring the trend of percentage changes over time.<sup>21</sup>

Incidence was measured as cases per 1000 population. Mortality was measured as deaths per 100,000 population. Cases and deaths were reported by UNAIDS for HIV (UNAIDS Global AIDS Update 2022) and the WHO for tuberculosis and malaria through the Global Tuberculosis Report (2022) and the World Malaria Report (2022) respectively. Population was sourced from the World Bank. Service delivery indicator performance was calculated for each country in each year as:

$$Performance_{it} = \min\left\{\frac{Grant\ Result_{it}}{Grant\ Target_{it}}, 1.2\right\}$$

Capping performance at 1.2 or 120% was in-line with Global Fund's operational upper bound. Grant result and grant target data was provided by the Global Fund.<sup>22</sup>

Countries were grouped by challenging operating environment (COE) status, impact group (Core, Focus, High Impact) and WHO region (Africa, Americas, Eastern Mediterranean, Europe, SE Asia, Pacific). Additionally, the trends in HTM incidence and mortality, and service delivery indicator performance were analysed for CEPA's case study countries.<sup>23</sup>

<sup>20</sup> These were selected based on feedback from the Global Fund Secretariat.

<sup>21</sup> On a technical note, if a country had 0 mortality in one period and then positive mortality in the next period, their measured percentage change would be infinite and hence the average percentage change would also be infinite.

<sup>22</sup> For a more detailed discussion of the data sources and data limitations see the Regression and Statistical Analysis appendix.

<sup>23</sup> CEPA's case study countries were Bolivia, Chad, Cote d'Ivoire, India, Kenya, Kyrgyzstan, Mozambique, Nigeria, Pakistan, Philippines, Sierra Leone, South Africa, South Sudan, Zambia. For further discussion refer to the Case Study annex.





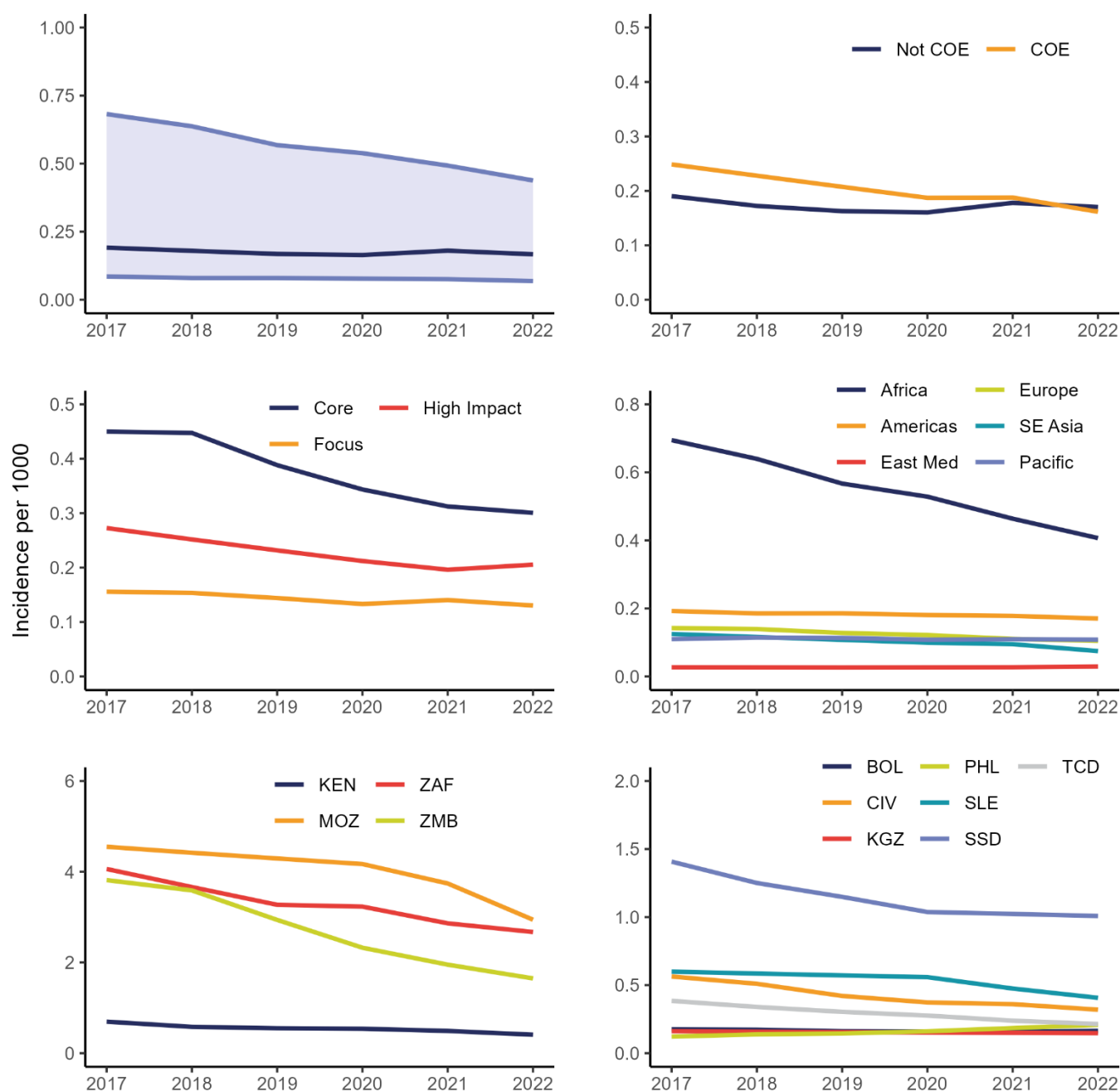
a. Incidence and mortality

i. HIV

This section illustrates time trends in HIV incidence and mortality across regions, impact groups and COE status, both in level changes (see Figure I.1 and I.3) and percentage changes (see Figure I.2 and I.4). Key highlights from this section are:

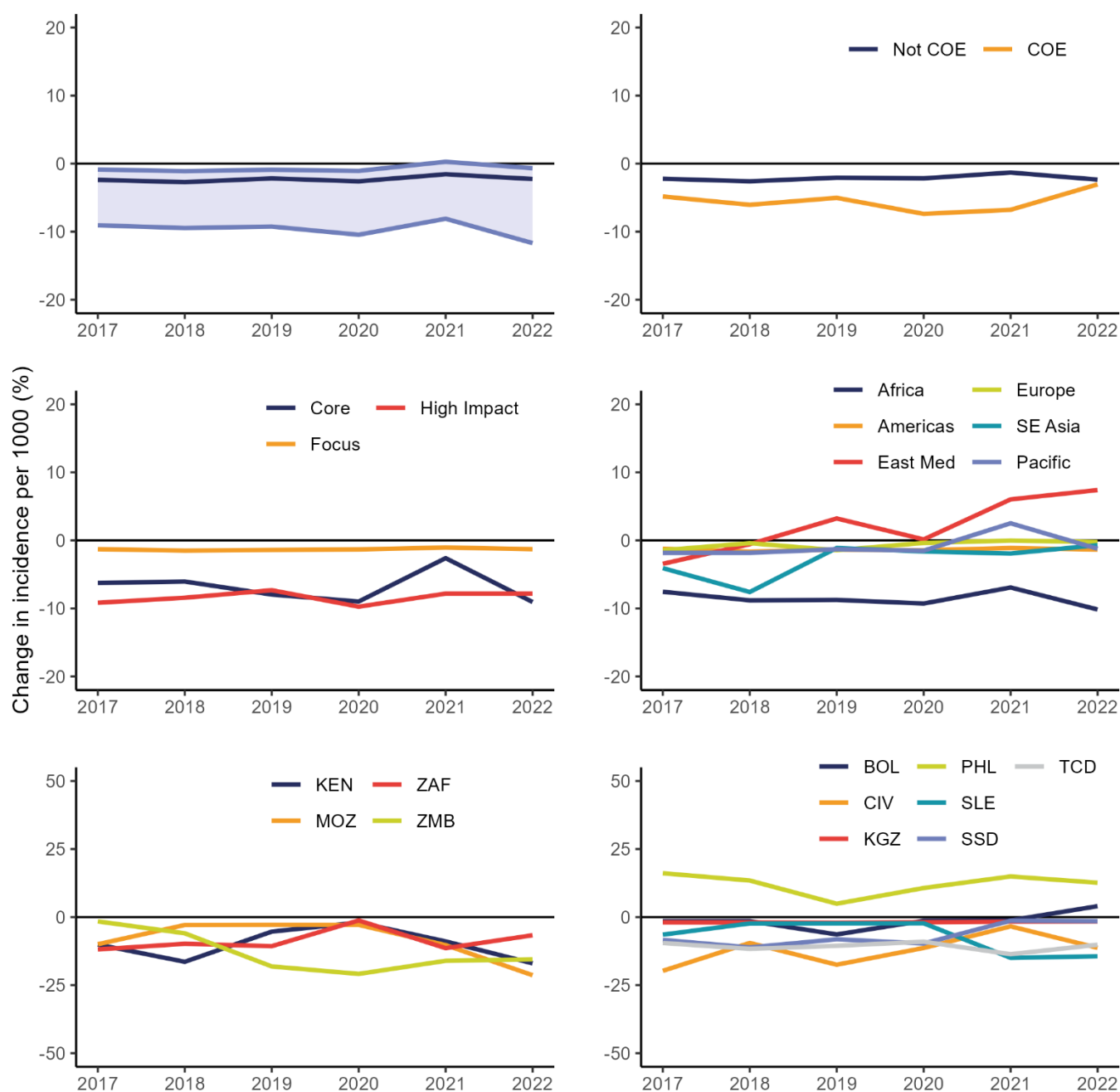
- Median HIV incidence remains higher for core countries, this group has experienced a sharper fall in median HIV incidence over the period compared to high impact and focus groups, which have experienced more gradual declines, and even slight increases in incidence in recent years. Similarly, the strongest decline has taken place in the Africa region.
- Case study countries outside of Africa are less likely to see large falls in HIV incidence. The Philippines has seen an increase in their HIV incidence every year from 2017 to 2022, being the only country from the analysis to not experience a fall in incidence during any year.
- Median HIV mortality has decreased by approximately 10-20% each year for core and high impact countries, while the median decrease in mortality for focus countries is much smaller. Median HIV mortality has decreased at the fastest rate in African countries, including Cote d'Ivoire, South Africa, Sierra Leone, and Chad in the country case studies. Pakistan is the only country to experience a persistent increase in HIV mortality, while the Philippines experienced an increase in 2021 and 2022 (from a very low base).

*Figure I.1: Trends in HIV incidence (per 1000) from 2017-2022*



Source: UNAIDS and World Bank. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of HIV incidence. Top right: Median HIV incidence for COE and not COE countries. Middle left: Median HIV incidence for Core, High Impact and Focus countries. Middle right: Median HIV incidence for WHO regions. Bottom panels: HIV incidence for case study countries. Note that data is missing for Nigeria, Pakistan, and India (pre-2021).

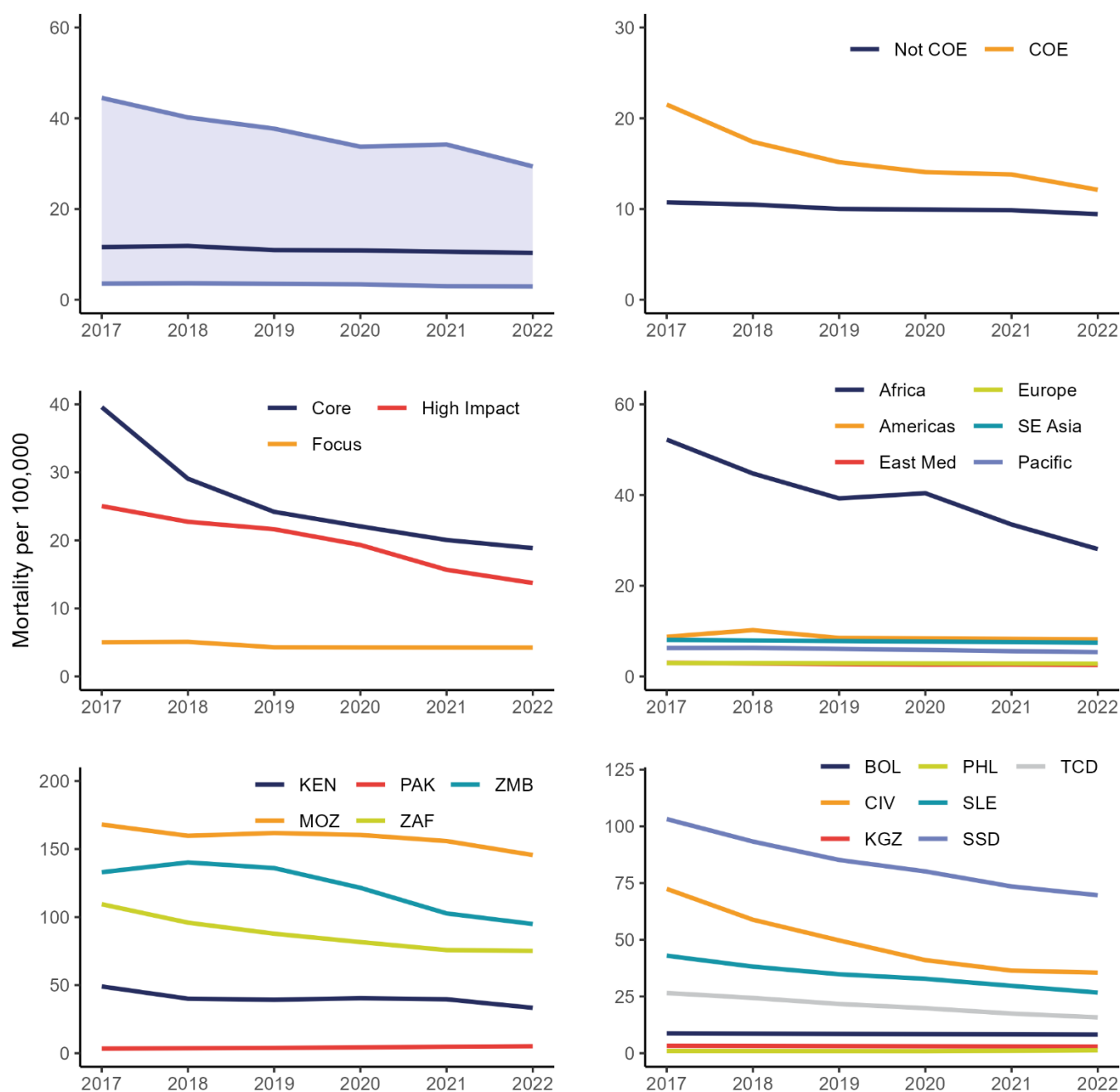
Figure I.2: Trends in change in HIV incidence (per 1000) from 2017-2022



Source: UNAIDS and World Bank. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile percentage changes in HIV incidence. Top right: Median percentage change in HIV incidence for COE and not COE countries. Middle left: Median percentage change in HIV incidence for Core, High Impact and Focus countries. Middle right: Median percentage change in HIV incidence for WHO regions. Bottom panels: Percentage change in HIV incidence for case study countries. Note that data is missing for Nigeria, Pakistan, and India (pre-2021).

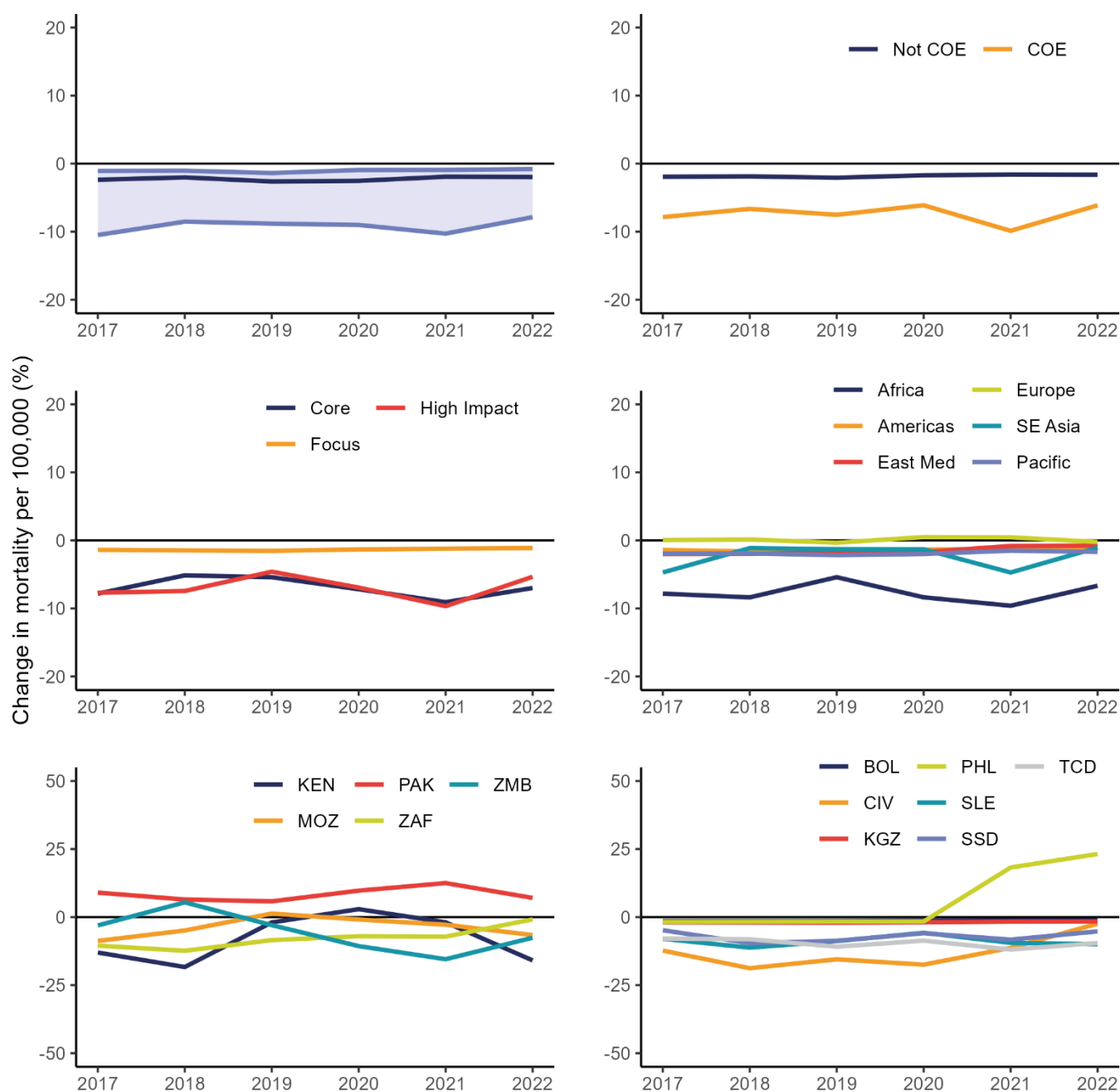
Figure I.3: Trends in HIV mortality (per 100,000) from 2017-2022<sup>24</sup>

<sup>24</sup> The plateau between 2019-2020 in Africa seems to be driven by the choice of using the median. When using the mean there is a smoother decline in over time.



Source: UNAIDS and World Bank. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of HIV mortality. Top right: Median HIV mortality for COE and not COE countries. Middle left: Median HIV mortality for Core, High Impact and Focus countries. Middle right: Median HIV mortality for WHO regions. Bottom panels: HIV mortality for case study countries. Note that data is missing for Nigeria and India (pre-2021).

Figure I.4: Trends in change in HIV mortality (per 100,000) from 2017-2022



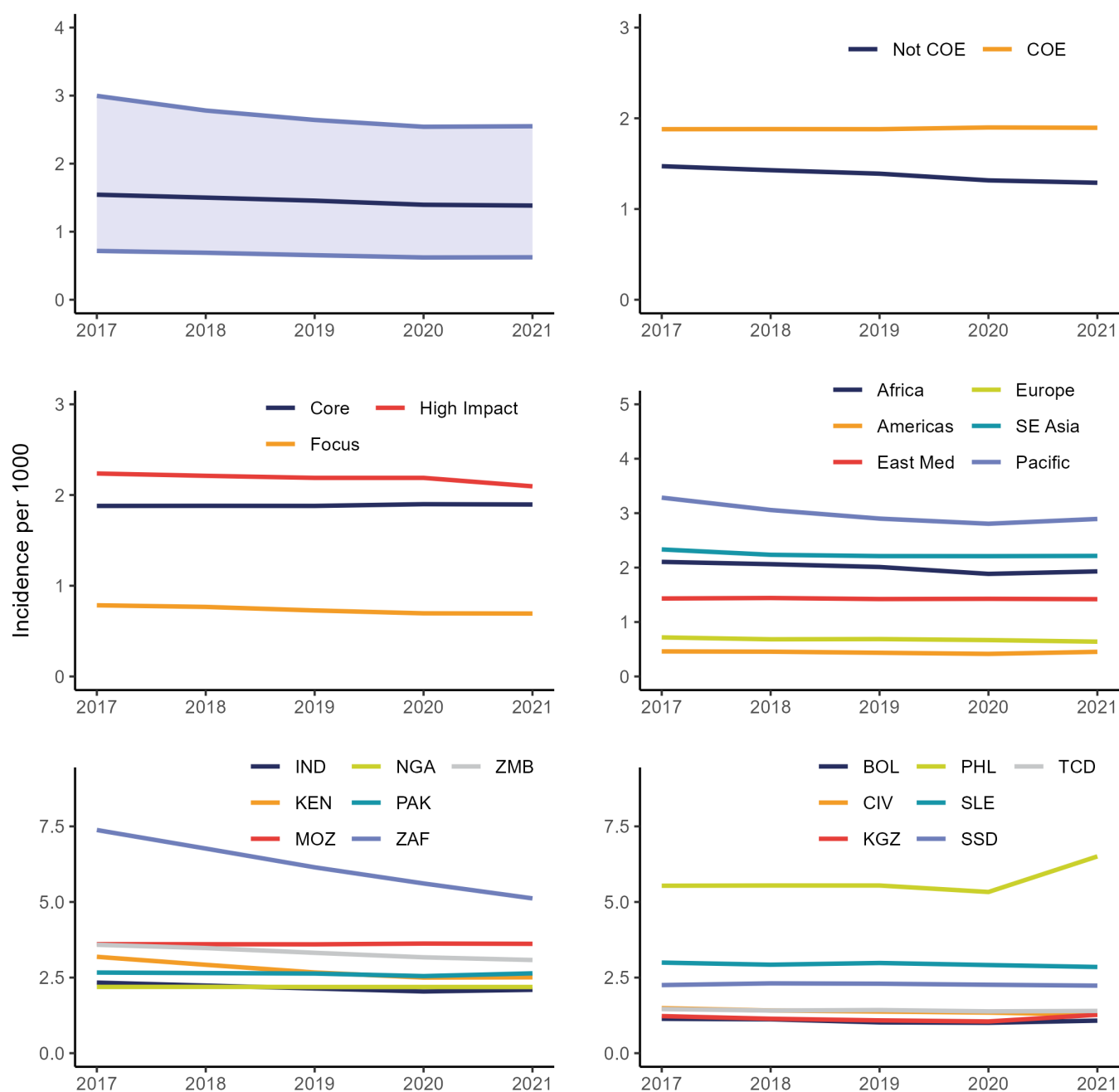
Source: UNAIDS and World Bank. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile percentage changes in HIV mortality. Top right: Median percentage change in HIV mortality for COE and not COE countries. Middle left: Median percentage change in HIV mortality for Core, High Impact and Focus countries. Middle right: Median percentage change in HIV mortality for WHO regions. Bottom panels: Percentage change in HIV mortality for case study countries. Note that data is missing for Nigeria, Pakistan, and India (pre-2021).

## *ii. Tuberculosis*

This section illustrates time trends in tuberculosis incidence and mortality across regions, impact groups and COE status, both in level changes (see Figure I.5 and Figure I.7) and percentage changes (see Figure I.6 and Figure I.8). Key highlights from this section are:

- Median TB incidence is higher for core and high impact countries and has remained relatively constant over the period. Median TB incidence is highest in the Pacific region, where growth has been variable. Median TB incidence has decreased in Africa and the Eastern Mediterranean regions over the period.
- Case study countries outside of Africa are less likely to see large falls in TB incidence. The Philippines and Kyrgyzstan experienced large increases in TB incidence in 2021, while South Africa, Zambia and Kenya experienced persistent decreases across the period.
- Median TB mortality decreased from 2017 to 2019 before increasing in 2020 and 2021. The spread of changes in TB mortality has increased since 2020. There was a clear change in direction in TB mortality in 2020 and 2021, likely caused by COVID-19.
- Median TB mortality is much higher for core and high impact countries, and median TB mortality is highest in Africa and Southeast Asia. Median TB mortality has decreased persistently in Africa, while Europe and the Americas experienced a large increase in median TB mortality in 2020 and 2021. TB mortality has decreased persistently across the period in Zambia and Nigeria, while Kenya experienced large decreases in 2017-2019 that have since slowed. Large increases in TB mortality were experienced by Sierra Leone in 2020 and Kyrgyzstan and the Philippines in 2021.

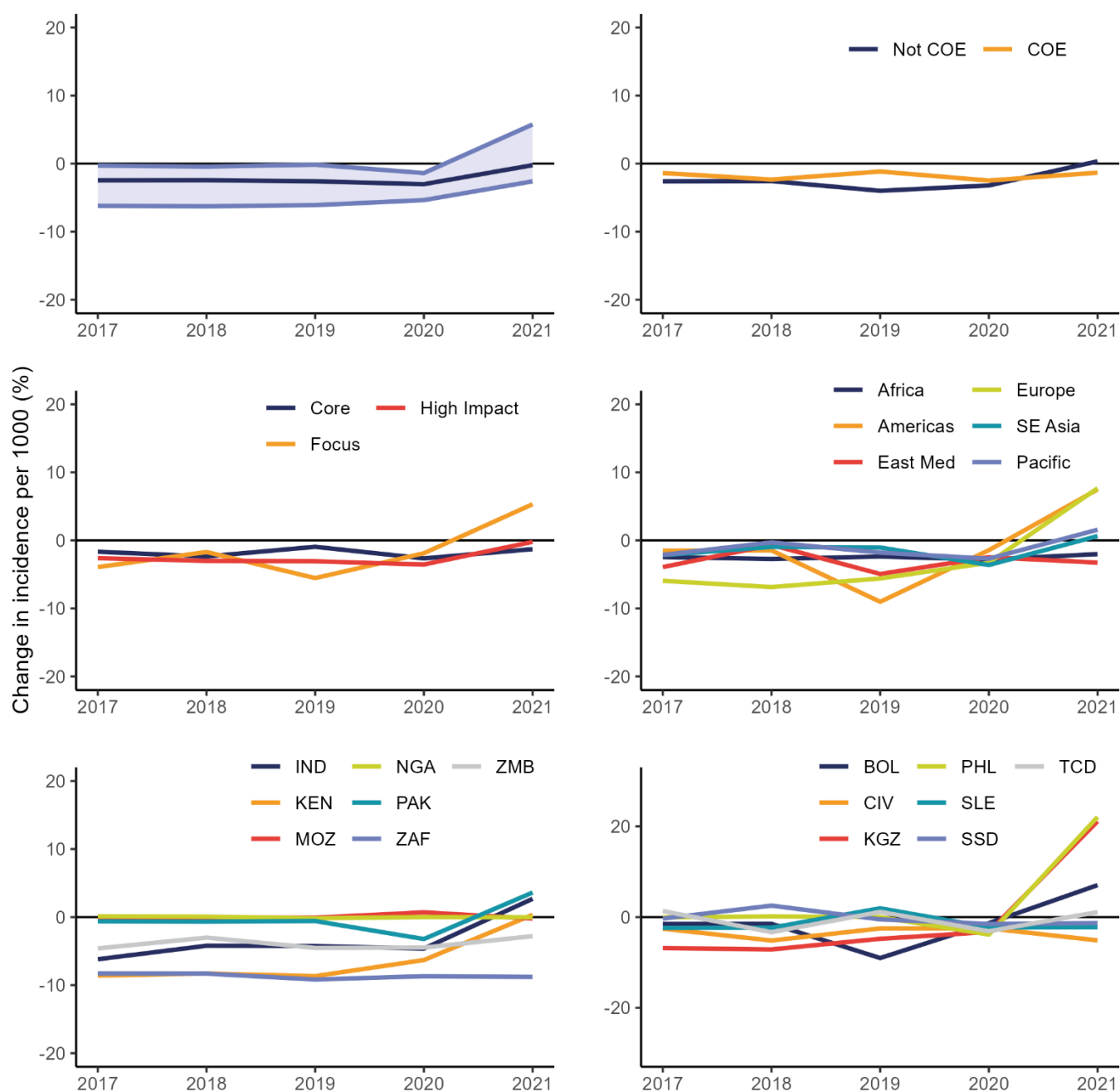
*Figure I.5: Trends in TB incidence (per 1000) from 2017-2022*



Source: UNAIDS and World Bank. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of TB incidence. Top right: Median TB incidence for COE and not COE countries. Middle left: Median TB incidence for Core, High Impact and Focus countries. Middle right: Median TB incidence for WHO regions. Bottom panels: TB incidence for case study countries. Note missing data for 2022.

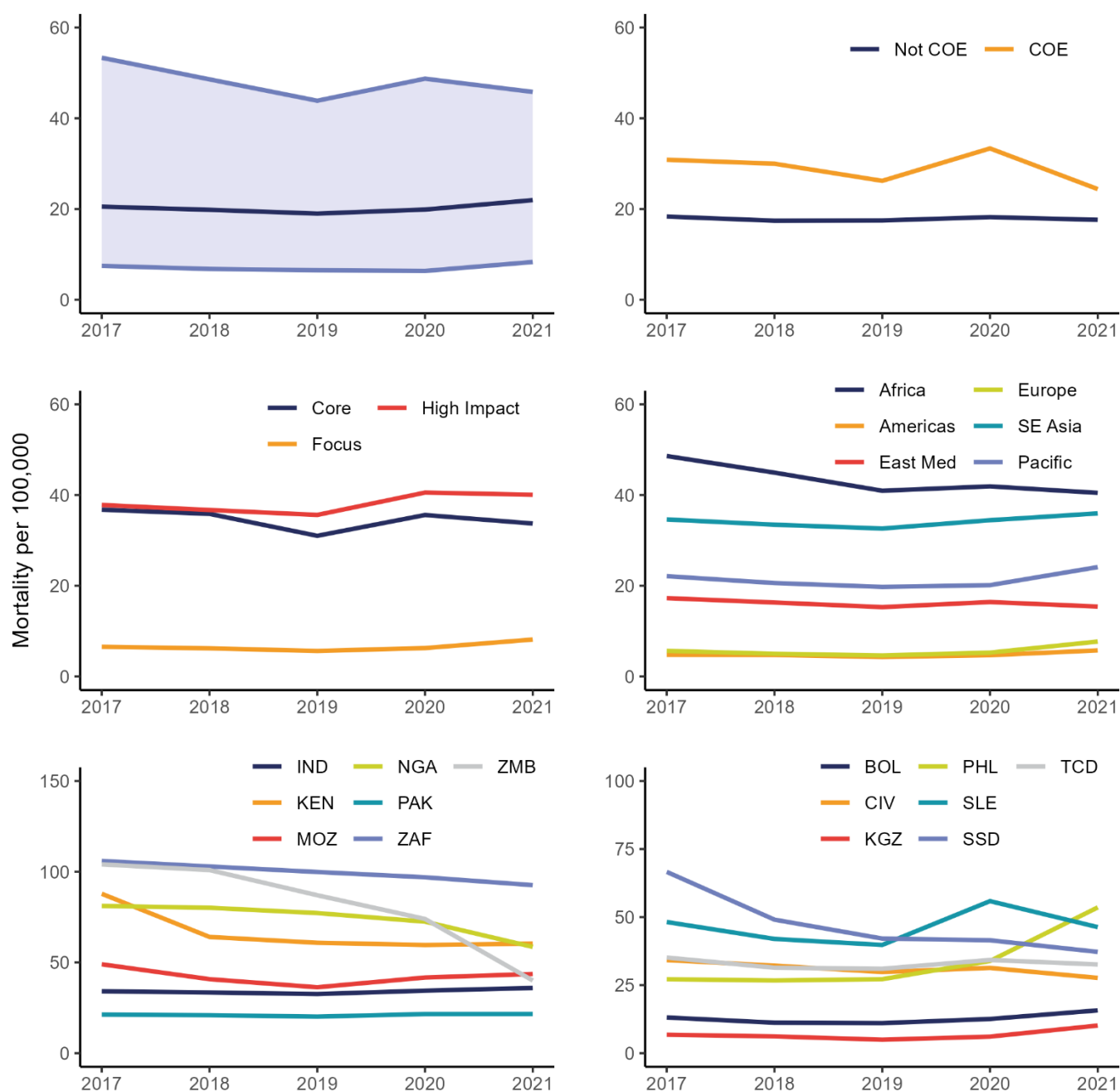
Figure I.6: Trends in change in TB incidence (per 1000) from 2017-2022





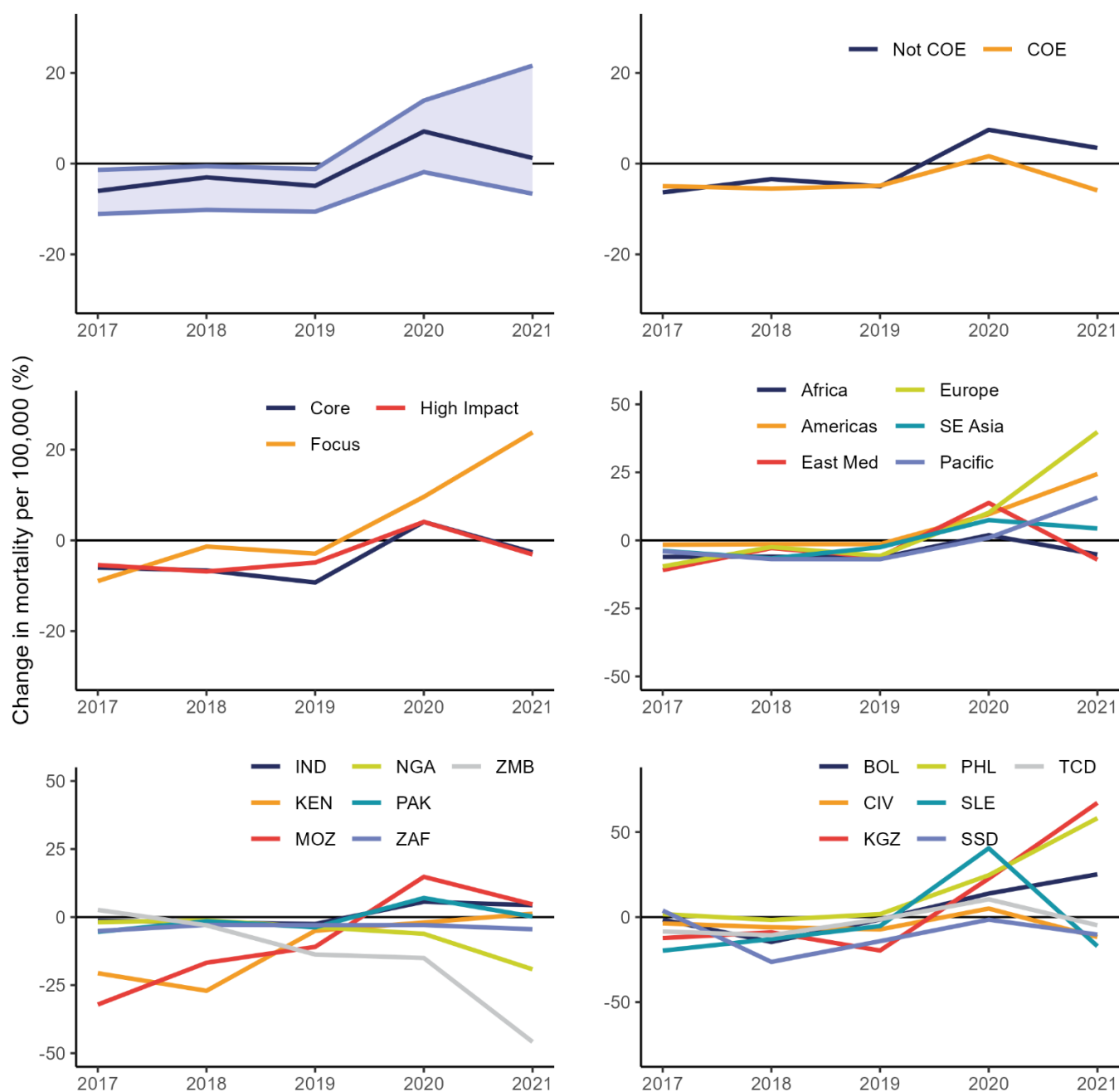
Source: UNAIDS and World Bank. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile percentage changes in TB incidence. Top right: Median percentage change in TB incidence for COE and not COE countries. Middle left: Median percentage change in TB incidence for Core, High Impact and Focus countries. Middle right: Median percentage change in TB incidence for WHO regions. Bottom panels: Percentage change in TB incidence for case study countries. Note missing data for 2022.

Figure I.7: Trends in TB mortality (per 100,000) from 2017-2022



Source: UNAIDS and World Bank. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of TB mortality. Top right: Median TB mortality for COE and not COE countries. Middle left: Median TB mortality for Core, High Impact and Focus countries. Middle right: Median TB mortality for WHO regions. Bottom panels: TB mortality for case study countries. Note missing data for 2022.

Figure I.8: Trends in change in TB mortality (per 100,000) from 2017-2022



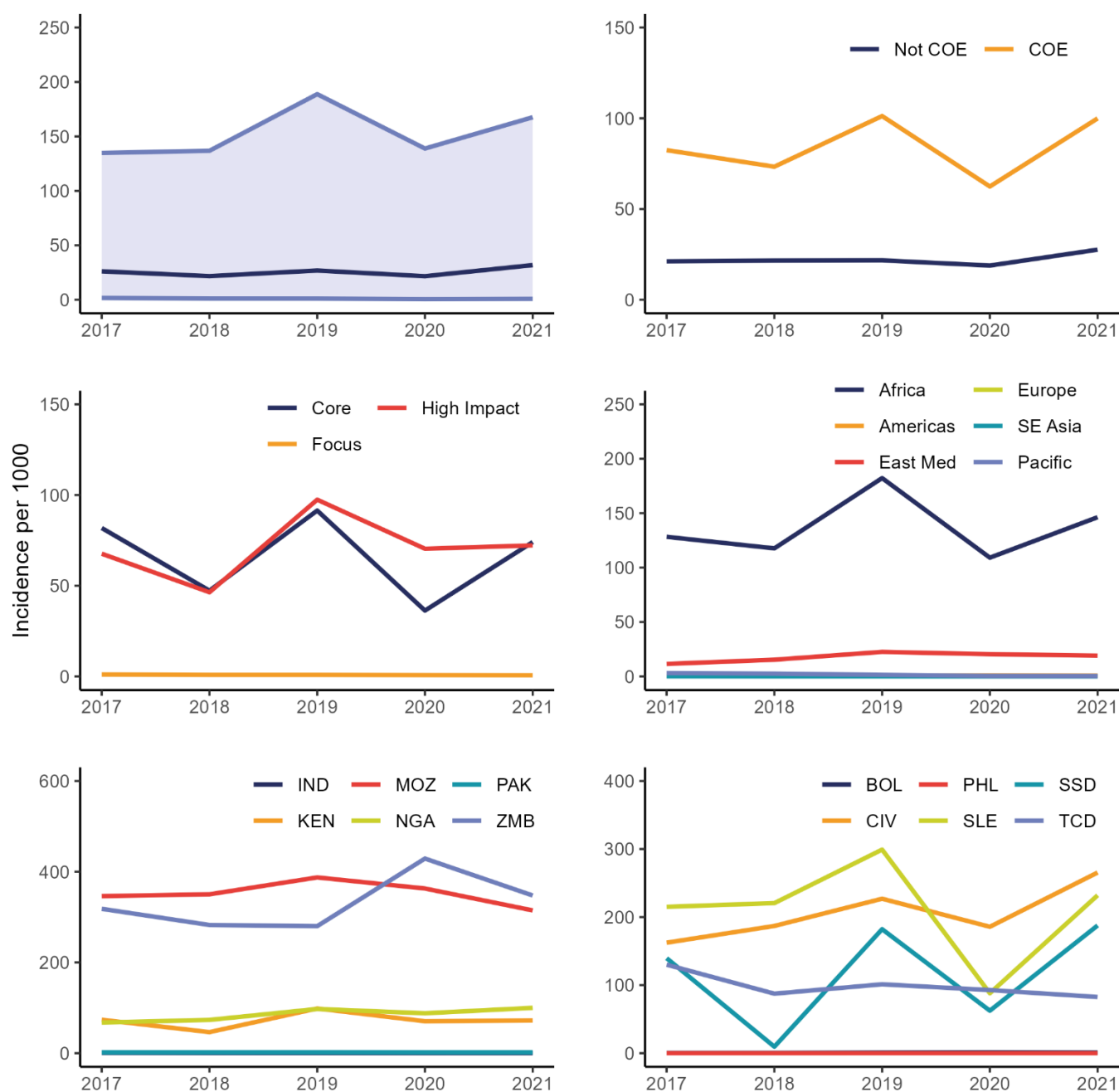
Source: UNAIDS and World Bank. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile percentage changes in TB mortality. Top right: Median percentage change in TB mortality for COE and not COE countries. Middle left: Median percentage change in TB mortality for Core, High Impact and Focus countries. Middle right: Median percentage change in TB mortality for WHO regions. Bottom panels: Percentage change in TB mortality for case study countries. Note missing data for 2022.

### *iii. Malaria*

This section illustrates time trends in malaria incidence and mortality across regions, impact groups and COE status, both in level changes (see Figure I.9 and Figure I.11) and percentage changes (see Figure I.10 and Figure I.12). Key highlights from this section are:

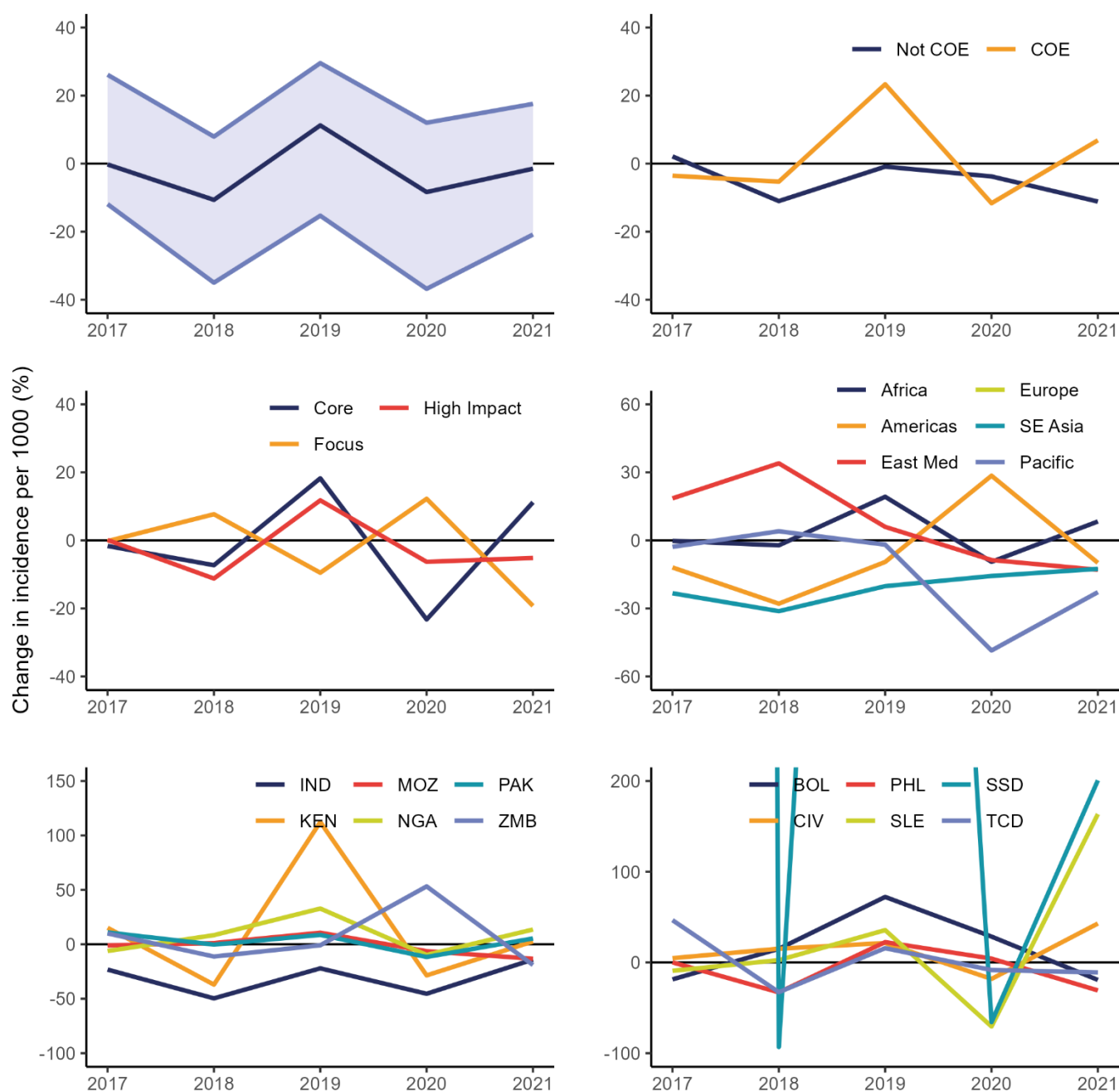
- Malaria incidence is highly variable compared to HIV and TB. Median malaria incidence exhibits a ‘W’ shape. The 75th percentile for malaria incidence has increased over the period, with a large spike in 2019. The difference between the 25<sup>th</sup> and 75<sup>th</sup> percentile growth rate is large, approximately 40% in 2021. This means that changes in malaria incidence is highly variable.
- Median malaria incidence is degrees of magnitude larger in African countries. Median malaria incidence has increased in high impact countries, driving the overall increase from 2017-2022.
- Of the African case study countries, none have experienced a persistent decrease in malaria incidence, while Kenya, Sierra Leone and South Sudan have all experienced year-on-year increases in malaria over 100% at least once during the 2017-2021 period.
- The 75<sup>th</sup> percentile for malaria mortality has decreased by around 30% each year from 2017-2022, while median and 25<sup>th</sup> percentile HIV mortality has decreased at a much slower rate. This means that high mortality countries have reduced their HIV mortality faster than other countries. Progress in reducing mortality rate has stalled since 2020 within an increase in High Impact and African countries between 2020 and 2021.

*Figure I.9: Trends in malaria incidence (per 1000) from 2017-2022*



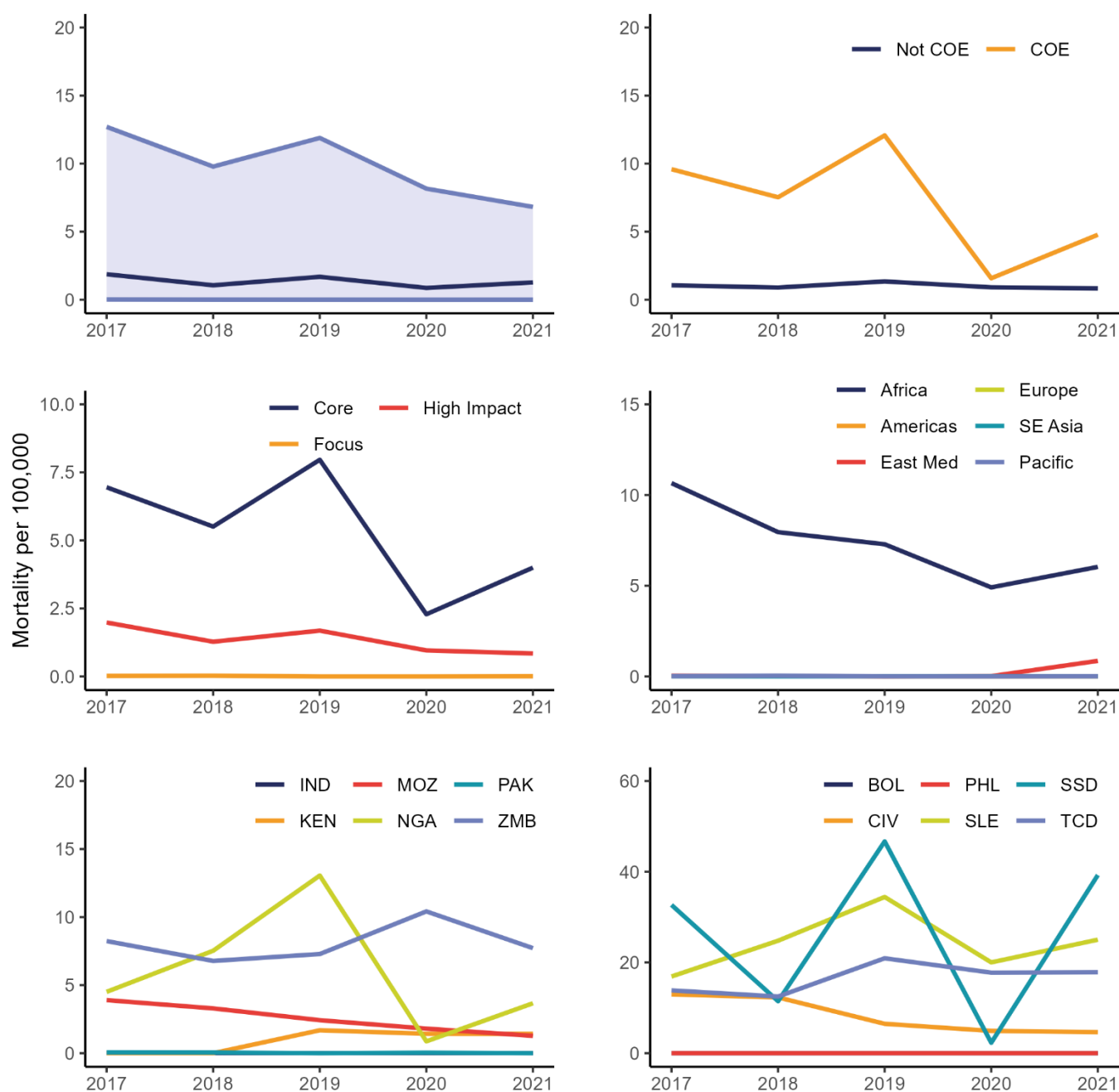
Source: UNAIDS and World Bank. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of malaria incidence. Top right: Median malaria incidence for COE and not COE countries. Middle left: Median malaria incidence for Core, High Impact and Focus countries. Middle right: Median malaria incidence for WHO regions. Bottom panels: Malaria incidence for case study countries. Note missing data for 2022. Data missing for South Africa and Kyrgyzstan.

Figure I.10: Trends in change in malaria incidence (per 1000) from 2017-2022



Source: UNAIDS and World Bank. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile percentage changes in malaria incidence. Top right: Median percentage change in malaria incidence for COE and not COE countries. Middle left: Median percentage change in malaria incidence for Core, High Impact and Focus countries. Middle right: Median percentage change in malaria incidence for WHO regions. Bottom panels: Percentage change in malaria incidence for case study countries. Note missing data for 2022. Data missing for South Africa and Kyrgyzstan. South Sudan has increases greater than 200% in 2017 and 2019.

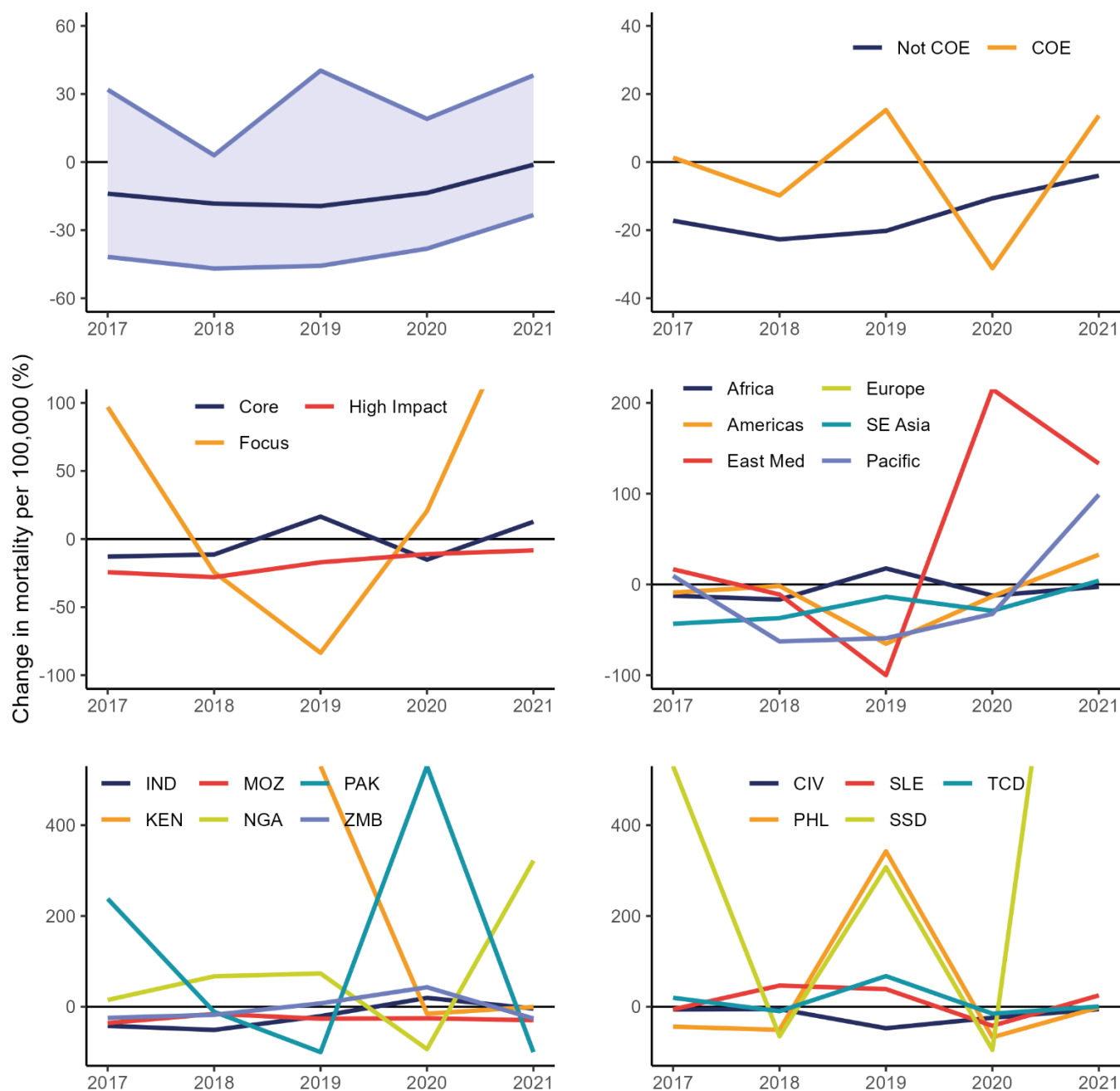
Figure I.11: Trends in malaria mortality (per 100,000) from 2017-2022



Source: UNAIDS and World Bank. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of malaria mortality. Top right: Median malaria mortality for COE and not COE countries. Middle left: Median malaria mortality for Core, High Impact and Focus countries. Middle right: Median malaria mortality for WHO regions. Bottom panels: Malaria mortality for case study countries. Note missing data for 2022. Missing data for South Africa and Kyrgyzstan.

Figure I.12: Trends in change in malaria mortality (per 100,000) from 2017-2022





Source: UNAIDS and World Bank. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile percentage changes in malaria mortality. Top right: Median percentage change in malaria mortality for COE and not COE countries. Middle left: Median percentage change in malaria mortality for Core, High Impact and Focus countries. Middle right: Median percentage change in malaria mortality for WHO regions. Bottom panels: Percentage change in malaria mortality for case study countries. Note missing data for 2022. Missing data for South Africa, Kyrgyzstan, and Bolivia. Kenya has increases greater than 500% in 2017 and 2018, while South Sudan has increases greater than 500% in 2017 and 2021.

b. Service delivery indicators (KPI2)

This section illustrates time trends in service delivery performance for a subset of priority service delivery indicators. Performance is calculated as grant results / grant target and is capped at 120% in line with Global Fund's internal operations. In many instances, maintaining performance actually requires an increase in grant results due to the general scale-up in national targets from one year to the next.

The priority service delivery indicators are:

- # of adults and children currently receiving ART (#ART);
- % HIV+ pregnant women receiving ART for PMTCT (%PMTCT);
- # of notified cases of all forms of TB – bacteriologically confirmed plus clinically diagnosed (#TB Notifs);
- # of cases with drug resistant TB (RR-TB and/or MDR-TB) that began second line treatment (#MDR-TB);
- # of LLINs distributed to at-risk-populations (#LLINs); and
- # of households in target areas that received IRS (#IRS).

For each service delivery indicator, the trend of median performance and the trend in the median change in performance was analysed for:

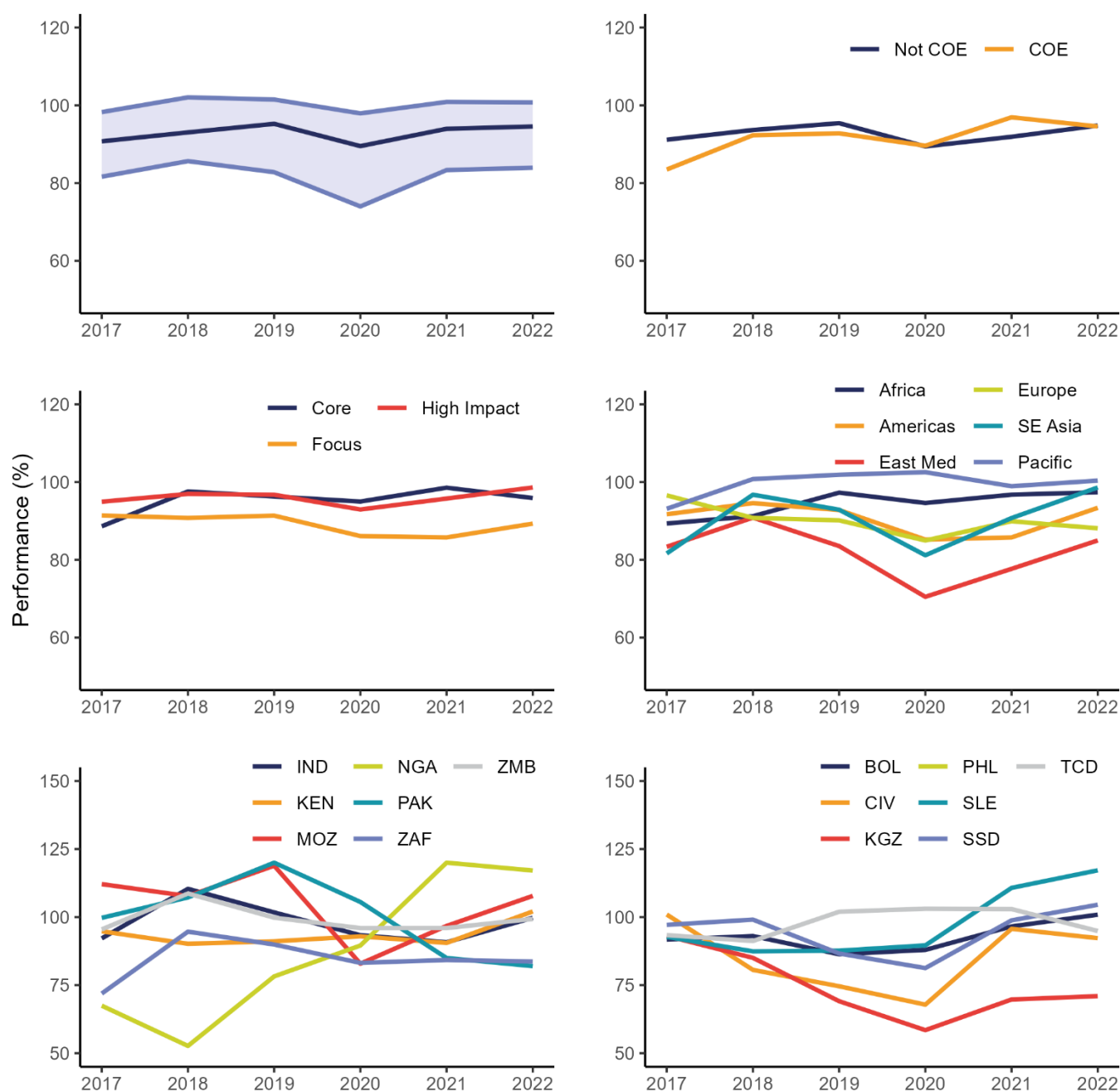
- All countries tracking that service delivery indicator;
- Countries grouped by COE and not COE;
- Countries grouped by impact group;
- Countries grouped by WHO region; and
- CEPA's case study countries.

The key findings of the service delivery indicators are directly discussed in the main report.

i. # of adults and children currently receiving ART (#ART)

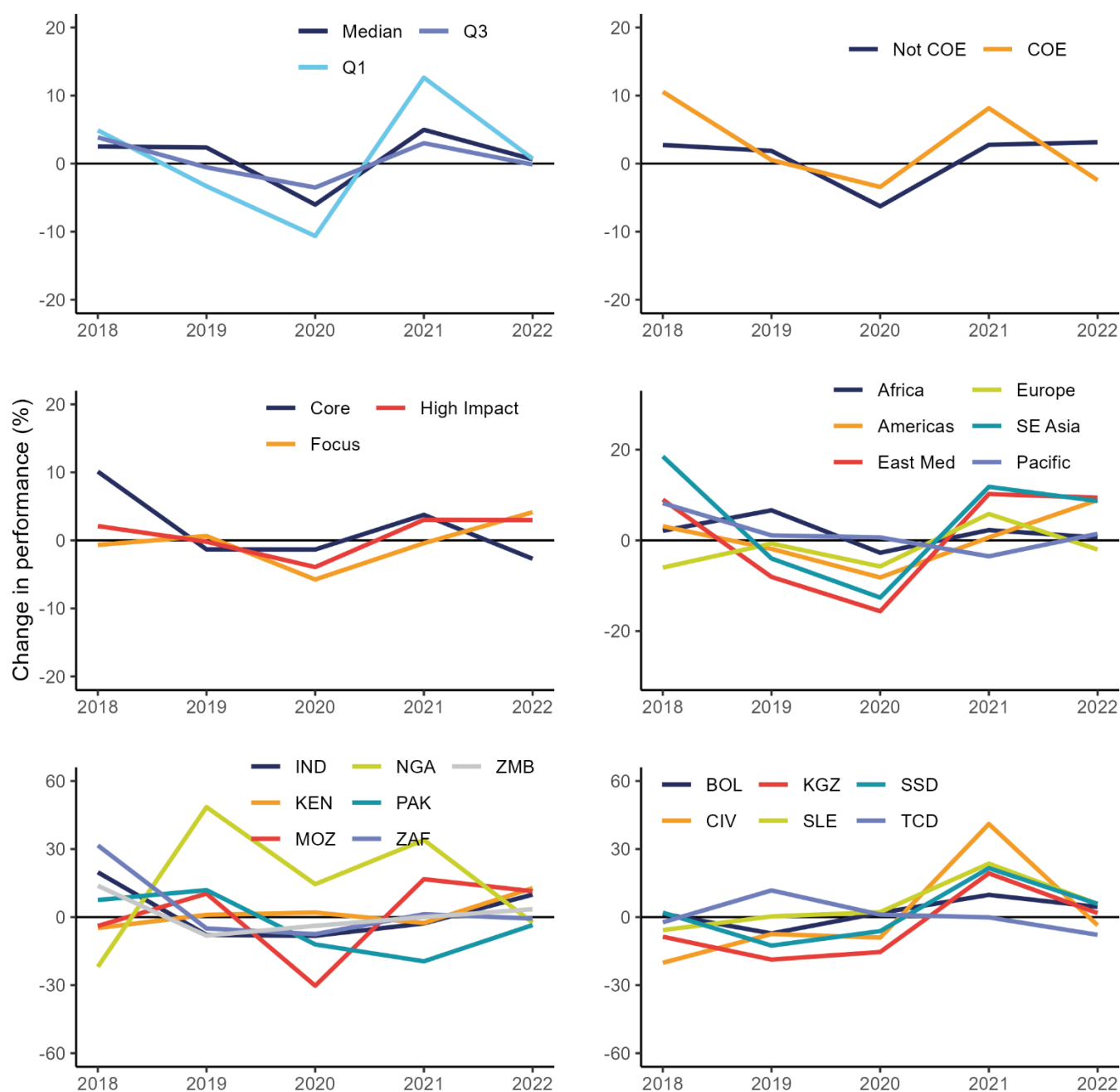
This section illustrates time trends in #ART performance across regions, impact groups and COE status, both in level changes and percentage changes.

Figure I.13: Trends in #ART performance from 2017-2022



Source: Global Fund KPI2 dataset. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of #ART performance. Top right: Median #ART performance for COE and not COE countries. Middle left: Median #ART performance for Core, High Impact and Focus countries. Middle right: Median #ART performance incidence for WHO regions. Bottom panels: #ART performance for case study countries.

Figure I.14: Percentage change in #ART performance from 2017-2022

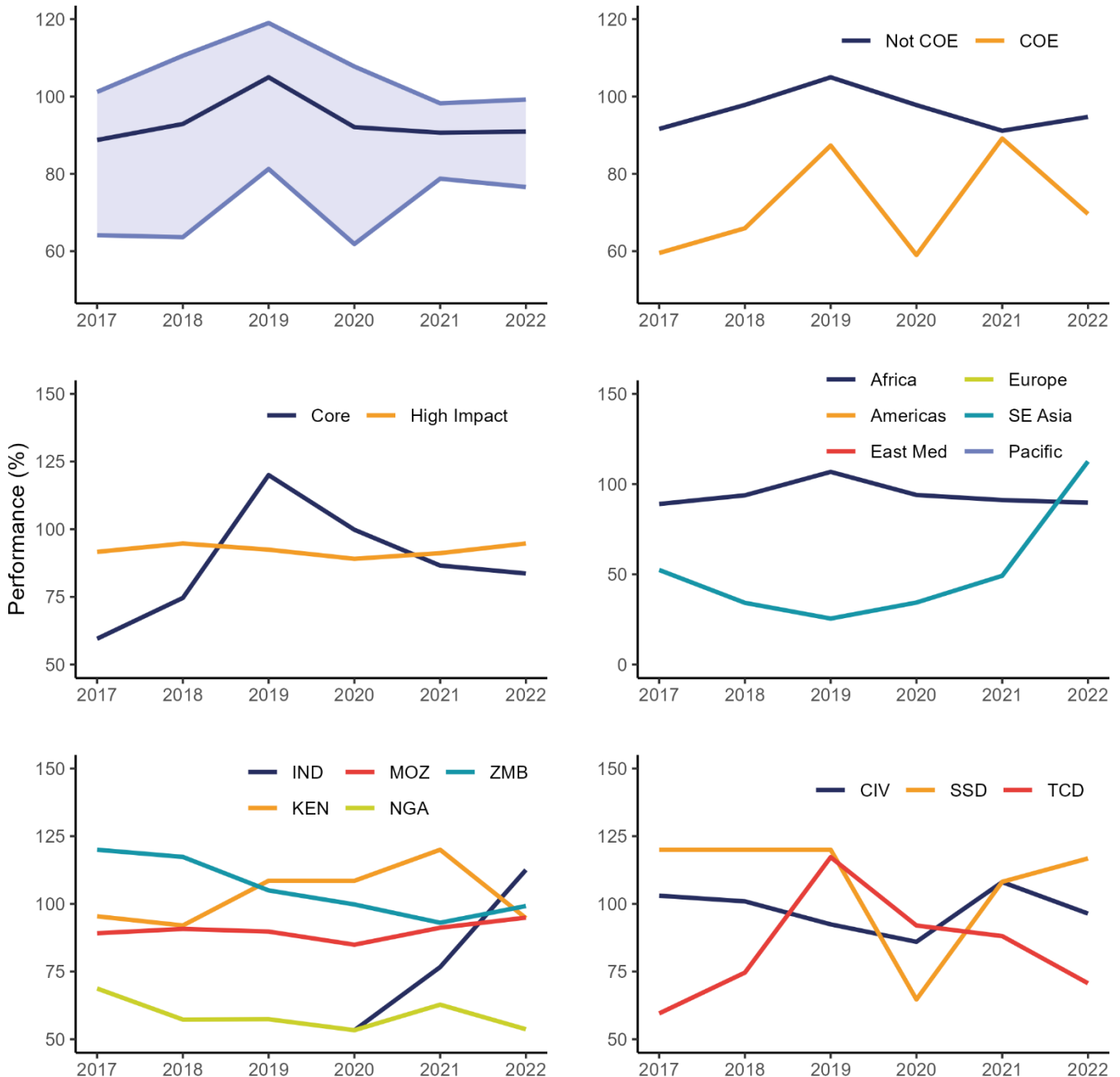


Source: Global Fund KPI2 dataset. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of percentage changes in #ART performance. Top right: Median percentage change in #ART performance for COE and not COE countries. Middle left: Median percentage change in #ART performance for Core, High Impact and Focus countries. Middle right: Median percentage change in #ART performance incidence for WHO regions. Bottom panels: Percentage change in #ART performance for case study countries.

ii. % HIV+ pregnant women receiving ART for PMTCT (%PMTCT)

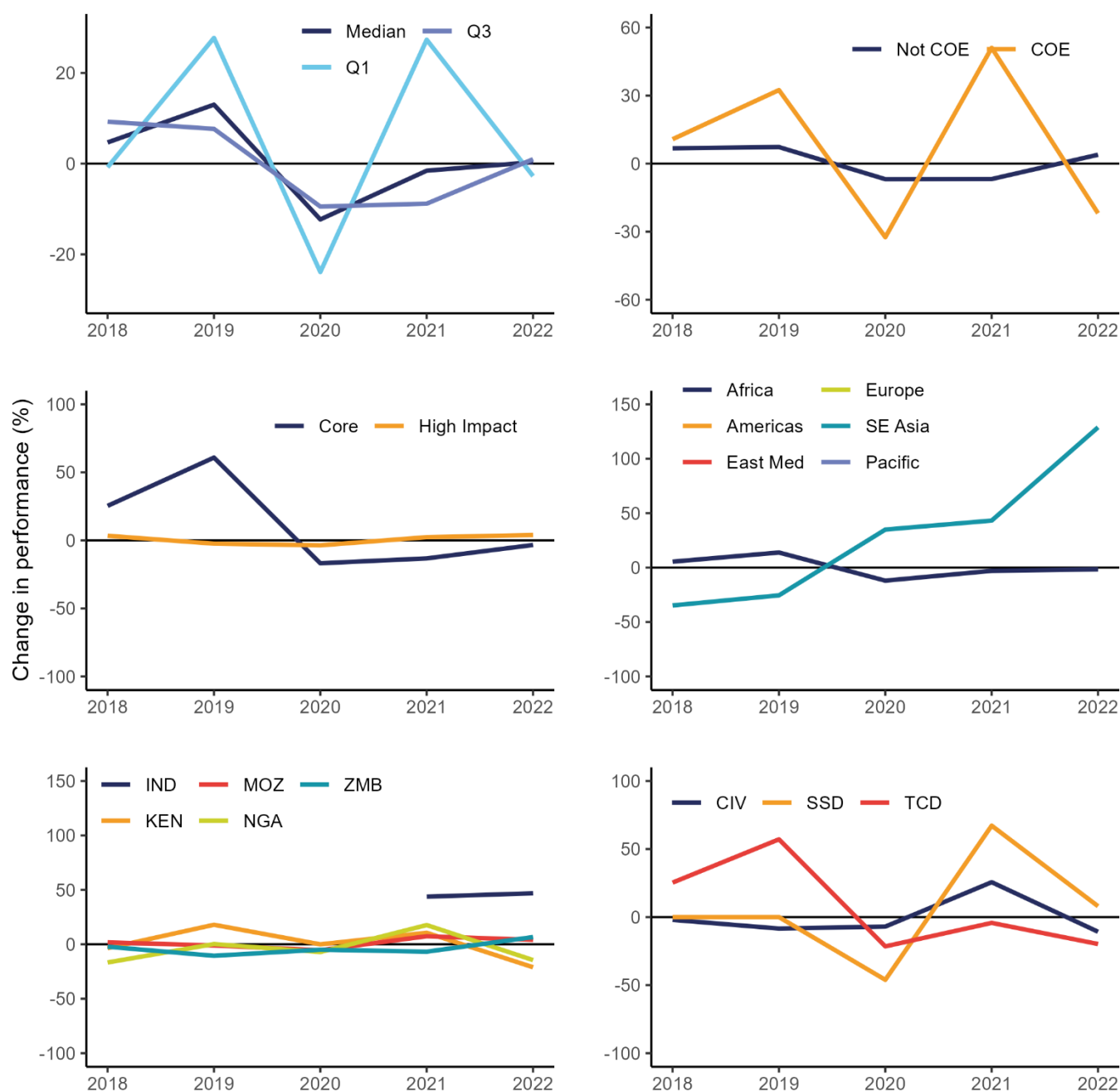
This section illustrates time trends in %PMTCT performance across regions, impact groups and COE status, both in level changes and percentage changes.

Figure I.15: Trends in %PMTCT performance from 2017-2022



Source: Global Fund KPI2 dataset. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of %PMTCT performance. Top right: Median %PMTCT performance for COE and not COE countries. Middle left: Median %PMTCT performance for Core, High Impact and Focus countries. Middle right: Median %PMTCT performance incidence for WHO regions. Bottom panels: %PMTCT performance for case study countries. Data only available from 2020 for India.

Figure I.16: Percentage change in %PMTCT performance from 2017-2022

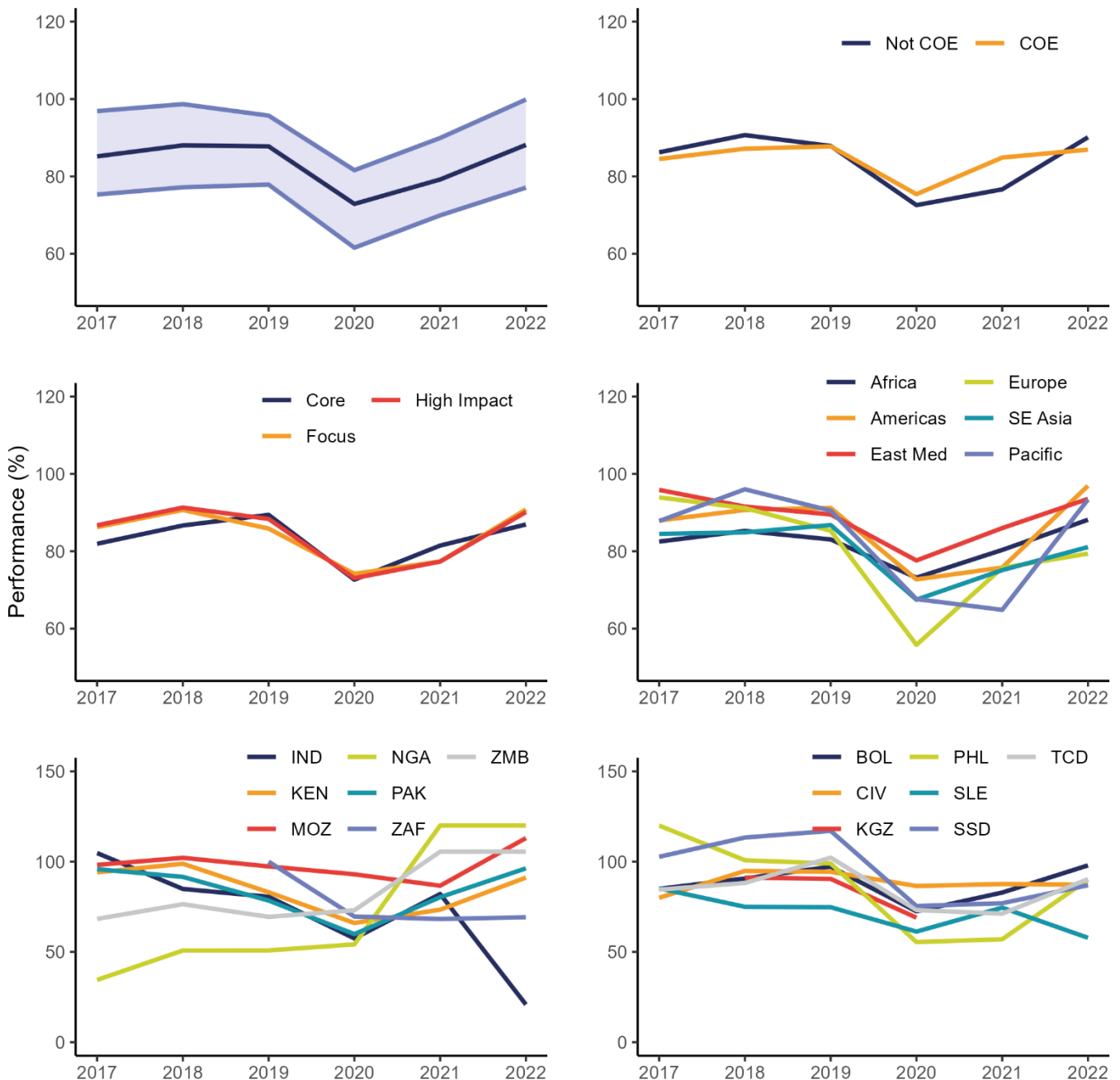


Source: Global Fund KPI2 dataset. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of percentage changes in %PMTCT performance. Top right: Median percentage change in %PMTCT performance for COE and not COE countries. Middle left: Median percentage change in %PMTCT performance for Core, High Impact and Focus countries. Middle right: Median percentage change in %PMTCT performance incidence for WHO regions. Bottom panels: Percentage change in %PMTCT performance for case study countries. Data only available from 2020 for India.

iii. # of notified cases of all forms of TB – bacteriologically confirmed plus clinically diagnosed (#TB Notifs)

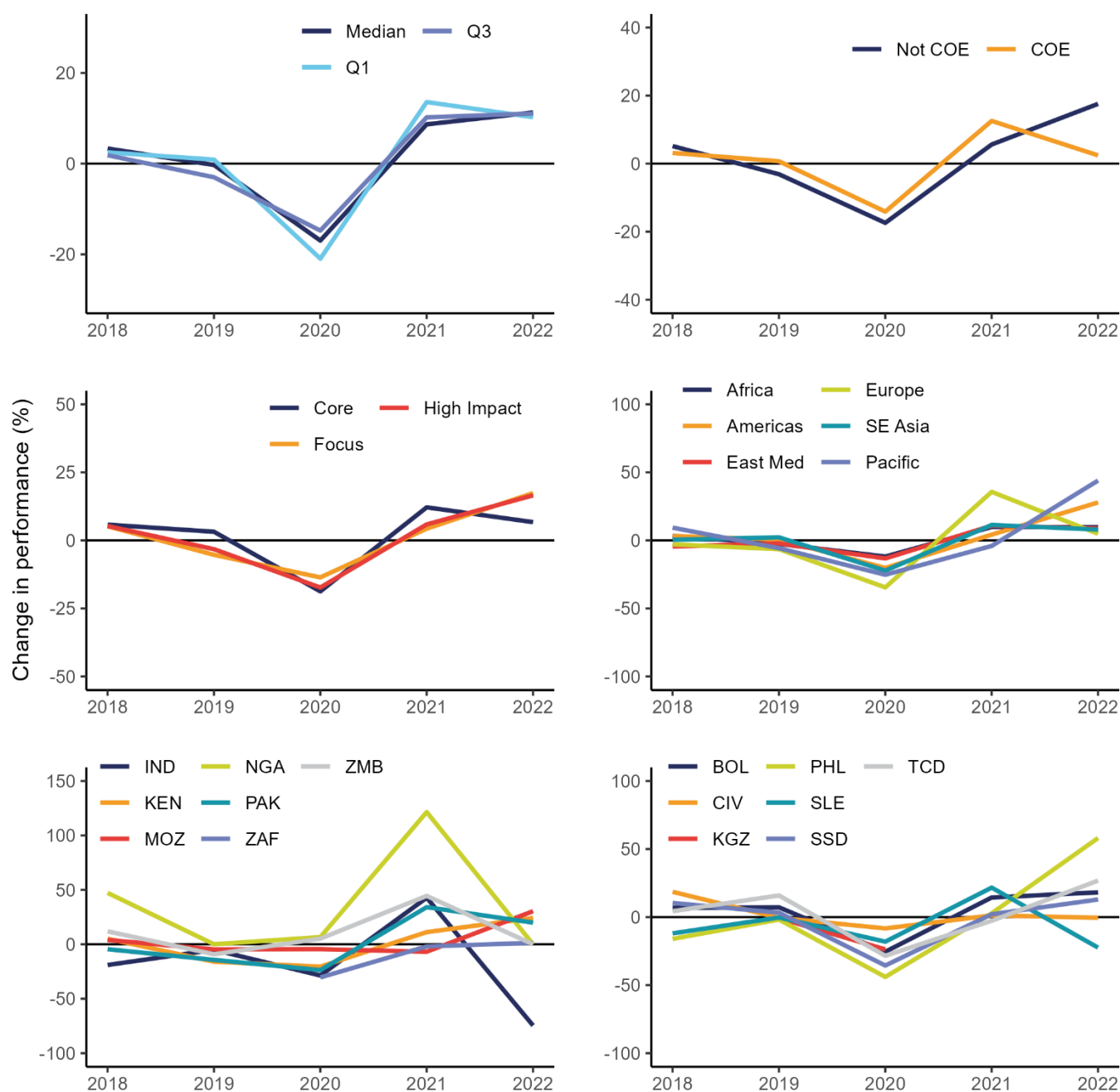
This section illustrates time trends in #TB Notifs performance across regions, impact groups and COE status, both in level changes and percentage changes.

Figure I.17: Trends in # TB Notifs performance from 2017-2022



Source: Global Fund KPI2 dataset. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of #TB Notifs performance. Top right: Median #TB Notifs performance for COE and not COE countries. Middle left: Median #TB Notifs performance for Core, High Impact and Focus countries. Middle right: Median #TB Notifs performance incidence for WHO regions. Bottom panels: #TB Notifs performance for case study countries. Data for South Africa from 2019 and for Kyrgyzstan only for 2018-2021.

Figure I.18: Percentage change in #TB Notifs performance from 2017-2022



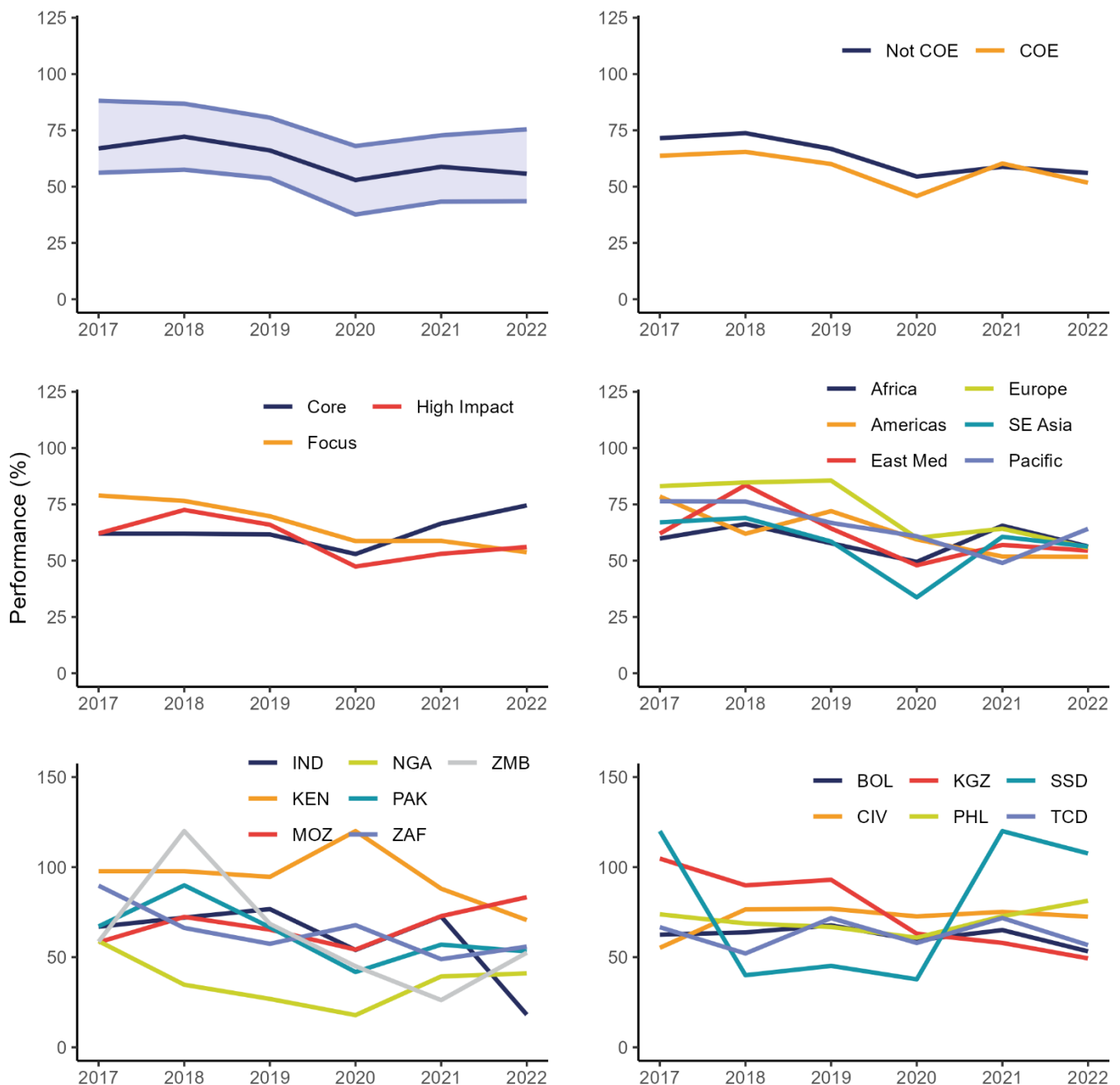
Source: Global Fund KPI2 dataset. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of percentage changes in #TB Notifs performance. Top right: Median percentage change in #TB Notifs performance for COE and not COE countries. Middle left: Median percentage change in #TB Notifs performance for Core, High Impact and Focus countries. Middle right: Median percentage change in #TB Notifs performance incidence for WHO regions. Bottom panels: Percentage change in #TB Notifs performance for case study countries. Data for South Africa from 2019 and for Kyrgyzstan only for 2018-2021.



iv. # of cases with drug resistant TB (RR-TB and/or MDR-TB) that began second line treatment (#MDR-TB)

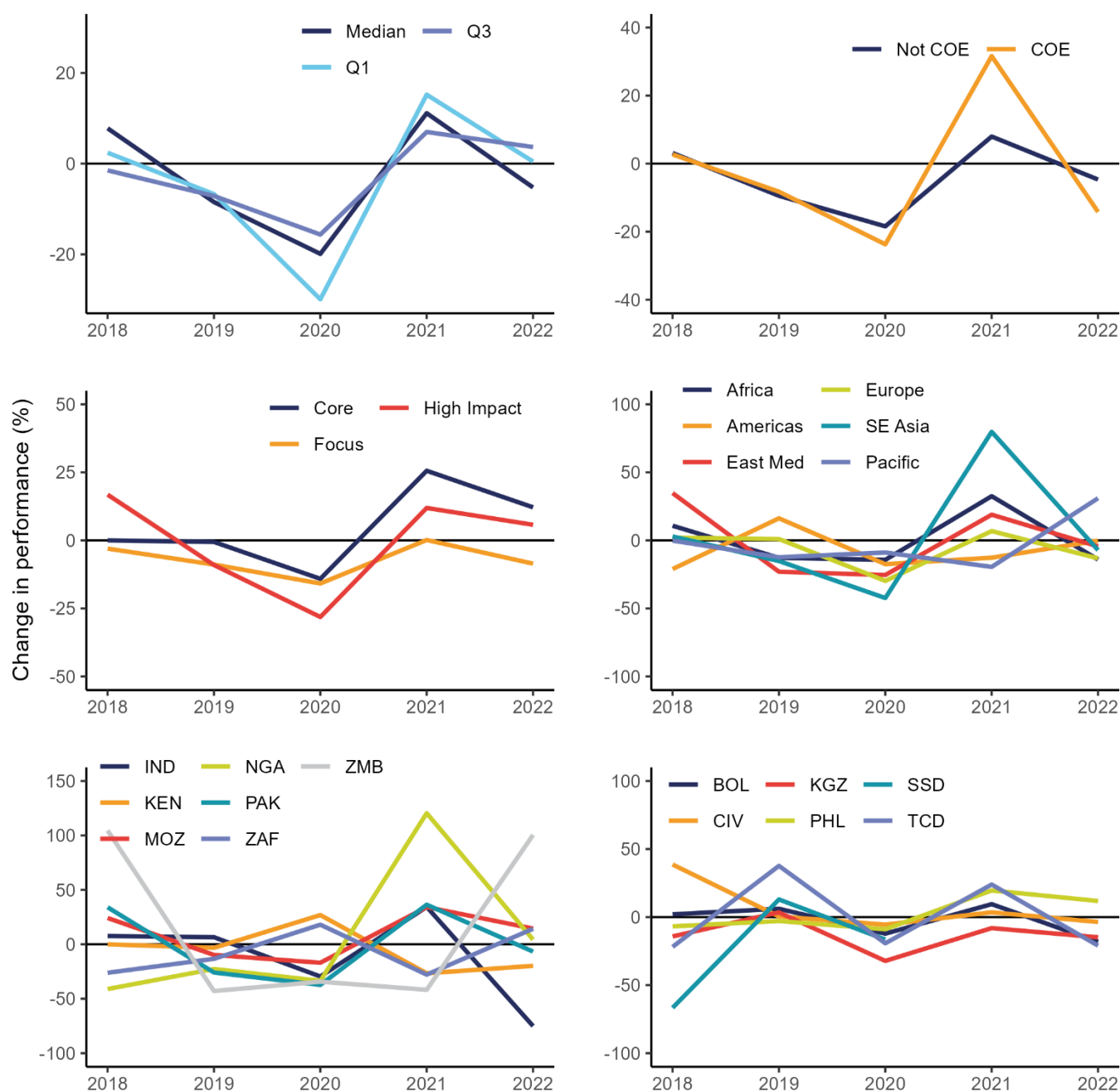
This section illustrates time trends in #MDR-TB performance across regions, impact groups and COE status, both in level changes and percentage changes.

Figure I.19: Trends in #MDR-TB performance from 2017-2022



Source: Global Fund KPI2 dataset. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of #MDR-TB performance. Top right: Median #MDR-TB performance for COE and not COE countries. Middle left: Median #MDR-TB performance for Core, High Impact and Focus countries. Middle right: Median #MDR-TB performance incidence for WHO regions. Bottom panels: #MDR-TB performance for case study countries.

Figure I.20: Percentage change in #MDR-TB performance from 2017-2022

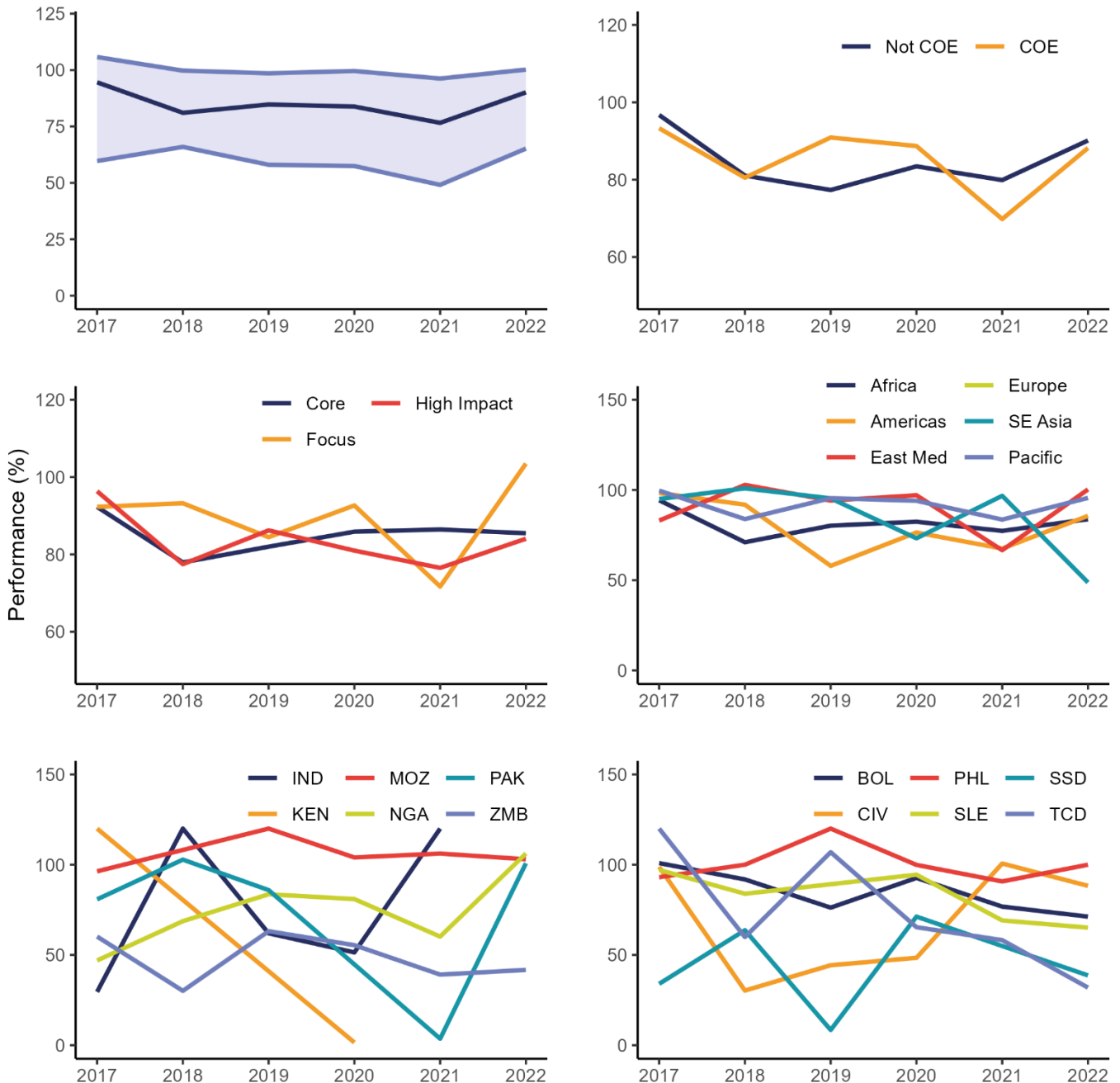


Source: Global Fund KPI2 dataset. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of percentage changes in #MDR-TB performance. Top right: Median percentage change in #MDR-TB performance for COE and not COE countries. Middle left: Median percentage change in #MDR-TB performance for Core, High Impact and Focus countries. Middle right: Median percentage change in #MDR-TB performance incidence for WHO regions. Bottom panels: Percentage change in #MDR-TB performance for case study countries.

v. # of LLINs distributed to at-risk-populations (#LLINs)

This section illustrates time trends in #LLINs performance across regions, impact groups and COE status, both in level changes and percentage changes.<sup>25</sup>

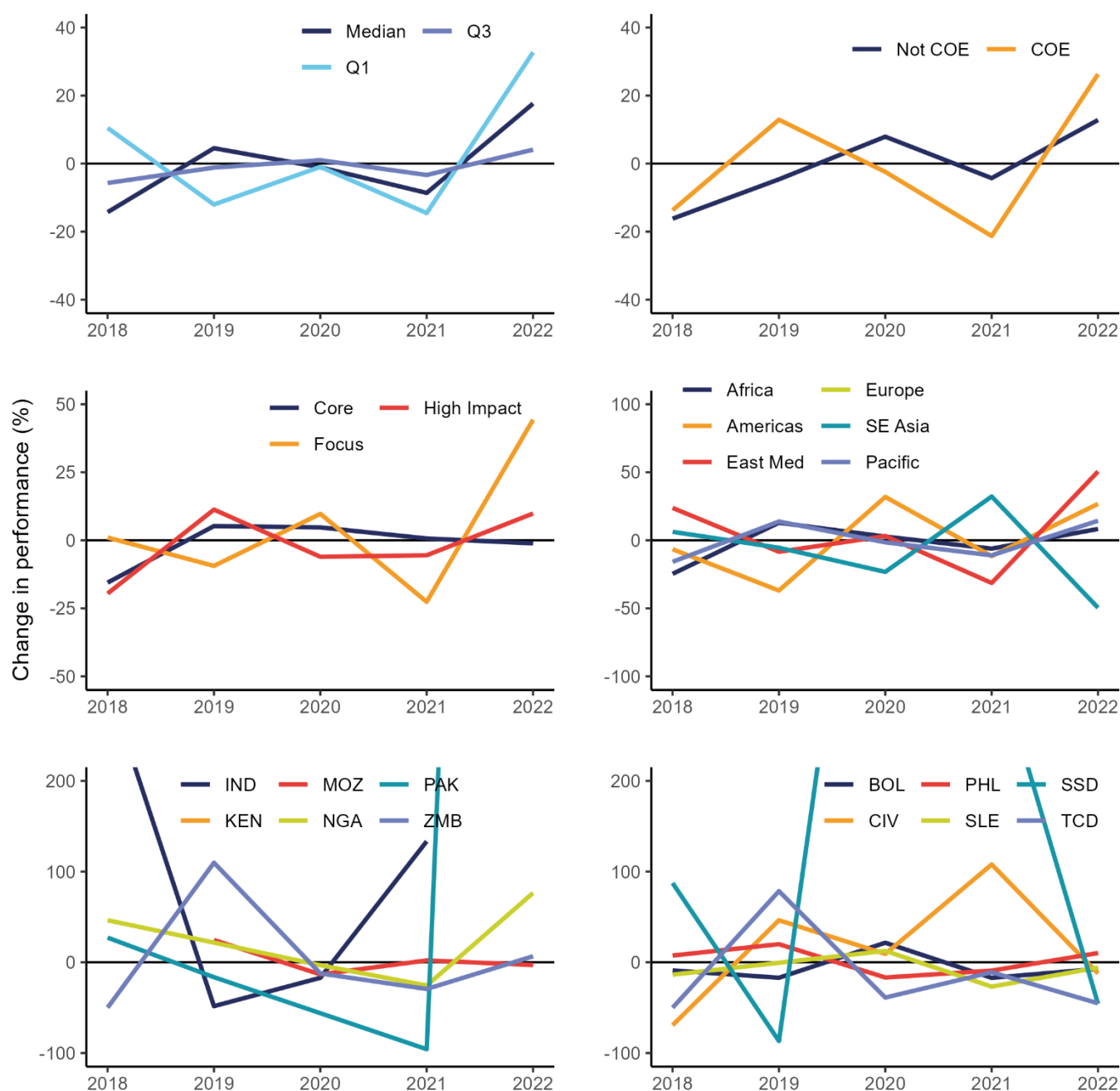
Figure I.21: Trends in # LLINs performance from 2017-2022



Source: Global Fund KPI2 dataset. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of #LLINs performance. Top right: Median #LLINs performance for COE and not COE countries. Middle left: Median #LLINs performance for Core, High Impact and Focus countries. Middle right: Median #LLINs performance incidence for WHO regions. Bottom panels: #LLINs performance for case study countries. Kenya data only available from 2017-2020. No India data for 2022.

<sup>25</sup> This indicator needs to be interpreted with care as LLINs performance is driven by mass campaigns happening every 3 years (with corresponding grant targets being high in the year of campaign and low in the other years). As result, a delay in the mass campaign can lead to extreme outliers missing the target in the initial year and then outperforming in the following year.

Figure I.22: Percentage change in #LLINs performance from 2017-2022

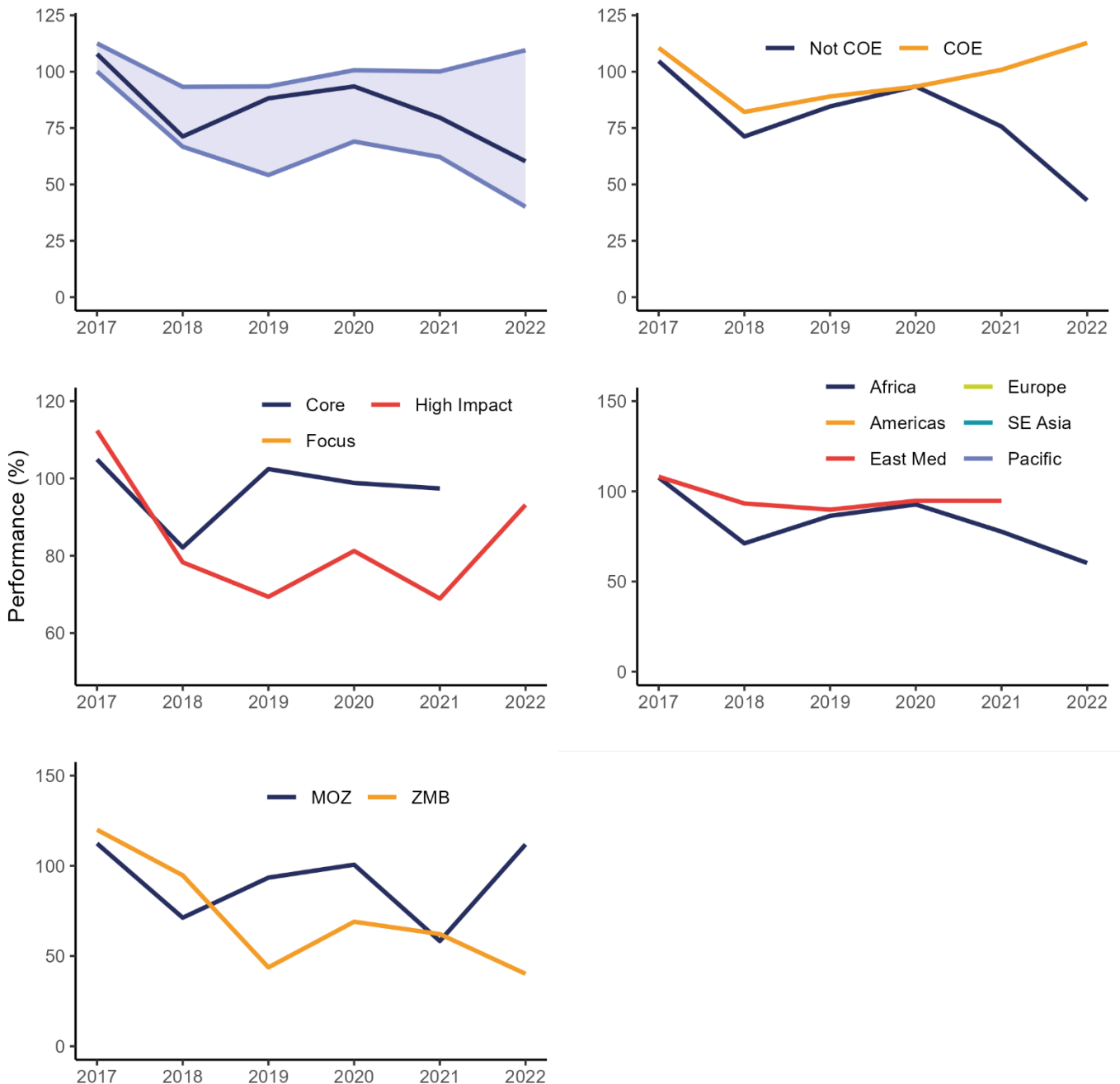


Source: Global Fund KPI2 dataset. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of percentage changes in #LLINs performance. Top right: Median percentage change in #LLINs performance for COE and not COE countries. Middle left: Median percentage change in #LLINs performance for Core, High Impact and Focus countries. Middle right: Median percentage change in #LLINs performance incidence for WHO regions. Bottom panels: Percentage change in #LLINs performance for case study countries. Kenya data only available for 2020, Mozambique only available from 2019. No India data for 2022. India (2018), Pakistan (2022) and South Sudan (2020, 2021) percentage increase exceed 200%.

vi. # of households in target areas that received IRS (#IRS)

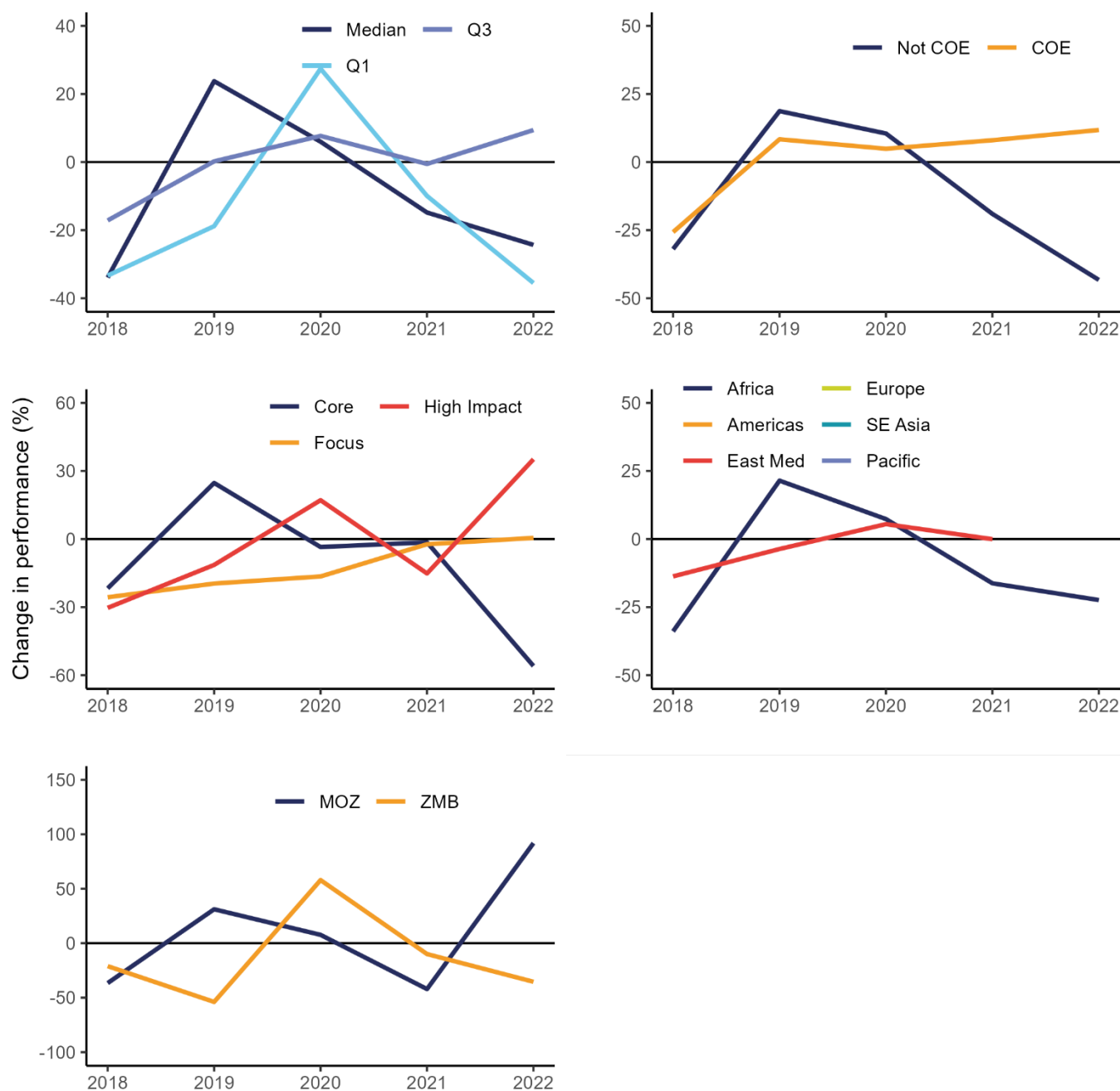
This section illustrates time trends in #IRS performance across regions, impact groups and COE status, both in level changes and percentage changes.

Figure I.23: Trends in #IRS performance from 2017-2022



Source: Global Fund KPI2 dataset. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of #IRS performance. Top right: Median #IRS performance for COE and not COE countries. Middle left: Median #IRS performance for Core, High Impact and Focus countries. Middle right: Median #IRS performance incidence for WHO regions. Bottom panels: #IRS performance for case study countries.

Figure I.24: Percentage change in #IRS performance from 2017-2022



Source: Global Fund KPI2 dataset. Country classifications from Global Fund and regions from WHO. Top left: Median, 25<sup>th</sup> and 75<sup>th</sup> percentile of percentage changes in #IRS performance. Top right: Median percentage change in #IRS performance for COE and not COE countries. Middle left: Median percentage change in #IRS performance for Core, High Impact and Focus countries. Middle right: Median percentage change in #IRS performance incidence for WHO regions. Bottom panels: Percentage change in #IRS performance for case study countries.

#### iv) WS2: statistical and regression analysis

##### a. Overview

This appendix presents findings from a regression analysis intended to inform the following review questions:

- To what extent has the Global Fund met its Strategic Objectives for 2017-22? How and why has performance varied by region and high impact countries? [SRQ2.1]
- How effectively have the interventions supported by C19RM contributed to mitigating the effect of COVID-19 on the three disease program outcomes? [SRQ4.2]

Regression analysis was used to explore associations between:

- **performance of priority service delivery indicators** against target (i.e., the difference between grant results and targets) for:
  - # of adults and children currently receiving ART (#ART)
  - % HIV+ pregnant women receiving ART for PMTCT (%PMTCT)
  - # of notified cases of all forms of TB – bacteriologically confirmed plus clinically diagnosed (#TB Notifs)
  - # of cases with drug resistant TB (RR-TB and/or MDR-TB) that began second line treatment (#MDR-TB)
  - # of LLINs distributed to at-risk-populations (#LLINs)
  - # of households in target areas that received IRS (#IRS); and
- **HTM incidence and mortality;**

...against a set of explanatory variables at the country-year level for the 2017-22 period.

The **data** panel used was constructed by combining Global Fund expenditure and service delivery indicators datasets with external datasets on incidence, mortality, domestic health funding, development assistance for health, and other demographic control variables. A range of model specifications were explored, using different estimation approaches, variables, and variable transformations (e.g., levels, proportions, logarithmic transformations, year-to-year changes, lags).

After accounting for country fixed effects, limited co-movement existed between service delivery indicator performance, HTM incidence and mortality, and the explanatory variables. Regression findings should be interpreted within the context of weak correlations between explanatory and dependent variables, and the results outlined in the remainder of this appendix are caveated by the fact that this regression exercise faced numerous and significant **limitations**. Primary limitations include the low number of observations for some indicators (especially #IRS and %PMTCT); the paucity of development assistance for health data for 2021-22; and the absence of HTM-specific domestic funding for countries with integrated health budgets.

Regressions for service delivery performance produced some variables with coefficients which were notably different from zero at commonly-used levels of statistical significance; were at least somewhat robust to specification; and were relevant to the hypotheses set in consultation with the ELO and SPH teams. In summary, from 2017 to 2022, after controlling for covariates, **grant performance** was positively associated with the proportion of external disease expenditure provided by the Global Fund for some indicators (#ART, #TB Notifs, #LLINs); and **C19RM expenditure** was positively associated with #ART performance. These findings could be interpreted as supporting evidence for the hypotheses that grants performed better in countries where the Global Fund played a greater role within the donor landscape; and that C19RM expenditure accelerated recovery of ART provision after Covid-19.

Regressions for **incidence and mortality** did not produce relevant coefficients which were significantly and consistently different from zero. This may be due to the time lag between Global Fund expenditure and incidence and eventual mortality. Time lags were explored in some specifications, but results were restricted by the short time-period and coarse year-on-year level of the dataset.

Importantly, causation is never claimed, and this analysis was not intended to and does not predict how changes in Global Fund expenditure may change service delivery performance or incidence and mortality rates. As a result, findings across service delivery indicators or diseases should not be used to inform global distribution of resources between HTM.

Table J.1 summarises headline findings against the hypotheses set in consultation with the ELO and SPH teams.

*Table J.1: Hypotheses and headline findings*

Hypothesis	Headline findings
H1: Grant performance is positively associated with the proportion of Global Fund disease expenditure over the country's total health expenditure	<ul style="list-style-type: none"> <li>Positive finding (weakly robust to specification). Disease-specific Global Fund expenditure as a proportion of total external disease expenditure is positively associated with performance for some indicators (#ART, #TB Notifs, #LLINs). → Could be interpreted as evidence supporting the position that grants perform better in countries where the Global Fund plays a bigger role.</li> </ul>
H2: Grant performance is positively associated with the size of Global Fund expenditure	<ul style="list-style-type: none"> <li>No significant association found between absolute Global Fund disease-specific expenditure and performance for any of the service delivery indicators once covariates and county fixed effects were controlled for. → May be due to correlation between absolute Global Fund expenditure and target setting, as well as unobserved correlation with underlying disease burdens and health system capacity.</li> </ul>
H3: Grant performance of the service delivery indicator is positively associated Global Fund C19RM expenditure	<ul style="list-style-type: none"> <li>Positive finding (weakly robust to specification). C19RM expenditure is associated with better performance for #ART. → Could be interpreted as evidence supporting the position that C19RM expenditure accelerated recovery of ART provision from Covid-19.</li> </ul>
H4: HTM incidence and mortality rates are negatively associated with the proportion of Global Fund disease expenditure over the country's total health expenditure	<ul style="list-style-type: none"> <li>Regressions did not produce relevant coefficients which were significantly and consistently different from zero. → May be due to time lags between Global Fund expenditure and incidence / eventual mortality. → There were numerous data limitations outlined in the limitations section that will make identifying a significant relationship between variables more challenging.</li> </ul>
H5: HTM incidence and mortality rates are negatively associated with the size of Global Fund expenditure	



H6: HTM incidence and mortality rates are negatively associated with Global Fund C19RM expenditure	
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The rest of this section presents the technical approach, data sources, descriptive statistics, findings, limitations, and regression outputs for this exercise.

b. Technical approach

Service delivery indicator performance ( $Perf_{it}$ ) is modelled as a function of current and lagged values of Global Fund's disease specific expenditure ( $GFEXP_{it}, GFEXP_{it-1}$ ), Global Fund's proportion of total development assistance for health expenditure on that disease ( $GFDAH_{it}, GFDAH_{it-1}$ ), Global Fund's expenditure on the Covid-19 Response Mechanism ( $C19RM_{it}, C19RM_{it-1}$ ) and a set of control variables ( $Z_{it}, Z_{it-1}$ ) including total domestic health expenditure, population, urban population, gross domestic product per capita, corruption, and time dummy variables for Covid-19 and the subsequent economic and health recovery. In addition, performance is allowed to depend on unobserved country-specific fixed effects ( $\alpha_i$ ), a time trend, and a stochastic error ( $\epsilon_{it}$ ). For notational simplicity we do not show the lagged variables. This model is summarised in the equation below.

$$\ln Perf_{it} = \alpha_i + \beta_0 t + \beta_1 \ln GFDAH_{it} + \beta_2 \ln GFEXP_{it} + \beta_3 \ln C19RM_{it} + \gamma Z_{it} + \epsilon_{it}$$

Given country specific fixed effects are unobservable, performing OLS on the above equation will generate estimates with omitted variable bias. Two commonly used estimation methods to overcome this issue are fixed effects and first differencing. For fixed effects estimates to be unbiased, the error terms must satisfy strict exogeneity, meaning that errors must be uncorrelated with the independent variables in every period. First differencing requires the slightly weaker assumption that errors are uncorrelated with covariates in the previous, present, and subsequent period. If exogeneity assumptions are satisfied, both the fixed effects and first differencing estimators will be consistent and unbiased. Given the weaker assumptions associated with first differencing, this Appendix primarily reports coefficients from the first difference model and reported coefficients from the fixed effects model as a robustness check.

In practice, strict exogeneity assumption is likely to be violated as changes in service delivery performance should change disease burden within a country and impact the amount of Global Fund expenditure on that disease in that country (a source of simultaneity). However, assuming that changes in performance today will not impact Global Fund funding in the previous, present and subsequent periods permits use of the first differencing approach. This assumption seems to be a reasonable approximation given that allocation cycles occur every three years rather than on a yearly basis.

The first differencing model is presented below.

$$\Delta \ln Perf_{it} = \ln Perf_{it} - \ln Perf_{it-1} = \beta_0 + \beta_1 \Delta \ln GFDAH_{it} + \beta_2 \Delta \ln GFEXP_{it} + \beta_3 \Delta \ln C19RM_{it} + \gamma \Delta Z_{it} + \Delta \epsilon_{it}$$

Notice that (unobserved) country-specific fixed effects have been differenced out of the equation and the intercept is the time trend from the original model.

The model used to regress incidence and mortality on explanatory variables takes the same form as the first differencing model presented above. In particular,  $\Delta \ln Perf_{it}$  is replaced with  $\Delta \ln Burd_{it}$  where  $Burd_{it}$  is a disease specific measure of incidence or mortality.

c. Data

The table below summarises the various data sources used for the regression analysis. All continuous variables were transformed using the natural log. Monetary variables were converted to 2021 USD using the CPI series from the Federal Reserve Bank of Minneapolis.

Table J.2: Summary of data sources used for this regression analysis

Variable	Source	Coverage / Limitations
<b>Dependent variables</b>		
• Performance ( $Perf_{it}$ )	Global Fund KPI2 dataset <sup>26</sup>	<ul style="list-style-type: none"> <li>• 2017-2022</li> <li>• Calculated as <math>\frac{Grant\ Result_{it}}{Grant\ Target_{it}}</math> for each Service Delivery Indicator.</li> <li>• Capped at 1.2 in line with Global Fund's operational assumptions.</li> </ul>
<ul style="list-style-type: none"> <li>• HIV Incidence (<math>HIV\ Inc_{it}</math>)</li> <li>• HIV Mortality (<math>HIV\ Mor_{it}</math>)</li> </ul>	UNAIDS	<ul style="list-style-type: none"> <li>• 2017-2022</li> <li>• Rounded to the nearest 100.</li> </ul>
<ul style="list-style-type: none"> <li>• TB Incidence (<math>TB\ Inc_{it}</math>)</li> <li>• TB Mortality (<math>TB\ Mor_{it}</math>)</li> </ul>	Global Tuberculosis Report 2022 (WHO)	<ul style="list-style-type: none"> <li>• 2017-2021</li> <li>• Missing data for 2022.</li> <li>• Rounded to the nearest 1000.</li> </ul>
<ul style="list-style-type: none"> <li>• Malaria Incidence (<math>Mal\ Inc_{it}</math>)</li> <li>• Malaria Mortality (<math>Mal\ Mor_{it}</math>)</li> </ul>	World Malaria Report 2022 (WHO)	<ul style="list-style-type: none"> <li>• 2017-2021</li> <li>• Missing data for 2022.</li> </ul>
<b>Explanatory variables</b>		
• Global Fund disease specific expenditure ( $GFEXP_{it}$ )	Global Fund budget and cumulative expenditure dataset <sup>27</sup>	<ul style="list-style-type: none"> <li>• 2018-2022</li> <li>• 2017 values have been calculated as <math>0.4 * GFEXP_{i,2014-2016}</math>, the Global Fund disease specific expenditure in the previous allocation cycle.</li> </ul>
• Global Fund disease specific expenditure as a proportion of disease specific development assistance for health ( $GFDAH_{it}$ )	IHME Development Assistance for Health dataset	<ul style="list-style-type: none"> <li>• 2017-2020 (<math>DAH_{it}</math>)</li> <li>• <math>GFDAH_{it} = \frac{GFEXP_{it}}{DAH_{it}}</math></li> <li>• 2021-2022 <math>DAH_{it}</math> imputed as the 2017-2020 mean.</li> </ul>
• Global Fund expenditure on C19RM ( $C19RM_{it}$ )	Global Fund budget and cumulative expenditure dataset	<ul style="list-style-type: none"> <li>• 2020-2022</li> <li>• Scaled by total Global Fund expenditure in a country.</li> </ul>
<b>Control variables (<math>Z_{it}</math>)</b>		
• Total domestic health funding	GHED (WHO)	<ul style="list-style-type: none"> <li>• 2017-2021</li> </ul>

<sup>26</sup> As provided to CEPA by the Global Fund Secretariat on 26 September 2023.

<sup>27</sup> Provided CEPA with GC5 and GC6 cumulative expenditure and detailed budget data on 3 August 2023, and GC4 cumulative expenditure on 24 September 2023. Cumulative expenditure was split into country-year-module observations by assuming cumulative expenditure across each module (within grants) remained the same as the actual cumulative expenditure data but that the time profile of expenditure matched the detailed budget data.

Variable	Source	Coverage / Limitations
		<ul style="list-style-type: none"> <li>Domestic health funding is calculated as the sum as current health expenditure and health capital.</li> <li>2022 missing data is imputed as the 2017-2021 mean.</li> </ul>
<ul style="list-style-type: none"> <li>Gross Domestic Product</li> <li>Population</li> <li>Urban Population</li> </ul>	World Bank Database	<ul style="list-style-type: none"> <li>2017-2022</li> </ul>
<ul style="list-style-type: none"> <li>Corruption Perception Index</li> </ul>	Transparency.org	<ul style="list-style-type: none"> <li>2017-2022</li> </ul>

The data panel collated from the sources above had different numbers of observations for each service delivery indicator, as reported in Table I.3 below by year. The low number of observations for some indicators (e.g., IRS) reduces the likelihood of coefficients being statistically significant.

Table J.3: Observations per service delivery indicator per year

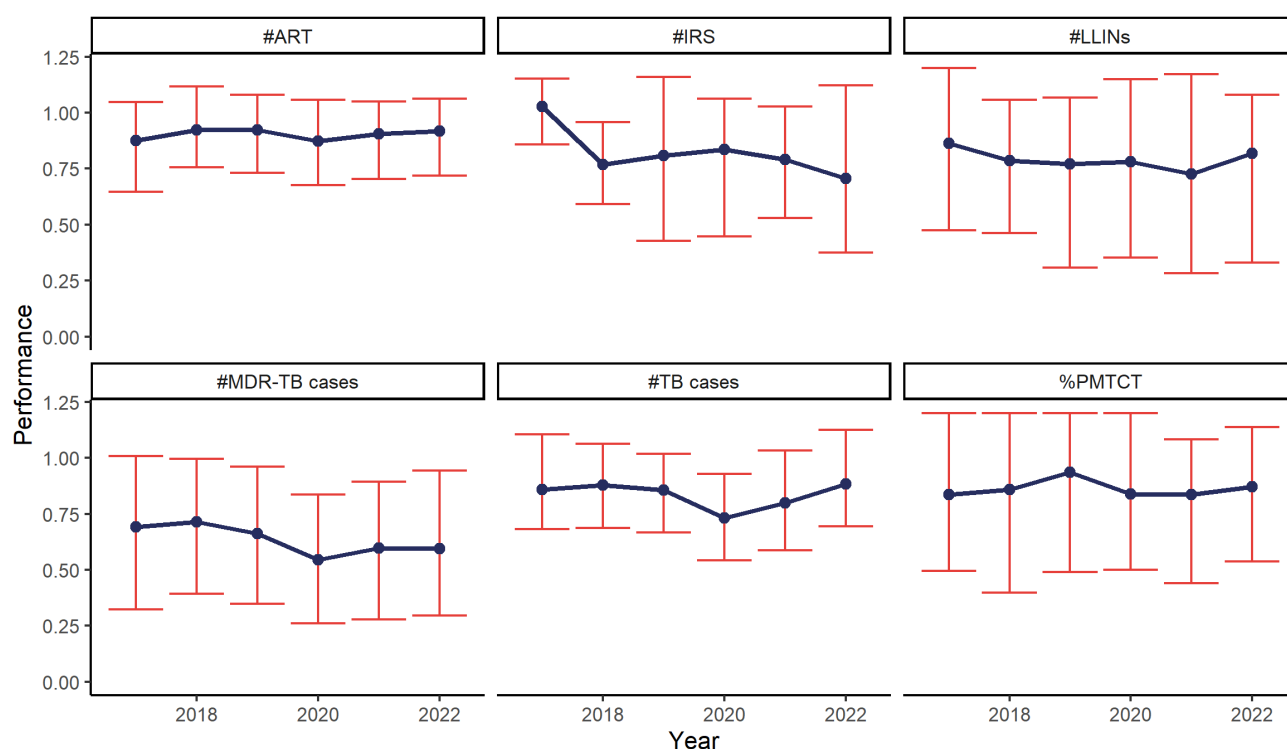
Service Delivery Indicator	2017	2018	2019	2020	2021	2022
<b>Service Delivery Indicator</b>						
#ART	88	87	89	90	90	87
%PMTCT	19	20	19	20	22	21
#TB Notifs	81	83	83	82	85	82
#MDR-TB	78	78	81	78	77	77
#LLINs	52	48	52	55	53	52
#IRS	8	9	9	9	9	8
<b>Incidence / mortality</b>						
HIV	92	92	92	92	92	92
Tuberculosis	92	92	92	92	92	-
Malaria	63	63	63	63	63	-

The Global Fund provided CEPA with GC4, GC5 and GC6 cumulative expenditure and GC5 and GC6 detailed budget data.

d. Average time trends

Performance for different service delivery indicators demonstrated various trends over the 2017-2022 Strategy period. A decrease in performance in 2020 was common across #ART, #MDR-TB, #TB cases, and %PMTCT, with a subsequent recovery in performance in 2021 and 2022. These time trends are illustrated in Figure I.1 below and discussed at length in a separate annex on “descriptive statistics”.

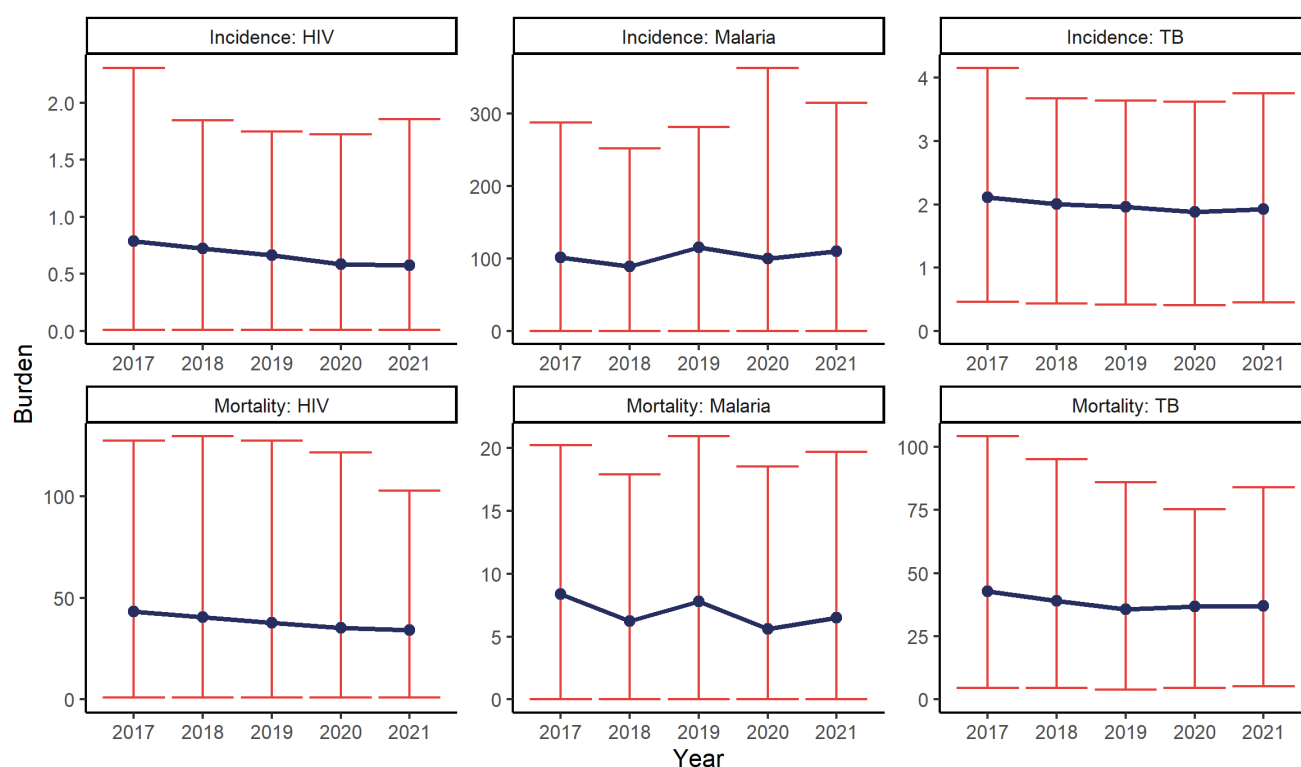
Figure J.1: Time trends in service delivery indicator performance, 2017-2022



Source: Global Fund KPI2 dataset. CEPA calculations. Blue line is mean, error bars represent 90-10<sup>th</sup> percentile range.

HIV incidence and mortality rates decreased over the Strategy period, both on average and for the 90<sup>th</sup> percentile country. Malaria incidence has increased since the beginning of the Strategy period in 2017 and the distribution of incidence significantly widened in 2020 as incidence in the 90<sup>th</sup> percentile country increased. Malaria mortality was variable across the Strategy period but on average there was an overall decrease in mortality. TB incidence and mortality also decreased from the beginning of the Strategy period to 2021. TB mortality also experienced a significant narrowing of the distribution, with mortality for the 90<sup>th</sup> percentile country falling quickly over the period.

Figure J.2: Time trend in HTM incidence and mortality, 2017-2021



Incidence per 1000; Mortality per 100,000. Source: UNAIDS; World Malaria Report (2022); Global Tuberculosis Report (2022); population estimates from World Bank. CEPA calculations. Blue line is mean, error bars represent 90-10<sup>th</sup> percentile range.

#### e. Findings

This section presents notable findings —both for the presence or absence of correlation — in the areas of:

- Global Fund expenditure;
- Global Fund expenditure as a share of direct assistance for health;
- C19RM expenditure;
- Grant results; and
- Relative magnitude of external versus domestic health funding.

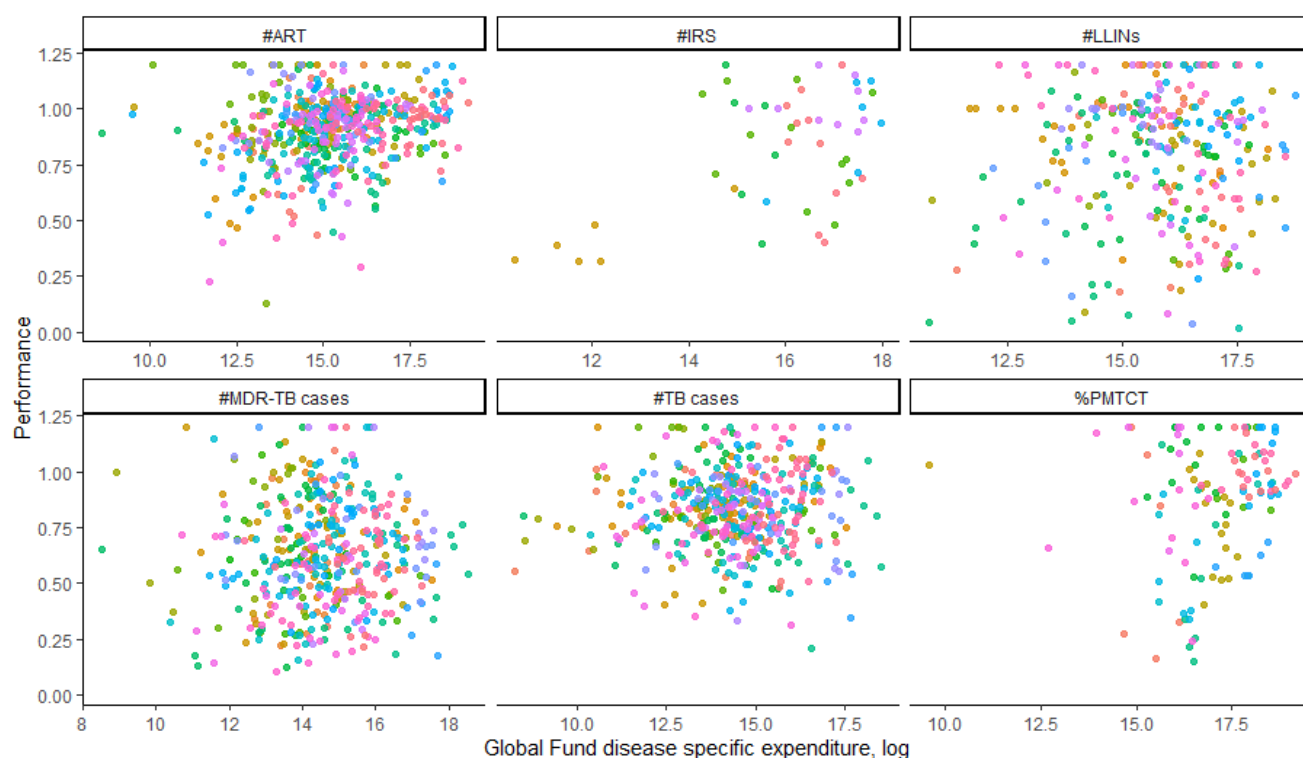
A full set of coefficient estimates for performance of each of the service delivery indicators is presented at the end of this appendix. These findings should be interpreted within the context of the data and methodological limitations outlined in the next section.

#### (xvi) Global Fund expenditure

**Performance of service delivery indicators against national targets was not significantly associated with Global Fund expenditure in absolute terms.** The relationship between performance and Global Fund disease specific expenditure is captured in the figure below. It appears that there is a slight positive relationship between Global Fund disease specific expenditure and performance, which is indeed reflected in correlation coefficients (#ART, %PMTCT, #MDR-TB and #IRS performance all demonstrates weak positive correlations with Global Fund expenditure). However, once country fixed effects are accounted for and the within country variation is analysed instead of the between country variation, changes in Global Fund

expenditure are no longer associated with changes in performance. This is the case for present Global Fund expenditure and expenditure in the previous year.

Figure J.3: Scatter plots of Global Fund disease specific expenditure (log) and performance, 2017-2022.



Source: Global Fund. CEPA calculations. Each colour represents a different country.

(xvii) *Global Fund proportion of development assistance for health*

**Global Fund disease-specific expenditure as a proportion of all disease specific development assistance for health (DAH) was found to be significantly related to performance for a range of service delivery indicators.** Coefficients should capture the association independent of changes in the level of Global Fund disease-specific funding, which was also included as a variable in all specifications. The Global Fund's proportion of DAH was found to be:

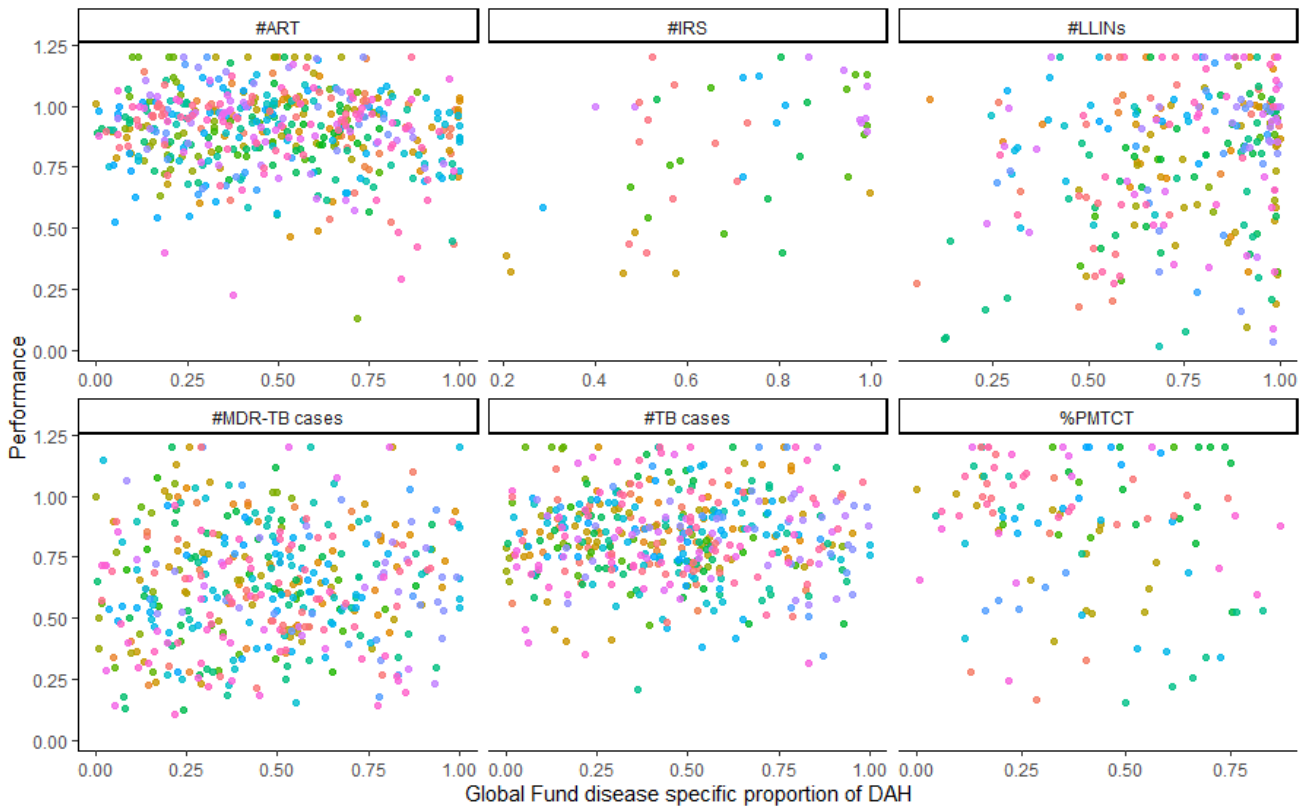
- Positively associated with #ART performance. The lagged  $GFDAH_{it}$  coefficient was estimated to be positive and significant at a 0.05 significance level. In the model without  $C19RM_{it}$  this estimated coefficient was 0.191\*\* (0.206\*\* with  $C19RM_{it}$  included), meaning that a 1% increase in Global Fund's proportion of DAH in the preceding year is expected to be associated with a 0.19% increase in current #ART performance.
- Positively associated with #TB Notifs performance. The lagged  $GFDAH_{it}$  coefficient was estimated to be positive and significant at a 0.05 significance level. In the model without  $C19RM_{it}$  this estimated coefficient was 0.260\*\* (0.236\*\* with  $C19RM_{it}$  included), meaning that a 1% increase in Global Fund's proportion of DAH in the preceding year is expected to be associated with a 0.26% increase in current #TB Notifs performance.
- Positively associated with #LLINs performance. Both the current and lagged  $GFDAH_{it}$  coefficients were estimated to be positive and significant at a 0.1 significance level. In the model without  $C19RM_{it}$  the estimated coefficients were 1.249\* and 0.986\* (1.251\* and 1.043\* with  $C19RM_{it}$  included), meaning that a 1% increase in Global Fund's proportion of DAH in the preceding year is expected to be associated with a 1.25% increase in current #LLINs performance, while a 1% increase in current Global Fund's proportion of DAH is expected to be associated with a 0.99% increase in current #LLINs.

- Association with #IRS performance not detected. The coefficient for current  $GFDAH_{it}$  is statistically significant and positive (1.438\*\*\*) when  $GFDAH_{it}$  is the only explanatory variable included. However, once malaria expenditure and  $C19RM_{it}$  are also included in the model, this association disappears. Further, the small sample size of #IRS increases the risk that this association was spuriously caused by variation in one country.
- Association with #MDR-TB performance not detected.
- Negatively associated with %PMTCT performance. The lagged  $GFDAH_{it}$  coefficient was estimated to be negative and significant at a 0.05 significance level. In the model without  $C19RM_{it}$  this estimated coefficient was -0.753\*\* (-0.828\*\* with  $C19RM_{it}$  included), meaning that a 1% increase in Global Fund's proportion of DAH in the preceding year is expected to be associated with a 0.75% decrease in current %PMTCT performance. However, this finding was sensitive to variation occurring in a few countries. The estimated effect of current and lagged  $GFDAH_{it}$  was not significantly different to zero if observations from India and Angola were removed from the sample, **implying there is no evidence a robust relationship between changes in Global Fund funding and changes %PMTCT performance.**

This is an intriguing finding, since it speaks directly to suggestions raised by Secretariat members that they may, in general, be empowered to affect change in settings where the Global Fund is a major contributor than in countries where the Global Fund was a less significant contributor to the overall donor response. The effect was only observed with a lag. That is, an increase in the Global Fund's share of external funding is positively associated with grant performance the following year, which seems consistent with typical timeframes between expenditure and service delivery.

This relationship is not clear when analysing the between-country variation as in Figure I.4 below, however once country specific fixed effects are controlled for (as well as the set of control variables) the association between Global Fund proportion of DAH and performance emerges. This highlights the importance of accounting for unobserved country heterogeneity when designing the model.

Figure J.4: Scatter plots of Global Fund proportion of disease specific development assistance for health and performance, 2017-2022.



Source: Global Fund; IHME DAH database. CEPA calculations. Each colour represents a different country.

#### (xviii) Covid-19 Response Mechanism

**Variation in expenditure on the Covid-19 Response Mechanism (C19RM) was found to be significantly associated with variation in #ART performance** but no relationship with the relative performance of other service delivery indicators was detected. The effects of C19RM on performance was measured by including Global Fund expenditure on the C19RM as a proportion of total Global Fund in-country expenditure as an additional regressor ( $C19RM_{it}$ ).

Given the time dummy variables for Covid-19 and the subsequent health and economic recovery, including  $C19RM_{it}$  as an additional regressor investigated whether countries that received relatively more  $C19RM_{it}$  funding had relatively better performance.

In the case of #ART, the effect of current C19RM expenditure was estimated to be negative and significant,  $-0.21^*$ , at the 0.10 level while the effect of expenditure on  $C19RM_{it}$  in the previous period was estimated to be positive and significant,  $0.56^{**}$ , at the 0.05 level. This is an encouraging finding, suggesting that countries receiving greater C19RM funding experienced relatively stronger performance of ART provision after Covid-19.

However, estimates of the effect of  $C19RM_{it}$  on performance may be at risk of endogeneity, introducing bias. One possible mechanism that would have introduced endogeneity was that Covid-19 had a heterogeneous effect across countries, both in magnitude and timing of disease burden and this impacted funding decisions for  $C19RM_{it}$  as well as performance of service delivery indicators. Further, the targeting of C19RM funding changed significantly as the Covid-19 pandemic unfolded, shifting from HTM funding to RSSH. A limitation of this analysis is that the regression analysis made no distinction about the target of  $C19RM_{it}$  funding.



There was a large decrease in performance across several service delivery indicators from 2019 to 2020, coinciding with Covid-19 and significant disruption to global health systems and supply chains. Performance was significantly more likely to decrease than increase across the #ART, #TB Notifs, #MDR-TB and %PMTCT service delivery indicators. However, performance was significantly more likely to increase for #LLINs in 2020, influenced by timing of mass campaigns in a few countries. These probabilities are presented in Table I.4. Similar analysis undertaken on other years did not reveal a similar pattern.

Table J.4: Probability of a performance decrease (2019-2020)

Service delivery indicator	P(decrease)
#ART	0.70***
#IRS	0.33
#LLINs	0.37**
#MDR-TB cases	0.79***
#TB notifs	0.81***
%PMTCT	0.68**

Source: CEPA analysis of Global Fund service delivery dataset. Probability is calculated as the number of countries experiencing a decrease in performance divided by the total number of countries. This is tested against the null hypothesis that  $P(\text{decrease}) = 0.5$  by calculating a Bernoulli standard error.

Given the structural change in performance experienced in 2020 driven by Covid-19, a dummy variable for 2020 was included in the regression. Once other variables were controlled for the estimated coefficient for the Covid-19 dummy variable was found to be significantly different to zero for only #ART, #TB Notifs and #MDR-TB. In all cases, the coefficient for Covid-19 was negative and significant at a 0.05 level.

To isolate the incremental effect of increasing  $C19RM_{it}$  and attempt to address the endogeneity issue highlighted above, the Covid-19 dummy variable and an additional 'Recovery' dummy variable were included in the regression models. The Recovery dummy variable is equal to 1 in 2021 and zero otherwise. This coincides with the first disbursement of  $C19RM_{it}$  funding so this variable will also capture the effects of Global Fund introducing C19RM, regardless of the level of funding. Hence, the coefficients for  $C19RM_{it}$  will capture the effect of this funding on the intensive margin as opposed to the extensive margin (i.e., "How much more funding did a country receive?" compared to "Did a country receive funding?").

#### (xix) Grant results

**Using grant results as the dependent variable instead of grant performance does not change the key findings.** The motivation for using grant results as opposed to performance was that changes in performance could be driven by changes in grant target and/or changes in grant results. Disentangling these effects in a sensible fashion may provide further insight into how Global Fund disease specific funding and proportion of DAH are associated with service delivery outcomes. At a minimum, including grant results as an explanatory variable provides a robustness check for the previous findings.

The motivation for transforming service delivery performance to grant results can also be derived mathematically. In particular,

$$\ln Perf_{it} = \ln \frac{Results_{it}}{Target_{it}} = \ln Results_{it} - \ln Target_{it}$$

Substituting this into the original model yields

$$\ln Results_{it} - \ln Target_{it} = \alpha_i + \beta_0 t + \beta_1 \ln GFDAH_{it} + \beta_2 \ln GFEXP_{it} + \beta_3 \ln C19RM_{it} + \gamma Z_{it} + \epsilon_{it}$$

Grant targets are set by each country and reflect changes in disease burden and country specific factors. Importantly they should be set once for each allocation cycle and decreases in grant targets are rarely observed in the data. By moving  $Target_{it}$  to the right-hand side of the model and introducing an additional coefficient  $\theta$ , the effects of Global Fund disease specific funding and proportion of DAH on service delivery results can be analysed conditional on target setting.

$$\ln Results_{it} = \alpha_i + \theta \ln Target_{it} + \beta_0 t + \beta_1 \ln GFDAH_{it} + \beta_2 \ln GFEXP_{it} + \beta_3 \ln C19RM_{it} + \gamma Z_{it} + \epsilon_{it}$$

Note the above model is simply a more flexible version of the regression model using performance as an explanatory variable. Performance is the nested case where  $\theta = 1$  is imposed. Table I.5 illustrates the estimated coefficients for  $Target_{it}$  for each service delivery indicator in the models that included the full set of controls and explanatory variables. For all service delivery indicators except for #LLINs, the null hypothesis that  $\theta = 1$  and hence using performance as the dependent variable was the true model, was rejected. #LLINs is highly cyclical, in that net distribution is not uniform over time. The grant target captures this cyclicity and therefore most of the variation in grant results is explained by changes in grant target. Additionally, for all service delivery indicators except #IRS and %PMTCT, estimates for  $\theta$  are significantly different to zero, meaning that controlling for grant target is important when using  $Results_{it}$  as the dependent variable. This is intuitive as grant target is a proxy for changes in disease burden and country specific factors.

Table J.5: Estimates of  $\theta$ , the coefficient of  $\ln Target_{it}$

Service delivery indicator	Coefficient	Standard error	Reject $H_0: \theta = 1$ ?
#ART	0.89***	0.031	Yes
#IRS	0.33	0.259	Yes
#LLINs	0.98***	0.039	No
#MDR-TB cases	0.17*	0.098	Yes
#TB notifs	0.54***	0.064	Yes
%PMTCT	-0.03	0.148	Yes

Source : CEPA regressions.  $H_0: \theta = 1$  was tested at a 0.05 significance level. \*/\*\*/\*\* illustrate coefficients are significantly different to zero.

The above analysis provides motivation for serious consideration of the more flexible class of models using grant results as the dependent variable, while controlling for grant target.

## Global Fund expenditure

- Global Fund disease specific expenditure was not found to be a significant co-variate of performance for any of the service delivery indicators.

## Global Fund proportion of DAH

- Global Fund disease specific proportion of DAH was positively associated with grant results for #ART, #TB Notifs, #LLINs and #IRS, and was not a significant covariate with grant results for %PMTCT and #MDR-TB. Table F.6 below compares the regression coefficients estimated using  $Perf_{it}$  and  $Results_{it}$  as dependent variables when  $GFDAH_{it}$  and  $GFEXP_{it}$  are included as explanatory variables.
- As illustrated in the table, the estimated effect of  $GFDAH_{it}$  is robust to whether performance or grant results is included as the dependent variable. There is a slight positive shift in results if grant results are used as the explanatory variable instead of performance.

Table J.6: Estimates of the coefficient of lagged and current  $\ln GFDAH_{it}$

Service delivery indicator	Performance		Grant Results	
	Current	Lagged	Current	Lagged
#ART	0.04	0.19**	0.07	0.20**
#IRS	1.03	-0.07	1.27**	-0.49
#LLINs	1.25*	0.97*	1.93**	1.23*
#MDR-TB cases	-0.06	0.19	-0.03	0.16
#TB notifs	-0.07	0.26**	0.04	0.24**
%PMTCT	-0.30	-0.75**	-0.22	-0.45

Source: CEPA regressions. \*/\*\*/\*\* illustrate coefficients are significantly different to zero at 0.1/0.05/0.01 levels of significance.

## Covid-19 Response Mechanism

- $C19RM_{it}$  remains a statistically significant explanatory variable for #ART results. The effect of current expenditure on  $C19RM_{it}$  is estimated to be negatively associated with results at a 0.1 level of significance. The coefficient is -0.26\* compared to -0.21\* in the previous model. The effect of lagged expenditure on  $C19RM_{it}$  is estimated to be positively associated with results at a 0.1 level of significance. The coefficient is 0.42\* compared to 0.56\*\* in the previous model. That is, controlling explicitly for changes in grant target has led to a slight decrease in the estimated effect of  $C19RM_{it}$ .

(xx) *Relative magnitude of external and domestic health funding*

**Allowing the effects of  $GFDAH_{it}$  to depend on the relative importance of external funding in each country did not change the key results.** The key finding that #ART, #TB notifs, and #LLINs performance is positively associated with the Global Fund's proportion of total external disease-specific funding can be difficult to interpret without considering the relative magnitude of external and domestic health funding. To address this concern, two sensitivities were considered:

- i.) Repeating the regression analysis on a subset of data only containing countries where external health funding is of a significant magnitude relative to domestic health funding

The effectiveness of repeating the regression analysis on a subset of data was limited by data quality issues. For instance, dropping observations from countries where external health funding is less than 15% of the total would restrict the panel to just 36 countries (19 low income and 17 lower-middle income), of which 30 would be in Africa. The smaller sample size would reduce statistical power and could arguably introduce a form of selection bias. For these reasons, the restricted regression analysis was not performed.

- b) ii.) Including an interaction term that allows the effect of  $GFDAH_{it}$  to depend on the ratio of external to domestic health funding

The ideal variable for refining the set of countries used in this analysis would be the disease-specific ratio of external to domestic health spending (rather than the ratio of total external to domestic health spending). Unfortunately, the availability, coverage and accuracy of health financing data is poor. Some governments have specific national HTM programs and publish budgets that separate domestic funding into HTM while other have integrated health budgets. The second-best variable to use was the ratio of total external health funding to total domestic health funding. To prevent the sample from changing over time, the ratio of external to domestic funding did not depend on time and was defined as:

$$\left(\frac{DAH}{Domestic}\right)_i = \frac{\sum_t DAH_{it}}{\sum_t Domestic_{it}}$$

$DAH_{it}$  was defined as total domestic assistance for health from the IHME database and  $Domestic_{it}$  was defined as total domestic health funding from the GHED database – consistent with variables used in the core results.

An interaction term was introduced to the original regression model so that analysis could be undertaken on the entire sample. The extended model took the form:<sup>28</sup>

$$\Delta \ln Perf_{it} = \beta_0 + \beta_1 \Delta \ln GFDAH_{it} + \beta_2 \Delta \ln GFEXP_{it} + \beta_3 \Delta \ln C19RM_{it} + \beta_4 \Delta \ln GFDAH_{it} * \left(\frac{DAH}{Domestic}\right)_i + \gamma \Delta Z_{it} + \Delta \epsilon_{it}$$

In this extended model the expected percentage change in  $Perf_{it}$  given a percentage increase in  $GFDAH_{it}$  is  $\beta_1 + \beta_4 \left(\frac{DAH}{Domestic}\right)_i$ . Hence, a positive  $\beta_4$  coefficient would suggest that the effects of a percentage increase in  $GFDAH_{it}$  increases when external health financing is relatively more important, while a negative  $\beta_4$  coefficient would suggest the opposite.

Table J.7: Estimates of the coefficient of lagged and current  $\ln GFDAH_{it}$

Service delivery indicator	Base model ( $\beta_1$ )		Extended model ( $\beta_1 + \beta_4 \left(\frac{DAH}{Domestic}\right)_i$ )			
	Current	Lagged	Current ( $\beta_1$ )	Lagged ( $\beta_1$ )	Current ( $\beta_4$ )	Lagged ( $\beta_4$ )
#ART	0.04	0.19**	0.06	0.25**	-0.03	-0.60
#IRS	1.03	-0.07	0.50	0.93	1.45	-3.43
#LLINs	1.25*	0.97*	0.56	0.71	3.08	1.35
#MDR-TB cases	-0.06	0.19	-0.14	0.24	0.56	-0.22
#TB notifs	-0.07	0.26**	-0.08	0.41***	0.08	-0.76*
%PMTCT	-0.30	-0.75**	-0.01	-2.16**	-0.36	7.48**

Source: CEPA regressions. \*/\*\*/\* illustrate coefficients are significantly different to zero at 0.1/0.05/0.01 levels of significance.

<sup>28</sup> Note that  $\left(\frac{DAH}{Domestic}\right)_i$  does not appear by itself in this model as it does not change over time and is removed from the model when first differencing (or using fixed effects).

Including the interaction term did not dramatically change estimates of the effect of  $GFDAH_{it}$  across the service delivery indicators. However, positive correlation between  $\left(\frac{DAH}{Domestic}\right)_i$  and  $GFDAH_{it}$  for malaria (0.41) introduced multicollinearity that increased the standard errors of estimated coefficients for #IRS and #LLINs, resulting in the estimates for the effect of  $GFDAH_{it}$  on #LLINs performance no longer being significant at a 0.1 level.

#### a. Limitations

This analysis is subject to the following limitations:

- Some indicators suffered from a **small number of observations** – weakening the statistical power of regression results. In particular, #LLINs had only 8-9 observations per year.
- **Deriving expenditure** from Global Fund's cumulative expenditure and detailed budget data introduces a risk that the  $GFEXP_{it}$  and  $GFDAH_{it}$  may not be accurately interpreted as Global Fund's disease specific expenditure and Global Fund's share of disease specific DAH. In practice, expenditure is likely to occur, on average, after it has been budgeted meaning that using the budget time profile may lead to biased estimates. An alternative was to use IHME DAH data instead of Global Fund's expenditure, however this data is only available for 2017-2020 and may not accurately reflect Global Fund's disease specific funding (e.g., it is the case that Global Fund's reported expenditure on TB is much higher than Global Fund's expenditure on TB in the IHME DAH database for many countries). In a sensitivity check, IHME DAH data was used where available (2017-2020) and the same positive association between Global Fund proportion of DAH and performance was not found for #ART, #TB Notifs and #LLINs.
- The availability, coverage and accuracy of **health financing data** is poor. In particular,
  - Some governments have specific national HTM programs and publish budgets that separate **domestic funding** into HTM while others have integrated health budgets (i.e., HTM expenditure is not isolated but included in general health expenditure). As a result, this analysis adopted total domestic health expenditure as a control instead of disease-specific domestic health expenditure.
  - **Development assistance for health** has good coverage from 2017 to 2020, but not for 2021 and 2022. As a result, this analysis relied on imputation decisions which may make it harder to interpret.
- **Unobserved endogeneity** between variables prevents us from interpreting any coefficient as strictly causative. That is, an unobserved variable may account for some of the non-zero coefficient results. Model specifications were designed specifically to reduce the impact of endogeneity, but results must necessarily be treated with caution and triangulated against a wider evidence base.

The robustness of results could be improved through a more accurate database of domestic health financing data, including breakdown of health budgets into HTM expenditure. Measurement error biases estimated coefficients towards zero so reducing measurement error all variables will lead to more robust estimates.

#### b. Supplementary material

This section contains supplementary material to the results section above, so that readers may interrogate results directly.

##### i. Regression tables

Tables 1-6 show results for each service delivery performance indicator, under several model specifications. Table 7 shows results for every performance indicator under a single model specification including most explanatory variables available. Regression results for incidence and mortality are not shown due to the lack of substantive findings.

Each column relates to a different model specification – which differ in the variables included and / or the estimation technique used (i.e., first difference vs fixed effects). Each row shows regression coefficients for a different explanatory variable. Values in brackets are standard errors. Asterisks denote coefficients which are different from zero at 10%, 5% and 1% thresholds for statistical significance (i.e. with p values below 0.1, 0.05 or 0.01 respectively).

(xxi) #ART

Results Table 1: #ART

	Dependent variable:				
	Grant Performance				Fixed Effects
	(1)	(2)	(3)	(4)	(5)
HIV Expenditure	0.0001 (0.005)		-0.001 (0.006)	-0.0001 (0.006)	0.004 (0.005)
HIV Expenditure, lagged	-0.002 (0.004)		-0.007 (0.005)	-0.007* (0.005)	-0.0004 (0.005)
GFDAH		0.026 (0.086)	0.044 (0.094)	0.049 (0.093)	0.019 (0.097)
GFDAH, lagged		0.100 (0.074)	0.191** (0.092)	0.206** (0.091)	0.105 (0.096)
Domestic health expenditure	0.045 (0.057)	0.035 (0.057)	0.025 (0.058)	0.017 (0.057)	0.066 (0.056)
Domestic health expenditure, lagged	-0.095 (0.060)	-0.097 (0.060)	-0.093 (0.060)	-0.115* (0.060)	-0.125** (0.058)
GDP per capita	-0.044 (0.089)	-0.051 (0.089)	-0.061 (0.090)	-0.043 (0.089)	-0.107 (0.087)
GDP per capita, lagged	0.142* (0.078)	0.136* (0.077)	0.131* (0.077)	0.124 (0.076)	0.187*** (0.072)
Covid	-0.077*** (0.025)	-0.094*** (0.027)	-0.097*** (0.027)	-0.090*** (0.027)	-0.095*** (0.021)
Recovery	0.036 (0.028)	0.032 (0.029)	0.037 (0.029)	0.053* (0.029)	0.071*** (0.025)
C19RM				-0.209* (0.122)	-0.214* (0.128)
C19RM, lagged				0.561** (0.232)	0.534** (0.221)
Constant	0.005 (0.015)	0.012 (0.016)	0.012 (0.016)	0.009 (0.017)	
Observations	314	314	314	314	402
R <sup>2</sup>	0.071	0.077	0.086	0.120	0.115
Adjusted R <sup>2</sup>	0.047	0.052	0.055	0.085	-0.175

Note:

\*p<0.1; \*\*p<0.05; \*\*\*p<0.01

(xxii) %PMTCT

Results Table 2: %PMTCT

	<i>Dependent variable:</i>				
	Grant Performance				Fixed Effects
	(1)	(2)	(3)	(4)	(5)
HIV Expenditure	-0.003 (0.020)		0.001 (0.023)	-0.003 (0.022)	-0.003 (0.016)
HIV Expenditure, lagged	-0.018 (0.013)		0.001 (0.016)	0.0003 (0.016)	0.001 (0.016)
GFDAH		-0.289 (0.340)	-0.302 (0.405)	-0.349 (0.402)	-0.026 (0.409)
GFDAH, lagged		-0.752*** (0.270)	-0.753** (0.354)	-0.828** (0.353)	-0.649* (0.389)
GDP per capita	-0.523* (0.301)	-0.521* (0.290)	-0.521* (0.296)	-0.461 (0.295)	-0.595** (0.272)
GDP per capita, lagged	-0.375 (0.304)	-0.515* (0.301)	-0.515* (0.306)	-0.407 (0.308)	0.020 (0.288)
C19RM				-1.868* (1.090)	-1.115 (0.878)
C19RM, lagged				-3.233 (2.887)	-3.914 (2.494)
Constant	-0.013 (0.041)	-0.019 (0.038)	-0.020 (0.040)	0.028 (0.047)	
Observations	72	72	72	72	93
R <sup>2</sup>	0.079	0.139	0.139	0.185	0.190
Adjusted R <sup>2</sup>	0.024	0.087	0.059	0.082	-0.164

Note: \* $p < 0.1$ ; \*\* $p < 0.05$ ; \*\*\* $p < 0.01$

## (xxiii) #TB Notifications

Results Table 3: #TB Notifications

	<i>Dependent variable:</i>				
	Grant Performance				Fixed Effects
	(1)	(2)	(3)	(4)	(5)
TB Expenditure	0.006 (0.005)		0.012* (0.007)	0.012* (0.007)	0.005 (0.006)
TB Expenditure, lagged	0.003 (0.004)		-0.003 (0.005)	-0.002 (0.005)	-0.005 (0.005)
GFDAH		0.067 (0.122)	-0.065 (0.153)	-0.061 (0.154)	0.275* (0.151)
GFDAH, lagged		0.160* (0.083)	0.260** (0.108)	0.236** (0.113)	0.234** (0.102)
Domestic health expenditure	-0.009 (0.073)	-0.007 (0.073)	-0.010 (0.072)	-0.009 (0.072)	-0.029 (0.068)
Domestic health expenditure, lagged	0.133* (0.071)	0.098 (0.073)	0.085 (0.073)	0.075 (0.074)	0.129* (0.069)
Covid	-0.182*** (0.034)	-0.217*** (0.039)	-0.234*** (0.040)	-0.223*** (0.043)	-0.205*** (0.029)
Recovery	0.082** (0.038)	0.050 (0.041)	0.033 (0.041)	0.046 (0.043)	0.120*** (0.035)
C19RM				-0.049 (0.205)	0.021 (0.216)
C19RM, lagged				0.397 (0.436)	0.096 (0.393)
Constant	0.009 (0.022)	0.037 (0.026)	0.049* (0.026)	0.040 (0.029)	
Observations	295	295	295	295	380
R <sup>2</sup>	0.183	0.189	0.205	0.208	0.186
Adjusted R <sup>2</sup>	0.166	0.173	0.182	0.180	-0.083

Note:

\* $p < 0.1$ ; \*\* $p < 0.05$ ; \*\*\* $p < 0.01$



(xxiv) #MDR-TB

Results Table 4: #MDR-TB

	Dependent variable:				
	Grant Performance				Fixed Effects
	(1)	(2)	(3)	(4)	(5)
TB Expenditure	-0.013 (0.010)		-0.010 (0.013)	-0.011 (0.013)	-0.004 (0.011)
TB Expenditure, lagged	-0.012* (0.007)		-0.017* (0.009)	-0.016* (0.009)	-0.015 (0.010)
GFDAH		-0.244 (0.221)	-0.057 (0.280)	-0.052 (0.281)	0.411 (0.277)
GFDAH, lagged		-0.047 (0.151)	0.188 (0.208)	0.146 (0.214)	0.424** (0.196)
Covid	-0.128** (0.059)	-0.141** (0.067)	-0.154** (0.069)	-0.126* (0.075)	-0.276*** (0.053)
Recovery	0.164*** (0.058)	0.134** (0.065)	0.128* (0.067)	0.137* (0.071)	0.130** (0.057)
C19RM				0.336 (0.376)	-0.228 (0.403)
C19RM, lagged				0.536 (0.729)	-0.623 (0.671)
Constant	-0.060* (0.034)	-0.048 (0.040)	-0.036 (0.042)	-0.061 (0.049)	
Observations	291	287	287	287	367
R <sup>2</sup>	0.084	0.074	0.084	0.088	0.124
Adjusted R <sup>2</sup>	0.071	0.061	0.065	0.062	-0.149

Note: \* $p < 0.1$ ; \*\* $p < 0.05$ ; \*\*\* $p < 0.01$

(xxv) #LLINS

Results Table 5: #LLINS

	<i>Dependent variable:</i>				
	Grant Performance				Fixed Effects
	(1)	(2)	(3)	(4)	(5)
Mal Expenditure	0.010 (0.025)		-0.045 (0.040)	-0.044 (0.040)	-0.033 (0.036)
Mal Expenditure, lagged	-0.001 (0.014)		-0.039 (0.025)	-0.041 (0.025)	-0.025 (0.025)
GFDAH		0.552 (0.428)	1.249* (0.691)	1.251* (0.694)	0.878 (0.658)
GFDAH, lagged		0.266 (0.322)	0.986* (0.575)	1.043* (0.583)	0.404 (0.571)
GDP per capita	0.284 (0.393)	0.288 (0.393)	0.224 (0.394)	0.198 (0.399)	0.572 (0.350)
GDP per capita, lagged	0.051 (0.289)	0.068 (0.288)	0.083 (0.288)	0.082 (0.290)	0.017 (0.263)
Covid	-0.065 (0.114)	-0.118 (0.121)	-0.161 (0.124)	-0.135 (0.133)	0.002 (0.098)
Recovery	-0.123 (0.120)	-0.109 (0.123)	-0.109 (0.123)	-0.108 (0.128)	-0.090 (0.106)
C19RM				1.176 (1.231)	1.341 (1.124)
C19RM, lagged				0.119 (2.634)	0.375 (2.311)
Constant	0.068 (0.070)	0.070 (0.072)	0.076 (0.072)	0.044 (0.088)	
Observations	161	161	161	161	216
R <sup>2</sup>	0.013	0.023	0.038	0.044	0.042
Adjusted R <sup>2</sup>	-0.026	-0.016	-0.012	-0.019	-0.364
<i>Note:</i>				* <i>p</i> <0.1; ** <i>p</i> <0.05; *** <i>p</i> <0.01	

Results Table 6: #IRS

	Dependent variable:				
	Grant Performance				Fixed Effects
	(1)	(2)	(3)	(4)	(5)
Mal Expenditure	0.066*** (0.021)		0.037 (0.030)	0.032 (0.031)	0.054 (0.034)
Mal Expenditure, lagged	0.00004 (0.020)		-0.007 (0.030)	-0.012 (0.032)	0.014 (0.032)
GFDAH		1.438*** (0.408)	1.029 (0.611)	1.089 (0.646)	0.257 (0.687)
GFDAH, lagged		0.030 (0.378)	-0.067 (0.612)	0.040 (0.652)	-0.332 (0.678)
Domestic health expenditure	-0.425 (0.306)	-0.568* (0.306)	-0.584* (0.305)	-0.572* (0.317)	-0.494 (0.299)
Domestic health expenditure, lagged	-0.233 (0.220)	-0.187 (0.214)	-0.190 (0.215)	-0.090 (0.263)	0.025 (0.244)
Covid	-0.075 (0.153)	-0.034 (0.148)	-0.064 (0.151)	-0.113 (0.169)	-0.030 (0.118)
Recovery	0.076 (0.190)	0.267 (0.199)	0.231 (0.199)	0.227 (0.216)	0.228 (0.200)
C19RM				-0.839 (2.146)	-0.655 (2.225)
C19RM, lagged				-2.621 (3.567)	-2.417 (2.731)
Constant	0.034 (0.093)	-0.044 (0.089)	-0.008 (0.093)	0.039 (0.115)	
Observations	33	33	33	33	42
R <sup>2</sup>	0.328	0.372	0.424	0.438	0.410
Adjusted R <sup>2</sup>	0.173	0.227	0.232	0.182	-0.052

Note: \* $p < 0.1$ ; \*\* $p < 0.05$ ; \*\*\* $p < 0.01$

(xxvii) Full model with all controls  
Results Table 7: All controls

	Dependent variable:					
	Grant Performance					
	#ART	%PMTCT	#TB Notifs	#MDR-TB	#LLINs	#IRS
	(1)	(2)	(3)	(4)	(5)	(6)
GFDAH – HIV	0.051 (0.094)	-0.391 (0.466)				
GFDAH – HIV, lagged	0.200** (0.093)	-0.783* (0.454)				
Expenditure – HIV	-0.001 (0.006)	-0.001 (0.025)				
Expenditure – HIV, lagged	-0.008 (0.005)	0.001 (0.017)				
GFDAH – TB			-0.068 (0.157)	-0.093 (0.288)		
GFDAH – TB, lagged			0.280** (0.116)	0.136 (0.222)		
Expenditure – TB			0.012* (0.007)	-0.012 (0.013)		
Expenditure – TB, lagged			-0.003 (0.005)	-0.016* (0.010)		
GFDAH – Malaria					1.376* (0.713)	1.526* (0.819)
GFDAH – Malaria, lagged					0.988* (0.595)	0.073 (0.992)
Expenditure – Malaria					-0.051 (0.042)	0.013 (0.038)
Expenditure – Malaria, lagged					-0.045* (0.026)	-0.004 (0.045)
Domestic health expenditure	-0.003 (0.060)	0.026 (0.373)	-0.029 (0.081)	0.064 (0.158)	-0.152 (0.327)	-0.793* (0.419)
Domestic health expenditure, lagged	-0.134** (0.063)	-0.100 (0.358)	0.043 (0.087)	-0.002 (0.164)	0.332 (0.343)	-0.160 (0.468)

GDP per capita	-0.044	-0.618	0.070	0.160	0.195	-0.280
	(0.092)	(0.376)	(0.137)	(0.274)	(0.458)	(0.628)
GDP per capita, lagged	0.135*	-0.279	-0.006	0.062	-0.186	0.262
	(0.079)	(0.444)	(0.115)	(0.218)	(0.368)	(0.451)
Population	1.434	72.983	0.872	0.775	73.969*	-68.255
	(1.076)	(98.365)	(1.533)	(2.843)	(37.734)	(116.253)
Population, lagged	-1.077	-68.341	1.305	3.348	-70.541*	63.583
	(1.430)	(98.580)	(2.044)	(3.893)	(36.229)	(110.377)
Corruption	-0.002	0.009	0.004	-0.011	0.003	0.096*
	(0.005)	(0.025)	(0.007)	(0.013)	(0.029)	(0.046)
Corruption, lagged	0.005	-0.023	0.004	0.004	-0.026	0.075*
	(0.005)	(0.024)	(0.007)	(0.014)	(0.028)	(0.036)
Urban Population	0.798	91.551	3.547	6.424	-147.499	99.950
	(2.925)	(116.290)	(4.171)	(7.822)	(106.394)	(209.910)
Urban Population, lagged	1.175	-81.409	-4.039	-8.427	138.796	-103.049
	(2.566)	(112.004)	(3.701)	(6.972)	(100.610)	(202.350)
Covid	-0.089***	-0.063	-0.235***	-0.116	-0.119	-0.061
	(0.028)	(0.140)	(0.046)	(0.084)	(0.141)	(0.250)
Recovery	0.057*	0.089	0.027	0.092	-0.047	0.469
	(0.029)	(0.141)	(0.048)	(0.094)	(0.150)	(0.321)
C19RM	-0.151	-2.563*	0.004	0.399	1.424	-0.175
	(0.127)	(1.333)	(0.218)	(0.394)	(1.328)	(2.993)
C19RM, lagged	0.582**	-2.975	0.538	0.729	0.485	0.475
	(0.258)	(3.411)	(0.456)	(0.775)	(2.927)	(4.734)
Constant	-0.017	-0.197	0.014	-0.118	0.068	0.014
	(0.027)	(0.199)	(0.043)	(0.080)	(0.165)	(0.700)
Observations	311	72	285	279	161	29
R2	0.125	0.284	0.224	0.099	0.083	0.726
Adjusted R2	0.071	0.040	0.172	0.037	-0.034	0.232

Note: p<0.1; **p<0.05**; p<0.01

i. Cross-variable correlations

Table I.7 illustrates correlations between service delivery indicators, disease burden, Global Fund expenditure and control variables. Correlations between performance and expenditure are weak and not significantly non-zero.

Table I.7: Variable correlation tables – by disease

<b>HIV</b>	#ART	%PMTCT	GFEXP (HIV)	GFDAH (HIV)	C19RM	Domestic Health	GDP PC	Population	HIV incidence	HIV mortality
#ART	1	0.371	0.144	-0.098	-0.009	0.037	-0.154	0.137	0.203	0.168
%PMTCT		1	0.158	-0.152	-0.055	-0.292	-0.299	-0.196	0.219	0.196
GFEXP (HIV)			1	0.153	-0.096	0.176	-0.298	0.357	0.285	0.321
GFDAH (HIV)				1	0.007	0.070	-0.001	0.052	-0.180	-0.104
C19RM					1	0.125	0.219	-0.048	-0.050	-0.089
Domestic Health						1	0.354	0.790	0.002	0.057
GDP pc							1	-0.222	-0.265	-0.326
Population								1	0.144	0.254
HIV incidence									1	0.851
HIV mortality										1
<b>Tuberculosis</b>	#TB Notifs	#MDR-TB	GFEXP (TB)	GFDAH (TB)	C19RM	Domestic Health	GDP pc	Population	TB incidence	TB mortality
#TB Notifs	1	0.342	-0.020	-0.013	0.024	0.069	-0.095	0.136	0.064	0.038
#MDR-TB		1	0.056	0.090	-0.074	0.085	0.036	0.077	0.090	0.019
GFEXP (TB)			1	0.680	-0.010	0.204	-0.251	0.368	0.456	0.433
GFDAH (TB)				1	-0.090	0.326	-0.020	0.381	0.411	0.370
C19RM					1	0.045	0.195	-0.094	-0.151	-0.143
Domestic Health						1	0.327	0.821	0.662	0.534
GDP pc							1	-0.202	-0.297	-0.384
Population								1	0.892	0.811
TB incidence									1	0.847
TB mortality										1

<b>Malaria</b>	<b>#LLINS</b>	<b>#IRS</b>	<b>GFEXP (Mal)</b>	<b>GFDA H (Mal)</b>	<b>C19RM</b>	<b>Domesti c Health</b>	<b>GDP pc</b>	<b>Populatio n</b>	<b>Malaria incidenc e</b>	<b>Malaria mortalit y</b>
#LLINs	1	0.254	-0.043	0.066	0.078	-0.024	- 0.063	-0.037	-0.092	-0.077
#IRS		1	0.358	0.459	-0.202	-0.207	- 0.543	0.188	0.428	0.241
GFEXP (Mal)			1	0.770	-0.088	-0.068	- 0.359	0.128	0.417	0.499
GFDAH (Mal)				1	-0.061	-0.136	- 0.181	-0.051	0.076	0.141
C19RM					1	-0.0004	0.077	-0.072	-0.038	-0.067
Domestic Health						1	0.360	0.881	0.139	-0.014
GDP pc							1	-0.045	-0.499	-0.518
Population								1	0.424	0.279
Malaria incidence									1	0.845
Malaria mortality										1

## ii) WS2: Summary of country-specific enablers and barriers

This Appendix provides an overview of country-specific enablers and barriers for each country case studies. These provide only a high-level summary and should be read in conjunction with the full country case study reports.

Figure K.1: Enabler/ barrier summary - Bolivia

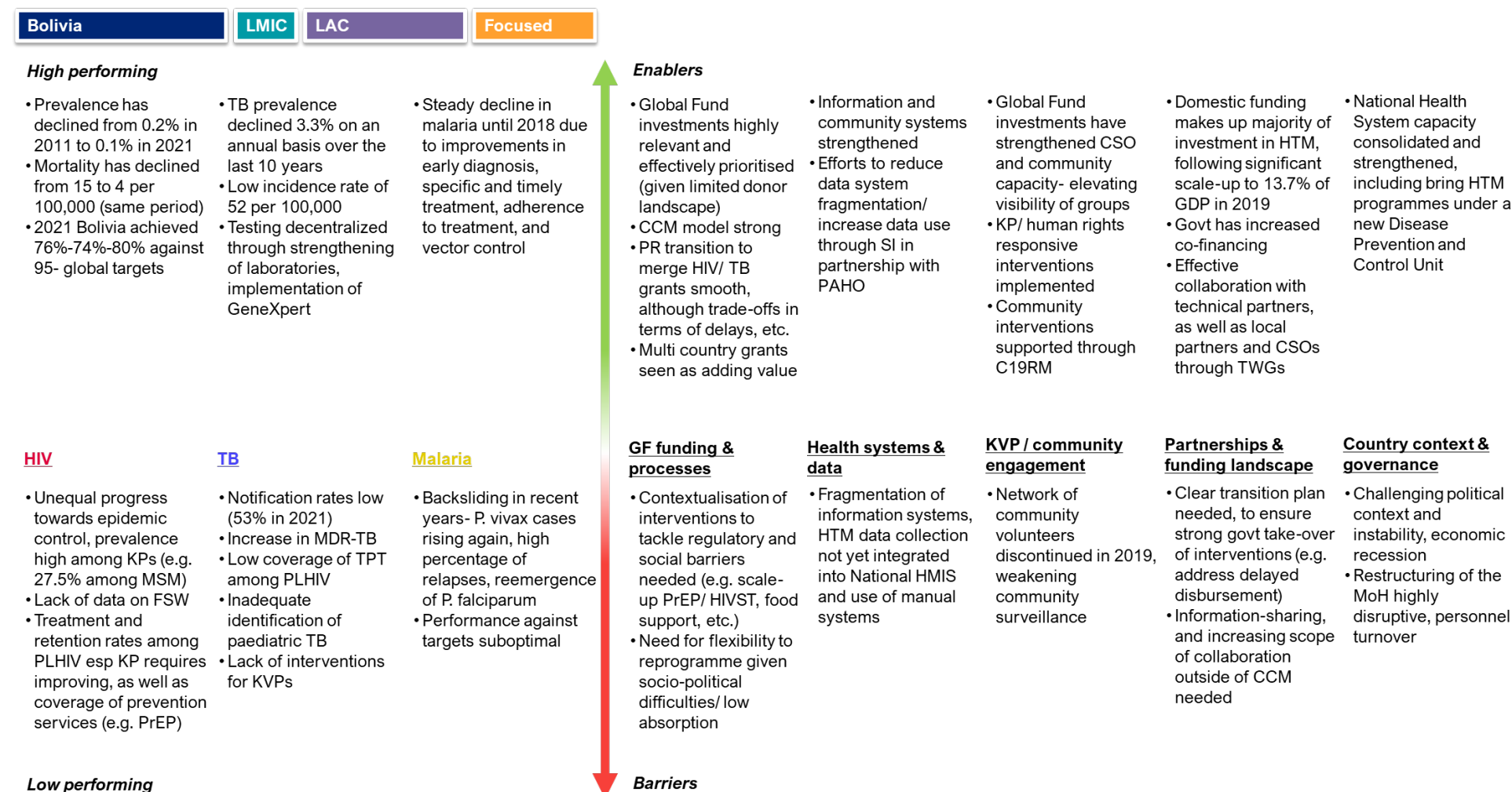




Figure K.2: Enabler/ barrier summary – Chad

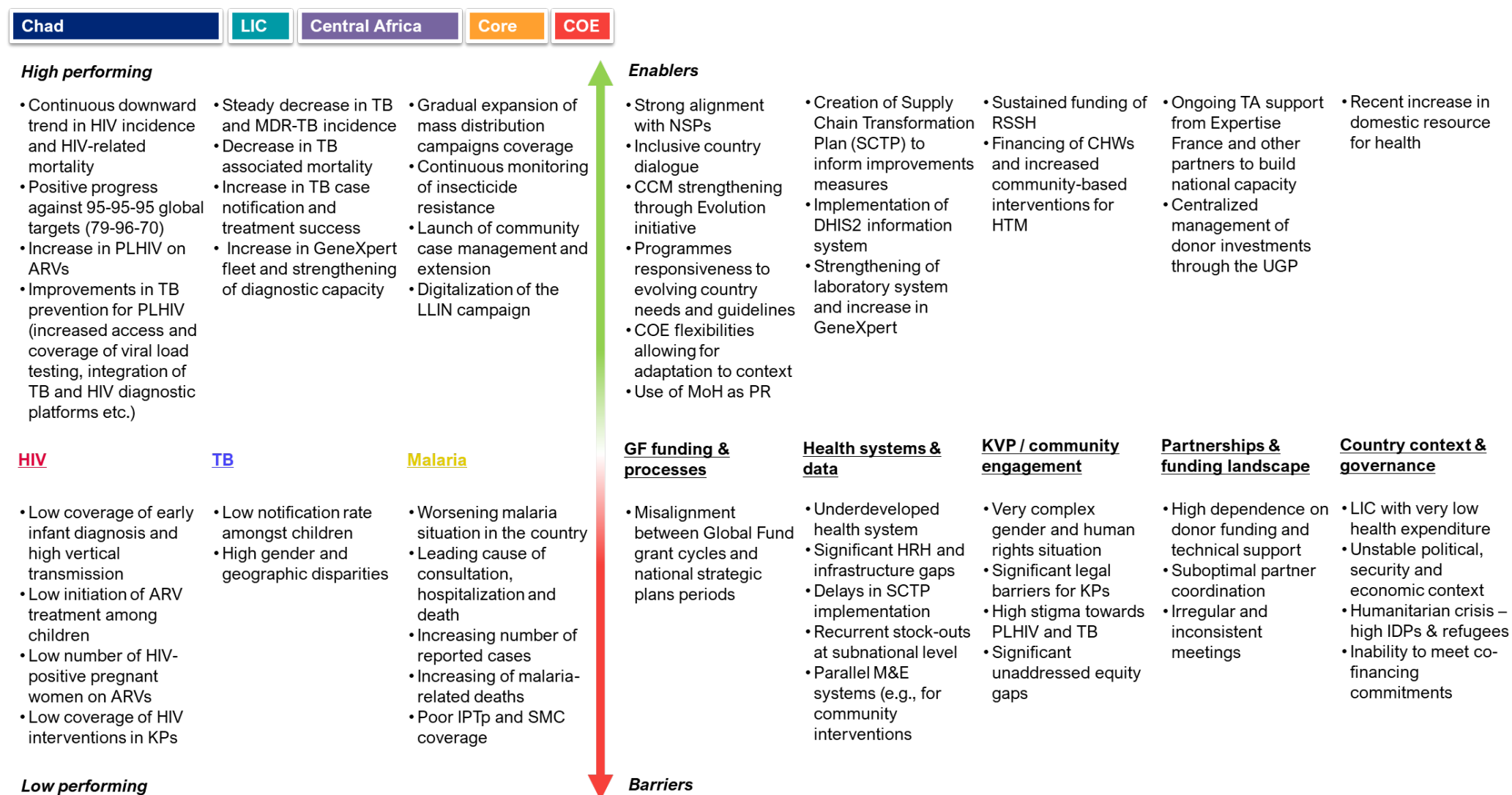


Figure K.3: Enabler/ barrier summary – Côte d'Ivoire

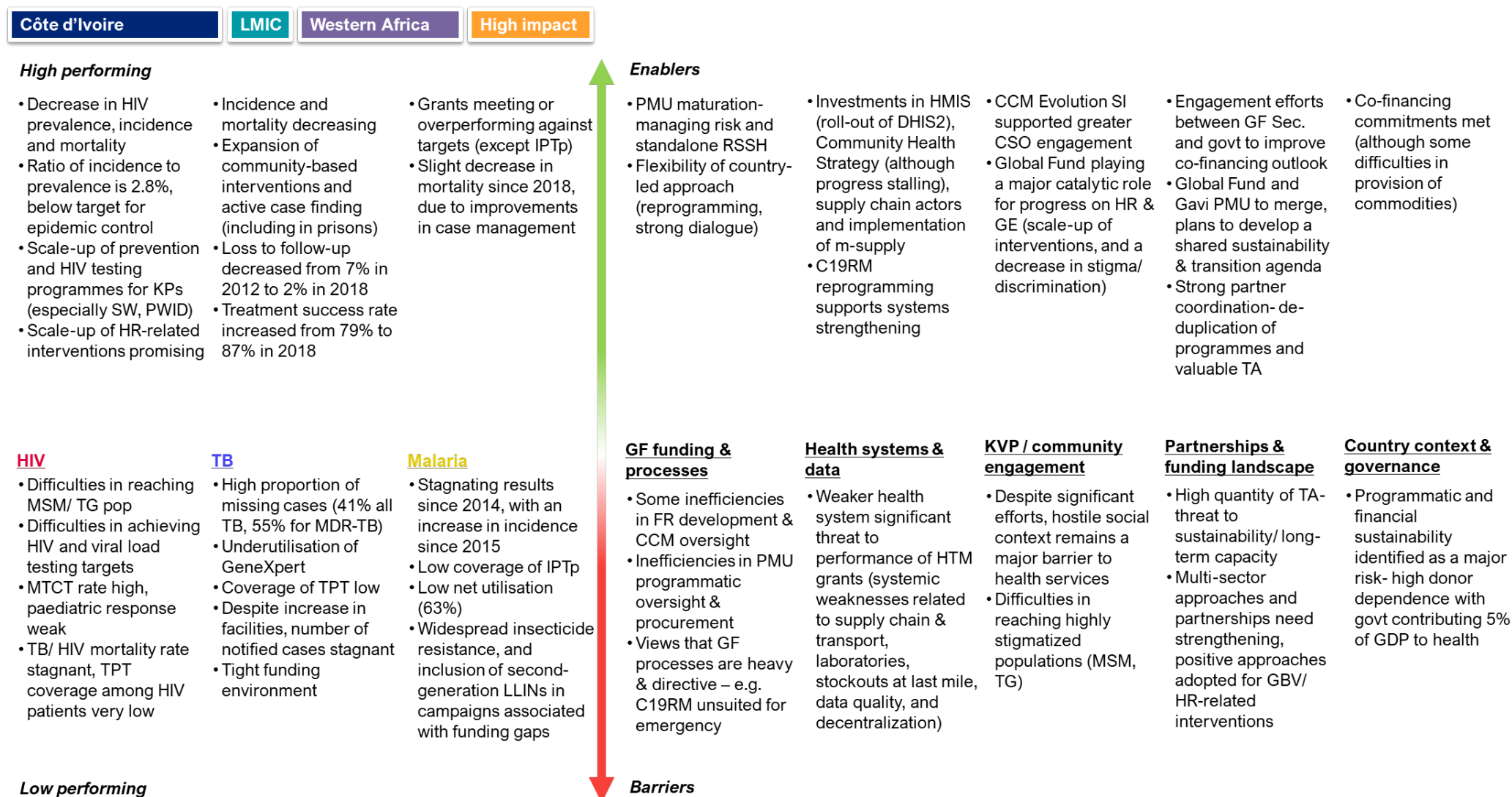
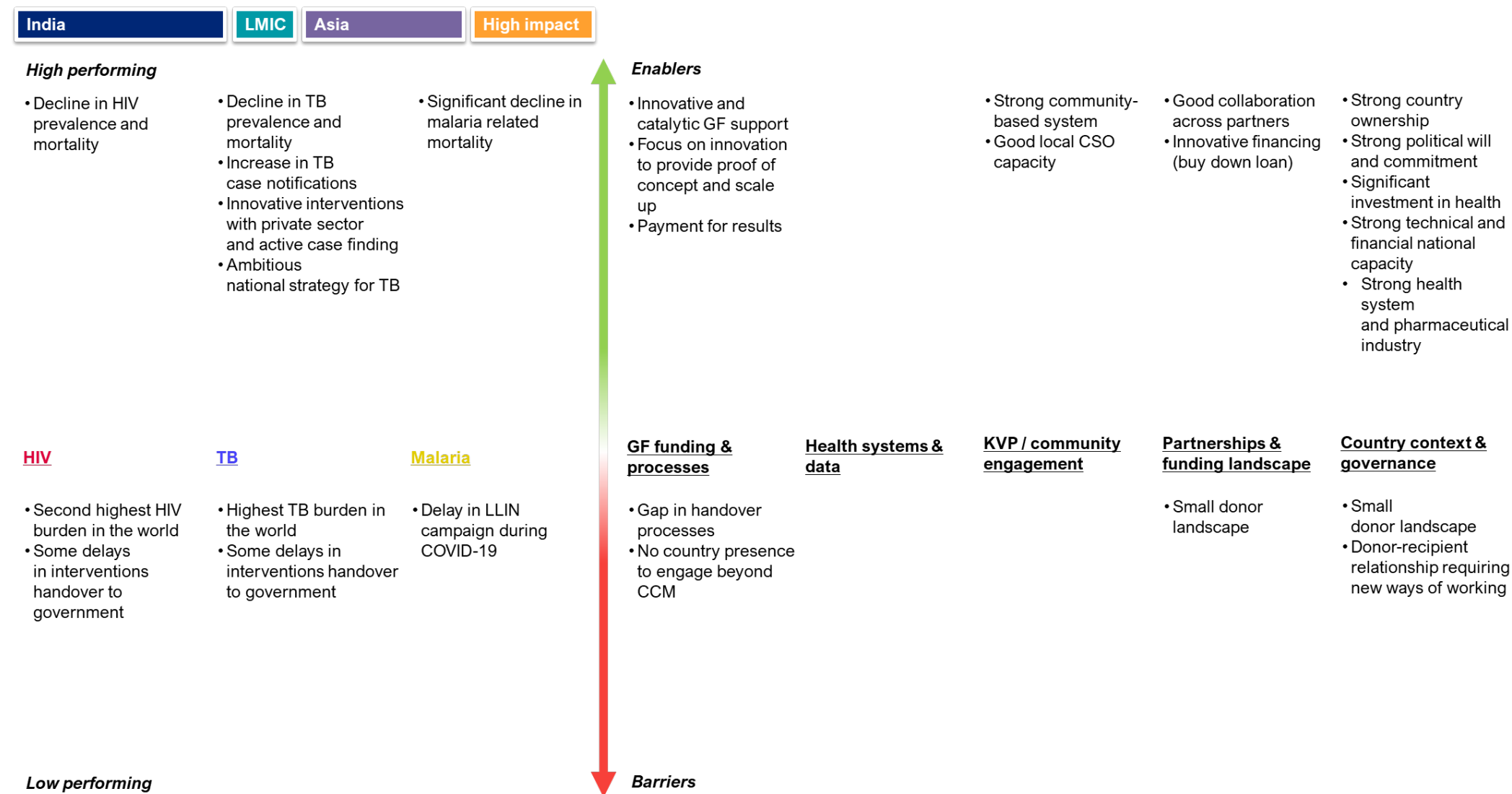


Figure K.4: Enabler/ barrier summary – India\*



\*Light touch case study

Figure K.5: Enabler/ barrier summary – Kenya

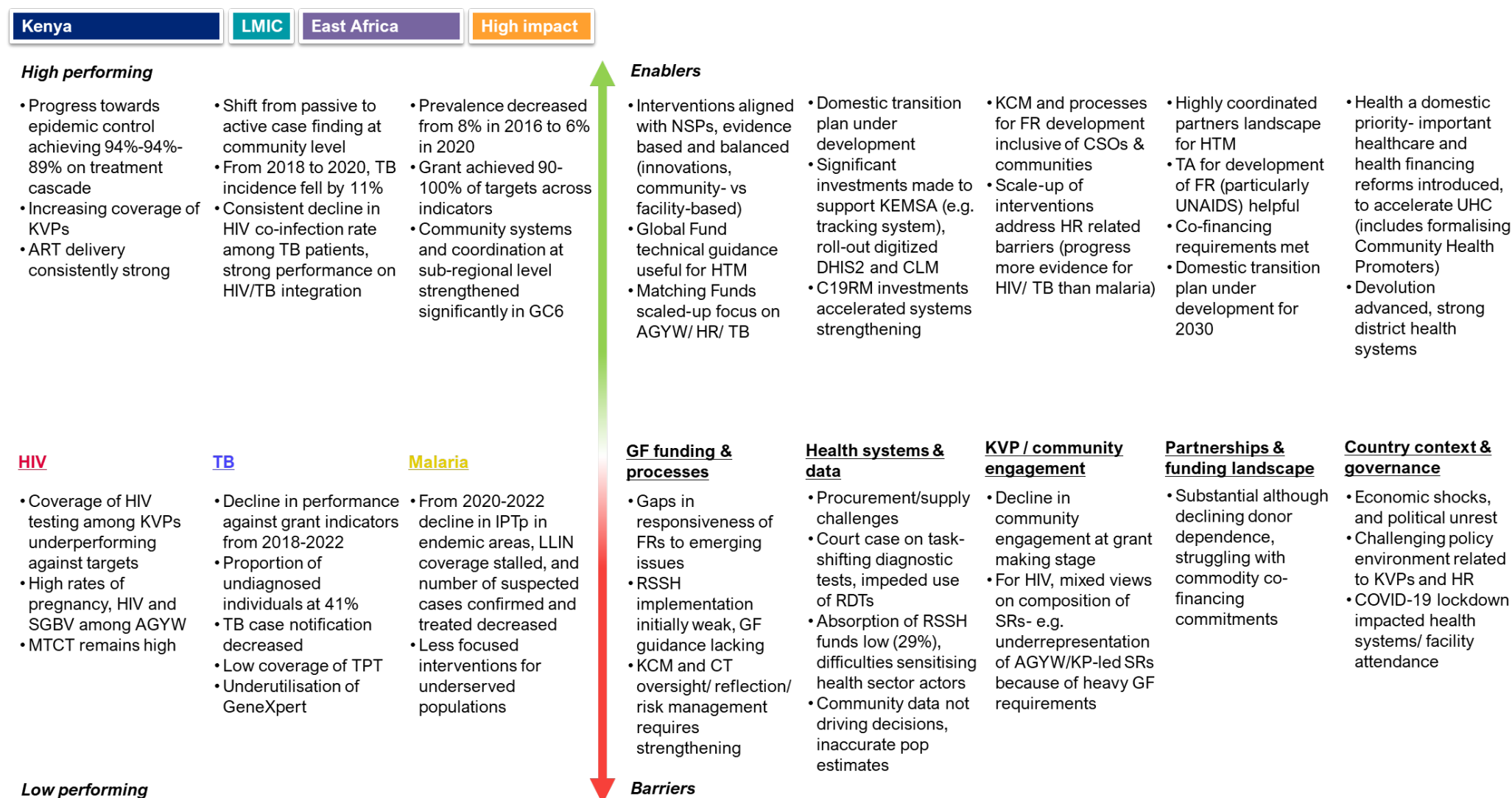


Figure K.6: Enabler/ barrier summary – Kyrgyz Republic

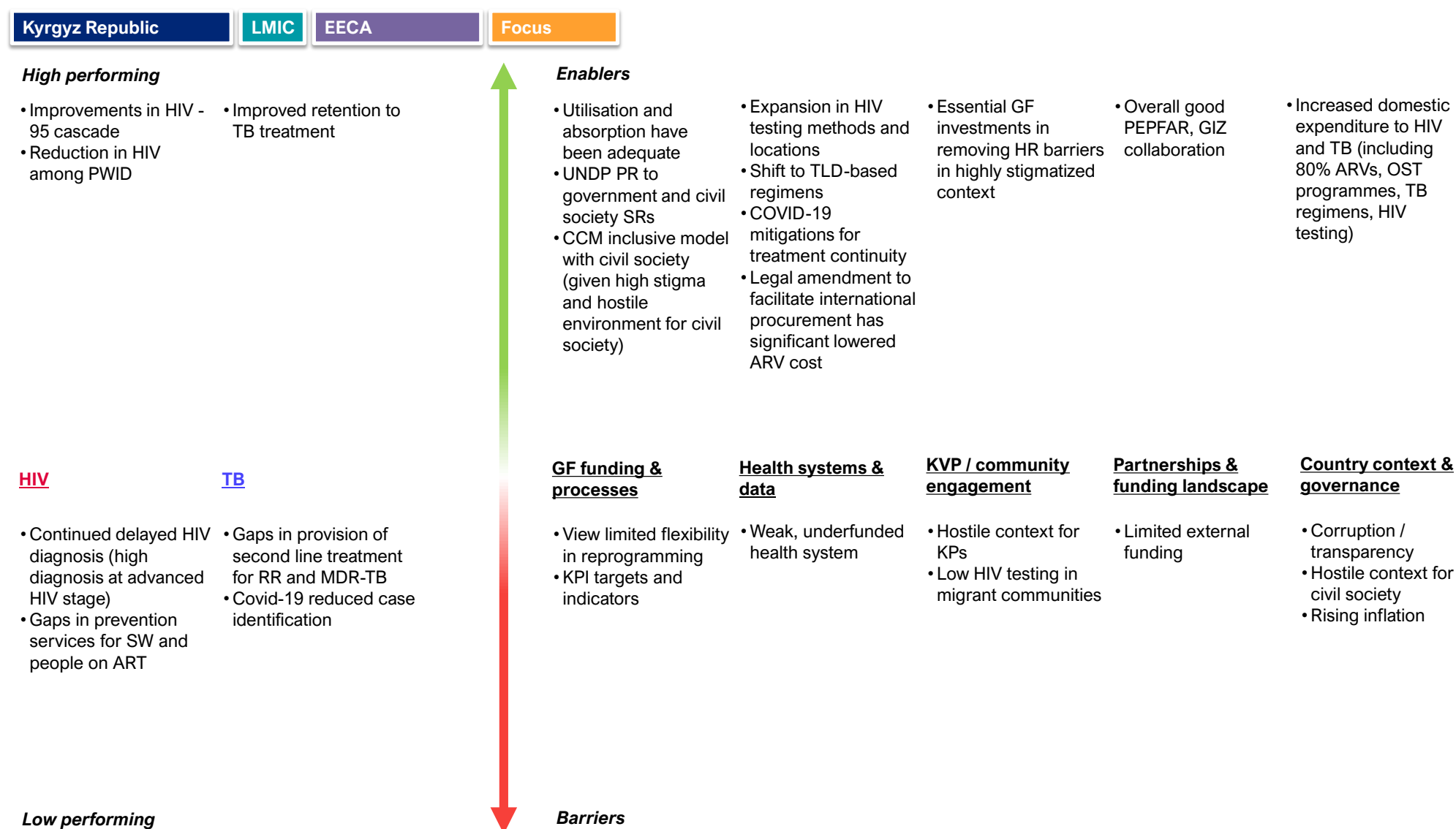


Figure K.7: Enabler/ barrier summary – Mozambique

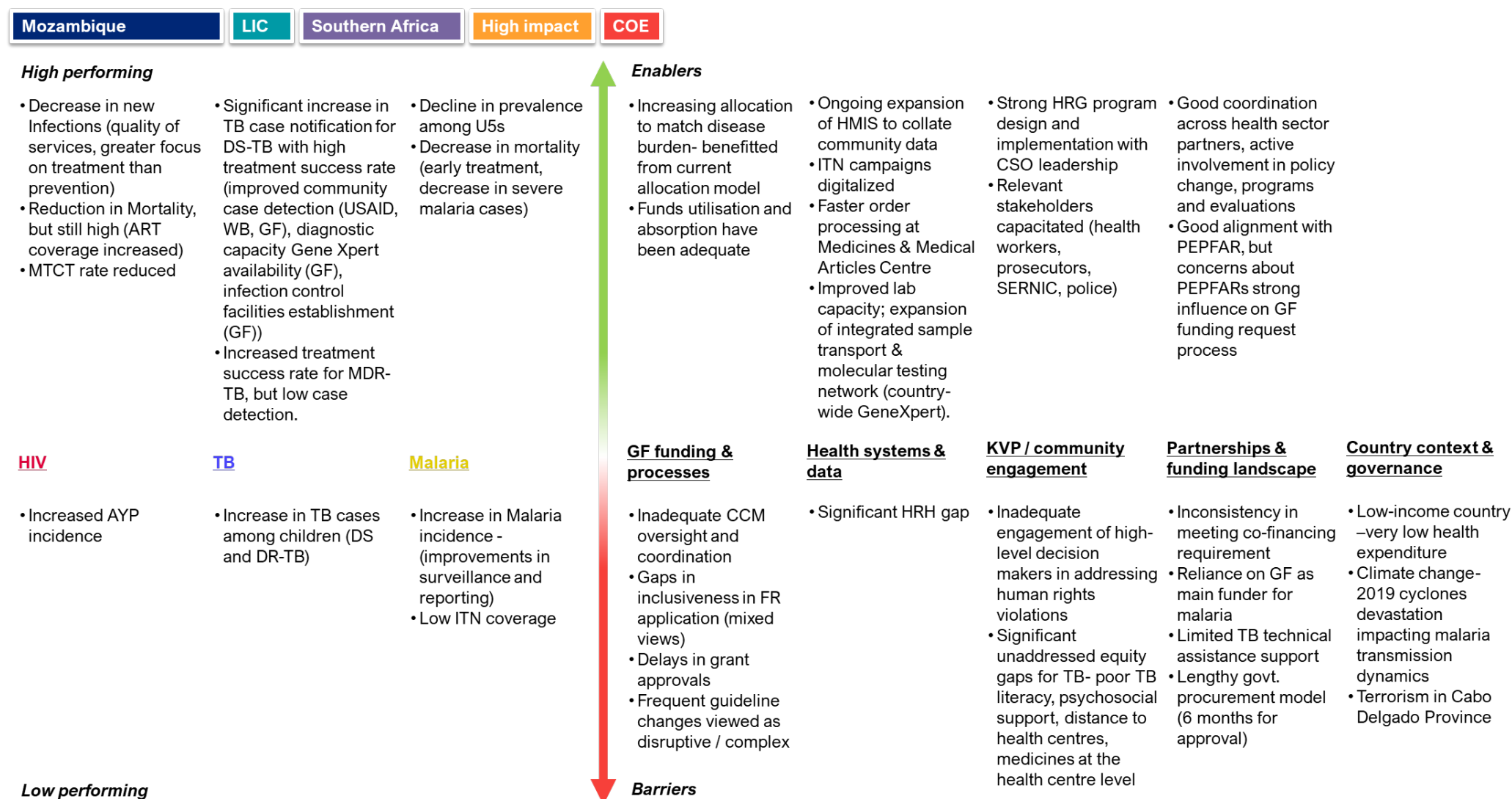




Figure K.8: Enabler / barrier summary – Nigeria

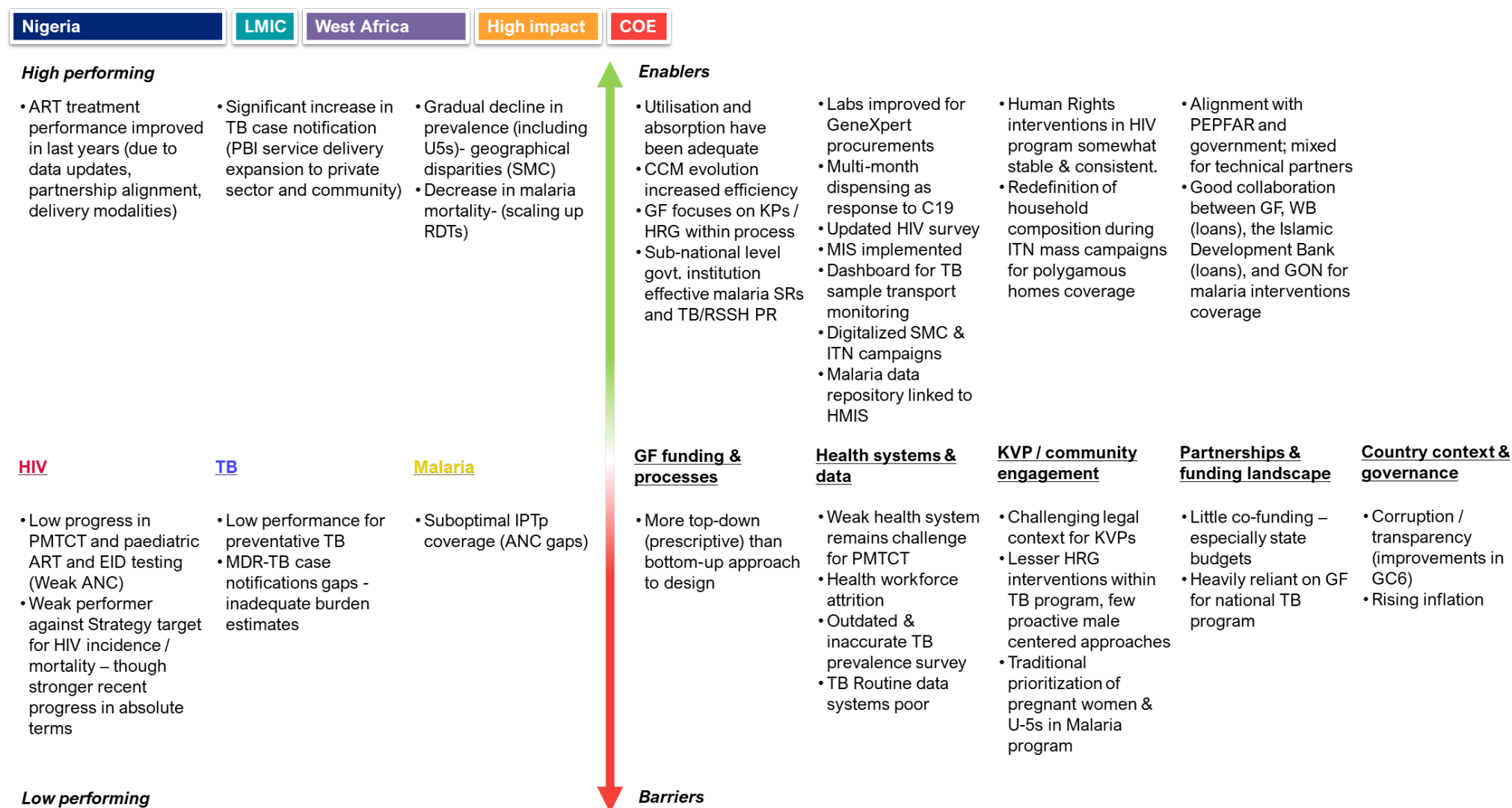


Figure K.9: Enabler / barrier summary – Pakistan

Pakistan

LMIC

Asia

High impact

COE

### High performing

- Increased ART coverage to 61% in 2022 (one-stop shops, improved coordination, multi-month dispensing)
- Declining HIV incidence and mortality
- CSO PR Nai Zindagi providing harm-reduction services to marginalised communities (PWID)
- Prevention services initiated 2019
- Increase in TB case notification (engagement with private sector and community-based case finding)
- Increase in case management and testing services (RDTs)
- Decrease in Annual Parasite Index
- Holistic and comprehensive approach- private sector and community engagement in remote areas

### HIV

- Low testing rates- 25% PLHIV aware of status
- PMTCT ARV coverage declined to 25% (2022)
- EID and paediatric ART coverage low
- Unequal access to services among KP and in rural areas
- Social stigma and discrimination barrier to services

### TB

- Despite improvements, case detection remains low esp. for DR-TB (weak service access, health system etc.)
- Social stigma associated with TB barrier to services
- Paediatric TB diagnosis and treatment adherence low

### Malaria

- Significant increase in malaria burden due to flooding (unmet funding need)
- IRS not being funded, although national elimination priority- misalignment of funded interventions and elimination focus
- Only 4% of nets distributed

### Low performing

### Enablers

- Global Fund investments relevant to country context
- Strong relationship between PRs and Global Fund CT
- LFA playing key capacity-building role
- Centralised unit (CMU) created to manage national grants (but concerns around sustainability/ strategic vision)
- Malaria module integrated into DHIS2 in 2020
- Scale-up in number of public and private facilities
- Lady Health Workers important to malaria/ TB service delivery
- CHW strategy expected to make up for human resources shortfall
- Recent efforts to scale-up community-based approaches, human rights and harm-reduction services (through new CSO PR Nai Zindagi), and prevention services
- Some national coordination mechanisms implemented- i.e. semi-annual provincial meetings and National Health Sector Coordination Mechanism at federal level
- Devolution advancing, with provincial contributions to DFH

### GF funding & processes

- Not adapting to devolution
- Funding model lacking flexibility (for budget reallocation due to currency fluctuations, etc.)
- HIV response led by UNDP not govt PR (due to ASP, but negatively viewed)
- CCM lacking strategic vision (freq. leadership changes)

### Barriers

### Health systems & data

- Data collection and reporting mechanisms remain weak (challenge for performance-based incentive approach)
- Health system a barrier to HTM programmes, particularly TB (sample transportation, data, human resources.)

### KVP / community engagement

- Limited progress reported on community engagement, reduction in gender-related disparities and human rights (however interventions only recently implemented)

### Partnerships & funding landscape

- CCM and CMU coordination of stakeholders lacking (esp. provincial level)
- Heavy reliance on WHO for technical guidance (malaria)
- Coordination gaps between UNDP, UNAIDS, and NACP
- Division of tasks between state and non-state PR based on geography rather than technical role

### Country context & governance

- Low domestic health investment (1.1%)
- Pakistan 161/191 on UNDP Human Development Index (inequality and catastrophic health expenditure high)
- PR sits at federal level but role of federal system in health limited since devolution, coordination with provinces lacking



Figure K.10: Enabler/ barrier summary – Philippines

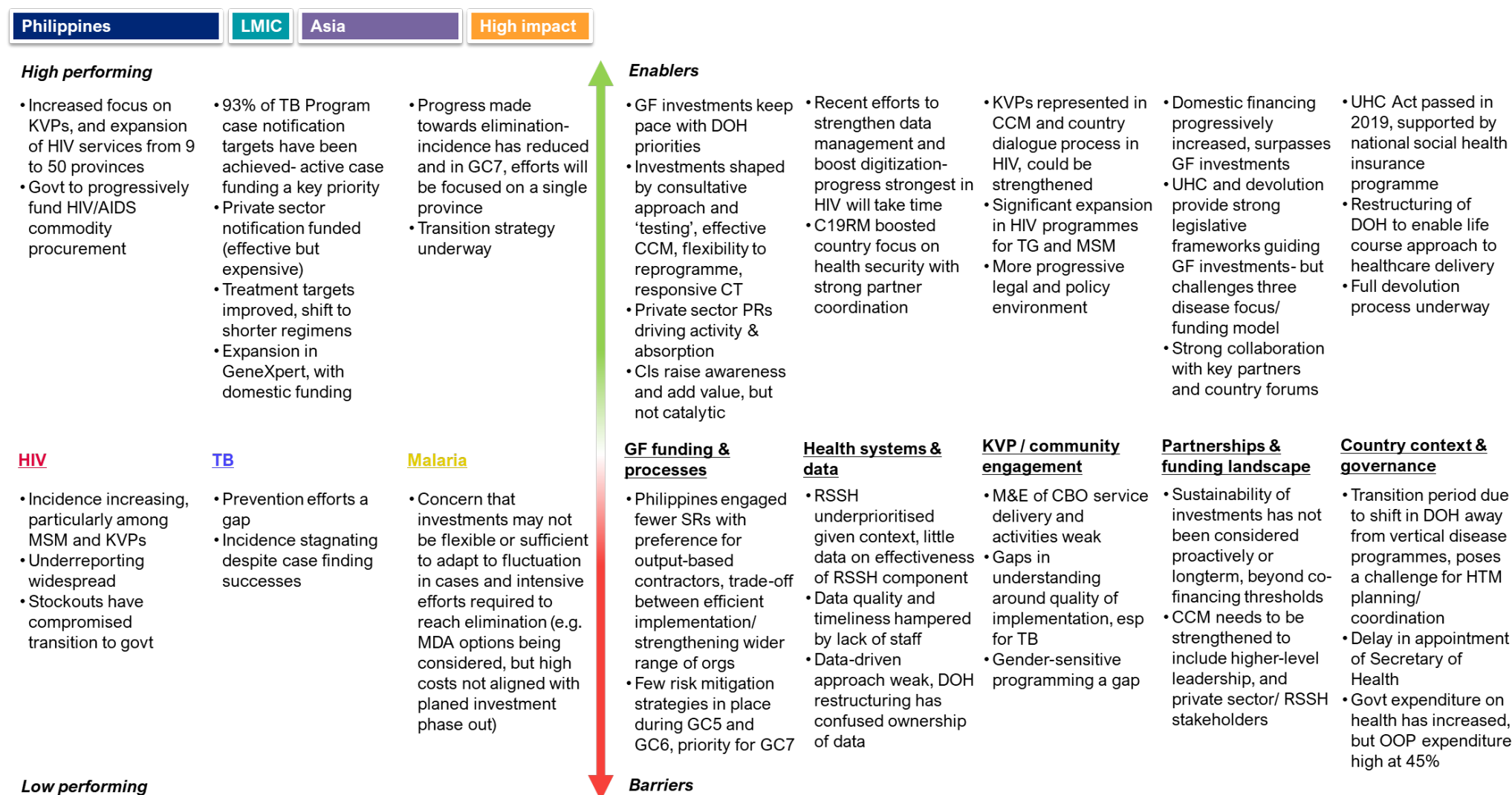


Figure K.11: Enabler/ barrier summary – Sierra Leone

Sierra Leone

LIC

Western Africa

Core

### High performing

- ART coverage high
- TB case notification dipped during C19 but rebounded
- Successful switch to MDR-TB treatment and guidelines in place
- Strong HIV/TB integration- testing and prevention in one stop shops
- Malaria incidence and mortality has declined since 2018 with the use of CHWs, PBO nets in GC5, and introduction of PMC
- ACT treatment and testing high
- High net usage

### Enablers

- Interventions aligned with NSPs, relevant and evidence-based
- Focus on commodities & scale-up of innovation appropriate
- Roll-out of DHIS2, improvement in data completeness
- M-supply introduced
- Some progress on laboratories and oxygen systems due to C19RM
- Global Fund dialogue works well, strong engagement of KPs and CBOs in process
- Support of BDB MF has increased focus on HR, catalysed five-year Strategy for Human Rights
- Gender given more of a focus in GC7
- Progress regarding donor coordination across GCs
- Technical partners providing valuable TA (including development of FRs, absorption of C19RM)
- Improved process for securing co-financing observed in GC7, engagement with key decision makers

### HIV

- Improvements in PLHIV knowing status, but overall low
- PMTCT and EID testing low
- KP Prevention services barely implemented in GC6 due to swapping of PRs
- Viral Load testing coverage low

### TB

- 5000 TB cases remain undetected annually
- Challenges in MDR-TB testing
- Prevention services for TB extremely limited

### Malaria

### Low performing

### GF funding & processes

- Implementation arrangement challenges (IHPAU/PMU, PR selection) leading to low absorption
- Response to fiduciary risk (e.g., swap of PRs) further impacted on implementation
- More proactive oversight needed

### Barriers

### Health systems & data

- Health system weaknesses a risk to HTM programmes, including laboratory specimen transport, data quality & use, procurement & supply-chain
- Lack of coordination amongst RSSH components as well as disease components

### KVP / community engagement

- Major disruptions to KVP services due to change in PR
- Integration of CLM and community-based data a challenge
- CHW update ineffective in design and implementation (training and payment delays)

### Partnerships & funding landscape

- IHPAU meant to optimise financial management for donors & improve collaboration, but led to implementation challenges
- Co-financing requirements only partially met, policy considered to ambitious
- Room to improve strategic coordination/ joint investments

### Country context & governance

- Inflation and exchange rate depreciation
- National procurement law and customs clearance
- COVID-19 especially disruptive for TB services

Figure K.12: Enabler/ barrier summary – South Sudan

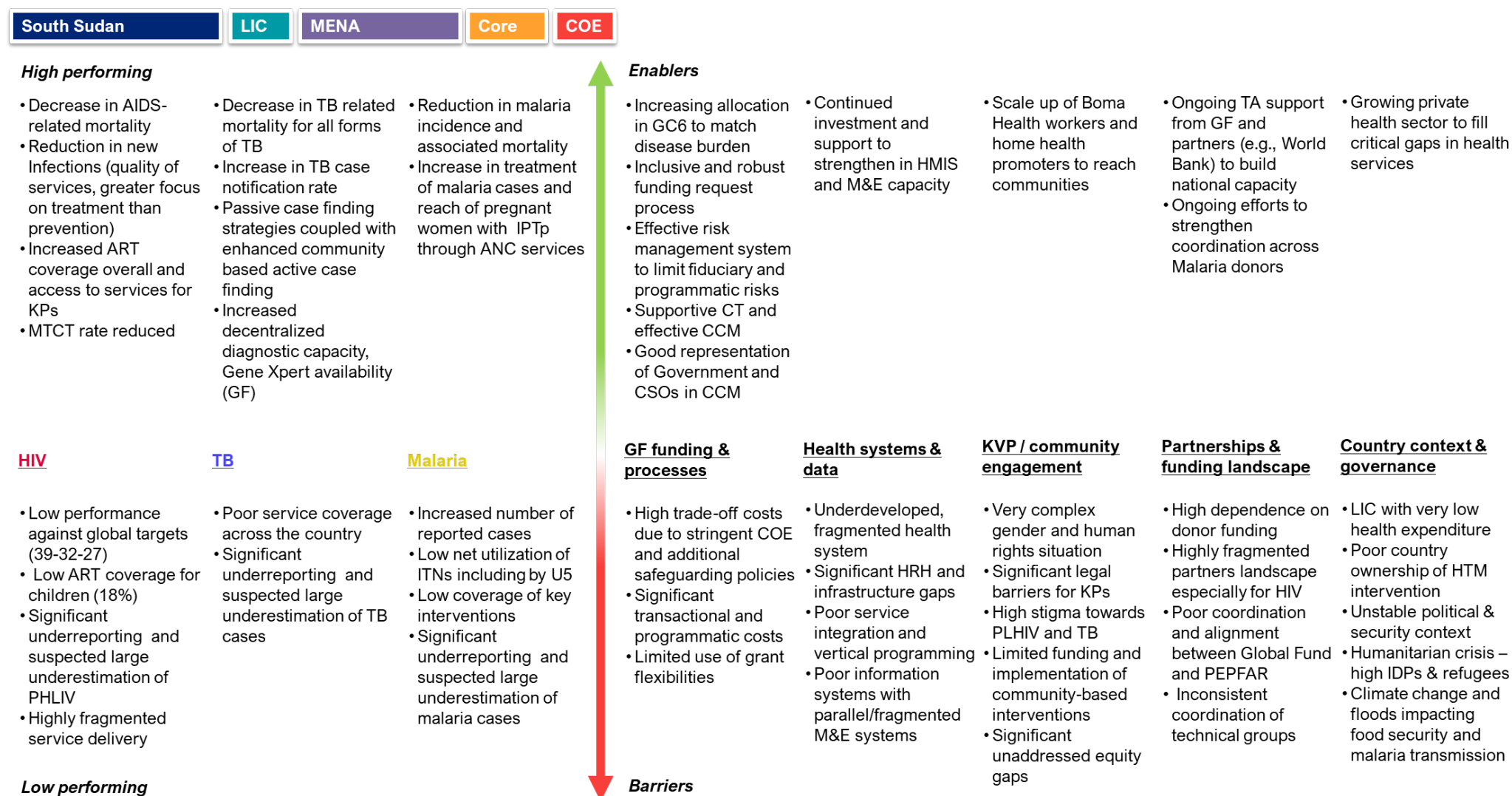


Figure K.13: Enabler/ barrier summary – South Africa

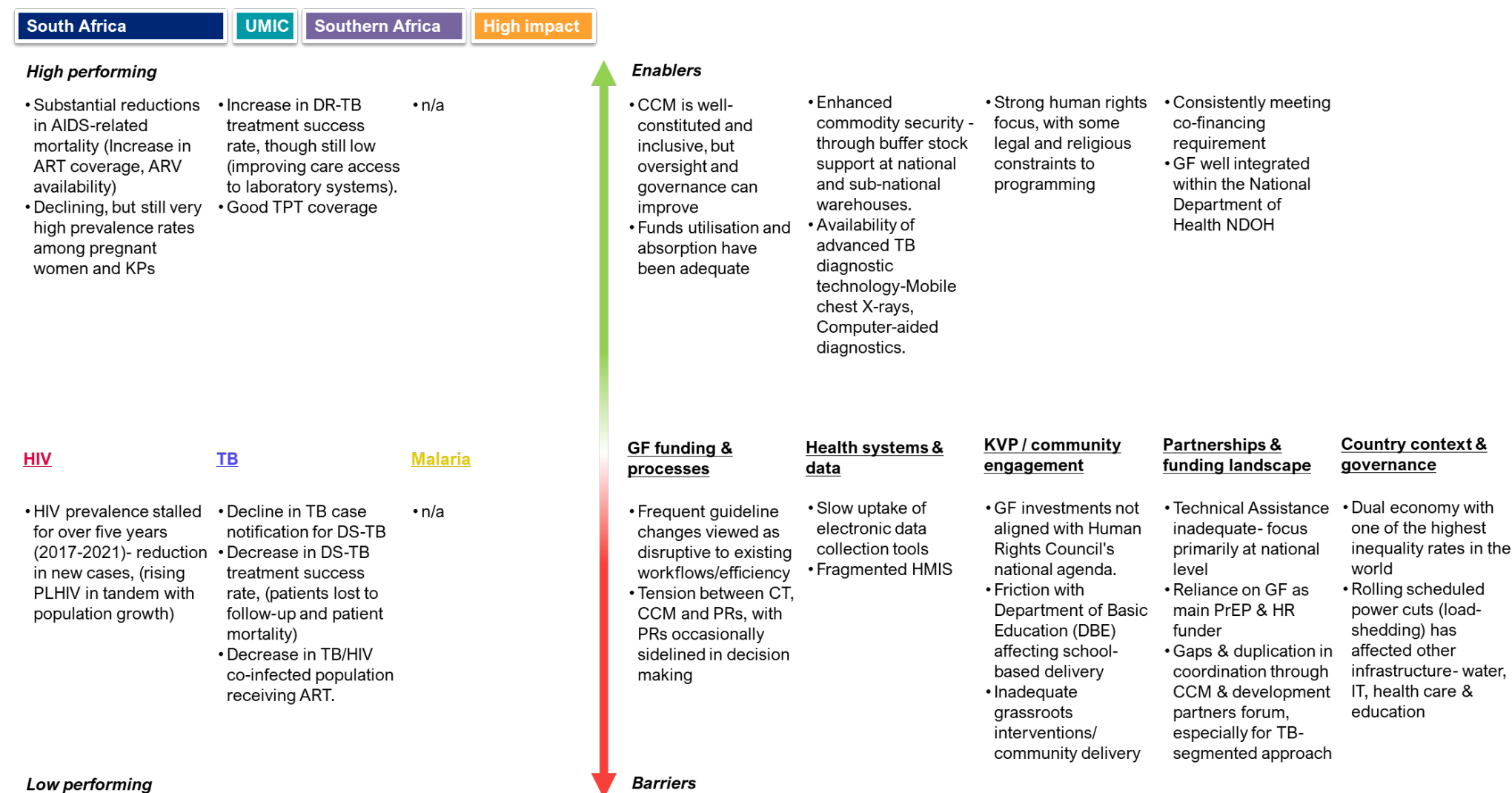


Figure K.14: Enabler/ barrier summary – Zambia

Zambia

LIC

Southern Africa

High impact

**High performing**

- Achieved 90:90:90 targets. ART coverage increased (enhanced adherence counselling, ART multi-month dispensing and ART home deliveries)
- Significant increase in TB case notification for DS-TB and DR-TB (improved community testing and diagnostic capacity)
- Increased treatment success rate for MDR-TB (decentralization of treatment centers, nutrition support)
- Good performance for preventative TB (inaccurate TPT denominator estimates/changing calculations)
- Reduced mortality (increased access to prompt diagnosis and treatment via expanded CHW workforce)

**HIV**

- High prevalence among KPs & AYP with inadequate programming (access to friendly services; stigma)
- VMMC coverage seems stalled or at saturation point (facility delivery in favour of past community outreaches)

**Low performing****TB****Malaria**

- Low IPTp coverage (ANC quality)
- Increasing malaria burden (Climate change, Covid-19 and changes in vector control tools)

**Enablers**

- CCM evolution increased efficiency
- Robust bottom-up approach, with sub-national community level engagements
- Funds utilisation and absorption have been adequate
- Integration of TB reporting into DHIS2
- Improved TB surveillance- utilizing situation room
- Increased commodity security - warehouse expansions/hubs
- HRH recruitments CHW and Nurses
- DR-TB treatment decentralisation
- Better equipped labs - GeneXpert & oxygen procurement
- Good HRG programs design, limited implementation
- Improved Civil Society Organizations visibility and voice
- Consistently meeting co-financing requirement
- Better coordination amongst malaria partners (Global Fund, PMI, Rotarians, PATH) - digital work planning tool, and annual harmonisation exercises

**GF funding & processes**

- CSO led decision making in CCM, less prominent partner voices

**Health systems & data****KVP / community engagement**

- Legal and religious context - challenges KVP engagement and AYP in HIV
- No CRG assessment
- No interventions to address inadequate legal frameworks
- KVP HIV programming primarily health facility based, limited community delivery

**Partnerships & funding landscape**

- Heavily reliant on GF for national TB program
- Limited visibility across health sector partners
- Some duplication with PEPFAR
- Limited partner support for TB

**Country context & governance**

- Rising debt levels
- Significant HRH gap
- Religious & cultural context impacts HIV prevention/KP services
- Climate change-heavy prolonged rainfall altering malaria profile

**Barriers**



### iii) WS3: Sustainability and co-financing

This Appendix provides further evidence for the Sustainability and Co-financing Section in the main report (Workstream 3, Section 6.2). This includes an overview of Gavi's co-financing approach in Box L.1 and further evidence from the country case studies on co-financing and other DRM levers in Box L.2.

#### Box N.1: Overview of Gavi's co-financing approach

Gavi's Co-financing Policy was established in 2007 and the key feature includes the requirement for countries to co-finance a portion of the vaccine commodity costs. The co-financing requirements are determined by transition status (which is determined predominantly by GNI per capita) and start to increase annually once countries are in the preparatory transition phase (i.e. countries above the World Bank's low-income threshold).<sup>29</sup> The co-financing approach by Gavi was considered by stakeholders to be a successful design that was considered to be simple and with high compliance of countries.<sup>30</sup> While the policy and operational context of the Global Fund is not directly comparable to Gavi and an exclusive commodity approach would not be appropriate for the Global Fund, there are a few features of Gavi's co-financing approach which have worked well and offer insights for the Global Fund:

- *Strong data quality due to the commodity payment approach allows for more effective enforcement of the policy.* The use of actual transaction and invoices from countries means Gavi has a very clear view on what countries have paid. The good data quality has been key for Gavi to apply its Co-financing policy with rigor and have stronger conversation with countries in case they are in default.
- *Policy does not provide an incentive but has a clear mechanism to withhold support in case countries are in default.* The strong data quality and a clear process on withholding funding allows Gavi to enforce its Policy more effectively – they also clearly track and communicate once countries are in default. There are clear steps to escalate the situation (including withholding support) but also a mechanism for a country to clear its past arrears to move forward. This coupled with clear processes on applying for waivers and exceptions in case countries cannot pay the requirements.
- *Gavi's increase in co-financing requirement is not linked to spending in previous allocation cycles and instead is based on overall commodity payments and country transition status.* The proportion that a country needs to cover of its total commodity costs increases gradually over time depending on its transition status (and the length it has spent in each transition phase) ensuring that countries are gradually build up to absorb the full costs by the time they are transitioning. This leads to highly differentiated co-financing requirements which are linked to the aim of phasing out Gavi support over time and ensure that overall requirements remain realistic for countries and do not compound across allocation cycles.
- A limitation of Gavi's approach is the lack of consideration non-commodity spending including HSS and the fact that there is no incentive to increase overall health spending. The narrower scope of Gavi's Policy means there are no wider incentives to increase health spending, nor does it take account of other interventions needed outside of commodities.

Source: Evaluators assessment based on document review and consultation feedback

#### Box N.2: Insights on the use of DFH levers in country case studies

**Nigeria:** Co-financing payments have been a large challenge in Nigeria partly driven also by the federal system in which sub-national (state) level institutions are responsible for funding and service delivery decisions in their

<sup>29</sup> Although the latest Policy iteration approved in November 2022 instituted also a requirement minimum 35% co-financing threshold for countries to move from preparatory transition to accelerated transition phase.

<sup>30</sup> Other reviews support this assessment such as the Evaluation of Gavi's Eligibility and Transition and Co-financing Policies conducted by CEPA in 2019

jurisdiction, with state institutions managing 80% of the government budget, responsible for 90% of services, and managing 90% of HRH. The co-financing policy was largely considered helpful to start conversations and dialogue but ultimately insufficient in its current form. A key challenge has been the verification of actual expenditure towards HTM as well as an understanding by many stakeholders that the Global Fund will ultimately disburse their grant irrespective of verification. However, there have been recent improvements in the approach to co-financing which were largely welcomed and included an increase in advocacy (including with state governors) and a stronger focus on verification of funds (including through the use of World Bank loans).

**Zambia:** 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. Government stakeholders are very supportive of increasing domestic contributions, but there has been no clear transition plan by CCM and PRs of Global Fund's investment scope to the government.

**Mozambique:** The country was only able to contribute about 10% of the required HTM funding in GC6, it is largely dependent on external funding, with limited capacity to implement the co-financing requirement. Stakeholders also express the need for a differentiated approach to co-financing per the country's economic context.

**South Sudan:** South Sudan is likely to continue to face key challenges to mobilize domestic resource for health in the foreseeable future being a COE, 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 (\$620m in 2018/19) and an underdeveloped, fragmented health system, heavily reliant on donor funding. The country requires a differentiated approach to sustainability and has received a waiver for the malaria component in the past.

**Bolivia:** There has been progress in the co-financing of activities by the government, including for the purchase of commodities (ARVs, HRH, TB medicines, cartridges of diagnosis for GeneXpert in TB, Malaria medicines and RDTs). Stakeholders are aligned with increasing the country's contribution towards this transition process, with a goal to avoid a so-called "Global Fund-dependency."

**Sierra Leone:** Sierra Leone benefited from the "de-linking" approach recently implemented by the Health Finance Department that waived the requirement that HTM funding needs to be additional to domestic spending the previous cycle. This feature of the co-financing requirement led to unrealistically high commitments. There has also been a noticeable improvement during GC7 to include key decision-makers including from the MoF in the co-financing process which was welcomed by stakeholders.

**Kenya:** 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 is held by the National Treasury and procured through the national agency KEMSA. This poses a challenge for the government to meet annual co-financing commitments given slow procurement processes which create a lag in actual government expenditure for commodities. For GC7 co-financing expectations from the Global Fund are reduced to 15% (from 20% in GC5-GC6) to account for Covid-19 and other domestic fiscal challenges. 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.

**Côte d'Ivoire:** Côte d'Ivoire's health system is highly dependent on external donor funding, with the government contributing 5% to health spending as a proportion of GDP. A commitment to raise health spending by 15% annually made in 2019 has reportedly not been met, and there are frequent stock-outs of government-financed health commodities. However, the government has consistently met the 15% co-financing requirement in GC5 and GC6. During GC7 the Global Fund CT has made significant efforts to engage with the Ministry of Health, as well as the Ministry of Budget and Finance in order to improve the co-financing outlook and increase domestic financing for health. This includes ensuring that commitments are in line with 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.



iv) WS3: M&E

This Appendix was developed in support of the M&E section in the main report (Workstream 3, Section 6.4). Table M.1 presents the main M&E-related challenges described in SR2020, as well as the progress that has been made by the Global Fund to mitigate these challenges since. Table M.2 summarises the key M&E findings at the country level, based on analysis of country case studies.

*Table M.1: SR2020 identified issues with M&E and progress against challenges since*

Limitation	SR2020 Findings	Progress since SR2020
MEL integration	<ul style="list-style-type: none"> <li>Activities take place at multiple levels and involve more than 12 functional areas of Secretariat and are not well integrated.</li> <li>Evaluations (Secretariat and TERG) are particularly uncoordinated.</li> <li>Connection between KPI Framework, Performance and Accountability Framework, and grant-level performance frameworks is limited.</li> <li>Ad hoc approach to monitoring catalytic investments and TA</li> </ul>	<p>(+) The Global Fund Board approved an M&amp;E Framework and Multi-Year Evaluation Calendar in 2022 representing an integrated framework and greater emphasis on learning. In particular, (i) the framework articulates the interlinkages and complementarity between the different types of M&amp;E approaches used by the Global Fund: strategic monitoring, strategic and thematic evaluation, programme monitoring and Secretariat monitoring; and (ii) the framework specifically describes how learning is assured for each of these components, detailing roles and responsibilities.</p> <p>(+) The programmatic monitoring department and the risk department were restructured to sit within a joint programmatic monitoring and risk department.</p> <p>(+) The new Global Fund's M&amp;E Framework also formalises the Global Fund's approach to monitoring catalytic investments. For Matching Funds and Multicountry Funds, these are integrated into or guided by the grant performance frameworks, and for Strategic Initiatives these are tailored to the specific measurement needs of investment priorities.</p>
Approach to learning	<ul style="list-style-type: none"> <li>Learning culture not yet embedded, lack of systematic approach to lesson-learning and sharing (especially for evaluations)</li> </ul>	<p>(+) A new evaluation model was implemented in 2023. Independent evaluation is now delivered by an Evaluation and Learning Office (ELO) based within the Office of the Executive Director (OED) while the Independent Evaluation Panel acts as an advisory group to provide assurance as to the quality and independence of evaluation activities. The new model addresses specific pain points in the previous model: (i) the Evaluation Unit strengthens coordination by identifying and consolidating learning needs across the organisation; (ii) the multi-year calendar and IEP review ensures relevance and utility of evaluations; (iii) dedicated staff drive learning dissemination and the OED is responsible for a timely and action-orientated management response and (iv) improved timeliness to ensure recommendations are relevant and can feed into upcoming Global Fund processes.</p>
Gaps in M&E coverage and	<ul style="list-style-type: none"> <li>Significant gaps and limitations related to RSSH and HRG (at organisational and grant level)</li> <li>Other key gaps related to innovation and differentiation, and partnerships which are not</li> </ul>	<p>(+) Following extensive review<sup>32</sup>, KPIs have shifted to better reflect grant achievements, improving integration with grant-level M&amp;E as well as accountability for performance. A key change has been to link the KPI2 service delivery indicators to the Global Fund grant portfolio performance rather than using modelled targets. Of all metrics, 49% track Global Fund-supported programme performance, 42% track global and in-country performance, and 9% track Global Fund operational performance- a notable shift from the 2017-2022 Strategy period.<sup>33</sup> Additionally, many indicators</p>

<sup>32</sup> Including the SR2020, the 2019 OIG audit on KPIs and internal assessments including a review and online survey

<sup>33</sup> KPI 2023-2028 Handbook

Limitation	SR2020 Findings	Progress since SR2020
performance measure <sup>31</sup>	<p>systematically incorporated in the MEL system.</p> <ul style="list-style-type: none"> <li>• Shift in Global Fund's MEL focus from operations to global outcomes and impacts in 2017-2022 KPI Framework was made for good reasons, but had consequences for accountabilities and incentives for performance across the partnership.</li> <li>• At the level of individual grants, performance ratings are a key part of annual funding decision process but largely assessed based on national level indicators and targets.</li> <li>• Extent to which grant rating exercise provides a performance sanction or incentive is unclear</li> </ul>	<p>criticised due to either design challenges (i.e., not addressing accountability or actionability) or methodological and data challenges have been replaced or updated (see Appendix G). Further, under the new KPI Framework there is stronger focus on the measurement on RSSH and health equity measures including gender quality and human rights.</p> <p>(+/-) Improvements have also been made to the modular framework, including development of specific RSSH and HRG indicators. In particular, rather than measuring RSSH investment inputs and outputs isolated from HTM, there is now a stronger focus on measuring integrated and people-centred quality service outcomes linked with HTM results.<sup>34</sup> These indicators are closely aligned to the areas in which the Global Fund invests and provide an accountability measure. RSSH indicators are captured outside of routine data systems through targeted health facility assessments and other modes of data collection.</p> <p>(+) The Global Fund introduced a new grant performance rating in 2021. A key difference was to move away from a single rating to three distinct ratings including: (i) programmatic rating, (ii) financial ratings and (iii) principal recipient ratings (rolled out in 2023).<sup>35</sup> This distinction allows greater focus on grant specific performance rather than just national programme performance, increasing accountability of the Global Fund processes.</p>

<sup>31</sup> This table merges SR2020 limitations (iii) gaps in M&E coverage and (iv) incentivization of performance due to overlap in measures adopted to address these.

<sup>34</sup> Global Fund Modular Framework 2023-25

<sup>35</sup> Global Fund (2022). Updates to the PU/DR Process and Performance Rating

Table M.2: M&E findings from country case studies

Country	Indicators and targets	Data availability and use
<b>Bolivia</b>		<p>(+) national HMIS strengthened (SNIS)</p> <p>(-) System highly fragmented, parallel systems supported by GF, PRs, and partners to collect disease specific data (e.g. standalone system 'SIMONE' supports HIV indicators and is funded by Global Fund, most TB data collected through SNIS but some indicators collected through manual system, and UNDP supports M&amp;E for malaria but unclear integration with SNIS)</p> <p>(-) persistent use of paper-based/ hybrid systems reduce interoperability and increase chances of error</p> <p>(+) recent efforts through Global Fund SI in partnership with PAHO, to strengthen national and sub-national data-driven decision making and consolidate data collection</p>
<b>Chad</b>	<p>(+) good alignment between indicators in PF and NSPs</p> <p>(+) target-setting negotiation viewed positively, as a way to encourage ambition</p>	<p>(+/-) Global Fund has supported DHIS2 roll-out, capacity-strengthening, data quality assurance, and digitisation of LMIS, although there have been delays</p> <p>(-) DHIS2 does not fully integrate HIV and community-based data, and parallel data collection mechanism created for community-based data</p> <p>(-) absence of disaggregated and sub-national data in order to guide supervision/ decision-making</p>
<b>Côte d'Ivoire</b>	<p>(+) PF indicators relevant and aligned with NSPs</p> <p>(-) challenges in defining new HR and GE indicators</p> <p>(-) targets perceived as overly ambitious, and imposed by Global Fund with limited flexibility for country stakeholders to adjust during implementation</p>	<p>(+) Significant investments made to support roll-out of DHIS2, including integration of data from HTM programmes and community-based data</p> <p>(+/-) Quality, completeness and coherence of reporting requires further improvement, Global Fund has supported data review workshops, and governance</p>
<b>India</b>	<p>(+) Disbursement of Global Fund investment is linked to the achievement of specific programmatic results through defined Disbursement Lined Indicators- government reports yearly on achievement of DLIs based on national HMIS</p>	
<b>Kenya</b>	<p>(+) PF aligned with national programmes and reporting priorities</p> <p>(-) Indicators important for the programme delivery but not in the PF are not consistently reviewed and acted upon to improve performance</p> <p>(+/-) most targets set based on NSPs, but some stakeholders report targets are not rigorously set based on data from previous funding cycles, or population estimates</p>	<p>(+) Significant investments in strengthening HMIS including through digitisation, data quality assessments, and scale-up of CLM</p> <p>(-) CLM in need of further strengthening</p>
<b>Kyrgyz Republic</b>	<p>(-) KPI targets and indicators viewed by some stakeholders as inflexible and not reflective of the evolution of the epidemic and programme models (e.g. targets for coverage of PWID by OST were considered not feasible)</p>	<p>(+) State ownership and capacity to conduct reporting and M&amp;E functions have been strengthened, by attracting leading state specialised institution for HIV and TB as SRs of the Global Fund grant</p>

Country	Indicators and targets	Data availability and use
	<p>due to significant decrease in use of opioids as a drug of choice)</p> <p>(+) shift to annual PR reporting supports greater focus on grant implementation, although concerns that this will reduce attention on semi-annual performance reporting</p>	
<b>Mozambique</b>	(+/-) M&E performance framework viewed as appropriate by stakeholders but significant gaps in their implementation due to resource gap	(-) Significant imbalance in resource allocation to M&E, less than 2% of investment (has resulted in issues such as inadequate community-based monitoring, paper-based medical records, inadequate monitoring of supplies and medicines, etc.)
<b>Nigeria</b>	<p>(-) Absence of specific indicators to measure RSSH progress</p> <p>(-) Inadequate denominator estimates on which to base programme targets due to poor routine data quality and outdated surveys, targets based on performance rather than disease burden (TB especially)</p> <p>(-/+ ) difficulty in delineating result of Global Fund investments from other donor contributions, expected to improve with establishment of common national targets and clear delineation of GF-specific targets in PR performance framework</p>	<p>(+/-) Global Fund M&amp;E requirements are aligned with country systems, although systems remain varied with parallel data management systems. Due to historically higher investments, HIV data is better collated through HMIS and EMR systems. Recent efforts to digitalise and integrate malaria programme's M&amp;E systems.</p> <p>(+) Reporting and programme review processes robust, Global Fund partners reporting portal recently established</p>
<b>Philippines</b>	<p>(+) The performance framework is reported to be "overall clear and reasonable"</p> <p>(-) Concern among some that Global Fund data needs have grown over time, without clarity of added-value</p> <p>(+) M&amp;E targets are reportedly well-aligned with country targets, with flexibility to adjust depending on the budget available</p> <p>(-) concern that 'real story' of progress not captured, given limited reporting around context</p>	<p>(+) recent shifts to strengthen data management and boost digitisation, under leadership of Epidemiology Bureau. Plans underway to improve data cleaning processes, access to data via dashboards, and LMIS.</p> <p>(+/-) progress has been made in relation to integration and strengthen of HIV data collection, but TB data systems remain weaker (including case tracking)(-)</p> <p>Challenges related to data quality, timeliness and access, in part because of lack of human resources (e.g. poor quality of KP disaggregated data). This in turn limits data-driven decision-making. Recent restructuring of Department of Health has also impacted data ownership and use.</p>
<b>Sierra Leone</b>	<p>(+) health outcomes and impact indicators of Global Fund considered well-aligned with national reporting requirements</p> <p>(+) overall level of ambition of targets considered fair, and target-setting process adequate</p> <p>(-) underlying population estimates inaccurate, limiting target-setting</p> <p>(-) some new additions to PF considered burdensome for countries- data disaggregation and new RSSH indicators</p>	<p>(+) Improvements in use of national DHIS2 for HMIS</p> <p>(-) Gaps remain including limited integration of community data into DHIS2, limited data quality for commodity consumption (recently improved through M-Supply) and paediatric health outcomes, and data use nationally and sub-nationally</p>
<b>South Africa</b>	<p>(+) M&amp;E requirements are aligned and coherent with national M&amp;E systems</p> <p>(+) rigorous target-setting process, well-aligned to national strategies and plans</p> <p>(-) frequent amendments to Global Fund's tools and frameworks disrupt workflows</p>	<p>(-) country has several data systems with limited alignment or interoperability</p> <p>(-) Stakeholders report grappling with the task of selecting and reporting indicators, primarily due to constraints in data availability/ fragmentation</p>

Country	Indicators and targets	Data availability and use
	(-) view that PF limited only to health indicators does not holistically capture programme's impact	(+) recent efforts by donors and government to address challenge include development of National Digital Health Strategy, scale-up of Health Patient Registration System, and migration to web-based DHIS2
<b>South Sudan</b>	(-) target selection limited because of inaccurate population/ disease prevalence estimates	<p>(-) inadequate design, operational capacity and infrastructure of M&amp;E systems a key risk – key surveys have not been conducted since 2011.</p> <p>(-) Global Fund and partners continue to implement and fund parallel reporting systems which are not consistently integrated in the national M&amp;E system</p> <p>(+) Global Fund has been investing in strengthening HMIS and funding data staff positions- includes support for key surveys, national programme reviews, and joint programme supervision</p>
<b>Zambia</b>	<p>(+/-) Global Fund investments mainly implemented through national M&amp;E systems, except in some instances when national system does not collect required indicators (in which case parallel system implemented)</p> <p>(+/-) most data manually integrated into the national M&amp;E system, except KP data which is collected by PEPFAR and uses a parallel NAC database due to legal constraints</p> <p>(+) flexibility in reporting timeline and process</p> <p>(-) frequent changes in reporting processes (e.g. disaggregation) without retraining</p> <p>(+/-) robust target-setting, but limited by inaccurate population/ disease burden estimates</p>	(+) Global Fund investments have supported M&E innovations, including digitisation. However, gaps in operationalisation of these innovations.

v) *WS3: Progress made against SR2020 recommendations*

This Appendix supports Section 6.5 in the main report (Workstream 3), on learnings from SR2020 and their contribution to transition planning for the 2023-2028 Strategy period. Table N.1 presents Global Fund progress against SR2020 recommendations.

Table N.1: SR2020 recommendations, management response, and evaluator assessment of progress

SR2020 recommendations	SR2020 management response (excerpts relevant for SR2023 assessment)	Progress and assessment
<p><b>Immediate recommendations</b></p> <p><b>1.Start now to strengthen the processes by which geographies, populations and intervention mixes are prioritized in National Strategic Plans (NSPs) and Funding Requests to ensure that Global Fund investments are evidence based and reflect an appropriate balance across the SOs, value for money (VfM) criteria and organizational theory of change (ToC).</b></p> <p>Operational Recommendations for current strategy period:</p> <ul style="list-style-type: none"> <li>• 1.1 Establish mechanism to action TRP recommendations and track follow-up</li> <li>• 1.2 Assess extent technical partners are able to provide capacity support</li> </ul> <p>Operational recommendations for next period:</p> <ul style="list-style-type: none"> <li>• 1.3 Work with technical partners to strengthen support for development of NSPs</li> <li>• 1.4 Refine funding model to ensure prioritisation decisions based on solid evidence and analysis, including VfM criteria</li> <li>• 1.5 Use CI selectively in areas with clear added value</li> </ul>	<ul style="list-style-type: none"> <li>• OR 1.3 Secretariat examining how systematic approach to Programme Reviews can include review of underlying NSP</li> <li>• OR 1.4 Secretariat committed to intensifying efforts related to VfM- framework for VfM under development</li> <li>• OR 1.2 SR2020 made several recommendations related to strengthening country and technical partner capacity- however recommendations need to consider larger landscape (e.g. not GF mandate to assess technical partner capacities)</li> </ul> <p>Many recommendations have been actioned upon or will be considered in next strategy period</p> <ul style="list-style-type: none"> <li>• OR 1.1 TRP recommendations systematically tracked through internal data systems</li> <li>• OR 1.3 SI on Sustainability, Transition, Efficiency working with technical partners to support prioritisation in NSPs and funding requests</li> <li>• OR 1.5 Secretariat agrees that catalytic investments should be more selective</li> </ul>	<ul style="list-style-type: none"> <li>• (+/-) this evaluation finds that evidence-based prioritisation of funding requests has improved over time, although there are still gaps (SR2023 Finding 1.5)</li> <li>• (+) Guidelines over successive funding rounds have improved and provided more clarity and direction, and in particular, GC7 has introduced Program Essentials (SR2023 Finding 3.1)</li> <li>• (-) VfM framework is still weak and challenging to implement (SR2023 Finding 1.5)</li> <li>• (+) improvements in SI selection process (SR2023 Finding 5.1)</li> </ul>

SR2020 recommendations	SR2020 management response (excerpts relevant for SR2023 assessment)	Progress and assessment
<p><b>2. Strengthen the partnership's focus on achieving results as a priority during the remainder of this strategy period, as the basis for enhancing impact from the start of the next strategy period. This should include establishing strong incentives to enhance performance across the business model.</b></p> <p>Operational Recommendations for current strategy period:</p> <ul style="list-style-type: none"> <li>• 2.1 Develop MEL framework</li> <li>• 2.2 Strengthen processes to manage VFM</li> <li>• 2.3 Strengthen tools to manage direct service providers</li> <li>• 2.4 Reform grant-rating and funding-decision processes to strengthen incentives</li> <li>• 2.5 Continue to address organisational disincentives to proportionate risk-taking</li> <li>• 2.6 Strengthen CCM</li> <li>• 2.7 Study implications to business model of working across different contexts/ different needs</li> </ul> <p>Operational recommendations for next period:</p> <ul style="list-style-type: none"> <li>• 2.8 Consider new grant modalities with longer-time horizons on grant agreements</li> <li>• 2.9 Build on and consider relevant activities for new strategic MEL framework at corporate level</li> <li>• 2.10 Ensure Secretariat resourced to meet evolving demand</li> </ul>	<ul style="list-style-type: none"> <li>• OR 2.5: Secretariat agrees with need to address organisational risk-taking disincentives, but shift would require alignment with Boad/ OIG</li> <li>• OR 2.8 Does not agree with recommendation to consider new grant modalities and longer implementation periods (allocation model, NSP and programme continuation application modalities should allow for longer-term planning horizons)</li> </ul> <p>Many recommendations have been actioned upon or will be considered in next strategy period:</p> <ul style="list-style-type: none"> <li>• OR 2.8 CCM strengthened through CCM Evolution SI</li> <li>• OR 2.1 Comprehensive M&amp;E framework and evaluation calendar developed</li> </ul>	<ul style="list-style-type: none"> <li>• (+) New MEL framework developed and grant rating approach reformed (SR2023 Finding 3.7)</li> <li>• (+/-) New Health Financing Department in place with greater emphasis on VFM but more progress needed (SR2023 Finding 1.5)</li> <li>• (-) Incentives and risk taking appear to still be a problematic are in some regards as flagged in this evaluation (SR2023 Finding 3.3 and 3.6)</li> </ul>
<p><b>Recommendations for next strategy</b></p> <p><b>3. Strengthen the Global Fund's ability to adapt to the range of possible contexts that it might operate in post COVID-19, which should be an important new emphasis in the next strategy.</b></p>	<ul style="list-style-type: none"> <li>• Recommendation too broad and lacks specificity to be operationalised</li> <li>• Secretariat agrees on need for continued flexibility without detracting from HTM response, for partnership to respond to C19 and other potential infectious disease threats</li> </ul>	<ul style="list-style-type: none"> <li>• (+/-) PPR as an evolving objective with more work ongoing in the area (as per Strategy 2023-28)</li> </ul>

SR2020 recommendations	SR2020 management response (excerpts relevant for SR2023 assessment)	Progress and assessment
<ul style="list-style-type: none"> <li>Development of the next strategy should include a significant focus on testing the resilience of the GF strategy and business model under multiple scenarios. Scenario planning should be incorporated in the process of developing the next strategy.</li> </ul> <p><b>4. The current SOs 1, 2 and 3 should remain at the forefront of the next strategy. However, the next strategy should make it clear that the SOs are mutually dependent with each critical to achieving the other. The business model should adapt to shift the priorities within each SO and enhance coherent management across the three SOs.</b></p> <ul style="list-style-type: none"> <li>SO1 – prevention, equity, KVPs focus</li> <li>SO2 – what is realistic for the GF to achieve and where it should link with others, whether current operational objectives are relevant and necessary, whether new areas like global health security might merit inclusion</li> <li>SO3 – increased focus, drawing lessons from the catalytic investments</li> </ul> <p>Operational recommendations for next period:</p> <ul style="list-style-type: none"> <li>4.1 Develop ToC to clarify and articulate how Global Fund partnership will achieve the SOs</li> </ul>	<ul style="list-style-type: none"> <li>Secretariat has already designed and rolled out C19 disruption monitoring tools</li> </ul>	<ul style="list-style-type: none"> <li>(+/-) Improved delineation in strategy document although different views on HTM for RSSH or RSSH for HTM continue (as per Strategy 2023-28, SR2023 Finding 1.4)</li> <li>(+/-) New strategy 10 key changes highlight some of the priorities by SO identified in the review. However “coherent management” (as noted in the SR2020 recommendation) across the three remains to be seen and cannot be assessed by SR2023</li> <li>Prioritisation impacted by available funding and Board-determined priorities.</li> <li>TOC developed for new strategy (as per Strategy 2023-28)</li> </ul>
<p><b>5. For the next strategy, position programmatic and financial sustainability for the three disease responses as a high-level strategic priority and ensure mechanisms are in place to operationalize this priority.</b></p> <ul style="list-style-type: none"> <li>Making sustainability an SO/ overarching goal</li> <li>Coherent rather than siloed approach required</li> </ul>	<ul style="list-style-type: none"> <li>OR 5.1 Secretariat shares TERG’s ambivalence on this recommendation, agrees on importance of sustainability but has reservations around making this a self-standing strategic objective</li> <li>OR 5.2 Differentiation already central pillar of Global Fund strategy, strategies for further strengthening differentiation an important ongoing discussion for strategy development</li> </ul>	<ul style="list-style-type: none"> <li>(-) Greater capacity in new strategy period but further areas for improvement needed (SR2023 Finding 3.4 and 3.5)</li> </ul>



SR2020 recommendations	SR2020 management response (excerpts relevant for SR2023 assessment)	Progress and assessment
<ul style="list-style-type: none"> <li>• Broadening definition beyond three diseases – implies clarification on RSSH</li> <li>• Changes to business model – prioritization of strengthened CSO and community led systems, investments for KVP and prevention, addressing HRG and inequity, strengthening health systems</li> </ul> <p>Operational Recommendations for current strategy period:</p> <ul style="list-style-type: none"> <li>• 5.1 Strengthen and expand the key ‘pillars’ of work on sustainability across the portfolio, differentiated by country positioning along the development continuum.</li> </ul> <p>Operational recommendations for next period:</p> <ul style="list-style-type: none"> <li>• 5.2 Further embed differentiation throughout the business model to ensure that context sensitive approaches are utilized to achieve all four SOs.</li> </ul>		

#### vi) WS4: C19RM

This Appendix is in support of Report Section 7.2 (Workstream 4, C19RM). Box O.1 provides examples of C19RM investments contributions to mitigating the impact of COVID-19 on HTM programmes, based on country case studies included in C19RM Board Updates.

##### **Box O.1: Examples of C19RM investments contributing to mitigating the impact of COVID-19 on HTM**

- Nigeria HIV program maintained a steady upward trend in enrolment on ART achieving 85% coverage in 2020. This is attributed to a vibrant partnership with PEPFAR and the government that prioritises data-driven planning alongside programmatic adaptations with a robust operating infrastructure anchored on the community. There was an increase in multi-month dispensing in 2020 which supported the access to treatment. (C19RM Board update, Jan-Feb 2022)
- Majority of the C19RM funds for HTM mitigation in Nigeria were focused on TB. Data on TB case notification shows a steady increase from 13% from 2018 to 2019 to 15% from 2019 to 2020 and a 50% increase from 2020 to 2021. This is viewed as attributable to implementation of evidence-based and targeted strategies that were set in motion in the 2017-19 cycle as well as a speedy roll out of programmatic adaptations during the pandemic. During the pandemic, the TB programme saw an expansion of service delivery, strong program leadership, optimisation of the use of Cepheid's GeneXpert molecular testing system as well as greater private sector and community-based notifications. There was also good TB-COVID integration with integrated outreach services, social mobilisation for TB and COVID, bi-directional screening and diagnosis, joint government department working and upscaling of community services. (C19RM Board update, April 2022)
- Campaign adaptations were put in place for malaria to ensure successful completion, together with a robust evaluation to understand, document and share experiences on usefulness and costs. (C19RM Board update, July 2022)
- In South Africa, majority of HTM mitigations funding was focused on HIV, where it was reported that agility and flexibility of the mechanism supported needed programme adaptations. C19RM funding was used to expand innovative differentiated service delivery modes and community-based services to ensure service delivery for KVPs and integrating TB-HIV and the COVID-19 response. There was also support for human rights and gender-based violence through scale-up of community-led monitoring. (C19RM Board update, April 2022)
- Liberia responded to COVID-19-related disruptions of prevention services (a 63% decrease between January and June 2020) by adapting service delivery to key populations. A pilot project of HIV self testing targeting female sex workers led to over 8,700 of them using rapid HIV self-tests and yielded a positivity rate of 3.4%. (C19RM Board update, July 2022)
- Cameroon succeeded in minimising COVID-19 disruptions on HIV service delivery and successfully increased its ART cohort by nearly 39,000 between 2019 and 2020. This was done through the early rollout and scale-up of differentiated service delivery methods such as multimonth dispensation of ARVs, community delivery of ARV through patient groups, and closer patient monitoring with psychosocial agents and community mediators. Rates of TB case notification have also increased steadily since December 2020, due to investments in support bidirectional screening, expanded use of Cepheid's GeneXpert molecular testing system, and service delivery adaptations to enable CHWs to take a greater role in case finding and contact tracing. (C19RM Board update, July 2022)
- In Burundi, effective cross-partner collaboration in support of campaign digitalization to help implementation of the campaign during COVID-19, leveraging support for other cross-disease interventions. (C19RM Board update, July 2022)
- In El Salvador, C19RM funds for HTM mitigation focused on innovative solutions to enhance delivery of HIV services for KPs and PLHIV and adapt TB activities. Despite a reduction by up to 42% in HIV testing among certain KP groups in 2020 compared to 2019, and a 32% reduction in TB case notifications in 2020 during the same period, El Salvador showed recovery to pre COVID-19 levels attributed to implementation of programme adaptations such as home delivery and multi-month dispensing, nutritional support for PLHIV and TB patients, outreach support to KPs, bi-direction TB and COVID-19 screening, and remote DOTS through C19RM funding. (C19RM Board update, April 2022)
- In Bolivia, PPE for malaria brigades/volunteers doubled-up as COVID-19 response teams. (C19RM Board update, July 2022)
- In the Philippines, C19RM was key in funding the Philippine's TB adaptive programme which enabled the National Tuberculosis Control Programme to ensure continuity and innovation for testing and treating TB patients. Innovations supported through the C19RM investment included bi-directional testing, Digital Adherence technology, TB case finding, sputum transport networks and telemedicine, which have succeeded in helping the Philippines regain lost ground. TB case notification which decreased by 50% from June 2019 to June 2021, has since recovered (still just under pre-COVID levels). (C19RM Board update, July 2022)

#### vii) WS5: Progress against CI terg recommendations

In this Appendix, we elaborate on the findings summarised in Table 8.2 of the main report reporting on progress against TERG recommendations for SIs and MCs.

**CI recommendation theme 1: Maintaining catalytic investments for areas adding value.**

*R1. Maintain MCs as a priority investment area for activities that demonstrably add value over and above what country grants can deliver to meet the Global Fund's SOs.*

**MCs:** The recommendation, whilst broad, has essentially been followed in that MCs have been maintained as a priority investment and follow the principles of CIs. This has been in the context of a lower allocation to CIs, and a shift in emphasis within the CI portfolio to MFs. However, while MC funding was relatively stable across GC5 and GC6 and saw declines from GC6 to GC7 from 25% to 21% of the overall CI portfolio, this was more modest than declines for SIs (39% to 26%). Another key driver for this decline was the discontinuation of some CI priorities in GC7 (either because they had achieved their catalytic effect or because they could be effectively funded elsewhere)<sup>36</sup>, specifically the TB MC approach, which was shown to have mixed grant performance and catalytic effect, and would therefore be better supported through other SIs, country allocations or alternative sources of funding. It is also worth noting that various CI priorities that could have been operationalised as MCs and may have been funded in higher replenishment scenarios were instead funded at lower levels or zeroed out based on the actual replenishment. Nevertheless, Some stakeholders raised concern that MCs appear to be generally a lower priority than SIs and MFs given the allocation for MCs is smallest and MFs the largest in GC7, which is seen as reflecting a shift to CI integration within country grants and recognition of the operational complexity and high transaction costs of MCs (discussed more below). The uncertainty of funding allocation for MCs 'cycle on cycle' can also be problematic for the planning of MCs (and indeed all CIs), including preparing exit strategies and strategic thinking around sustainability.

Stakeholder consultation and documentation review indicate however that if well targeted, MCs are seen to add significant value through boosting regional coordination efforts and enabling cross-country learning, and by addressing niche implementation gaps (i.e., strengthening regional laboratory capacity) which cannot easily be addressed through country grants. The Regional Artemisinin-resistance Initiative (RAI), for which a third phase, the RAI3-Elimination (RAI3E) programme, was approved for GC6 and GC7, is commonly put forward as a well-designed and effective MC. The RAI/ RAI3E has reportedly make solid strides in strengthening multi-country coordination and collaboration, including around surveillance, and through enabling funding of CSOs working in remote areas within the Greater Mekong Sub-region where it was politically challenging for the government to conduct activities and yet these were key areas key for combatting resistance.

**CI recommendation theme 2: Developing an agreed definition of 'catalytic'.**

*R1. Develop a clear, consistent, and shared definition of what 'catalytic' means, develop catalytic criteria that are measurable and relevant and define the expected impact.*

*R2a. Strengthen MC selection, prioritization, design and review processes by developing an agreed definition of 'catalytic' as applied to all catalytic investments that is used consistently across the Board, SC, GAC, TRP and Secretariat.*

**SIs and MCs:** The TERG thematic reviews for SIs and MCs (2021) proposed a definition of 'catalytic effect' which was approved by the Board for use and as part of CI prioritization for GC7. The definition was "as leading to one or more of the following operational criteria being met: More: incentivize increased funding from allocations to priority areas and/or additional funding outside of Global Fund; • New: initiate new or innovative activities for more efficient and impactful

<sup>36</sup> Global Fund: Catalytic Investments for the 2023-2025 Allocation Period. 47th Board Meeting (2022)

*programming; • Improved: enable more effective use of country allocations and coordinated responses for cross-border contexts; • Faster: accelerate implementation of specific priorities.”*

While the TERG reviews acknowledged that catalytic effect was “*hard to quantify*”<sup>37</sup>, the expectation coming out of the TERG review was seemingly that the definition would drive quantitative considerations and assessments around i.e., additional funding leveraged, effectiveness or efficiency of additional activities, a focus on innovation, or accelerated implementation. However, it has not been possible to produce data/ evidence in this way, and the definition does not link to an objective framework which can guide the assessment/ measurement of catalytic effect as such. Based on interviews with Secretariat members and our assessment, some other challenges are also noted:

- ‘Effectiveness’ must be seen differently for the three CI modalities as they are aiming to achieve catalytic effect in different ways (as outlined in the Approach section above);
- In practical terms, it is not usually feasible to ‘assess’ catalytic effect as there is no baseline measurement, comparators cannot easily be used and it is difficult to apply standardised metrics across variable CIs;
- The integration and complementarity of CIs with other grants would challenge any efforts to isolate their specific catalytic effect;
- Operational contexts can be complex, for example, cross-country working arrangements can both support and hinder progress under MCs – this context variability, and the contribution of CIs within that, can be hard to capture;
- The TERG recommendation and proposed definition suggests an intensive assessment and measurement effort which if attempted, may be intensive to the point of compromising value for money of CIs (given the large undertaking and effort required) and overall efforts to streamline CIs towards integration (including measurement efforts) with country grants; and
- The idea of also measuring ‘catalytic change and impact’ within a three-year timeframe, and for relatively small amounts of funds, has also been critiqued.

There remains some debate around what ‘catalytic’ is in relation to what CIs are trying to or realistically can achieve. Some Secretariat stakeholders suggested that the key value-adds of CIs for example are in implementing innovations or testing new approaches to extend reach of disease interventions, fostering active investor roles through profile raising of key technical priorities, boosting partner engagement through shaping funding commitments and other resources (such as technical assistance), as well as eventual boosts in domestic financing. Many of these aspects tend not be easily captured through existing measurement frameworks. Many country stakeholders also struggled to articulate the purpose of catalytic funding or describe with insight how they have been effective, though there seems to be general positive opinion in countries that they have been broadly useful in furthering progress as relating to the core investment.

Secretariat stakeholders appear to have usefully operationalised the definition by viewing it as a framework to inform the consideration and prioritisation of what should be funded and why i.e., *“the focus has been on nuancing the definition which can be summarised as ‘adding value over and above the county grant’ during the proposal process”*. The preparation for GC7 has seen a shift towards more investment-specific approaches to identifying catalytic opportunities and assessing their effect, and the recognition that *“catalytic effect can be small but represent*

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<sup>37</sup> (Global Fund update, SIs, 2021)

*important steps along the way to somewhere important.*” Key to this shift are also the Theories of Change (ToC) which were also recommended by the TERG and discussed below.

There are a multitude of examples of SIs and MCs which are considered to have been effective, and it is beyond the scope of this review to analyse these in depth, including catalytic outcomes or driving (or inhibiting) factors. The available data (documentation and stakeholder insight) suggests that **SIs and MCs which best demonstrate a catalytic effect are those with a strong focus on scaling up access to and utilisation of new, innovative or unique technologies and approaches at the country level, or which promote opportunity for cross-country collaboration, exchange and learning.** Examples of effective SIs include the RSSH SI, ‘Technical Support, South-to-South Collaboration, Peer Review and Learning’ implemented in GC5, which focused on strengthening partnerships, facilitating country leadership exchanges, enabling various effective technical support channels and sharing lessons around preparing countries in transitioning towards domestic financing. The SI, Breaking Down Barriers/ Human Rights (also a MF grant), was reportedly pioneering for its work in the scaling of programmes to address human rights and gender-related barriers to HTM services by enabling an increased investment in HR-related interventions across 20 countries. An MC example is already included above (RAI).

**CI recommendation theme 3: Strengthening criteria for prioritisation and selection of areas for catalytic investment.**

*R2. Put in place a stronger mechanism to identify a strategic and coherent set of issues for potential SI selection and prioritisation.*

*R2b. Strengthen MC selection, prioritization, design processes by estimating financial needs and resource availability, strengthening consideration of sustainability, and strengthening design through more robust risk matrices.*

**SIs and MCs:** Recommendations here emphasise stronger mechanisms and processes to guide the prioritisation and selection of issues for catalytic investment. Key changes through GC6 and in the planning of GC7 are outlined below:

***At the initial CI prioritisation stage***

- Documentation review and stakeholder consultation suggests that for GC7, using the CI prioritisation approach based on selection criteria set by the definition of ‘catalytic’ has worked well with some ongoing refinements to strengthen strategic focus. However, there was some suggestion from stakeholders that the framework is more focused on the ‘what’ and the ‘why’ rather than the ‘how’ in terms of how catalytic effect can be realised. It is also recognised that there is a need to ensure a consistent interpretation/ consideration of catalytic effect continues downstream into design and operationalization.
- Stakeholder consultations and documentation also suggest that Board approval time for CI priorities reduced over allocation periods, specifically 6 months earlier for GC6 and GC7 compared to GC5, which has enabled more time for CI design and implementation readiness.<sup>38</sup>

***At the CI operationalisation stage***

- The recommendations highlighted the need for fewer and more focused investments and in GC7, SI investments were reduced considerably (24 SIs in GC6 to 9 SIs in GC7<sup>39</sup>). From GC7, a limit is set whereby

<sup>38</sup> Global Fund (2019). 41st Board Meeting. Catalytic Investments for the 2020-2022 Allocation Period (GF/B41/03 – Revision 1)

<sup>39</sup> CI PMO team

no more than 4 SIs can be planned per country. A fewer number has enabled more streamlining and has helped address reports in earlier cycles of multiple, uncoordinated or overlapping SIs and thus more compromised engagement effort. The inclusion of fewer SIs in the allocation letters for GC7 has boosted their visibility, which is also seen as a key part of the catalytic process, given it raises the potential for follow-through to enhanced country partnership engagement and complementarity of investments from partners or domestic funding. For example, in Mozambique, there were eight SIs in GC5 which was described as “over -saturation” because there was less opportunity for effective engagement across all SIs.

- Since the onset of GC7, a detailed mapping of the proposed scope and geographic focus of SIs has been conducted, enabling a more focused review on regional feasibility, coherence and relevance of the SI portfolio. This has been supported by GAC approval of SI geographic prioritisation and inclusion of SIs in allocation letters.
- Linked to this, transparency in investment decisions on geographic prioritisation and country selection has also increased, which helps to raise country-level awareness of SIs, the breadth of SI eligibility, and later, SI implementation efforts.<sup>40</sup> There were mixed views however on the enhanced specificity of CIs generally in allocation letters. In the Philippines, there was appreciation of Secretariat-led CI scope-setting because it reduced the need for decision making at the country end at the application point, easing the process. In South Africa, it is suggested that this centralised decision making on eligibility limited broad-based stakeholder engagement in determining and putting forward CI investment priorities which may have enhanced their relevance to local context as well as country impetus to effectively drive/ implement the investments if approved.
- Since GC6, there has also been a live mapping of eligible countries by SI and countries are able to shift during implementation to respond to country demand.<sup>41</sup>
- The recommendation emphasis on linkage to SO objectives and robustness of the business case has also reportedly shifted focus towards prioritising and selecting CIs “*based on evidence of what is likely to work*”. Whilst it appears that SIs and MCs with a focus on innovation were among those which best demonstrated a catalytic effect, as discussed above, there were some concerns that in GC5, CIs were “*too focused on innovation*”, or were too detached from country grants. This has since boosted the resolve to streamline and link CIs more generally to country grant outcomes and driven by a scope defined by the Secretariat.

From the perspective of understanding the operationalisation of the definition of ‘catalytic’, it is useful to note that there are mixed views on the extent to which CIs do drive, or should be driving **innovation**, with some stakeholders of the impression that CIs do not take this opportunity far enough. Similarly, ‘innovative CIs’ are often seen as a contributor of incremental change on a larger change pathway (not always seen specifically in short grant cycles). In a similar vein, from the country end, numerous stakeholders (i.e., Nigeria, Philippines) discussed the tendency for country stakeholders to design grants that “*do more of the same*”, or “*just allow the country grants to go a bit further*”, rather than explore new approaches (as also discussed under workstream 3). In particular, interventions such as service delivery models and grant implementation arrangements that are well tested seem to be priorities for CI investment, across both SIs and MCs. This is not necessarily seen as negative - in South Africa for example, the SIs were described as a “*saviour*” for their agility as they enabled fast-tracking of resource deployment where it was most needed, in support of disease specific aims of the country portfolio. Across case studies, the appreciation of CIs tends to lie in their flexibility rather than enabling the planning for or driving catalytic change specifically.

The TERG recommendations also emphasise strengthening consideration of **sustainability** in CI (and particularly MC) selection and prioritisation. There are mixed opinions here on progress made. The Board has previously encouraged the development of sustainability plans for CIs with the aim of either being mainstreamed into country allocations or funded with domestic

<sup>40</sup> Global Fund (2022). Catalytic Investment Operationalization Strategic Initiative Geographic Prioritization

<sup>41</sup> The CI PMO maintains the tracker, but it is accessible across the Secretariat so that colleagues (namely GMD) can easily see which SIs their country is eligible for. Some SIs have a defined set of countries where they implement; while other SIs may be designed to be responsive to country requests as they arise.

resources.<sup>42</sup> At the priority level, proposals also include a section on sustainability. While steps have been made to integrate CI funding with country grants, the transfer to domestic finances continues to prove challenging. Within SI investment plans, brief exit strategies are developed which aim to be realistic and clear on what is feasible with regards to any sustainability aims. For example, they may state the importance of advocacy to boost domestic resources and the need for profile raising, and/ or the likely need for Global Fund investment across multiple cycles. These exit strategies are seen as both transparent and helpful, and reportedly aid the management of expectations around ongoing support needed, though some stakeholders critique the sustainability planning process for not going far enough. This is also linked to questions around the extent of country engagement in identifying gaps and determining country specific priorities for CI funding. It was also frequently raised that availability and quality of technical assistance, funded by SIs, is a key lever for enhancing sustainability, though not enough focus is often given to this in the design stage, compromising effective and quality delivery of some TA. Others emphasised the potential for CIs in raising awareness of priority issues on the political and partner agenda at the country end and how the advocacy focus of the CIs could be further optimised. It is also noted that ‘sustainable’ outcomes need to be seen in context and that small steps can lead to boosting sustainability of country grants overall (i.e., regional coordination capacity building efforts under MCs).

**CI recommendation theme 4: Strengthening design through ensuring a Theory of Change and evaluation /review are included in each investment case.**

*R3. Continue to strengthen SI design process to include a robust theory of change and evaluation incorporated into its design.*

*R2c. Strengthening MC designs through the inclusion of robust theories of change and reviews after two years.*

**SIs:** In general, solid progress has been made in operationalising ToCs for SIs. In GC6, all SIs had ToCs to some level of detail, though not all were comprehensive or had been subjected to detailed reviews. By GC7, more guidance was available to support their development, and ToCs are now available for all SIs. In place is also a more detailed and thorough ToC review processes of up to six rounds. There is wide support for the ToCs as they enable articulation of change rooted in the specific context of the SI and allow for significant variability across SIs. The ToCs also emphasise the contribution of the CI investment towards the ‘totality’, rather than looking to measure the catalytic effect as a separate piece which is unrealistic. For example, an improvement in human rights may reflect programmatic progress across SIs, country grants and MFs and it would not be feasible or useful to specifically link this progress to a small injection of i.e., US\$5m for one SI. Overall, the view from the CI PMO team is that ToCs for SIs are “*in a good place for now*” and are more robust and consistent than before. In forthcoming cycles, there is expectation that more focus will be given to enhancing insight into how well implementation is tracking against the ToC to further inform their development and utility.

**MCs:** At the prioritisation stage, each CI priority (which could be operationalised as any CI modality) includes a brief ToC, so MCs are subjected to some consideration in that regard. However, as MCs are considered more variable than other CIs in the approaches and intervention areas they span, there is no specific guidance for the detailed development of ToCs for them. Instead, MCs are monitored and reviewed through work plan tracking measures (WPTM) and

<sup>42</sup> Global Fund: 41st Board paper (2019)



often, but not always, have performance frameworks. Similar to SIs, there is acceptance that the measurement approach for MCs is “*operating fine*” and there is little appetite for adding workload to measure what are small pots of funds.

**SIs and MCs:** No significant changes were considered to be needed in relation to designing and implementing **evaluations and reviews** for either SIs or MCs following the TERG recommendations. Evaluations and reviews have been built into SIs for multiple cycles on an as-needed basis, with many having midterm and endline evaluations with learning generated every 18 months. For smaller investments, evaluations are often conducted internally. Programmatic progress is also measured using various process and outcome indicators. For MCs, evaluations tend to take place towards the end of the grant which give insight into progress and impact to inform future cycles.

**CI recommendation theme 5: Strengthening the harmonisation and coherence of catalytic investment design with other grant funding.**

*R4. Identify a mechanism to ensure greater harmonization between the SI activities, objectives and the Fund’s broader portfolio of support.*

*R2c. Strengthening MC designs through the inclusion of comprehensive landscape analyses to identify gaps and overlaps with country grants, other catalytic investments and initiatives funded or implemented by other agencies.*

**SIs and MCs:** With regards to ensuring greater coherence and harmonisation in relation to partner/ agency investments, partner engagement appears to have both evolved and varied across grant cycles. Secretariat stakeholders discussed how at times, partner engagement has been extensive, for example, when CIs were first launched, WHO and technical partners were very involved in defining CI priorities with the Global Fund through the Situation Rooms<sup>43</sup>. Partner involvement in CI priority setting is also inherent through selected partner participation in the Strategy Committee. However, in relation to GC7, partners have reportedly become less engaged as “*CI priority setting has become more Secretariat orientated*” with more emphasis on pre-defined scopes, as well as in response to CI funding cuts. This dynamic is described further under the Partnerships workstream in the main report.

In terms of coherence and harmonisation within the Global Fund grant portfolio, the reduced funding from GC7 and enhanced orientation around the Secretariat agenda has apparently facilitated complementarity across funding streams. This has been aided by the strengthened mechanisms for prioritising and selecting CIs, such as the business cases and gap analyses outlined above, and more explicit linkage to the SOs. There has also been specific effort to “*look across and see what makes sense, how to integrate CIs into disease allocation foci, and CI teamwork with the CTs to look at totality more.*” There were also positive reports from combining SIs, MFs and country allocations into specific programmatic areas, for example Breaking Down Barriers, as this enables more levers to drive change.

<sup>43</sup> Global Fund: 41st Board paper (2019)



**CI recommendation theme 6: Strengthening implementation and performance management arrangements.**

*R5. Continue to evolve contracting, management, and oversight arrangements, ensure appropriateness for the nature of activities being implemented and continue to incentivize partner performance towards the achievement of results.*

*R2d. Strengthening MC review processes through a limited set of grant-specific performance measures focused on output/outcome levels, and to continue to strengthen MC implementation and governance arrangements.*

**SIs and MCs:** Through GC6 and into GC7, there has been a shift to deliverable-based agreements for technical partners like WHO as well as suppliers, with a particular focus on SIs. This has helped to track alignment between inputs, processes and performance and strengthened overall accountability which was seen previously as a gap. These contracts also aimed to incentivise partner performance towards the achievement of results. For partners, this represented a big change as they were used to “*just working with us in partnership*” and not being paid based on outputs completed. In GC6, Finance conducted a self-audit of partners and commercial agreements and found that in GC5, contracts were often not as clear in mapping defined deliverables to specific payment amounts, yet similar reviews of GC6 agreements revealed much clearer, more direct linkage of deliverables to payment amounts. More emphasis has also reportedly been given to reviewing the quality of deliverables.

The Secretariat has in general resolved to avoid intensifying the management of CIs, particularly given the higher proportion of CI funding going to MFs in GC7 which already follow a rigorous review and management process and with less funding overall, there is a need to ensure ‘right-size’ processes. That there are fewer SIs and MCs from GC7 further reduces the impetus for boosting management efforts which could lead to increasing workloads, thereby raising questions around value for money. This is particularly the case for MCs which are especially labour intensive at both Secretariat and country/ regional ends and so there are few motivations for adding further administrative layers.

There do continue to be ongoing concerns of high transaction costs given the small funding amounts for SIs and MCs, however. Previous reviews have raised concerns that country teams in particular may spend a disproportionate amount of time programming relatively small amounts of catalytic funding for MCs (country teams do not program SIs) to the detriment of overall grant implementation processes.<sup>44</sup> Both SIs and MCs however still have complex management and implementation arrangements, with higher transaction costs partly due to multiple parties involved – this was also highlighted through the TERG reviews.<sup>45</sup> Through GC5 and 6, there have been efforts to strike a more optimal balance between boosting accountability for CIs whilst reducing the level of effort to support processes, transparency and reporting. With the more recent reduction in overall funding, this tension could be further enhanced.

Since GC6, the Secretariat has also been required to report regularly to the SC on all CIs, with the overall aim of providing insight into progress, key milestones and important developments or changes. This is operationalised through semesterly reporting both on programmatic and financial performance. Progress against targets is based on indicators from the Results Framework (RF) which is based on the ToC, and detailed budget. Through GC6, ToC and RF quality varied

<sup>44</sup> Global Fund Strategic Review (2017)

<sup>45</sup> TERG Report: Thematic Evaluation on multi-country catalytic investment grants (2021)

significantly across SIs, affected by when the SI was approved. An operational procedure (OPN) was also approved to clearly define roles and responsibilities of all stakeholders involved in SI design, approval and implementation monitoring. This includes clear guidance on the approach to programmatic and budget revisions during implementation, with material revisions (based on clear thresholds) requiring GAC approval. The OPN also outlines a more rigorous process to monitoring implementer performance of technical and implementing partners.

### *viii) WS5: Matching funds analysis*

This appendix provides an overview of Matching Funds allocation analysis across the 3 recent allocation cycles (2017-2019, 2020-2022 and 2023-2025), based on available data from the Global Fund website.

Please note a few limitations and considerations on the analysis below:

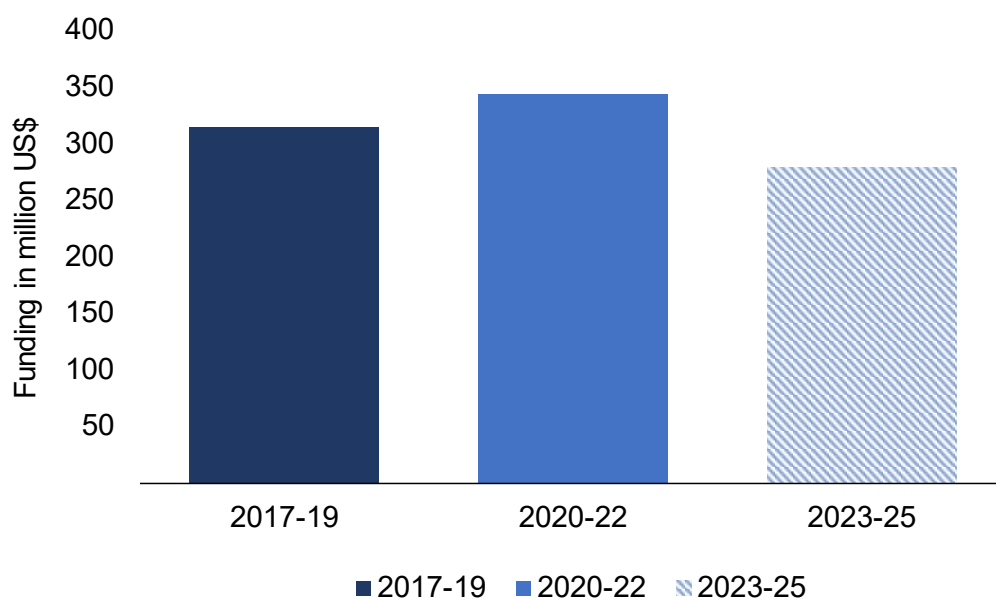
- As the underlying dataset for this analysis was compiled from different sources, some components of the data had to be manually coded or streamlined across allocation cycles to allow for comparisons and analysis, e.g., names of interventions, disease areas, etc.
- Some allocation amounts had to be converted to USD (from Euros) based on an [average exchange rate](#) for each allocation cycle. <sup>46</sup>For this reason, exact amounts for total allocated funding across cycles may vary compared to Global Fund reporting.
- In addition, the 2023-25 allocation data included in this analysis is based on a 2023 dataset. Therefore, it may not represent the final amounts of matching funds allocated to countries for the entire 2023-2025 period. In order to compare across cycles, the analysis was conducted based on matching funds communicated to countries.

#### *a. Overview of matching funds allocation across cycles*

##### *i. Overall change across 3 cycles*

2020-2022 is the allocation cycle with highest amount of matching funds allocation, for a total of \$341.5 million USD. The 2017-2019 allocation cycle has the second largest allocation of matching funds, \$311.3million USD. Matching funds allocated in the 2023-2025 cycle amount to \$277.1million USD based on 2023 data.

*Figure Q.1: Change in matching fund allocations across funding cycles*



##### *ii. Allocation across disease areas, 2017-2025*

Figure Q.2 shows an overview of matching funds allocated across disease areas in the last 2017-2022 allocation period. HIV was allocated the highest amount of matching funds in that

<sup>46</sup> The following exchange rates have been used: 1.358 US\$ per € for 2017-19; 1.157 US\$ per € for 2020-22; and 1.070 US\$ per € for 2023-25;

period, \$289 million USD, followed by TB, \$265.8 million USD and RSSH with \$99.5million USD.

Comparatively, the allocation to RSSH seems to have increased significantly in the 2023-25 period and is the highest allocation to RSSH across the 3 allocation cycles, as shown in figure Q.3.

Figure Q.2: Matching funds allocation across disease areas in the 2017-2022 combined period

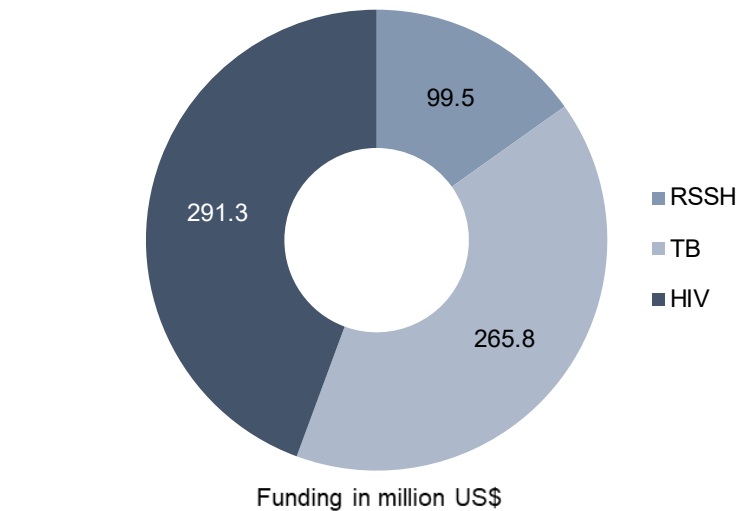
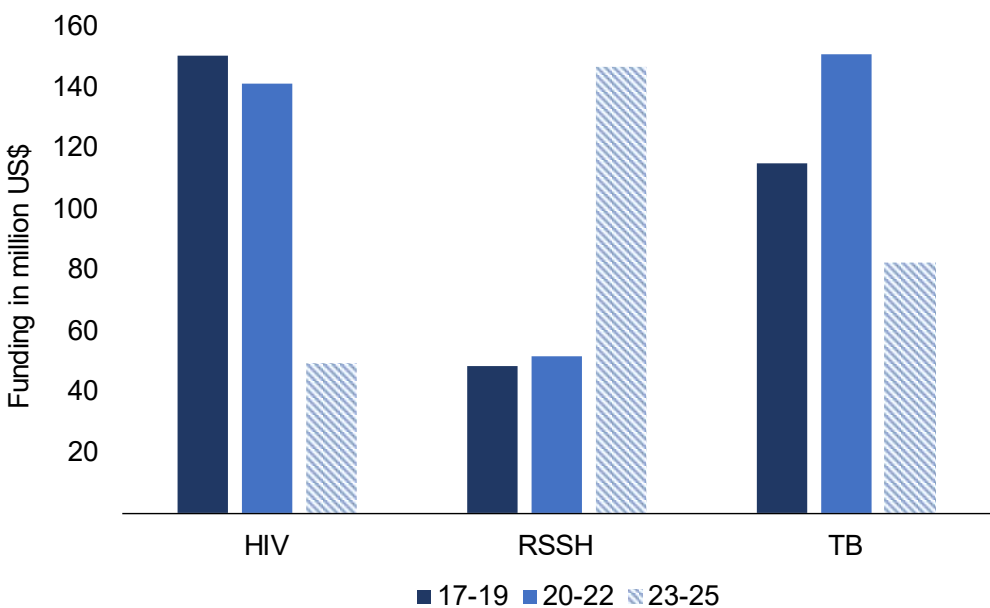


Figure Q.3: Matching funds allocation across disease area across allocation cycles



iii. Matching funds allocation per interventions across the 3 cycles

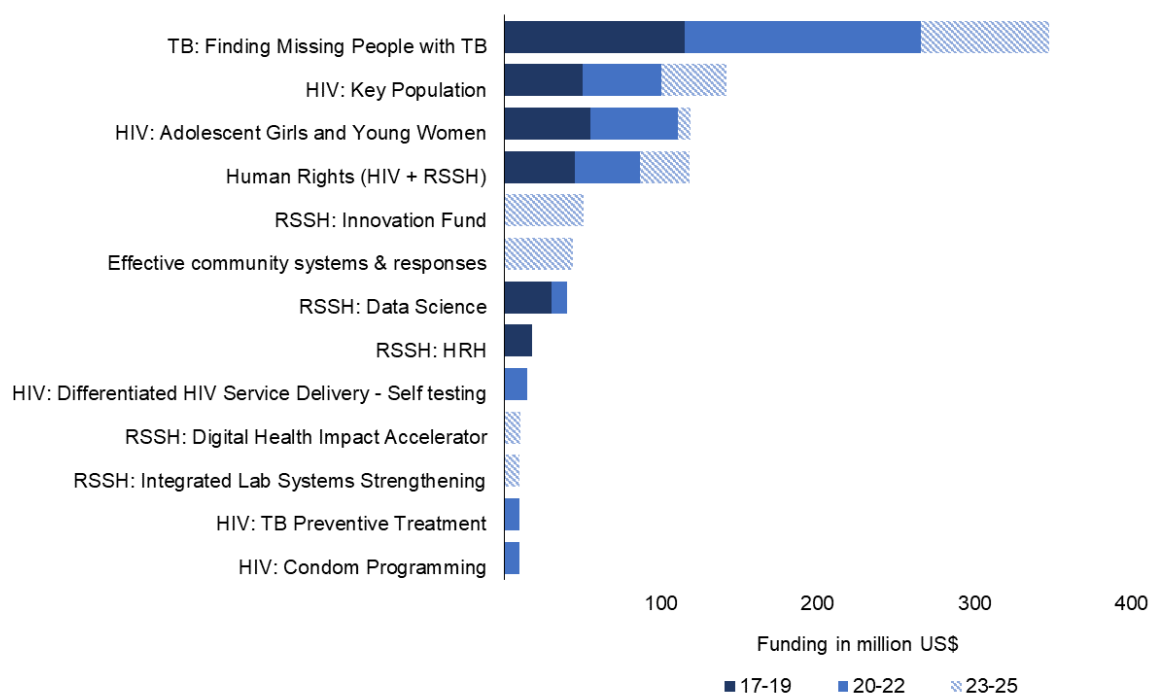
Across all interventions, “Finding missing people with TB” has received the most matching funds allocation, \$348.1 million USD, in the last 3 cycles. The second and third interventions that have received the most matching funds allocations are “HIV: Key Population” (\$141.6 million USD)<sup>47</sup> and “HIV: Adolescent Girls and Young Women” (\$119.1 million USD).

<sup>47</sup> Including also the MF for PrEP

Highlights are as follows:

- Human Rights-related MF were funded through HIV allocations during the 17-19 cycle, and then through RSSH allocations in the 20-22 cycle (coded as 'HIV/AIDS – HR' and 'RSSH: Human Rights' respectively) and again in the 23-25 cycle. **These have been combined in Figure Q.4. below as we understand this was a continuation of the same MF.**
- **Four MFs were implemented in GC5, GC6 and GC7:** Finding missing people with TB, HIV key population, HIV AGYW and addressing human rights related barriers. **One MF was implemented in both GC5 and GC6:** RSSH Data Science. While the priorities were the same for the MFs across the cycles, their specific focus and interventions could still vary.
- The remaining MFs were only implemented in a single grant cycle. This includes the Human Resources for Health (HRH) in GC5, the 'HIV: Differentiated HIV Service Delivery - Self testing', 'HIV: TB Preventive Treatment' and 'HIV: Condom Programming' in GC6 and the 'RSSH: Innovation Fund', 'Effective community systems & responses' and 'Scaling up programs to remove human rights and gender related barriers', 'RSSH: Digital Health Impact Accelerator' and 'RSSH: Integrated Lab Systems Strengthening' in GC7.

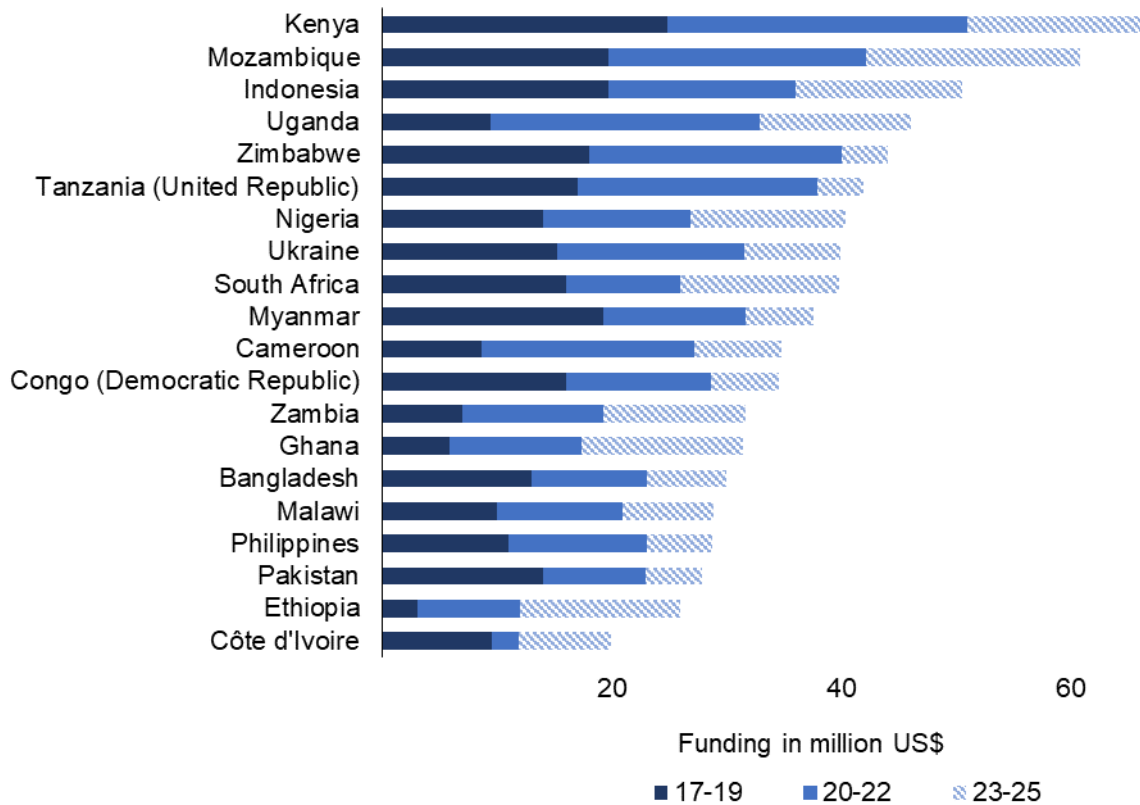
Figure Q.4: Matching funds allocations across interventions by grant cycle



#### iv. Top recipient countries of matching funds across the 3 cycles

Kenya received the largest amount of matching funds across the 3 allocation cycles, with a total of \$66 million USD. This is followed by Mozambique and Indonesia with \$60.9 million USD and \$50.5 million USD respectively. Zimbabwe was the 3<sup>rd</sup> largest recipient of matching funds in the last two allocation cycles combined 2017-2022 (\$40.0 million USD) but has since been surpassed by Indonesia who received more funding so far in the new 2023-2025 allocation cycle. Figure Q.5. shows the top 20 countries recipients of matching funds across the 3 allocation cycles.

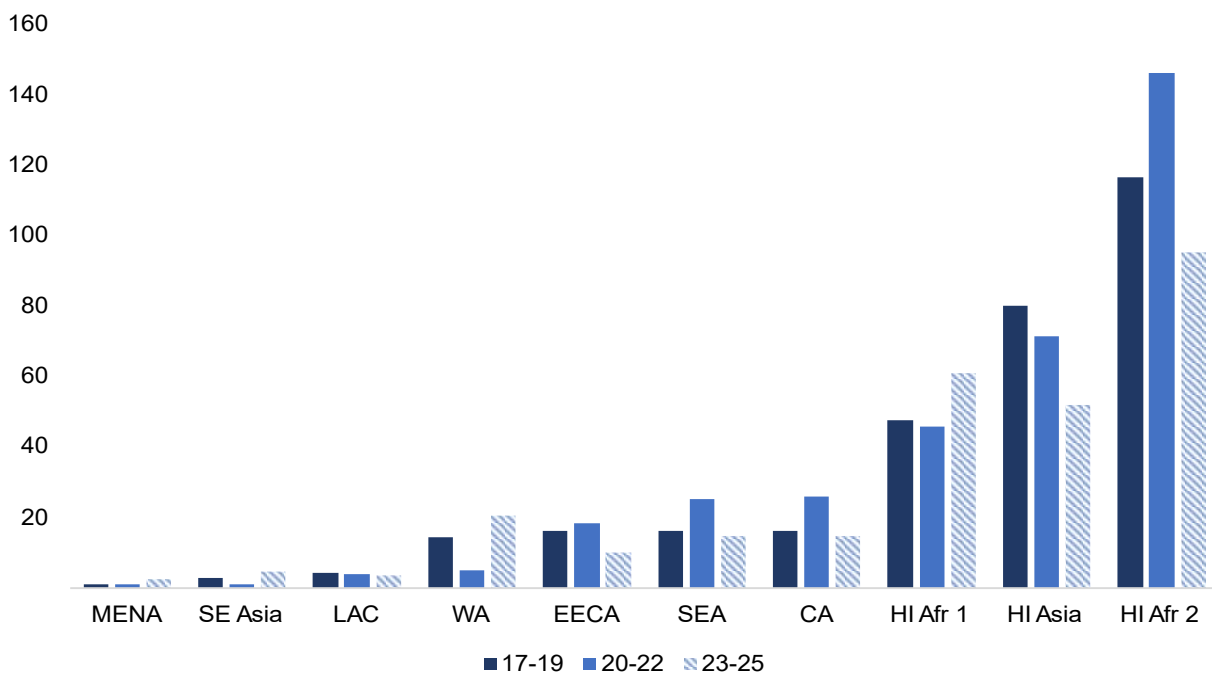
Figure Q.5. Top 20 countries recipients of matching funds across allocation cycles



*v. Matching funds allocation per region across the 3 cycles*

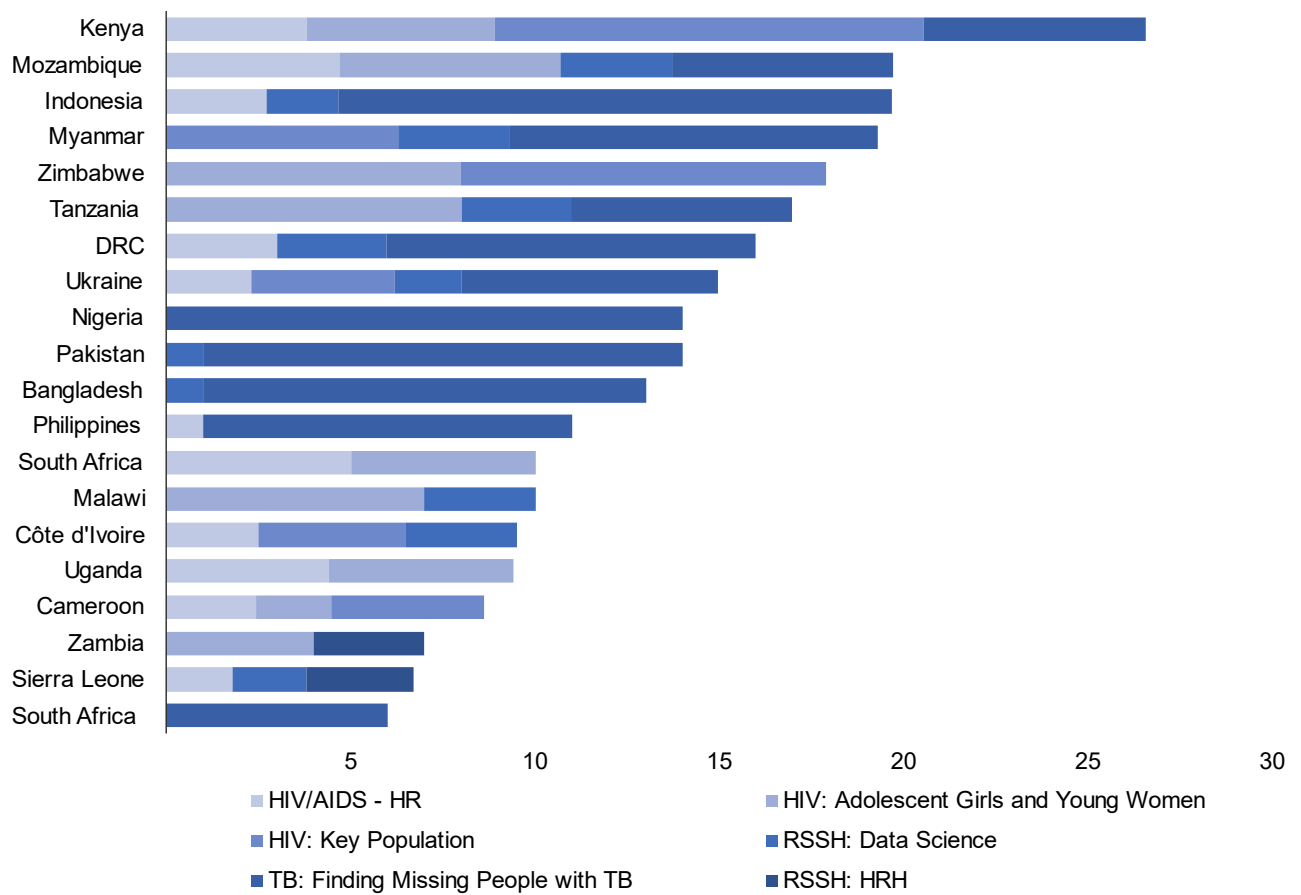
The High Impact Africa 2 region has been the largest recipient of matching funds across the 3 cycles, having received a total of \$356.3 million USD, followed by High Impact Asia and High Impact Africa 1, which received \$203.4 million USD and \$153.8 million USD respectively. It is worth noting that in the new 2023-2025 allocation period, High Impact Asia has received (so far) less matching funds allocation compared to High Impact Africa 1.

Figure Q.6: Matching funds allocation per region across the 3 cycles



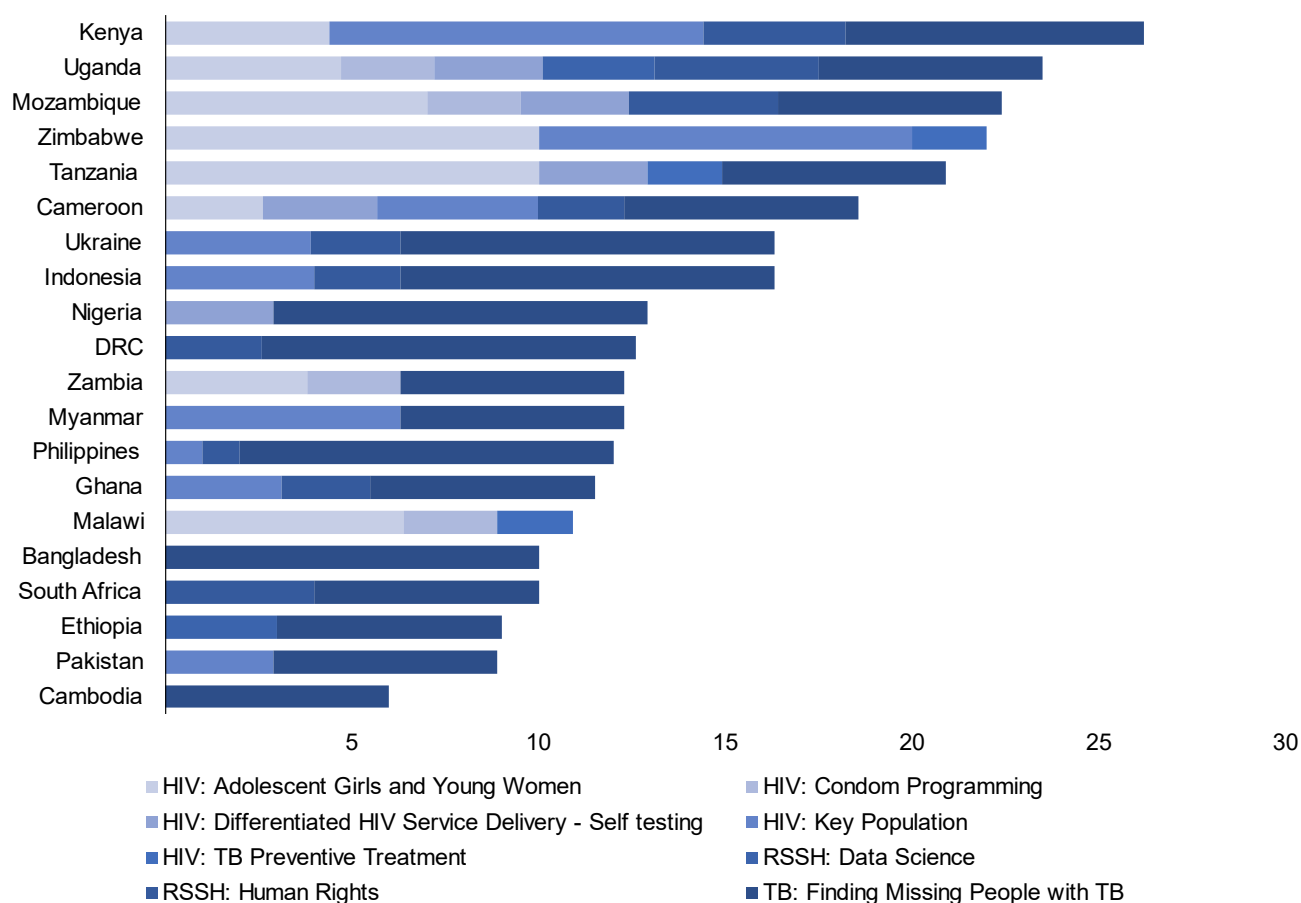
### b. 2017-19 Matching funds allocation

Figure Q.7: Top 20 recipient countries by interventions in the 2017-2019 cycle



### c. 2020-22 Matching funds allocation

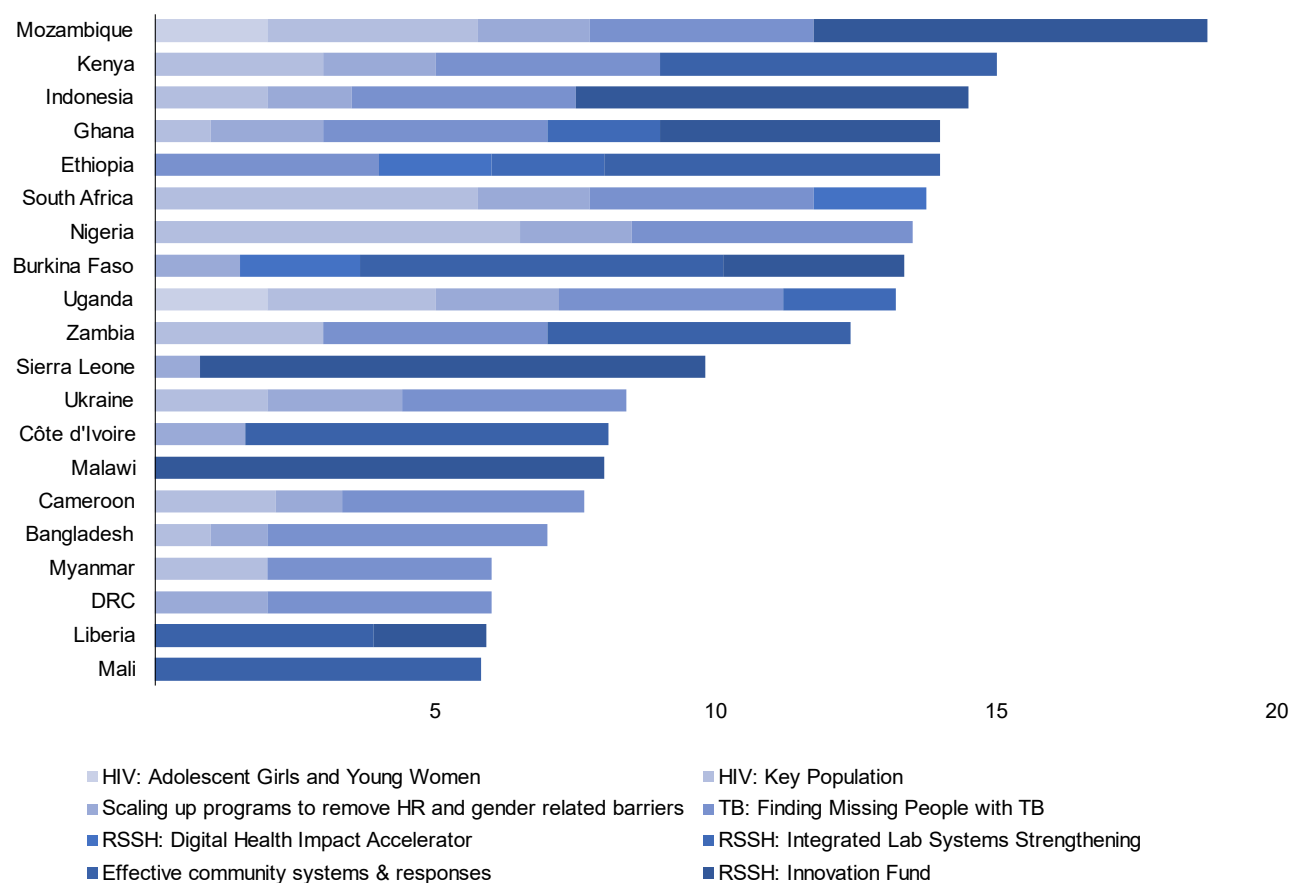
Figure Q.8: Top 20 recipient countries by interventions in the 2020-2022 cycle



#### d. 2023-25 Matching funds allocation

Figure Q.9: Top 20 recipient countries by interventions in the 2023-2025 cycle





e. Matching Fund tracking analysis by select countries

In Table Q.1, we present findings from a macro-level MF tracking analysis based on a selection of three countries: Mozambique, Nigeria and Philippines. The data is drawn from stakeholder insight via country case studies, documentation review, specifically FRs<sup>48</sup> and Global Fund website data (GC5 and GC6) and the MF tracker data (GC7), given this is more up to date for GC7 (this is seen as acceptable given the focus of this analysis is qualitative rather than quantitative aggregates). Colour categorisation is solely for ease of identifying MF continuation across cycles within countries. High level reflections are reported in Box 8.1 in the main report.

Table Q.1: Findings from macro-level MF tracking analysis in Mozambique, Nigeria and Philippines

Country	Selection notes	GC5		GC6		GC7		Reflections on evolving focus and contribution/value add of MFs
		MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	
<b>Mozambique</b>	<ul style="list-style-type: none"> <li>High impact country</li> <li>One of largest MF portfolio for GC5 and GC6</li> <li>Southern Africa</li> </ul>	<p><b>HIV AGYW (\$6m)</b></p> <p><b>HIV HR (\$4.7m)</b></p> <p><b>TB MP (\$6m)</b></p> <p><b>RSSH Data (\$3m)</b></p>	<p><b>HIV AGYW:</b> To boost promotion of access to, and creation of demand for, HIV preventive services among adolescents and young people in and out of school; to strengthen monitoring and evaluation of the national response.</p> <p><b>HIV HR:</b> To address human rights barriers to access among key populations – specific focus of MFs dependent on results of a Global Fund supported baseline study on human rights barriers to HIV from which evidence informed prioritisation of interventions for MFs. Also used to fund boosting of MDR-TB efforts: MFs aimed at boosting</p>	<p><b>HIV AGYW (\$7m)</b></p> <p><b>HIV Condom (\$2.5m)</b></p> <p><b>TB MP (\$6m)</b></p> <p><b>RSSH HR (\$4m)</b></p> <p><b>HIV DSD (\$2.9m)</b></p>	<p><b>HIV AGYW:</b> To boost implementation of a layered and holistic package of care for vulnerable AGYW aged 10-24 years, in and out of school, in 78 high-burden districts (up from 50 in previous cycle). MF request prioritizes AGYW investments in support of ambitious targets for coverage scenarios that have been modelled and defined in national strategies.</p> <p><b>HIV Condom:</b> To boost investments in the three main priorities of the approved National Condom Strategy: (1) program stewardship; (2) increased demand and (3) improved</p>	<p><b>HIV AGYW (\$2m)</b></p> <p><b>HIV PrEP (\$3.75m)</b></p> <p><b>TB MP (\$4m)</b></p> <p><b>RSSH Innovation (\$7m)</b></p> <p><b>HRG (\$2m)</b></p>	<p><b>HIV AGYW:</b> Expansion of service delivery platforms for key elements of the HIV prevention program (e.g., HIV prevention provision in family planning/sexual and reproductive health services, community and community-led organizations, pharmacies and other private sector outlets, and online service provision); innovation and improvement of HIV outcomes, through using virtual platforms to reach boys with prevention messages and the use of buses to disseminate prevention messages; strengthening of HIV/STI prevention program management and coordination.</p>	<ul style="list-style-type: none"> <li>HIV AGYW MF across all 3 cycles, varying amounts – ongoing focus of this MF is on expanding service delivery platforms, boosting access to services and creation of demand for HIV prevention among AGYW. Specific linkage of activities across cycles in the FRs is unclear however, in particular how activities proposed in each cycle build off successes or challenges of the former (noting the intention is not to measure specific effect of MFs). The MFs have enabled the expansion of activities into new districts.</li> <li>TB MP MF is funded at the same amount across 3 cycles, with the similar broad aim of intensifying efforts to find missing cases to boost TB case notification targets. Slightly different foci are articulated with the linkage across each not full clear. Stakeholder consultations</li> </ul>

<sup>48</sup> Some amounts vary between FRs and eventual allocations.

Country	Selection notes	GC5		GC6		GC7		Reflections on evolving focus and contribution/value add of MFs
		MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	
			<p>identification of estimated MDR-TB patients each year so as to enable reaching of 100% of country targets.</p> <p><b>TB MP:</b> To intensify efforts to find missing TB (and HIV) cases and additional co-infected patients by continuing the successful implementation of the integrated 'One Stop Model' services at health facilities and implementing an integrated community package – MFs targeted at finding missing TB cases at community level. MFs needed to reach 100% of country targets requested (5,228 in 2018, 5,625 in 2019, and 5,945 in 2020)</p> <p><b>RSSH Data:</b> MF additional benefit not specified. Support to strengthening HMIS and M&amp;E (i.e. routine reporting, program data quality and use, vital registration system) and national health strategies.</p>		<p>supply, as a complement to PEPFAR investment.</p> <p><b>TB MP:</b> To strengthen priority approaches aimed at finding the estimated 63,889 people with TB missed by the health system each year (i.e. facility-based screening and diagnosis, community-based awareness and referrals, systematic screening, engaging providers, collaborative activities with other sectors). Specific mention of MF contribution towards field level usage of Truenat MTB technology through mobile TB screening services in the key population community, among remote populations, with the specific aim of being innovative. Supportive activities to strengthen implementation of a people-centred continuum of care.</p> <p><b>RSSH HR:</b> Seems to build off previous HR investment relating to both HIV and TB (previous cycle) and based on priority interventions articulated in the aforementioned baseline assessment. Little specific</p>		<p><b>HIV PrEP:</b> Further expansion of service delivery platforms (i.e. delivery of PrEP services on of KP mobile clinics and mobile brigades, and through the inclusion of private health sectors in the dispensing of PrEP); piloting of innovative options to increase scale i.e. combined prevention service delivery, virtual and mass media demand creation, multi-month dispensing); strengthening data systems and programmatic stewardship.</p> <p><b>TB MP:</b> Further strengthening of TB screening and diagnosis of BC TB cases, increasing rates of BC TB from 54% in 2026 in regular allocation to 59%; increasing total cases of BC TB notified by 7000 annually, of which 210 will be DR-TB cases; increasing total number of presumptive TB patients identified as part of increased scope of symptom screen, dXR and CAD; and advancing HIV Disease Package, screening PLHIV and high-risk groups by 10%.</p>	<p>suggest that this MF was reported to be impactful, with marked increases in TB case notifications, accelerating progress through the available additional funding.</p> <ul style="list-style-type: none"> <li>There is some continuity of a human rights focus through MFs across the 3 cycles. The HIV and RSSH Innovation MF reportedly enabled the introduction of better intervention refining and the introduction of better approaches. Initially country plans were to facilitate access to services/more ARVs for vulnerable and key populations, though the funds allowed a paradigm shift to a wider range of interventions that better addressed the key barriers and harnessed enablers (address self-stigma, better positioning of paralegal services, addressing BV, KP police harassment etc.) It is suggested that these MFs enabled the country to go “<i>beyond the basic activities and encourage the country to invest in these areas</i>”). The HR MF was also developed in collaboration across disease programs and intentionally designed to be implemented through an integrated approach within services targeting different beneficiary groups.</li> <li>Two MFs are included as relating to one cycle only (i.e HIV Condom, HIV PrEP) with the assumption that this ‘top up’ of funding is needed for</li> </ul>

Country	Selection notes	GC5		GC6		GC7		Reflections on evolving focus and contribution/value add of MFs
		MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	
					<p>articulation of activity priorities.</p> <p><b>HIV DSD:</b> Scaling-up differentiated service delivery models and specific service delivery adaptations for HIV testing and treatment; providing learning and tools for country specific and portfolio-wide implementation in forthcoming funding cycles.</p>		<p><b>RSSH Innovation:</b> Improved leadership, coordination and accountability of HRG responses to HIV: elimination of stigma, discrimination and violence against people living with HIV and key and vulnerable populations; greater access to justice and protection of human rights for people living with HIV and key and vulnerable populations; improved access to affordable, acceptable, accessible and quality HIV services for people living with HIV and key and vulnerable populations; reduced gender inequality and gender-based violence faced by women and girls in their diversity, people living with HIV and key and vulnerable populations.</p> <p><b>HRG:</b> To strengthen the legislative arm of government on the linkages between HIV, TB and malaria and human rights and to improve the legal environment to address human rights violations related to TB. Capacity building workshops for health reporters and media</p>	<p>specific within-cycle intervention and activity targets.</p> <ul style="list-style-type: none"> <li>Specific catalytic effect across MFs not discussed directly but indicated largely as accelerating coverage and scaling up to new or key intervention areas, and introducing innovation.</li> </ul>

Country	Selection notes	GC5		GC6		GC7		Reflections on evolving focus and contribution/value add of MFs
		MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	
							executives and CSOs on addressing TB, TB stigma in local languages. Support the implementation of the National Community Rights and Gender Action Plan to overcome HRG barriers to access.	
<b>Nigeria</b>	<ul style="list-style-type: none"> <li>High impact country</li> <li>West Africa</li> <li>Complex environment and recipient of large Global Fund grant</li> </ul>	<b>TB MP (\$14m)</b>	<b>TB MP:</b> Focus on private sector engagement, with activities including, engagement of professional bodies, support to TB services through faith-based networks spanning the country, direct support to the patent and proprietary medicine vendors (PPMVs) and individual medical practitioners, expanded use of IT for notification, engagement with corporate partners for the mobilisation of resources and expansion in TB control activity. Targets an increase in the number of private sector participation with 70% of facilities covered with a focus on faith-based facilities and PPMVs.	<b>HIV Self testing (\$2.9m)</b>  <b>TB MP (\$10m)</b>	<b>HIV Self testing:</b> Support to scale up of HIVST through both public and private sector delivery channels. For the public sector, the 8 high HIV burden states targeted for procurement and distribution of HIVST kits and associated consumables (to complement PEPFAR COP 20 planned procurements). For the private sector, a nationwide geographical area of focus, with the main interventions being that of building an enabling environment for individuals to access to quality HIVST kits in the market and strengthening support systems for those who self-test. Cross-cutting activities to support both strategies include advocacy/sensitization, governance/coordination, call centre-based support	<b>HIV PrEP (\$6.5m)</b>  <b>TB MP (\$5m)</b>  <b>HRG (\$2m)</b>	<b>HIV PrEP:</b> Focus on scaling programmes for removing HRG related barriers in support of KPs and vulnerable populations, specifically, community active case finding; Program Quality and Efficiency (PQE); multi-sectoral integration of services; private sector engagement; active contact tracing and linkage to TB preventive treatment (TPT). Focus across KAPs, including young KP and high risk AGYW.  <b>TB MP:</b> Focus on bridging the case detection gap of 40% for DS-TB and 74% for DR-TB. Focus on sustaining and expanding high impact interventions such as: Community active case finding in 5 states; Program Quality and Efficiency (PQE) in 8 states; Multisectoral integration of services in 6	<ul style="list-style-type: none"> <li>TB MP a consistent MF across funding cycles, with linkage across grants relatively clear and logical, with increased emphasis on building on previous investment over time. Overall investment focus on sustaining and expanding high impact interventions in high burden areas, and generating lessons to inform further scale up. This also enables adjustment of policy and implementation frameworks therefore strengthening the enabling environment. Reported to be impactful over GC5 and GC6, with marked increases in TB case notifications, accelerating progress. In-country stakeholders suggest that MF investment in TB in Nigeria was innovative e.g. the PBI for private sector and community service delivery in Nigeria, scaled up to FBOs using MFs, with the MF scaling up an innovation already being implemented through the main allocation. However, while effective, efforts to boost sustainability of investments are not directly well articulated (relevant to core investment as well as MF).</li> </ul>

Country	Selection notes	GC5		GC6		GC7		Reflections on evolving focus and contribution/value add of MFs
		MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	
					<p>systems, QA/QC as well as PMS of the kits, service mapping/documentation and service delivery monitoring. Funded by incentive funding allocation and matching funds.</p> <p><b>TB MP:</b> Focused in five high TB burden states in six distinct areas: ( i) private sector engagement (ii) active contact tracing (iii) 100% saturation of TB services in all health facilities ( iv) targeted community outreach programs (v) intensifying diagnosis of clinical TB through the use of X-ray as screening and diagnostic tool and (vi) implementation of Program Quality and Efficiency (PQE). In addition, efforts to strengthen private sector engagement in other states. This investment aims to complement efforts to close the case detection gap of 74% for DS-TB and 89% for DR-TB. Case finding investments to complement efforts of USAID (LON in 18 states &amp; private sector engagement [SHOPS Plus]) and PEPFAR (systematic</p>		<p>states; Active contact tracing and linkage to TPT in 11 states. Focus on states that are high burden with limited interventions, high prevalence of malnutrition and gap in TB treatment coverage. The investment through the MF is expected to add additional 29,872 TB cases, 485 DR-TB cases and place 74,832 on TPT.</p> <p><b>HRG:</b> To strengthen the legislative arm of government on the linkages between HIV, TB and malaria and human rights and to improve the legal environment to address human rights violations related to TB. Also to conduct capacity building workshops for health reporters and media executives and CSOs on addressing TB, TB stigma in local languages. Support the implementation of the National Community Rights and Gender Action Plan to overcome HRG barriers to access.</p>	<ul style="list-style-type: none"> <li>• The HIV MFs were focused on boosting scale up of interventions. The HIVST was considered to be designed well and timely due to COVID-19.</li> <li>• Specific catalytic effect across MFs not discussed directly but indicated largely as accelerating coverage and scaling up to new or key intervention areas, and boosting the enabling environment.</li> </ul>

Country	Selection notes	GC5		GC6		GC7		Reflections on evolving focus and contribution/value add of MFs
		MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	
					screening of TB in PLHIV) in finding missing cases.			
Philippines	<ul style="list-style-type: none"> <li>High impact country</li> <li>Asia</li> <li>Interesting context with proactive shift towards horizontal programming and integration of services</li> </ul>	<p>HIV HR (\$1m)</p> <p>TB MP (\$10m)</p>	<p><b>HIV HR:</b> Allocation is focused on strategies that will increase access to and utilization of HIV services including provision of KP-specific and gender and age-sensitive HIV services. Anticipating difficulties in implementing these strategies, the MF is focused on integrating and implementing supportive interventions to establish an enabling environment for HIV response, with activities: high-level advocacy for policy reforms (related to discrimination on account of sexual orientation, gender identity and expression (SOGIE) and age-sensitive); capacity building on rights-based, age-, and HIV-sensitive program delivery, with emphasis on rights education of KP and PLHIV; and expansion of legal networks and building capacity in HIV, gender, and legal issues to increase access to justice.</p> <p><b>TB MP:</b> Procurement and distribution of GX machines</p>	<p>HIV KP (\$1m)</p> <p>TB MP (\$10m)</p> <p>RSSH HR (\$1m)</p>	<p><b>HIV KP:</b> Focus on 1) community empowerment activities i.e. establishment of TGW-specific CBO community centres to provide safe spaces for TGW and deliver services from trans health to treatment and provision of support and capacity building for existing transgender-led CBOs for advocacy and service delivery; 2) Sexual and reproductive health services i.e. provision and support for development of clinical practice guidelines which includes integrated HIV and hormone replacement therapy (HRT) and capacity building for health service providers on integrated HIV and HRT counselling and SOGIE.</p> <p><b>TB MP:</b> Enables optimising efforts to find missing TB cases with a focus on private health care sector engagement. Engaging private providers expected to directly contribute to TB case notification by an extra 75,750 (2021), 92,925</p>	<p>HIV KP (\$1m)</p> <p>TB MP (\$4m)</p> <p>HRG (\$0.75m)</p>	<p><b>HIV KP:</b> Innovation focused investment including 1) the deployment of mobile Combi Vans to carry prevention and testing services to hardest to reach groups; 2) conduct of virtual campaigns to generate demand for prevention and testing services in platforms like Grindr, What's App, Planet Romeo, and others; 3) integration of HIV, STI, TB and Hepatitis B, and C and other gender-sensitive health services for PUDs in the community-based drug rehabilitation (CBDR) programs in LGUs; 4) integration of HIV combination prevention into the programs and activities of 27 newly organized CBOs which are part of a national network of LGBTQI organizations; 5) development and implementation of transhealth package of services including HRT; 6) operations research on Injectable Cabotegravir (CBG) to inform policy and program.</p>	<ul style="list-style-type: none"> <li>MFs have only supported HIV and TB and RSSH (which spans both HIV and TB). This reflects the focus of the disease investments in country.</li> <li>Good linkage across cycles in terms of MF investments in both the HIV and TB space – the narrative explains how the MFs each cycle are linked to challenges and successes in the previous cycle.</li> <li>Overall MF investment is generally targeted at innovative programming areas to support and enable the scale up of key interventions and the generation of useful learning to inform intervention design and effective targeting.</li> <li>Stakeholder enquiry suggests that MFs in recent cycles have been effective. The TB MP grant, which aims to boost the reporting of TB from the private sector, was seen as a valuable component of the TB programme 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 also 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</li> </ul>



Country	Selection notes	GC5		GC6		GC7		Reflections on evolving focus and contribution/value add of MFs
		MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	
			to primary care units – an expanded number owing to the MF contribution (580 GX machines from the country grant and MF combined). Also a boost to detection and enrolment of DRTB cases.		(2022), and 97,615 (2023). Target of engagement of 10,103 private physicians in highly urbanized cities nationwide as part of the comprehensive TB care network.  <b>RSSH HR:</b> Scale up of ongoing human rights interventions, e.g., sensitization and legal literacy training, provision of legal services. Also to support expansion of its policy work to target non-health sectors and settings where stigma and discrimination have been reported and which impact on KPs' choices to access HIV services, e.g., workplace (targeting of both HIV KPs and TB cohorts).		<b>TB MP:</b> To boost private sector engagement in TB case finding and effective TB treatment efforts, especially people with drug-susceptible and drug-resistant TB. Also to increase TB case notification and treatment outcome reporting using GeneXpert as the primary diagnostic tool.  <b>HRG:</b> Based on a roadmap from the PNSC to address right related barriers in access HIV/AIDS related services, the MF boosts 1) the prevention package for MSM and their sexual partners, transgender women, and young key populations; 2) the conduct of an operations research on the effects of the expanded service provision approach integrating harm reduction and comprehensive treatment services for drug-related needs within Social Hygiene Clinics and Recovery clinics for PUD; 3) conduct of legal literacy trainings on HIV and TB for MSM, TGW, YKP, PUD, and PLHIV; 4) development and conduct of an education and advocacy campaign and	reporting including the passing of a TB Mandatory Notification Law which applies to public and private sectors. The project has involved 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 challenges 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 Local Government Units (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.  • The MF focussed on Human Rights in GC6 transitioned to Scaling up Barriers to HRG in GC7, which has reportedly helped catalyse the process by which individuals can seek support and legal advice for



Country	Selection notes	GC5		GC6		GC7		Reflections on evolving focus and contribution/value add of MFs
		MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	MF allocation and number	MF contribution/ intervention scope	
							<p>strategies on harm reduction; 5) development of a guide/ implementation tool on community-based learning group sessions for PUD; 6) prevention package for People in jails/prisons to develop joint plan with the duty bearers to conduct outreach activities of various service providers in closed settings; 7) support to differentiated testing services for KPs.</p>	<p>addressing stigma and human right violations. While the funding is small, it was perceived as a valuable contribution to the support of the program.</p> <ul style="list-style-type: none"> <li>Overall, MFs (and other CIs in country) are perceived to have contributed to raising awareness of key priorities and provided flexibility to explore new approaches that have contributed to learning and progress in both HIV/AIDS and TB.</li> </ul>

*ix) WS6: Partnerships appendix*

This Appendix provides supplementary information regarding technical partnerships with donors in support of Global Fund objectives over the last strategy period.

a. technical partnerships with (bilateral and multilateral) donors

As noted in the main report, technical partnerships with donors are generally well-functioning at both the global and country levels, with improvements noted with PEPFAR in particular and some improvements in coordination of set-asides. Partnerships for DRM were inadequate over the last strategy period, with more recent steps by the Global Fund to strengthen this area.

In regards to partnerships with PEPFAR and PMI, Box R.1 provides country examples of stronger and less strong coordination with PEPFAR and PMI and Global Fund supported grants.

## **Box R.1 Country examples of technical partnerships with (bilateral and multilateral) donors**

### **Nigeria: strong partner coordination**

In Nigeria, there is an alignment strategy between PEPFAR, Global Fund and the Government of Nigeria to optimise the countries' HIV response, referred to as Alignment 1.0. It is currently evolving into Alignment 2.0 which addresses some gaps in the previous strategy. The results of the alignment are the optimisation of both donors' investments in the country through harmonised service delivery packages and delineated responsibilities, which have contributed to programmatic improvements especially increasing ART coverage. The alignment also harnessed key strengths of each donor: e.g., Global Fund experience with KP and ability to fund harm reduction programming, as well as its commodity security focus and procurement processes (wambo.org), and PEPFAR's larger service delivery budget and large commodity logistics project. The Global Fund and PMI also have a complementary partnership working closely with the NMEP (Global Fund PR) alongside other donors. The donors have structured their support to cover different states in the country with Global Fund supporting 13, PMI supporting 11 states, and 12 others supported by WB and Islamic Development Bank. Both donors also take turns in supporting therapeutic efficacy monitoring for ACTs and have also supported entomological monitoring studies in different states. Lastly, through the leadership of NMEP, PMI and the Global Fund have developed a framework for loaning and swapping commodities/health products across donors to prevent expiries, especially ACTs and RDTs.

### **South Sudan: more challenging partner context**

Challenges observed regarding PEPFAR and Global Fund coordination have resulted in major duplication and high inefficiencies in the delivery of HIV interventions. Whilst a geographical division had been agreed between both partners in an attempt to minimise overlaps in HIV interventions, stakeholders reported this has led to high disparities in the coverage and quality of services between geographical areas, as well as a highly fragmented care pathway for patients in facilities where both partners operate to deliver HIV and TB services (i.e., PEPFAR providing HIV and Global Fund TB services). This is further exacerbated by a lack of consensus on ways of working and diverging internal processes (especially regarding staff recruitment and incentives policies) as well as a lack of integration of services in the national health system including for data monitoring and reporting processes.

Malaria stakeholders (Global Fund, World Bank and FCDO-led Health Pool Fund) on the other hand have been strengthening their coordination in South Sudan, providing a good example of consolidated partnerships including through streamlining package of services, harmonizing monitoring and aligning HRH incentives across partners. Going forward, a new IDA multi-donor fund is being set up to pool funding across all malaria donors and further strengthen malaria service delivery by centralising management of interventions and removing duplications

## **Partnerships for domestic financing for health (DFH)**

**SR2023 finds that partnership with the World Bank and other DFIs in support of domestic financing for health (DFH) was an area of less strong Global Fund performance** over the last strategy period, but with improvements since 2022 (refer to main report).<sup>49</sup> The OIG Advisory Report (2022)<sup>50</sup> on the Global Fund's Role and Approach to

<sup>49</sup> An MOU has been developed recently between the Global Fund and the World Bank

<sup>50</sup> Global Fund (2022) OIG Advisory report on Sustainable Financing for Health.

DFH found that improving Partnerships was one of eight ‘themes’ for priority intervention where the Global Fund could influence. Key findings pertaining to partnerships were as follows:

- Global Fund is not effectively leveraging partners to support DFH agenda
- Insufficient alignment between global partners in the ‘DFH Space’ is leading to inefficient support to countries
- Limited strategic engagement and alignment with partners in the field causes weak impact
- Perceived permanence of external assistance and over-reliance on key donors is preventing government ownership over funding

Recognising the complexity of DFH partner landscape and that several partners have more extensive influence in DFH than the Global Fund, the OIG report called for strengthening how partnerships are identified, managed and leveraged, focusing on:

- Developing a DFH partnership engagement and alignment strategy: periodic updating of the GF’s assessment of the DFH landscape, creating operational roadmaps, leveraging partnership platforms and jointly developing clear, country-level plans.
- Increasing in-country and regional cooperation with traditional and non-traditional partners to better leverage their influence with key in-country stakeholders.

#### x) *WS7: Gender, human rights, equity and communities*

This appendix is a supplement to the crosscutting workstream 7 on gender, HR, equity and communities. Section S.1 presents a glossary of key terms, and Sections S.2 and S.3 include additional supporting information to assessment of progress related to Global Fund SO3 operational objectives 2 and 3 (Section 10.2 of main report).

##### a. Key terms

The table below defines key terms used by the Global Fund in describing investments in key population programmes. A subset of these terms are used in the following report.

*Table S.1: Glossary*

Terms	Definition
<b>Key populations: HIV</b>	Gay men and other men who have sex with men, sex workers, trans and gender diverse people, people who use and/or inject drugs, people in prisons (PIP) and other closed settings, people living with HIV
<b>Key populations: TB</b>	Migrants, refugees and displaced people, people living in poverty, people living with HIV (PLHIV), people in prisons (PIP) and incarcerated populations, miners and people who work in poorly ventilated conditions, and indigenous populations
<b>Underserved populations: malaria</b>	Rural and mobile populations (migrants, IDPs and refugees), children under the age of 5 years, pregnant women, and indigenous populations in malaria-endemic areas
<b>Community-based organisations</b>	Operate in community settings or locations. Often organisations that have arisen from a community in response to particular needs or challenges.

Terms	Definition
<b>Community-led organisations</b>	Organisations that are governed, led and staffed by people who are experienced and affiliated with the communities being served or intended to benefit from the organization's work.
<b>Community-led responses</b>	Specifically informed and implemented by and for communities themselves and the organisations, groups and networks that represent them
<b>Community systems</b>	Structures, mechanisms, processes, and actors that engage and deliver interventions to communities. They may be community focused, community-based, or community-led

b. Additional information related to operational objective 2

i. *Strengths and challenges related to expanding access to data*

Successes related to expanding access to reliable and relevant data with a specific disease focus include the development of the Malaria Matchbox.<sup>51</sup> This toolkit, designed by the Global Fund in consultation with technical partners, including RBM Partnership to End Malaria, UNICEF, WHO, and civil society representatives, provides country partners with guidance on how to identify risk factors and barriers impeding equitable and integrated, people-centred malaria programmes, coupled with recommendations on how to address them. There is evidence that this toolkit is being used to good effect in some of the countries selected for case study purposes. For example, stakeholders in Kenya highlighted the use of the Malaria Matchbox as supporting programme design and effectiveness, noting that it had been coupled with a capacity assessment of organisations providing malaria services.

The Stop TB Partnership Stigma Measurement Assessment tool was also formulated over the strategy period to assist national TB programmes and TB-affected communities in measuring the level of stigma faced by people affected by TB.<sup>52</sup> This information can be used to inform the design of TB programmes with an equity focus. In addition, Secretariat interviewees reported the design of a data-driven strategic decision-making toolkit and training manual, which is being piloted in the Democratic Republic of the Congo (DRC) and South Africa. The toolkit aims to build capacity in data analysis and utilisation in the design of priority interventions, with a focus on community-based data collection systems.

The Community-Led Monitoring (CLM) SI, which aimed to strengthen and scale CLM approaches in 9 countries in GC6, was also highlighted as a key success of the 2017-2022 strategy period. As noted by a Secretariat interviewee, *"The CLM SI was a significant achievement. All of the targets were achieved after two and a half years of implementation with a very small investment of US\$3 million. It also enabled innovation in relation to understanding how to integrate CLM, especially during the COVID-19 period, into quality of care."* Country case study information supports this; for example, South African interviewees reported the strengthening of KP networks to conduct primary data collection<sup>53</sup> as a means of documenting programme-related challenges and outcomes for reporting to PRs. While CLM falls under Community Systems Strengthening (CSS), in RSSH<sup>54</sup>, it supports progress towards operational objectives 2 and 4 under SO3 in that

<sup>51</sup> See [https://endmalaria.org/sites/default/files/Malaria%20Matchbox%20Tool\\_en\\_web.pdf](https://endmalaria.org/sites/default/files/Malaria%20Matchbox%20Tool_en_web.pdf) ; accessed 01 October 2023.

<sup>52</sup> Technical Brief: Tuberculosis, Gender and Human Rights (February 2020)

<sup>53</sup> Community focus group discussions

<sup>54</sup> CSS is supported by the Global Fund as part of RSSH. Four CSS interventions are prioritized; namely, CLM; community-led research and advocacy; capacity building and leadership development; and community engagement, linkages and coordination. This area overlaps with SO3 initiatives to strengthen KP engagement in Global Fund-related processes as well as the collection of appropriate data to support the development and implementation of equitable health strategies.

it helps to address data gaps, while facilitating community engagement in grant implementation and oversight.

However, country case study data indicates that, despite the efforts and achievements outlined above, challenges related to data gaps and utilisation persist in some areas. For example, interviewees in Bolivia reported that no HR-related baselines nor gender assessments had been undertaken to support programme planning over the strategy period under review. Data limitations were also noted in South Sudan and Zambia, particularly in relation to population size estimates for KPs.

Where data is available, the utilisation thereof does not always proceed as planned. A Secretariat interviewee observed that, *“The work is largely driven by Global Fund and PEPFAR; and countries show little interest in investing in this area of work and using the data to inform prioritisation of investments, national FRs and programme improvements. They also really struggle to prioritise and to translate findings into action. If the recommendation is clear, then country resources are limited. It becomes a political process of prioritising.”* Factors possibly contributing to low levels of country utilisation of data include the limited number of quality assurance mechanisms, which affects the quality of the assessments, key findings and recommendations, and thus their usefulness and usability for country partners. Skills gaps amongst consultants contracted to undertake research assignments are another possible limitation, while the quote above suggests gaps in partner capacity to utilise data for programme planning. In Kenya, interviewees reported challenges related to CLM including low levels of trust in community-generated data amongst some stakeholders, while in the Philippines, stakeholders reported challenges with data quality and timeliness, as well as access to disaggregated data. These issues require further investigation, together with the identification of interventions to support country partners’ data use.

c. Additional information related to operational objective 3

i. Overview of interventions to address HR-related barriers to accessing HIV, TB and malaria services

Table S.2: Summary of interventions addressing HR-related barriers to HTM services

HIV	TB	Malaria
Stigma and discrimination reduction	Stigma and discrimination reduction	Human rights and gender assessments
Legal literacy / “Know Your Rights”	Legal literacy / “Know Your TB-related Rights”	Malaria in people living with HIV
Training health care providers on human rights and medical ethics related to HIV and HIV/TB	Training health care providers on human rights and medical ethics related to TB	Improving access to services for refugees and others affected by emergencies
HIV-related legal services	TB-related legal services	Improved services in prison and pre-trial detention
Sensitisation of lawmakers and law enforcement agents	Sensitisation of lawmakers, judicial officers and law enforcement agents	Addressing gender-related vulnerabilities and barriers

HIV	TB	Malaria
Monitoring and reforming laws, regulations and policies related to HIV and HIV/TB service provision	Monitoring and reforming policies, regulations and laws that impede TB services	
Reducing HIV-related gender discrimination, vulnerabilities and barriers; harmful gender norms, and violence against women and girls in all their diversity	Reducing gender-related barriers to TB services Programmes in prisons and other closed settings	

*ii. Positive outcomes reported in relation to the BDB initiative*

A number of positive outcomes were reported in relation to the BDB initiative. For example, a mid-term review found that programmes to address stigma and discrimination were scaled in all participating countries. These programmes included radio and social media campaigns as well as community engagement through dialogues. In Kyrgyzstan, Mozambique, South Africa, Côte d'Ivoire, and Kenya, HR-related programming included legal literacy (Know Your Rights) and strengthening of legal service provision, including the recruitment and capacitation of community-based paralegals. Training of police, health care workers and community health volunteers in human rights and patient-centred care was also a key component of country programming across the BDB priority countries. Of note is reporting that several of these programmes were designed and led by members of KP groups.<sup>55</sup> In addition, SR2023 country case study interviewees in South Africa and Kenya highlighted a shift from a health-centric or biomedical focus to the recognition of the value of a broader, systems approach to the achievement of health outcomes that included structural interventions. Interviewees in Mozambique and Kyrgyzstan reported a reduction in stigmatisation of those living with HIV and TB, particularly amongst health care workers, while those in Côte d'Ivoire reported the establishment of GBV response coordination platforms.

<sup>55</sup> As noted in the Mid-term Assessment Summary Report: Global Fund Breaking Down Barriers Initiative (July 2022) and during primary data collection in Kyrgyzstan and South Africa.

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