

Technical Evaluation Reference Group:
Thematic Review on Sustainability,
Transition and Co-financing (STC) Policy
Position Paper, Management Response and Report

January 2020

TERG Position Paper

Executive Summary

Context

The Global Fund Board approved the Global Fund Sustainability, Transition and Co-financing Policy (STC Policy) in April 2016¹. The Global Fund, in cooperation with countries and partners, began implementing the STC Policy during the allocation period 2017-2019.

The Technical Evaluation Reference Group (TERG) commissioned the Thematic Review of the STC Policy (Review) following on a request from the Strategy Committee (SC) at its March 2018 meeting.

Overall, the TERG is satisfied with the presented Review report, which provides useful findings, conclusions and recommendations. Based on these, the TERG recommends that the SC should consider recommendations described in this paper to further improve the implementation of the STC Policy.

Conclusions

- A. The Review found that the Global Fund Secretariat is transforming the work of the organization in line with the STC Policy. Skills and tools are in place and substantial gains have been made in helping lower middle-income countries (LMICs) with non-high disease burdens and upper middle-income countries (UMICs) to plan for and better manage transitions from external financing. This work is on-going and needs to continue, with intensification of effort in key areas.
- B. To address challenges identified, the Review provides fourteen recommendations. The TERG agrees with these recommendations but has categorized them to make prioritization clearer.
- C. a) Given that the implementation of the STC Policy is still at an early stage, the TERG recommends that a follow-up review on post-transition outcomes should be undertaken in about three years.
b) The TERG advises that efforts to strengthen sustainability be further prioritized in countries with higher disease burdens and lower economic capacity that are not currently required to focus on transition planning.
- D. Each of the ten case studies conducted for the Review highlights several “promising practices” that the Global Fund Secretariat could take into consideration across countries.

Input Received

The Review has been initiated and prepared with detailed and valuable contributions from the Global Fund Secretariat, particularly with extensive support from the STC Senior Manager.

¹ GF/B35/DP08

Report

The STC Policy was approved by the Global Fund Board in April 2016², which was prompted and informed by TERG reviews on transition and sustainability in 2013 and 2015. It was quickly operationalized, and the Global Fund, in cooperation with countries and partners, began implementing the policy during the 2017-2019 allocation period. Grants reflecting key STC Policy focus areas and principles are being implemented (the majority from mid-2018), following funding request and grant-making processes.

The four objectives of the Review were:

- a. To assess how the **Global Fund** has operationalized and is implementing (in the early stages) the STC Policy, with the exception of aspects of the “transition” component which were covered by the [OIG audit](#);
- b. To understand how **country programs and stakeholders** are incorporating key principles and focus areas of the STC Policy into their national programs and funding requests (FR), including strengthening sustainability, increasing domestic financing, and preparing for transition from Global Fund financing;
- c. To understand the extent to which the STC Policy is helping foster **greater sustainability of national programs**, including (but not limited to) how the co-financing policy is supporting greater domestic investment in health and strategic areas of the three diseases;
- d. To document **lessons learned** on how STC Policy implementation and the key focus areas of the Global Fund’s sustainability efforts may be further improved, at the Global Fund Secretariat, at country level, and amongst key Global Fund partners.

To meet these objectives, the Review examined the STC Policy operationalization and implementation at both the corporate and country level, utilizing a mixed methods approach encompassing both qualitative and quantitative data collection and analysis. It included document reviews, key informant interviews with Global Fund and external stakeholders, and ten country case studies: five field-based (Côte d’Ivoire, Kenya, Rwanda, Ukraine and Viet Nam) and five desk-based (Dominican Republic, Georgia, Ghana, Namibia and Sri Lanka).

The STC Policy review was part of a prioritized list of areas the TERG was asked by the Strategy Committee to conduct.

STC Policy Review Findings and Conclusions

A. Key Findings on Corporate Level Operationalization and Implementation of the STC Policy

- *The Secretariat has put in place clear operational guidance and revised grant making processes to effectively support Policy implementation, particularly for transition and co-financing.*

² GF/B35/DP08

- *The Secretariat's initial efforts under the STC Policy prioritized helping countries to prepare for component transitions and implementing amended co-financing requirements.*
- *The Global Fund Secretariat and associated bodies (e.g., OIG and the TRP) are building extensive internal capacity to support STC objectives.*
- *The Secretariat is revising Global Fund partnerships to better support STC efforts.*
- *A strengthened STC lens is in place in review of other policies and strategic guidance notes.*
- *While there are efforts to increase attention to domestic resource mobilization, innovative finance, RSSH and CRG across the portfolio, less attention seems to have been afforded to strategically operationalize country-led sustainability efforts beyond AELAC [Asia, Europe, Latin America & the Caribbean] countries.*

B. Key Findings on Operationalizing, Supporting and Monitoring Implementation at the Country Level

- *The Global Fund provides significant STC technical support to countries, particularly for transition assessment and planning, and health financing and efficiency.*
- *Dedicated expert staff with regional STC strategies guide and accelerate STC implementation in [AELAC].*
- *The Global Fund is engaging more in country dialogue on health financing based on mutual interests in universal health coverage (UHC).*
- *The Global Fund uses part of the Catalytic Funding, including Matching Grants, Multi-country Grants, and Strategic Initiatives funding, to support countries in achieving STC objectives.*
- *A wide range of global partners is enlisted to support country-level STC efforts.*
- *Additional sustainability monitoring indicators to provide greater detail on integration of services, use of national systems, VfM [Value for Money] in national budget utilization, and more timely and better disaggregated data on realization of co-financing, among others, would seem to be appropriate.*

C. Key Findings on Initial Results and Implications of the STC Policy at Country Level

For the ten case study countries:

- *The implementation of Global Fund grants is largely aligned with NSPs [national strategic plans].*
- *Transitioning programs demonstrated strong adherence to key transition focus areas in the STC Policy.*
- *Most countries have or are developing national health financing strategies, mostly in the context of universal health coverage (UHC).*
- *There is increasing use of country systems, but areas for better integration remain even in transition settings.*
- *Grant RSSH activities generally focused on support for grant implementation rather than on systems strengthening. (A finding consistent with both the TERG and TRP RSSH reviews).*
- *Most KVP [key and vulnerable population] and human rights interventions are funded through external sources, regardless of proximity to transition, and are at risk of neither*

being scaled-up nor sustained. Legal and regulatory impediments to “social contracting³” remain.

- *All case studies [sic] countries committed to increased health sector financing and absorption of disease program costs.*
- *Countries have limited fiscal capacity for domestic resource mobilization (DRM); increases in health budgets will largely require national budget reprioritization.*
- *Prevention programs were often not clearly identified nor costed in national budgets, raising allocative efficiency concerns.*
- *Attention is still needed for coordination and alignment of external partners on sustainability and transition processes at the country level. Engagement of the private sector is also lagging.*
- *Existing governance structures (e.g., Global Fund CCMs) may constrain sustainability.*

The TERG agrees with the overall conclusion that the Global Fund Secretariat is transforming the work of the organization in line with the STC Policy. This should result in countries being better prepared for transition away from Global Fund financing, with increased domestic financing for HIV, TB and malaria (HTM) services (and health more broadly), and better integration of HTM into national UHC efforts. The TERG would like to emphasize the importance of a focus on sustainability across the Global Fund’s grant portfolio, including the sustainability of KVP services. Greater emphasis is needed on health system strengthening and differentiation in Global Fund RSSH investments. Access to affordable drugs and other commodities remains a significant constraint to longer-term sustainability. There should be wider use of country-led sustainability assessment and planning tools, linked to efforts to foster greater country ownership of STC efforts.

STC Policy Review Recommendations and TERG’s position

The team that conducted the Review made fourteen recommendations to improve the implementation of the STC Policy, with four of them identified as priorities for increased attention. The TERG agrees with the recommendations. However, given the centrality of financing issues to sustainability and transition, the TERG has made the recommendation that the Global Fund should “continue scaling up efforts on DRM, including through innovative financing mechanisms such as debt buy-downs and swaps” a higher priority.

As its position, the TERG has grouped its recommendations, which are based on the findings from the Review, into four categories to make prioritization clearer: (i) the TERG’s Overall Recommendation; (ii) High Priority Recommendations; (iii) Recommendations for Fine-tuning STC Operationalization and Implementation; and, (iv) Additional Considerations. Suggestions for operationalization are summarized in the bullet points underneath each recommendation, with suggested key implementers noted [in square brackets].

³ As per the Global Fund’s STC Guidance Note, “social contracting” in the Global Fund context refers to public financing of civil society service delivery, or public financing of services provided by civil society organizations.

A. Overall recommendation

Further strengthen efforts to operationalize and implement the STC Policy.

- Continue to **prioritize and monitor successful transition.**
- Continue to **build internal capacities, evolve grant-making processes, and maintain attention to sustainability in grant implementation.**
- Continue efforts to **increase value for money** in grant negotiations. This is particularly important given the limited options in LICs and high burden LMICs to increase domestic resources.
- **Fine-tune accountabilities, work plans and incentives**, to ensure that they are fully consistent with prioritizing the sustainability of disease outcomes and ensure that adequate staff time and attention is given to STC Policy implementation.

[Global Fund Board, Secretariat, and related bodies – OIG, Technical Review Panel (TRP), Grant Approval Committee (GAC), TERG]

B. High Priority Recommendations

1. Continue scaling up efforts to catalyze increased Domestic Resource Mobilization (DRM), including through innovative financing mechanisms.

- Prioritize increases in **domestic financing for scale-up of KVP services.**
- **Increase the level of support to country teams from health financing and sustainability specialists**, to better support robust co-financing discussions at the country level, particularly in LICs and LMICs.
- **Undertake more joint planning and missions with the World Bank/regional banks** to facilitate increased engagement with planning, budgeting and finance authorities.
- **Better align discussions and Global Fund funding processes with national medium-term expenditure frameworks (MTEF)** and other budgeting procedures.

[Countries, Secretariat, Partners]

2. Prioritize and strengthen efforts to address impediments to the scale-up and sustainability of effective HIV, TB and malaria services, with particular attention to KVPs across the portfolio.

- **Intensify efforts to promote domestic or alternate financing and “social contracting” mechanisms for CSOs and human rights advocacy** that support primary prevention, treatment and compliance adherence activities.
- **Continue efforts to improve the enabling environment for KVP services.**

[Countries, Secretariat, Partners]

3. Further address health systems weaknesses that impact the sustainability of disease outcomes.

- **Implement the RSSH Roadmap** (March 2019)⁴ to target investments that address sustainability challenges, increasing strengthening vs. support activities.
- **Urgently expand efforts to address systems constraints in three areas:** (i) **national procurement and supply chain management**, (ii) **public financial management**; and (iii) **integration of programs and systems**, to achieve increased efficiency and effectiveness.
- Consider providing guidance internally and to countries regarding **rationalizing program management costs**.

[Countries, Secretariat, Partners]

4. Increase attention to sustainability assessment and planning in high-burden, lower-middle income countries.

- Encourage and **support country-level sustainability planning for all countries**.
- **Consider expanding the successful regional approach** (developing frameworks, strategies and priorities for addressing sustainability) **demonstrated in AELAC countries, to cover all regions**, with provision of support from **Sustainability and Transition Specialists**.
- **Modify grant application processes** to encourage greater attention to sustainability considerations.
- **Modify the current Transition Readiness Assessment methodology to facilitate an increased focus on long-term sustainability issues in these settings**, especially including: health systems strengthening; value for money; and, addressing constraints to scaling up and sustaining KVP and human rights activities.
- **Increase coordination with PEPFAR, the President's Malaria Initiative (PMI) and other donors** to ensure sustainability planning considers the broad context of external support.

[Countries, Secretariat, Partners]

5. Continue to create and ensure access to Global Public Goods in key areas, especially market shaping for key drugs, diagnostics and commodities, as well as knowledge sharing opportunities around increasing program efficiencies, and facilitating meaningful engagement with KVPs.

- Ensure countries retain access to such Global Public Goods post-transition.
- **Provide access to wambo.org or other pooled procurement mechanisms** post-transition, especially for countries that lack the capacity or purchasing power to procure efficiently in global markets.
- **Encourage**, through policy dialogue and partner support, the **Global Fund-supported countries to utilize these pricing and procurement mechanisms**.

[Board, Secretariat, Partners]

⁴ GF/SC09/03

C. Fine-tuning STC Operationalization and Implementation:

1. Continue and intensify efforts related to efficiency and value-for-money across all Global Fund-supported components.

- **Sustain a “value-for-money” culture** across Global Fund-supported programs and activities, strengthen the narrative on increasing program efficiency in all funding requests, and provide support to countries to assess, implement and evaluate health services reforms to increase efficiency and effectiveness.
- **Continue to support allocative efficiency studies** to ensure sufficient attention to scale-up of prevention activities.
- **Ramp up attention and technical support for value for money analysis** of national programs and interventions, including national drug procurement and community-level services.

[Countries, Secretariat, Partners]

2. Sharpen focus on tools and processes for prioritization of disease responses at the country level, particularly for high-burden upper middle and lower middle-income countries.

- Continue to support country-level HTM stakeholders in **building sound investment cases and advocating for domestic resources** within the context of the country's plans for UHC.
- In collaboration with partners, **further improve epidemiological and financial modeling and translation of this information into priorities, plans and budgets.**

[Countries, Secretariat, Partners]

3. Continue to evolve the operationalization of co-financing requirements of the STC Policy.

- Document and replicate the Global Fund's **successful experience** in leveraging increased domestic financing for health including the three diseases.
- **Continue active risk assessment and monitoring of commitments.** Further attention to mechanisms for mitigating risk while maximizing the use of country systems is needed
- Further work with countries to **ensure co-financing reflects increased uptake of a broad range of key program elements, including KVP program costs.**
- Consider **revising commitment and reporting formats** to more readily obtain up-to-date information that includes information on items funded.

[Secretariat]

4. Expand country ownership and responsibility for STC efforts, and ensure country-centered, demand-driven Global Fund support.

- Continue to **increase the use of national systems**, including national budgeting and procurement processes, to the extent possible.

- **Replicate the successes of the transition readiness assessment and planning process in AELAC countries** – which has contributed to building significant levels of ownership – in non-AELAC regions.
- **Expand the use of innovative models**, such as the NSP-based model used in Rwanda, **to other countries**.

[Countries, Secretariat, Board].

5. Consider incorporating additional STC indicators in the Global Fund's Key Performance Indicator Frameworks (strategic KPIs, operational KPIs, and grant-level KPIs).

- Review Key Performance Indicators (KPIs) and internal management indicators to ensure they include key data needed to assess STC progress.
- At Global Fund management level, ensure indicators are available to routinely monitor
 - (i) RSSH investments in health systems strengthening; (ii) KVP program sustainability, and (iii) progress on co-financing commitments with easy comparison across countries.
- Consider incorporating indicators focused on quality of program services in implementation of STC activities at country level. To this end, corporate KPIs on quality of services may be strengthened.

[Secretariat]

D. For additional consideration

1. Learn from sustainability and transition efforts already underway in Global Fund countries and regions.

- Further share experiences within the Global Fund on working with countries to improve STC outcomes.
- Review STC relevant efforts to **identify best practices and hazards**.

[Countries, Secretariat, Partners]

2. Further align grant management and governance processes to frameworks and mechanisms that promote longer-term sustainability, and away from quick responses to reducing the disease burden.

- Address inherent barriers and constraints to sustainability posed by the original grant management and governance processes, e.g., historical capture of the grant process by disease program managers may hinder robust RSSH proposals.
- Further attention to **mechanisms for mitigating risks while maximizing use of country systems** is needed (e.g., NSP based programs and performance-based grants).

[Board, Secretariat]

3. Consider greater use of the Country Coordinating Mechanism (CCM), the Local Fund Agent (LFA), and other on-the-ground mechanisms to strengthen coordination and oversight of STC efforts.

- The CCMs could support strategic approaches to improve sustainability.
- The CCM could establish a task force for sustainability and transition.
- The LFA could support both **capacity building and oversight** for STC efforts.

[Board, Secretariat]

TERG's position on next steps and lessons for the future

The TERG conducted a mid-term review of the Global Fund Market Shaping Strategy (MSS) during about the same timeframe as this review⁵. The MSS mid-term review may have relevant findings and recommendations to STC Policy implementation in the area of procurement, as one of the market shaping strategic objectives is to prepare for country transition and long-term market viability. The TERG reported this MSS mid-term review to the Strategy Committee at its October 2019 meeting and in November 2019 at its Board meeting.

The Strategy Committee should consider requesting the TERG to conduct a **review on post-transition outcomes** in about three years, i.e. on how countries are maintaining progress against the three diseases post transition. Given the early stages of STC Policy implementation, it has been challenging for both the [OIG audit](#) – published in September 2018 – and this Review to assess impact of the implementation of transition grants and other efforts in the transition preparedness part of the portfolio, as most of these grants have either not yet been approved by the Board or have only recently begun implementation. Therefore, it will make sense to fully assess the impact that Global Fund efforts have on transition only when a **full cycle of activities initiated under the STC Policy** (including transition grants) **has been completed**.

While the Review finds that **important progress has been made to operationalize the STC Policy**, the TERG advises that efforts to strengthen longer-term sustainability be further prioritized by countries and within the Secretariat in those **regions where no or few countries are planning for transition**, therefore increasing the focus more toward the “**left side**” of the **development continuum**. As stated in the Review, this will require further internal capacity building, consideration of additional STC staff and review of Terms of Reference (ToRs) to ensure STC is a key responsibility of country teams and others, evolving tools that support better country-led sustainability assessment and planning, and refining the Global Fund's internal strategic processes to further support activities to strengthen long-term sustainability. Ultimate sustainability is to end the epidemics and achieve UHC and disease elimination sub-goals of the Sustainable Development Goals (SDGs), and requires long-term projection and strategic planning at the country level.

Each of the **ten case studies** conducted for the Review highlights several “**promising practices**” that the Global Fund Secretariat could take into consideration across countries.

⁵ The MSS mid-term review is available [here](#).

Annexes

The following items can be found in Annex:

- Annex 1: Relevant Past Board Decisions
- Annex 2: Relevant Past Documents & Reference Materials
- Annex 3: Recommendations matrix by the STC Deep Dive Thematic Areas
- Annex 4: TERG Thematic Review on Sustainability, Transition and Co-financing (STC) Policy
- Annex 5: List of Abbreviations

Annex 1 – Relevant Past Board Decisions

Relevant past Decision Point	Summary and Impact
GF/B35/DP08: The Global Fund Sustainability, Transition and Co-financing Policy (April 2016) ⁶	The Board approved the Global Fund Sustainability, Transition and Co-financing Policy, which outlines the high-level principles for engaging with countries on long term sustainability of Global Fund supported programs, as well as a framework for ensuring successful transitions from Global Fund financing.
GF/B35/DP04: The Global Fund Strategy 2017 – 2022: Investing to End Epidemics (April 2016) ⁷	The Board approved the Global Fund Strategy 2017 – 2022. Its first Strategic Objective and related sub-objective 5 outlines how the Global Fund will work to “support sustainable responses for epidemic control and successful transitions”.
GF/B34/DP04: Strategic Framework 2017 - 2022 (November 2015) ⁸	The Board approved the Strategic Framework 2017 – 2022 with a sub-objective to “support sustainable responses for epidemic control and successful transitions.” The policy presented in this paper for Board approval outlines the principles that will guide the Global Fund’s approach and engagement with respect to sustainability and successful transition.

Annex 2 – Relevant Past Documents & Reference Materials

- [The Global Fund Sustainability, Transition and Co-financing Policy](#), GF/B35/04
- [Guidance Note: STC of programs supported by the Global Fund](#), 13 January 2017. Please note that the STC Guidance Note was updated in December 2019 and can be found on the Global Fund website [here](#).
- [Update on Sustainability, Transition, and Co-Financing](#), GF/B37/ 17
- [Audit of Global Fund Transition Management Processes](#), OIG, 3 September 2018
- [Thematic review on Transition and Sustainability of the Global Fund Supported Programs](#), GF/SIIC16/03
- [Thematic Review on Resilient and Sustainable Systems for Health \(RSSH\)](#), GF/SC09/07
- [Mechanisms for Review and Decision Making of Concept Notes in the Global Fund Funding Model](#), GF/SIIC 17/10

⁶ <https://www.theglobalfund.org/board-decisions/b35-dp08/>

⁷ <https://www.theglobalfund.org/board-decisions/b35-dp04/>

⁸ <https://www.theglobalfund.org/board-decisions/b34-dp04/>

- [Thematic review on NSPs against the minimum requirements for their use in the Global Fund application process](#), GF/SC02/21
- [Thematic Review of Partnerships](#), GF/SC09/06

Annex 3 – Recommendations matrix by STC Deep Dive Thematic Areas

Thematic Areas	RECOMMENDATIONS	AGENT	HIGHEST PRIORITY
Co-Financing	<p><i>Continue to evolve the application of co-financing to meet both the intent and the requirements of the STC policy.</i> To follow the Global Fund’s successful experience in gaining commitments for increased domestic financing of health sector and HTM component financing,</p> <ul style="list-style-type: none"> • Improve reporting and accountability for realizing committed amounts; consider revising commitment and reporting formats to more readily obtain up-to-date information that includes information on items funded and can be compared across time periods for the same country and across countries; • Continue active risk assessment and monitoring of commitments; • Further work with countries to ensure co-financing reflects increased uptake of a broad range of key program elements, including KVP program costs. 	Countries, Secretariat	
Transition and Sustainability Planning	<p><i>Increase attention to sustainability assessment and planning in high-burden, lower-middle income countries.</i></p> <ul style="list-style-type: none"> • Encourage and support country-level sustainability planning for all countries. • Consider expanding successful internal regional STC efforts to cover all regions: Assign S&T specialists to the remaining regions. • Modify grant applications to reflect greater attention to sustainability assessment and planning. • Develop regional frameworks, strategies and priorities for addressing sustainability. • Modify the current transition readiness assessment methodology to better serve broader sustainability assessment in these settings, with a greater emphasis on systems strengthening, efficiency and value for money, and addressing constraints to scaling up and sustaining KP and human rights activities. • Increase coordination with PEPFAR, the President’s Malaria Initiative (PMI) and other donors to ensure sustainability planning considers the broad context of external support. 	Countries, Secretariat, Partners	X

Grant Design to Support Sustainability	<p><i>Further address health systems weaknesses that impact the sustainability of disease outcomes.</i></p> <ul style="list-style-type: none"> • Implement the new RSSH Roadmap (March 2019) to target investments that address sustainability challenges, including differentiation across the systems development continuum and increasing strengthening vs. support activities. • Urgently expand efforts in three areas: (i) diagnose and address constraints to effective national procurement and supply management, (ii) address public financial management constraints to program implementation under increased domestic financing; and (iii) address constraints to integration of programs and systems, seeking greater efficiency and effectiveness in health services delivery, health information, human resources for health, program management and governance. • Consider providing guidance internally and to countries regarding rationalizing program management costs. <p><i>Expand country ownership and responsibility for STC efforts, and ensure country-centered, demand-driven Global Fund support.</i></p> <ul style="list-style-type: none"> • Continue to increase use of national systems, including national budgeting and procurement processes, to the extent possible. • Consider means of extending the level of country ownership that seems to have been built through the TRA process of identifying and addressing challenges to broader sustainability issues in non-AELAC regions. • Expand use of innovative models, such as the NSP-based model used in Rwanda, to other countries. <p><i>Further align grant management and governance processes to frameworks and mechanisms that promote longer-term sustainability,</i> and away from quick responses to reducing the disease burden.</p> <ul style="list-style-type: none"> • Address inherent barriers and constraints to sustainability posed by the original grants management and governance processes, e.g., historical capture of the grant process by disease program managers may hinder robust RSSH proposals or integration across programs and systems. • In addition, risk management vs sustainability continues to be a trade-off in use of country systems. Further attention to mechanisms for mitigating risks while maximizing use of country systems is needed (e.g., NSP based programs and performance-based grants). 	Countries, Secretariat, Partners	X
		Countries, Secretariat, Board	
		Board, Secretariat	

Efficiency and Value for Money	<p><i>Heighten emphasis on efficiency and value-for-money across all Global Fund supported components.</i> Inculcate a culture of efficiency across Global Fund supported programs and activities.</p> <ul style="list-style-type: none"> • Strengthen the narrative on increasing program efficiencies in all funding requests. • Work with countries individually or regionally to develop country-driven strategies and priorities for addressing efficiency during the allocation period. • Continue to support allocative efficiency studies to ensure sufficient attention to scale-up of prevention activities. • Ramp up attention and technical support for value for money analysis of national programs and interventions, including national drug procurement and community-level services. • Provide support to countries to assess, implement and evaluate efficient health services reforms, including decentralization. • Ensure KVP programs that are to be taken over under national budgets represent value for money. <p><i>Sharpen focus on tools and processes for prioritization of disease responses at the country level, particularly for high-burden upper-middle and lower-middle income countries.</i></p> <ul style="list-style-type: none"> • Continue to support country-level HTM stakeholders in building a sound investment case and advocating for domestic resources within the context of the country's plans for UHC. • In collaboration with partners, further improve epidemiological and financial modeling and translation of this information into priorities, plans and budgets; especially, better prioritized and realistically costed national strategic plans (NSPs), analyses for the inclusion of HTM services in social health insurance, and national health financing strategies. <p><i>Continue scaling up efforts on domestic resource mobilization,</i> including through innovative financing mechanisms such as debt buy-downs and swaps.</p> <ul style="list-style-type: none"> • Prioritize increases in domestic financing for scale-up of KVP services in UMICs and LMICs where needed to address the epidemics (domestic funds and funding mechanisms). • Increase the level of health financing and sustainability support from internal specialists to support Country Teams dialog and co-financing discussions, particularly in LICs and LMICs. • Undertake more joint planning and missions with the World Bank/regional banks to more fully engage with planning, budgeting and finance authorities. • Consider innovative financing mechanisms such as debt buy-downs and swaps. 	Countries, Secretariat, Partners	
		Countries, Secretariat, Partners	
		Countries, Secretariat, Partners	

	<ul style="list-style-type: none"> Better align discussions and Global Fund funding processes with national medium-term expenditure frameworks (MTEF) and other budgeting procedures. 		
Financing and Service Provision for Key and Vulnerable Populations (including “social contracting”)	<p><i>Prioritize and strengthen efforts to address impediments to the scale-up and sustainability of effective HIV, TB and malaria services for KVPs across the portfolio.</i></p> <ul style="list-style-type: none"> Intensify efforts to promote domestic or alternate financing and “social contracting” mechanisms for CSOs and human rights advocacy that support primary prevention and compliance adherence activities, even at early stages in the process toward self-reliance. Continue efforts to improve the enabling environment for KVP activities. 	Countries, Secretariat, Partners	X
Access to Affordable Health Products and Procurement	<p><i>Continue to create and ensure access to Global Public Goods in key areas, especially market shaping for key drugs, diagnostics and commodities;</i> knowledge around building program efficiencies; and engagement with KVPs. These public goods create value for money across the global HIV, TB and malaria responses.</p> <ul style="list-style-type: none"> Ensure countries retain access to these key areas, beyond their period of access to funding. Provide access to wambo.org or other pooled procurement or price determining mechanisms during and for some period beyond Global Fund eligibility for countries that lack value pricing for national procurements in open markets due to limited scale or other market factors. Encourage, through policy dialog and partner support, the Global Fund supported countries to utilize these pricing and procurement mechanisms when national procurement regulations or market conditions constrain access to value pricing under domestic financing. 	Board, Secretariat, Partners	X
Ongoing learning and monitoring of STC progress	<p><i>Learn from sustainability and transition efforts already underway in Global Fund countries and regions.</i></p> <ul style="list-style-type: none"> Further gather and share experiences routinely within Global Fund on working with countries to improve STC outcomes. Review STC relevant efforts covering low, lower-middle and upper-middle income countries to identify best practices and hazards. <p><i>Consider additional STC indicators as part of the Key Performance Frameworks guiding the Global Fund and its country grants.</i></p> <ul style="list-style-type: none"> Review KPIs and internal management indicators to ensure they reflect key data needed to assess STC progress. 	<p>Countries, Secretariat, Partners</p> <p>Secretariat</p>	

Annex 4 –TERG Thematic Review on STC Policy

Report is attached separately.

Annex 5 – List of Abbreviations

Asia, Europe, Latin America & the Caribbean	AELAC
Country Coordinating Mechanism	CCM
Domestic Resource Mobilization	DRM
HIV, TB and malaria	HTM
Local Fund Agent	LFA
Lower middle-income countries	LMICs
National Strategic Plan	NSP
Office of Inspector General	OIG
Resilient and Sustainable Systems for Health	RSSH
Strategy Committee	SC
Sustainability, Transition and Co-financing	STC
Technical Evaluation Reference Group	TERG
Universal Health Coverage	UHC



Secretariat management response to TERG evaluation

Thematic Review on Sustainability, Transition and Co-financing (STC) Policy

January 2020

Introduction

The Technical Evaluation Reference Group (TERG) provides valuable insight through its independent evaluations of the Global Fund's model, investments and impact. The Global Fund operates with a high degree of transparency and now publishes reports undertaken by the TERG. We thank the TERG for its 2019 review of STC Policy implementation.

Strengthening sustainability, enhancing domestic financing, and supporting countries to prepare for transition from external financing are critical to accelerating the end of AIDS, TB and malaria. The Review highlights significant efforts by the Secretariat and the broader Global Fund partnership to prioritize the operationalization and implementation of the STC policy following Board approval in 2016. Even though we are at an early stage of STC policy implementation, the TERG review concluded that the *"Global Fund Secretariat is transforming the work of the organization in line with the STC policy,"* and that *"in particular... substantial gains have been made in helping LMICs with non-high disease burdens and UMICs to plan for and better manage transitions from external financing."* The report highlights efforts underway across many thematic areas to accelerate policy implementation and embed principles of the Policy into the Global Fund's core operations. At the same time, the review also highlights a variety of ongoing challenges and notes that further efforts to operationalize and implement the STC Policy will be required to meet them. While some of these challenges are strongly related to country ownership and political will and there will be limitations to our influence, the Secretariat acknowledges that there are additional actions we can take in collaboration with partners and countries to further mitigate them.

Areas of agreement

The Secretariat broadly agrees with many of the conclusions in the TERG STC Review, including the overall conclusion that increased efforts are needed to *"support LMICs with high disease burden and LICs in increasing the sustainability of their disease control efforts."* Although a variety of efforts are already underway to strengthen the GF's focus on long-term sustainability challenges across the entire portfolio, to a large extent early STC policy implementation prioritized addressing transition related challenges and enhancing co-financing. The Secretariat agrees that enhanced efforts to strengthen long-term sustainability will be an ongoing priority.

As part of the presentation of the TERG Review to the Strategy Committee in July 2019, the Secretariat agreed with the TERG, the TRP leadership, and the OIG on joint recommendations to guide continued STC Policy implementation. These joint recommendations drew heavily upon the core conclusions of the TERG's STC Policy review and outlined key thematic / priority

areas that build upon the existing progress and continue furthering the goals of the STC Policy. They included:

- **Overall** -- Continue efforts to strengthen transition preparedness and support countries to prepare for transition from GF financing, *while enhancing focus on longer term sustainability challenges in portfolios with larger GF allocations & disease burdens*, a principle finding of the TERG's review.
- **Co-Financing** -- As a key piece of DRM efforts, maintain an ambitious approach to co-financing, including leveraging the co-financing policy to support specific portfolio strategic objectives in the 2020-2022 allocation cycle, including an enhanced focus on fostering overall increases in health spending & specific increases in domestic resources for interventions heavily financed by GF, or external financing, including services for KVPs.
- **Transition / Sustainability Planning** -- Gradually enhance and support earlier sustainability and transition planning across the GF portfolio, including collaborating with partners where relevant and possible
- **Grant Design** -- Continue to leverage grant design to increase alignment of GF investments with national systems, strengthen strategic investments in RSSH, address country specific sustainability & transition challenges, institutionalize domestic financing of services for KVPs, and enhance integration (in line with the RSSH Road Map).
- **VfM and Efficiency** -- Continue and intensify efforts related to value for money and efficiency across the portfolio, including an enhanced focus in the 2020-2022 funding request development and grant-making process.
- **Domestic Financing for KVP Services** -- Continue and intensify efforts to promote domestic or alternate financing of services provided by CSOs (ie "social contracting" mechanisms), including via co-financing, grant design, engagement of partners, and explicit recognition of barriers / challenges in funding requests.
- **Access to Health Products** -- Continue efforts to support access to health products, including through pooled procurement mechanisms (including wambo.org), strengthened early planning, and leveraging available tools, guidance, and partnerships to address country specific procurement and health product challenges, including in transition contexts.
- **Learning and Monitoring of STC Progress** -- Learn from STC efforts already under way and review strategies for enhancing monitoring of STC policy implementation.

The Secretariat is committed to using these joint recommendations to guide ongoing efforts and is already working to address them as we begin the 2020-2022 allocation cycle. These efforts will continue as the Secretariat, in collaboration with partners and countries, begins to support the development of funding requests, grant-making, and the implementation of strategic initiatives in the next allocation cycle.

Observations on recommendations

While the Secretariat broadly agrees with the report's conclusions, there is one item that we believe requires additional emphasis, and several recommendations that require further analysis / consideration.

First and foremost, although the Review notes the importance of political will and recognizes the limitations of the GF Secretariat in addressing some STC related challenges, it is important to re-emphasize this reality. The STC policy provides a strong foundation for strategic Global

Fund engagement and support countries to address transition challenges, encourage increased domestic financing, and strengthen long term sustainability of health systems and national disease responses. However, given that many sustainability and transition challenges depend fundamentally on political will and policy decisions at the national level, the GF's ability to influence these challenges will remain inherently limited. The Global Fund can and should engage strategically, advocate, finance, support, and utilize all levers at its disposal (including the design of our grants and our Board approved policies) to address STC related challenges. But decisions made by countries will significantly affect overall sustainability and transition outcomes.

In addition, there are several specific recommendations where the Secretariat believes additional analysis or further considerations are necessary, including:

- **Resourcing** – On the level of support to country teams from health financing and sustainability specialists, the Secretariat agrees with the importance of prioritizing resources for STC efforts. However, resource constraints under our operating budget cap will continue to limit the ability to enhance specific resources, particularly in the short term.
- **Funding Processes** – On aligning discussions and Global Fund funding processes with national medium-term expenditure frameworks and other budgeting procedures, we will continue to utilize available flexibilities to address misalignments in funding processes with national frameworks. However, fundamental changes to core funding processes, including grant cycles, are challenging to undertake and may carry significant costs for both the Secretariat and countries.
- **STC Indicators** – On considering incorporating additional STC indicators in the KPI framework, the Secretariat will review the availability, rigor and quality of potential additional metrics as we undertake the next strategy cycle.
- **KVP financing** – On prioritizing efforts to address impediments to KVP scale up, the Secretariat strongly agrees with the need to enhance this focus, but notes that ongoing political, legal, and other enabling environment challenges may continue to hinder these efforts in some contexts.
- **Use of the LFA** – On the role of LFAs and CCMs in STC efforts, the Secretariat is already working to enhance the role of the CCM in STC related efforts, but notes that the mandate of Global Fund LFAs does not include capacity building, nor can it due to a conflict of interest.
- **Partnerships** – On enhancing work with partners, the Secretariat strongly agrees with recommendations related to enhancing our work with key partners to address sustainability and transition challenges, but emphasizes that the Global Fund does not control how partners set priorities. Ensuring overall alignment and joint efforts will require significant work and efforts on the part of all stakeholders within the Global Fund partnership.

Conclusion

The Secretariat thanks the TERG for our continued partnership to strengthen the impact of the Global Fund. The development of the STC Policy itself was in part based on findings from a previous TERG review in 2015, and the Secretariat is committed to using the TERG's review and the joint recommendations to further enhance STC efforts. While success and progress will not always be easy – and will often depend on factors not fully under the control of the Secretariat – strengthening our STC efforts will remain a significant priority as we enter the 2020-2022 allocation cycle.



Final Report

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TERG Thematic Review on Sustainability, Transition and Co-financing (STC) Policy

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DISCLAIMER

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

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ACRONYMS AND ABBREVIATIONS

AELAC	Asia, Europe, Latin America and the Caribbean (Department of the Global Fund)
ARV	Anti-Retroviral Therapy
BMGF	Bill and Melinda Gates Foundation
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CHW	Community Health Worker
CHV	Community Health Volunteer
CIV	Côte d'Ivoire
COE	Challenging Operating Environment
CRG	Community Rights and Gender
CSO	Civil Society Organizations
CTE	Consultant Team of Experts
EECA	Eastern Europe and Central Asia
DHIS2	District Health Information Software 2
DR	Dominican Republic
DRM	Domestic Resource Mobilization
EHG	Euro Health Group
FPM	Fund Portfolio Manager
GAC	Grant Approvals Committee
GE	Government Expenditures
GFF	Global Financing Facility
GHE	Government Health Expenditures
GMD	Grant Management Division
GMP	Global Malaria Program
HFS	Health Financing Strategy
HMIS	Health Management and Information System
HMST	Health Management Support Team
HRH	Human Resources for Health
HTM	HIV, tuberculosis and malaria
IHP+	International Health Partnership
KPI	Key Performance Indicator
KVP	Key and Vulnerable Populations
LAC	Latin America and the Caribbean
LFA	Global Fund Local Fund Agent
LICs	Lower Income Countries
LMICs	Lower-Middle Income Countries
MDGs	Millennium Development Goals
MoH	Ministry of Health
NHA	National Health Account
NSP	National Strategic Plans
OIG	Global Fund Office of the Inspector General

OOPE	Out-of-Pocket Expenditures (for health
OPN	The Global Fund Operational Policy Note
PAAC	Public Advisory Advocacy Committee (Republic of Georgia)
PEPFAR	US Government President's Emergency Plan for AIDS Relief
PFM	Public Financial Management
PIU	Project Implementation Unit
PLWHIV	Person Living With HIV
PM	Project Management
PMI	US Government President's Malaria Initiative
PMU	Project Management Unit
PR	Global Fund Principal Recipient
PrEP	Pre-Exposure Prophylaxis for HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PSM	Procurement and Supply Chain Management
RBF	Results Based Financing
RMEI	Regional Malaria Elimination Initiative (Central America and Hispaniola)
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
RSSH	Resilient and Sustainable Systems for Health
SDGs	Sustainable Development Goals
SISF	Strategic Investment and Sustainable Finance
SI-STE	Sustainability, Transition and Efficiency Strategic Initiative
SR	Global Fund Sub-recipient
STC	Sustainability, Transition and Co-financing
STP	Sustainability and Transition Plan
TB	Tuberculosis
TERG	Technical Evaluation Reference Group
THE	Total Health Expenditures
TOR	Terms of Reference
TRA	Global Fund Transition Readiness Assessment Tool
TRP	Technical Review Panel
UMICs	Upper-Middle Income Countries
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
UQD	Global Fund Unfunded Quality Demand
USG	United States Government
VfM	Value for Money
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

Introduction

The global context for addressing HIV, tuberculosis and malaria (HTM) has changed over the past decade as global alignment has shifted from the Millennium Development Goals (MDGs) towards the new Sustainable Development Goals (SDGs). While the MDGs focused on achieving disease-specific program outcomes and mobilizing external assistance, the single health SDG (3.3) focuses on integration and equity in achieving improved health, placing greater emphasis on increasing domestic financing for sustained health services and on achieving the overarching sector goal of universal health coverage (UHC).

Many countries have experienced relatively consistent economic growth over the past decade and have allocated increased funding for health. However, current domestic financing for health in lower income (LICs) and lower-middle income countries (LMICs) remains insufficient to ensure sustained progress in addressing HTM and achieving UHC. While both domestic and external health sector funding increased substantially during the MDG era, domestic resource mobilization (DRM) is now advancing too slowly and levels of development assistance for health (DAH), stagnant since the 2008 global financial crisis, are at risk in the face of changing global priorities. Even if current DAH levels are maintained, gaps in meeting HTM program needs will persist. Coupled with a re-alignment of available development assistance for health towards LICs and LMICs with high disease burdens, this has concentrated overall external assistance on fewer programs and countries.

This provides the context for the Global Fund's current approach to the three diseases. Begun as an emergency effort in 2002, the overall Global Fund Strategy, *Investing to End the Epidemics 2017 – 2022*, embodies both the Fund's early focus on results and its longer-term, more systemic objectives to: i) maximize impact against HTM; ii) build resilient and sustainable systems for health (RSSH); iii) promote and protect human rights and gender equality; and iv) mobilize increased resources required for successful scale-up of the response to the three diseases. One of the Strategy's operational objectives is to "support sustainable responses for epidemic control and successful transitions."

The [Global Fund's Sustainability, Transition and Co-financing \(STC\) Policy \(2016\)](#) supports this overall Strategy. It outlines an approach for further aligning Global Fund support with increasingly self-reliant national efforts. The Policy also provides guidance for ensuring that countries are better prepared for transition from Global Fund financing as they reach higher income status and further achieve disease reduction goals. In addition, the Policy contains updated grant co-financing requirements to encourage country partners to finance an increasing share of disease program costs through domestic resources and to increase overall national budgets for health.⁹

Review Scope and Methodology

The STC Policy was approved by the Global Fund Board in April 2016 and came into effect for the first time during the 2017-2019 allocation period. The objectives of this review were to: (1) assess how the Global Fund has operationalized and is implementing (in the early stages) the "Sustainability" and "Co-financing" aspects of the STC Policy; (2) understand how country programs and stakeholders are incorporating key principles and focus areas of the STC Policy into their national programs and funding requests (FR), including strengthening sustainability, increasing domestic financing, and preparing for transition from Global Fund financing; (3) understand the extent to which the STC Policy is helping foster greater sustainability of national programs, including (but not limited to) how the co-financing policy is supporting greater domestic investment in health and strategic areas of the three diseases; and (4) document lessons learned on how STC Policy implementation and the key focus areas of the Global

⁹ The Global Fund STC Policy (2016).

Fund's sustainability efforts might be further improved at the Global Fund Secretariat (the Global Fund) and the country level, and amongst key Global Fund partners.

The review examined the STC policy at both the corporate and country level, utilizing a mixed methods approach encompassing both qualitative and quantitative data collection and analysis. It included document reviews, key informant interviews with Global Fund and external stakeholders, and ten country case studies: five field-based (Côte d'Ivoire, Kenya, Rwanda, Ukraine and Viet Nam) and five desk-based (Dominican Republic, Georgia, Ghana, Namibia, and Sri Lanka). These included 27 disease components, representing total grants of US\$ 1,344 billion. Ten of the 27 components were at or "near transition", i.e. projected to transition or recommended to begin early planning for transition (7 percent or US\$ 92,345,615 of components reviewed). The findings from this review are summarized below.

Review Area 1: How is the Global Fund Operationalizing and Implementing the STC Policy at the Corporate Level?

The Global Fund has operationalized and is implementing the STC Policy throughout its business processes, from grant making to audit. The implementation of the STC Policy is already well integrated into the day to day work of the Global Fund, country-level grant managers and global partners. An STC Steering Committee chaired by the head of the Grant Management Division (GMD) and including a wide range of Global Fund leadership oversees these efforts to ensure prioritization of STC Policy actions.

Key Findings on Corporate Level Operationalization and Implementation of the STC Policy

- The Secretariat has put in place clear operational guidance and revised grant making processes to effectively support Policy implementation, particularly for transition and co-financing.
- The Secretariat's initial efforts under the STC Policy prioritized helping countries to prepare for component transitions and implementing amended co-financing requirements concurrent with the 2016 – 2018 grants allocation cycle. The STC Policy and associated documents contribute to a high level of predictability around the timing and recommended processes for transition from Global Fund financing.
- The Global Fund Secretariat and associated bodies (e.g., OIG and the TRP) are building extensive internal capacity to support STC objectives.
- The Secretariat is revising Global Fund partnerships to better support STC efforts.
- A strengthened STC lens is in place in review of other policies and strategic guidance notes.
- While there are efforts to increase attention to domestic resource mobilization, innovative finance, RSSH and CRG across the portfolio, less attention seems to have been afforded to strategically operationalize country-led sustainability efforts beyond AELAC countries.

As noted above, the Policy was approved in April 2016. Expectations and requirements for countries around sustainability and transition were further detailed under the *Guidance Note for STC of Programs Supported by the Global Fund* (January 2017)¹⁰, while an additional document¹¹ provided more specific timelines and expectations for countries with components at or nearing exit from Global Fund financing.

The Global Fund revised the Operational Policy Note (OPN) on Co-Financing (April 2017), reflecting the differentiated scope and focus areas of the amended co-financing requirements. The OPN integrated co-financing implementation into the 2017 – 2019 grant and funding request cycle, including verifying new commitments and compliance with previous commitments, assessing and mitigating co-financing risks, and ensuring greater Country Team engagement with ministries of finance and other relevant stakeholders, among other procedures.

¹⁰ Please note that the STC Guidance Note was updated in December 2019 and is available on the Global Fund website [here](#).

¹¹ Global Fund Projected Transition for Global Fund Support by 2025 (March 2018). Please note that the Transition Projections are updated annually and the most updated version is available on the Global Fund website [here](#).

To reflect the expanded focus on STC, the Global Fund revised its funding processes for the 2017 – 2019 allocation period, including modification of allocation letters and revisions in the OPN for Access to Funding, Grant Making and Approval (December 2017). These changes emphasized key elements of the STC Policy including increasing attention to sustainability, transition preparedness and the new co-financing requirements. In addition, the OPN included a new differentiated Tailored to Transition Funding Request (FR) format to support the use of transition or near-to-transition funding in line with the new STC policy. The Technical Review Panel (TRP) was also expanded to include strategic investment and sustainable financing (SISF) experts to provide cross-cutting STC reviews of funding requests (FRs).

Three transition readiness assessment tools and transition work plan prototypes were also developed with support from external consultants in 2016 and 2017. While all countries are expected to take actions needed for sustainability, the Global Fund recommends that countries with components already transitioning or projected to transition, as well as LMICs with lower disease burdens and all upper-middle-income countries (UMICs) begin transition planning.

The Global Fund has strengthened internal capacities to operationalize the STC policy and guidance. The Health Financing Team was expanded, adding a senior manager with an expanded mandate. Internal and external training programs on STC topics have been designed and are being implemented. More than 150 Global Fund staff and key partners had participated in the internal courses as of March 2019.

To support STC activities in regions with multiple countries preparing for transition, five regional sustainability and transition specialists have been assigned to the Asia, Eastern Europe, Latin America and Caribbean (AELAC) Department. These specialists support Country Teams in managing transition processes and promote strategies and actions to improve long-term sustainability and domestic resource mobilization in the Latin America and Caribbean (LAC), Eastern Europe and Central Asia (EECA) and South East Asia (SEA) regions.

The Global Fund has aligned its global partnerships to further address STC issues. The organization has revised or is currently revising agreements with the World Health Organization (WHO), UNAIDS and the World Bank to more prominently feature sustainability and transition; and is collaborating with USAID and UNAIDS on transition planning processes and “social contracting”. The Global Fund is also fostering new partnerships for sustainability through the Strategic Initiative for Sustainability, Transition and Efficiency (STE-SI), including work with the Organization for Economic Co-operation and Development (OECD) to strengthen Ministries of Finance (MoF) and Ministries of Health (MoH) networks, and extensive work on National Health Accounts and Expenditure Tracking, in partnership with the WHO. Furthermore, the Global Fund is participating in global efforts to align external health funding partners in a more consistent approach to sustainability, transition and financing of health systems (e.g., UHC 2030, the Sustainable Health Financing Accelerator and the HIV Economics Working Group).

In September 2018, an audit was published by the OIG on the Global Fund’s management of transition processes in line with the STC Policy¹². The findings were generally positive, confirming that STC policy actions related to transition were largely in place, with recognition of some remaining areas for attention, which have been addressed. In addition, several key informants for this review from countries and partner organizations expressed appreciation to the Global Fund for the clarity of its transition processes and perceived the Global Fund (through the STC Policy) to be a leader in transition.

The Global Fund and associated independent bodies (e.g., the TERG and the TRP) are also undertaking other activities that impact sustainability and transition and should reinforce the objectives of the STC

¹² OIG Audit available [here](#)

Policy. These include: the Country Coordinating Mechanism (CCM) Evolution Project to strengthen the sustainability of the CCMs and the mechanism for multi-stakeholder engagement on STC issues; a review on market shaping¹³; the TRP and access to funding reviews of grant application processes; and on-going strategic work on value for money (VfM)¹⁴, innovative financing and “social contracting” mechanisms. In addition, the recent TERG and TRP reviews of the Global Fund’s support for resilient and sustainable systems for health (RSSH) also focused on sustainability of health services.

However, while work on sustainability is expanding, comprehensive tools or diagnostics for helping high-burden LMICs and LICs identify and prioritize constraints to sustainability of outcomes are not in place. Such reviews are being undertaken strategically by regional teams in AELAC and for specific areas (re: by CRG, RSSH and Health Financing teams). A more systematic, evidence-based approach to country-led sustainability planning is still needed for those countries.

Review area 2: How is the Global Fund Operationalizing, Supporting and Monitoring Implementation of the STC Policy at the Country Level?

The STC Policy and Guidance Note considers countries across a continuum based on income and disease burden. Categories are LICs, LMICs with high disease burdens, LMICs with non-high burdens, UMICs and countries ineligible for Global Fund support.

The STC Guidance Note¹⁵ recommends five focus areas for embedding sustainability into country component design and implementation and is intended for use by all countries receiving Global Fund financing. These focus areas include a robust, costed, and prioritized national strategic plan (NSP); attention to health care financing and development of a health financing strategy; tracking health and disease program spending; implementing through national systems; and gradual absorption of more program costs. However, the five focus areas are not exhaustive. One of the key principles of STC Policy implementation is that it should be responsive to the context of the country/component.

Additional actions beyond those recommended for sustainability are needed by countries preparing for transition (identified as in or projected to transition, UMICs and LMICs with non-high burden of disease). These include a transition assessment, transition and/or sustainability planning, directly addressing sustainability challenges, increased attention to key and vulnerable populations, and accelerated uptake of program costs.

Key Findings on Operationalizing, Supporting and Monitoring Implementation at the Country Level

- The Global Fund provides significant STC technical support to countries, particularly for transition assessment and planning, and health financing and efficiency.
- Dedicated expert staff with regional STC strategies guide and accelerate STC implementation in AELAC.
- The Global Fund is engaging more in country dialogue on health financing based on mutual interests in universal health coverage (UHC).
- The Global Fund uses part of the Catalytic Funding, including Matching Grants, Multi-country Grants, and Strategic Initiatives funding, to support countries in achieving STC objectives.
- A wide range of global partners is enlisted to support country-level STC efforts.
- Additional sustainability monitoring indicators to provide greater detail on integration of services, use of national systems, VfM in national budget utilization, and more timely and better disaggregated data on realization of co-financing, among others, would seem to be appropriate.

¹³ Published in December 2019 and available [here](#)

¹⁴ Updated Technical Brief on Value for Money is available on the Global Fund website [here](#)

¹⁵ Please note that the STC Guidance Note was updated in December 2019 and now has an expanded “sustainability” section that references more focus areas than are referenced here. Available on the Global Fund website [here](#)

Implementation of the policy during the 2017 – 2019 funding cycle required a great deal of attention from the Global Fund on LMICs with non-high burden of disease and UMICs. As of 2018, the Global Fund was working with countries to conduct transition readiness assessments (TRAs) or TRA equivalents in about 30 countries, covering approximately 60 disease components. For many country-components, these processes are undertaken as “sustainability assessments” and plans to increase self-reliance and prepare for reduced external support in general as the timeline for exit from Global Fund financing is not precisely known.

The five sustainability and transition specialists noted earlier play a strategic and technical role in supporting regional and country-component specific efforts on transition in Eastern Europe and Central Asia, South East Asia, and Latin American and the Caribbean, the regions most impacted by earlier transition and transition in the 2017 – 2019 and 2020 – 2022 allocation cycles. They also support regional STC strategic planning and monitoring of STC policy implementation.

An important element of the Global Fund support for transition planning was the development of the three TRA tools: a tool to assess HIV and TB programs and health systems aspects of transition readiness; a malaria-specific tool given the nature of the disease; and a diagnostic tool for sustainable financing of CSO services. These instruments address critical issues of transition and sustainability planning. Although the Global Fund does not require countries to use the specific format, the prototype serves as an example of the robustness of the analysis expected. To strengthen technical support to countries in undertaking TRAs, the Global Fund is also collaborating with key partners, including UNAIDS and USAID, that finance technical assistance for these efforts.

The Global Fund has utilized catalytic funding to support countries in implementing STC activities, including through multi-country grants, matching funds and strategic initiatives for sustainability, transition and efficiency. In addition, the Global Fund has worked with country stakeholders and partners to operationalize and approve multi-country grants (for a total of \$50 million) to support STC efforts at a regional level. These grants support human rights and harm reduction advocacy and sustaining CSO based HIV services for key populations, amongst other key topics. MFs and STE

The Global Fund provides technical support directly and through partners or through component grants, as needed, to support country efforts to improve sustainability of outcomes. For example, the STC Guidance Note states that the Global Fund will engage with countries by working with partners at all levels to support the development of health financing strategies, a focus area under sustainability in the note. While all countries are encouraged to have health financing strategies, the Global Fund prioritizes support in collaboration with partners to countries that: a) have a high, severe or extreme disease burden for two or more disease components¹⁶; and b) where health accounts for less than 8% of government expenditure and/or tax revenues are lower than 15% of the GDP. This reflects an effort to address countries with the greatest need to increase domestic resources.

In addition to support for health financing strategies, the Global Fund provides a wide, and *increasing* array of health financing support for DRM, increased efficiency, and innovative financing. Support for DRM includes:

- strategic engagement with key domestic stakeholders (including MoF), development partners and civil society on broader health financing as well as on focused priority areas for the Global Fund;
- negotiation and incorporation into grant agreements of co-financing requirements and other risk mitigation measures related to transition and sustainability and their monitoring during grant implementation;

¹⁶ Please note that following the modification of the Global Fund’s eligibility policy in 2019, the “extreme” and “severe” disease burden classifications have been removed; disease burdens are now classified as either “High” or “Not High”.

- advocacy and technical support for integration of Global Fund supported programs in UHC dialogue, reforms and financing mechanisms; and
- leveraging global partnerships to support STC objectives, among others.

This support is based on extensive, cross departmental efforts, and runs across divisions and teams in the Secretariat. For example, the Health Financing Team provides technical support internally and to countries, directly and in collaboration with external partners. Regional teams assist in developing evidence-based regional and country-specific strategies. The Global Fund's External Relations team engages with the African Union Leaders to support domestic resource mobilization. Country Teams are on the front lines of negotiating for increased efficiency and effectiveness as grants are signed, as well as for co-financing and counterpart commitments.

As part of health financing efforts, the Global Fund actively supports countries to improve efficiency, and more broadly, value for money. Grant-making and oversight processes have been fine-tuned to respond to the STC Policy. This includes adding guidance in the allocation letters on efficiencies and use of costed and targeted national strategic plans. Also included is guidance on requirements to address sustainability and value for money in funding requests, TRP reviews of all technical aspects of the funding requests, and the negotiations undertaken by the Country Teams in finalizing component grants and in reprogramming funds that are not utilized. Other measures for improving VfM include increased TRP attention to program targeting, normative guidance and rational use of technologies; careful review by the Country Teams of grant budgets and quantities; and portfolio optimization exercises driven by STC concerns. In addition, the Secretariat supports a growing portfolio of in-country efficiency and innovative finance efforts, many supported through the STE-SI.

However, far less attention seems to have been given across the portfolio to sustainability assessments and planning in countries other than the countries encouraged to plan for transition.

The monitoring of the policy is largely aligned with the institution's Key Performance Indicators (KPI). Additional indicators to provide greater detail on integration of services, use of national systems, VfM in national budget utilization, and more timely and better disaggregated data on realization of co-financing, among others, would be appropriate.

Review area 3: What are the Initial Results and Implications of STC Policy at the Country Level?

Overview: The Consultant Team of Experts (CTE) noted a range of responses from in-country key informants on the STC Policy. In countries with sustainability and transition planning, key informants were better informed and had a more holistic view of in-country STC activities and challenges. In other countries, key informants (except for budget and finance informants) were largely unaware of the STC Policy and sustainability and transition recommendations and requirements. In addition, many in-country informants were familiar only with the co-financing incentive and the differentiated focus of the co-financing depending on country income, and not the need for increasing health sector resources overall.

Sustainability key themes: The review of FRs and Grant Approvals Committee (GAC) Review and Sign Off forms for the ten case study countries confirmed that the FRs were largely responsive to new requirements on sustainability and co-financing during the grant making process. The ten case studies demonstrated good but varied progress across the five thematic areas. Nine of the ten countries have costed NSPs for disease programs based on broad country consultation. The selected NSPs reviewed are adequately prioritized for countries to make decisions based on available, rather than needed, funding. However, many NSPs have large gaps between the financing available and NSP identified program needs. For the ten countries reviewed, financing gaps averaged 20, 30 and 34 percent for HTM programs, respectively; with gaps ranging from 0 to 78 percent.

Nine of the ten countries have or are developing a national health financing strategy or equivalent, inclusive of the three diseases. All ten countries have institutionalized expenditure tracking mechanisms (e.g., national health accounts or other mechanisms), although measurement is infrequent and/or sporadic for some countries.

The Global Fund grants show uneven alignment with national systems. This is partly due to weaknesses in underlying health systems, and partly a result of programmatic and financial risk mitigation measures. Examples of good alignment include Rwanda, with National Strategy Financing (NSF) budget support where country systems are almost exclusively used and Ukraine, where the Government

Key Findings on Initial Results and Implications of the STC Policy at Country Level

For the ten case study countries:

- The implementation of Global Fund grants is largely aligned with NSPs. The NSPs are costed, and some with prioritization. Some of the NSPs are out of date or in the process of being updated, but still relevant. However, all but one of the NSPs show substantial, unfunded gaps between needed and available funding.
- Transitioning programs demonstrated strong adherence to key transition focus areas in the STC Policy. This is in line with findings from the OIG Audit on Transition Policy implementation. All transitioning programs had undertaken a transition assessment and transition and/or sustainability planning and included transition/sustainability planning outcome and process indicators. The engagement of a range of stakeholders (such as CSOs) in transition processes and monitoring has helped to secure wider country-level buy-in around STC objectives.
- Most countries have or are developing national health financing strategies, mostly in the context of universal health coverage (UHC). All countries indicated national health accounts (NHA) or other expenditure tracking systems for health. Almost all proposed integration of some aspects of HTM services into on-going UHC efforts (e.g., social insurance expansion or primary health care services packages).
- There is increasing use of country systems, but areas for better integration remain even in transition settings.
- Health systems weaknesses are not adequately addressed to promote sustainability. Grant RSSH activities generally focused on support for grant implementation rather than on systems strengthening.
 - In many of the ten countries, national procurement remains constrained by weak public financial management (PFM) systems, other systems constraints, and limited market power.
 - In some programs, data capture continues to be vertical and, in most countries, gaps remain in capturing private sector information.
 - Program management (PM) costs remain substantial.
 - Salary supports remain in the current portfolio; most countries are responding to efforts to absorb the salary costs in national or local government budgets during the current allocation cycle.
 - Community Health Workers (CHWs) feature prominently in grants, including disease-specific CHWs without clear plans for integration into broader service delivery or sustained funding.
- KVP services remain a key risk for program sustainability. Most KVP and human rights interventions are funded through external sources, regardless of proximity to transition, and are at risk of neither being scaled-up nor sustained. Legal and regulatory impediments to "social contracting" remain.
- All case studies countries committed to increased health sector financing and absorption of disease program costs, particularly first-line drugs and some human resources. Components in transition committed to the rapid uptake of remaining essential costs.
- Countries have limited fiscal capacity for domestic resource mobilization (DRM); increases in health budgets will largely require national budget reprioritization.
- Prevention programs were often not clearly identified nor costed in national budgets, raising allocative efficiency concerns.
- Attention is still needed for coordination and alignment of external partners on sustainability and transition processes at the country level. Engagement of the private sector is also lagging.
- Existing governance structures (e.g., Global Fund CCMs) may constrain sustainability. For example, disease program managers who have been strongly engaged in grant design for vertical programs may be reluctant to integrate disease activities (e.g., TB and HIV) or across RSSH systems".

is developing institutions and processes as needed to internalize all disease related interventions. As programs move toward transition, there is greater use of country systems, with more attention to resolving key constraints, particularly issues in PSM as national procurement becomes an increasingly important factor. The alignment and sustainability of key and vulnerable populations (KVP) activities in the non-state sector continue to need attention for most countries.

Health Financing: The CTE found evidence of strong political commitment for UHC, and to some extent, to the three diseases, with both health budgets and disease budgets increasing. The case studies presented various macro and microeconomic challenges to program sustainability – but also held positive examples, such as increased social insurance coverage and reduced out of pocket expenditures in Georgia, Rwanda and Viet Nam, among others. Most of the countries are engaged in health system reforms including health financing and/or health delivery systems to improve the efficiency and reach of the health services. These reforms were often in conjunction with broader national reforms. An example is Kenya where health financing and related responsibilities have been devolved to county governments. As noted, the Global Fund is playing a supportive role in many of these reforms, either directly, or in partnership with other organizations (e.g. WHO and the World Bank). This includes developing benefit packages and undertaking actuarial analyses for the inclusion of HTM in UHC mechanisms across the range of country settings and classifications and supporting the integration of HTM into primary health services. Co-financing requirements also support Country Teams and Secretariat staff in engaging on health financing issues and identifying opportunities for DRM.

However, CTE analyses of the fiscal setting for the ten countries notes that financing these programs, particularly the large HIV programs, represents quite a burden in countries with limited fiscal capacity to absorb the additional program costs. Analysis indicates there is limited or no potential to increase total government expenditure in the short-term. Across the countries, any real increases are likely only to be realized through increases in tax revenue generation and/or continued economic growth, the prospects for which are uncertain. As such, any significant increase in government allocations to health would most likely require a commensurate reduction to other sectors.

The Global Fund is also actively supporting countries in two other areas related to health financing: improving efficiency, or more broadly, value for money; and innovative financing. As noted above, operationalization of the STC Policy has further oriented grant making and oversight processes toward obtaining value for money for Global Fund resources – that is, maximizing impacts. In terms of grant funding processes, the funding requests, TRP Reviews and GAC Review and Sign Off forms all address VfM to the extent required. The CTE did not analyze data on the funding request amounts saved through grant negotiations and portfolio optimization in the 2017 – 2019 allocation cycle, but it is likely that the total amount saved (or expanded results achieved) through these processes was substantial.

Key informants noted that many countries have had substantial reductions in external financing due to reduced support from Global Fund or transition from other donor support, yet many have maintained and improved on HTM results (e.g., Rwanda, Namibia). Learning lessons from how these countries obtain efficiencies could be useful.

Results of Global Fund's pre-STC Policy and on-going work can be seen in the allocative efficiency modeling that was the background for most of the country component NSPs in the ten case studies. Results from more recent work, e.g., cross-programmatic efficiency studies, geospatial modeling and differentiated models of care and other efficiency initiatives are only recently being undertaken. However, concerns are raised in the case studies around allocative efficiency given low levels of financing for disease prevention programs. Prevention programs were often not clearly identified or costed in national budgets. Where budgets were clear, these activities garnered very little funding (e.g. 4.5 percent in Kenya). Positive exceptions are the HIV and TB programs in Ukraine, Georgia and the

Dominican Republic, where the Global Fund is supporting activities to define and cost the package of preventative services. In addition, few efficiency studies cover CSO interventions that reach KVPs.¹⁷

Both strategic work at the Secretariat level and country and regional efforts on innovative financing efforts are underway (e.g., trust funds, Debt2Health, loan buy-downs, among others). This includes work with the Global Fund Board and its Audit and Finance Committee to better define innovative finance (IF) principles, approaches and potential instruments to be pursued under different conditions, as well as outlining the potential role of the Global Fund as a catalyst for IF.¹⁸

RSSH: The findings of this STC Review are similar to many of the findings of the recent TERG and TRP reviews of Global Fund support to RSSH; and provide further evidence for the need to more clearly focus RSSH activities on longer-term health systems strengthening, rather than mainly on grant implementation support activities. Operationalizing the RSSH Roadmap and further addressing systems challenges to sustainability will be extremely important to sustaining disease impacts. External partners also questioned the appropriateness of the CCM as the oversight mechanism in guiding the development of RSSH proposals given that these mechanisms are often driven by program managers and others who may have difficulty relinquishing “turf” for integration of programs. The current interventions seem to reflect the needs of the HTM programs in achieving Global Fund objectives, rather than addressing broader health systems challenges (e.g., integration of disease control programs, overarching human resources for health issues).

In terms of RSSH key “building blocks”, the case studies demonstrated a range of gains and challenges. For example, for information systems, while some countries were integrating county-level reporting into integrated DHIS2 (e.g., Kenya) and e-health systems (Ukraine), others maintained at least one component with vertical reporting systems (e.g., Viet Nam, Sri Lanka, Namibia and Ghana). While this may be cost-effective in some settings, the default should be integration given the needs of long-term sustainability, unless there is a strategic cause for duplicative systems.

Human Resources for Health (HRH), often for program support, continue to be prominent in grant budgets. However, in the 2017-2019 cycle, funding requests for all ten countries included human resources plans to increasingly absorb the costs and positions for grant-funded human resources into the public-sector budget and personnel plan in a staggered manner; with difficult to fill or highly specialized positions absorbed last. Financing for Community Health Workers (CHWs) features prominently in most of the NSPs. These posts are sometimes disease-specific (e.g., not integrated into broader services delivery) and in general, plans for supervision, absorption and future funding of positions are not well specified. Also not addressed, except for being partially addressed in the countries undertaking transition and sustainability planning, was the absorption of the costs of delivering CSO or other non-governmental services to key populations, a continued weakness in sustainability planning.

While the case studies show improvements in national procurement capacities, rapid scale-up of local procurement given increased co-financing requirements and reduced external assistance has challenged the systems. Several countries (Kenya, Côte d’Ivoire and Dominican Republic) noted public financial management and procurement regulation constraints to effective national procurement of HTM commodities. At least four of the ten case study countries reported recent stock-outs, especially of ARVs (Namibia, Ghana and Côte d’Ivoire) and laboratory supplies (Dominican Republic). This suggests there is a further need to address forecasting, procurement and distribution systems. Also, several countries lack market power and benefit from the Global Fund as well as other global and regional mechanisms for procuring health commodities. Eight of the ten case studies procure Global Fund financed commodities through the Global Fund’s innovative procurement tool (wambo.org). A

¹⁷ A 2019 effort by LAC will conduct an efficiency analysis of CSO delivery of KVP interventions.

¹⁸ See “Update on Innovative Financing,” Global Fund Board, GF/B39/25, May 2018, available [here](#).

current review¹⁹ of the Global Fund Market Shaping Strategy (MSS) being undertaken by the Global Fund should highlight the need for such mechanisms, as well as the potential to serve countries to ensure access to affordable, quality medicines after transition. In addition, there remain some items that are inefficiently procured (e.g., nationally funded ARVs in Namibia).

Program management costs are still a significant investment element: analysis ²⁰ of the funding request budgets by the CTE found that on average 12 percent of grant costs in the ten case-study countries. These costs are included in the Global Fund's definition of RSSH, even though these costs are strictly not an RSSH element. Removing the countries where program management is already significantly in government hands (Georgia, Ukraine, Vietnam, Namibia, and Rwanda, the latter having an NSP-based grant), the average program management costs for the remaining six case studies rises to 17 percent.

KVP Services: There is wide recognition that sustaining disease impacts requires prevention and care activities that reach key and vulnerable populations. Few of the ten case study countries have yet to establish the processes and legal frameworks needed to promote state funding of non-state actors for important key population interventions. Even where processes and frameworks are being piloted, constraints to these approaches are clear. For example, in Georgia, where a mechanism for the public financing of civil society organizations does exist²¹, the requirement for the non-state actor to provide a bond – even for a small percent of the overall contract – limits the ability of community and local non-state organizations to respond²². In other countries, “social contracting” mechanisms are in a pilot phase (Dominican Republic, Ukraine) or are underfunded (Côte d’Ivoire), and countries often lack financial capacity to sustain primary prevention programs at the levels supported by the Global Fund. While progress is being made with countries such as the Dominican Republic progressively taking on CSO financing needs, more progress will be needed if KP services are to be scaled-up and sustained.

Partnerships: Different levels of in-country coordination of external partners were seen across the case-study countries. Factors that seem to impact coordination include the level of Global Fund investment vis-à-vis other partners, the placement of the funded support within the health sector (e.g., on/off budget, separate PMUs or integrated into overall government management of the program), and the ‘strength’ of the CCM in coordinating activities. More aligned processes, such as the National Strategy Financing RBF instrument in Rwanda, support efficiency and provide governments with a better framework for donor collaboration. In Namibia, increased coordination between the Global Fund, PEPFAR and the World Bank has strengthened dialog between the Government and the donors and efforts to address HIV and TB. In Ukraine, under the UN Partnership Framework and Joint Program 2018-2022, sustainable HIV response is a key strategic priority. However, there were still instances detailed in the case-studies of poor coordination across donors. For example, a new World Bank loan for PMNCAH in Kenya failed to include PMTCT or malaria indicators as these activities were being undertaken with Global Fund rather than loan resources. Several of the case-study countries have PEPFAR supported activities outside of and in parallel with Global Fund financed activities. External key informants expressed concerns that TRAs and fiscal space analyses were often undertaken as Global Fund specific activities, without reference to the broader donor community.

The need to engage more with the private health services sector is widely recognized, but little is done. For example, in Kenya, an estimated 43 percent of TB cases seek first treatment in private clinics or pharmacies. However, in the case studies, little collaboration is noted on the ground, despite private

¹⁹ The TERG conducted a mid-term review of the MSS during about the same timeframe as this review. It was published in December 2019 and is available [here](#).

²⁰ The CTE notes that these costs are often amended during grant negotiations and likely represent a smaller portion of the actual grants.

²¹ Please note that in the in the context of Georgia there are challenges at the country level related to the use of term “social contracting” given the distinctions between “social services” and “health services” and exclusive use of the term “social contracting” to describe contracting of “social services” provided by public, private or CSOs entities.

²² With respect to the requirement for a bond, exemptions from this requirement are granted during the tendering process in order to reduce the impact on CSOs.

sector presence on all CCMs. Particularly noticeable is the absence of private sector data across the three diseases, even in those that have integrated, interoperable information systems. An exception is malaria and TB support by the corporate sector in Namibia (22 percent of program financing).

Transition: Two of the twenty-seven disease components in the ten STC review case study countries are identified by the Global Fund as in or projected to transition in the 2017-2019 allocation cycle (Sri Lanka malaria; Dominican Republic TB) and another eight are recommended to begin early planning for transition based on country national per capita income category and disease burden. Transitioning programs demonstrated strong adherence to STC Policy key transition focus areas.²³ This is in line with findings from the OIG Audit on Transition Policy implementation. All transitioning programs had undertaken a transition assessment and transition and/or sustainability planning. Transition/sustainability planning outcome and process indicators are included in updated NSP frameworks in the Dominican Republic, Georgia, and Sri Lanka. Investments for addressing sustainability challenges are included in the grants. The two programs receiving transition funding for this allocation period (Sri Lanka malaria and Dominican Republic TB) rapidly increased the absorption of financing for program elements in the current grant period.

For the Secretariat, these activities were happening on a bigger scale. Overall, 23 countries in EECA/LAC conducted TRAs or TRA equivalents and developed transition/sustainability plans by the end of 2018.

Co-financing: Negotiations, including identifying co-financing commitments, were completed for 2018–2020 program grants in the 10 countries prior to or during the STC Review. All countries committed sufficient amounts of co-financing to meet the Global Fund requirements, as well as meeting the focus requirements for KVP programs, resulting in increased financing for the health sector and the three diseases. However, lack of conformity in the data (e.g., information on items financed, availability of line item figures) means cross country comparison is difficult. Verifying both commitments and amounts spent remains a labor-intensive endeavor that requires specific knowledge of the country's fiscal setting and counterpart choices.

Two of the case study countries (Côte d'Ivoire and Kenya) noted difficulties in meeting co-financing initial year amounts. The former due to lack of alignment with national budget processes, meaning funds would flow only in the following year; the latter sees prospective issues due to difficulties in public financial management associated with national procurement (the procurement authority is unable to work on an accrual basis, thereby creating issues if invoices cannot be paid before the June 30 end of the fiscal year).

More broadly, countries are clearly taking on more responsibility for financing all three diseases, with accelerated co-financing in LMI and UMI countries, and for HIV and TB. In particular, LMICs are responding with increasing commitments for uptake of program costs.

However, the co-financing guidelines are complex, differentiated and flexibly applied. The data is difficult to follow and no clear KPI seems to exist requiring regular timely reporting. This makes cross-country assessment challenging. Very few of the key informants could respond to questions about co-financing, however, the majority seemed to consider the level of co-financing being requested as not overly challenging for the national governments to provide. There were issues raised regarding public financial management and the ability to spend growing budget commitments.

²³ Transition program grants included in the STC review were Dominican Republic TB and Sri Lanka Malaria. Six other programs have been identified by the Global Fund for priority transition and sustainability planning: Georgia HIV and TB programs, Dominican Republic TB, and all three programs in Namibia, although no timeline is given for transition from Global Fund support (after 2025). However, transition projections are updated periodically and published by the Global Fund.

Conclusions/Key Challenges

Overall, the review finds that the Global Fund Secretariat is transforming the work of the organization in line with the STC Policy. In particular, skills and tools are in place and substantial gains have been made in helping LMICs with non-high disease burdens and UMICs to plan for and better manage transitions from external financing. This work is on-going and needs to continue, including better monitoring of transition outcomes beyond cessation of Global Fund financing and finding means to ensure that programs maintain their successes as they exit from external financing.

Similar attention and effort are needed to support LMICs with high disease burden and LICs in increasing the sustainability of their disease control efforts. For many of these countries, ambitious timelines for elimination or eradication of the diseases may be unrealistic given resource limitations and institutional constraints. The Secretariat needs to increase attention on developing longer-term, sustained responses in these settings. At the same time, it is imperative that the countries take on greater responsibility for HTM programs. Many LICs and LMICs are already committing more funding to the health sector in response to the call for UHC and the decline in donor funding for the three diseases. Encouraging countries to own the response to the HTM epidemics as UHC health reforms take place will be critical for sustaining disease outcomes.

The Secretariat's operationalization of the STC policy already leads in this direction. The revised co-financing policy provides both requirements and incentives for increased domestic financing of the health sector and to address the three diseases, as well as increasing focus on services for KPs. The health financing team, Country Teams and others are working with external partners and country counterparts to improve health financing strategies, domestic resource mobilization, and sector and programmatic planning and efficiency. Grant activities are being better aligned with national systems and processes. Grant design is addressing sustainability challenges. For example, greater attention is being placed on resilient and sustainable systems for health and key population and human rights interventions. Revised processes for the 2017 -2019 allocation cycle include consideration of sustainability issues by funding requestors, reviewers and approvers. Catalytic funding is also addressing many key sustainability issues.

Conclusions

- The Global Fund Secretariat is transforming the work of the organization in line with the STC Policy. This should result in better preparation of countries for transition from Global Fund financing, increased domestic financing for HIV, TB and malaria (HTM) services, and better integration of HTM into national UHC efforts.
- Well-designed grants that promote sustainability are crucial to successful STC policy implementation at every stage of the development continuum.
- Support for KVP services is critical to the long-term sustainability of outcomes. More attention is needed as early as possible to ensure that KVP services are brought to scale and sustained.
- Greater emphasis is needed in Global Fund RSSH investments on system strengthening and differentiation for the systems development continuum to support the sustainability of disease outcomes.
- The extent to which the Global Fund can support and encourage countries to access affordable commodities before and after transition will affect the outcomes of STC Policy implementation.
- Wider use of country-led sustainability assessment and planning tools could further support building mutually agreed on STC efforts. The Global Fund's ability to influence sustainability and transition preparedness is inherently limited. Ultimately, countries will determine to what extent their programs address core sustainability and transition challenges. Greater country ownership of STC efforts is critical to policy success.
- Consideration is needed re: more consistent monitoring and/or better measures of key STC outcomes and processes, especially around co-financing (real-time, consistent data); RSSH reforms (integrated service delivery, use of national systems, program management); and value for money in obtaining results (e.g., drug costs).
- STC elements in the grant-making process should be further strengthened for the next allocation cycle.
- The Global Fund should further align grant management and governance processes to frameworks and mechanisms that promote longer-term sustainability.
- Greater attention should be paid to improving program efficiencies, particularly given limited options in LICs and high-burden LMICs to increase domestic resources.
- Several key areas should receive greater consideration: ensuring that diseases are under control, interventions are affordable, the use of new technologies is cost-effective, and that the efficiency of program management and governance is improved.

However, the CTE perceived a large difference in the level of strategic thinking and ownership of the STC processes evident in documents and key informant interviews between countries that had undertaken transition and sustainability planning and the countries that were yet to move forward with comprehensive TRA type assessments.

Similar differences were noted in focus across Global Fund regional divisions between those targeting transition planning and others. While it is important not to underestimate the level of effort needed to support lower capacity countries with high disease burdens in implementing large Global Fund grants, it is important that *sustainability* of the disease outcomes be further prioritized by countries and within the Secretariat even in those regions where no or few countries are planning for transition. This will require further internal capacity building, consideration of additional STC staff and review of ToRs to ensure STC is a key responsibility of Country Teams and others, developing new tools that support better country-led sustainability assessment, and refining the Global Fund’s internal strategic processes that support sustainability actions. In addition, the STC Review case studies underscore remaining challenges that require attention and effort from the Global Fund, external partners and countries across the portfolio.

The case studies do show that countries are responsive to efforts to improve program financing and efficiency, and to address continuing constraints. The task now is to build a more comprehensive, country-driven approach to sustained HTM outcomes.

Key Challenges

- Ensuring the scale-up and sustainability of outcomes from KVP programs. Many of these programs are externally financed and provided through NGOs and other non-state actors, development “social contracting” mechanisms and domestic financing are lagging;
- Maximizing systems strengthening outcomes from RSSH investments;
- Ensuring strategic, country-driven approaches to sustaining disease outcomes across the portfolio (including and beyond AELAC regions);
- Overcoming overall limitations on sufficient financing/DRM given constraints on domestic resources for health, particularly for lower income, high disease burden countries, including expanding efforts on improving efficiency and value for money;
- Ensuring access to efficient commodity pricing before and after transition;
- Using co-financing requirements more strategically to leverage further uptake of non-commodity program costs, particularly for prevention and KVP programs; and
- Balancing short-term versus long-term views of implementation versus sustainable outcomes, which are not always fully concordant. For example, the Global Fund risk management measures versus the use of country systems, as well as RSSH support versus strengthening, pose trade-offs for sustainability.

Recommendations

Overall:

Further strengthen efforts to operationalize and implement the STC Policy. Continue to prioritize and monitor successful transition for country disease components exiting or on a path to exit from Global Fund financing. Continue to build internal capacities, evolve grant-making processes, and maintain attention to sustainability in grant implementation. Continue efforts to increase efficiencies and value for money in grant negotiations. Fine-tune accountabilities, work plans and incentives, as needed, across the organization, and with grantees, contractors and partners to ensure that they are fully consistent with prioritizing the *sustainability* of disease outcomes. Ensure adequate staff time, capacity and attention are available to strategically implement the STC Policy. [Global Fund Board, Secretariat, and related bodies (OIG, TRP, GAC, TERG)].

Priorities for increased attention:

Prioritize and strengthen efforts to address impediments to the scale-up and sustainability of effective HIV, TB and malaria services for KVPs across the portfolio.

Intensify efforts to promote domestic or alternate financing and “social contracting” mechanisms for CSOs and human rights advocacy that support primary prevention, treatment and compliance adherence activities, even at early stages in the process toward self-reliance. [Countries, Secretariat, Partners].

Further address health systems weaknesses that impact the sustainability of disease outcomes. Implement the new RSSH Roadmap (March 2019) to target investments that address sustainability challenges, including differentiation across the systems development continuum and increasing strengthening vs. support activities. Urgently expand efforts in three areas: (i) diagnose and address constraints to effective national procurement and supply management, (ii) address public financial management constraints to program implementation under increased domestic financing; and (iii) address constraints to integration of programs and systems, seeking greater efficiency and effectiveness in health services delivery, health information, human resources for health, program management and governance. Consider providing guidance internally and to countries regarding rationalizing program management costs. [Countries, Secretariat, Partners].

Increase attention to sustainability assessment and planning in high-burden, lower-middle income countries. Encourage and support country-level sustainability planning for all countries. Consider expanding successful internal regional STC efforts to cover all regions: Assign S&T specialists to the remaining regions. Modify grant applications to reflect greater sustainability. Develop regional frameworks, strategies and priorities for addressing sustainability. Modify the current transition readiness assessment methodology to better serve broader sustainability assessment in these settings, with a greater emphasis on systems strengthening, efficiency and value for money, and addressing constraints to scaling up and sustaining KP and human rights activities. Increase coordination with PEPFAR, the President’s Malaria Initiative (PMI) and other donors to ensure sustainability planning considers the broad context of external support. [Countries, Secretariat, Partners].

Continue to create and ensure access to Global Public Goods in key areas, especially market shaping for key drugs, diagnostics and commodities; knowledge around building program efficiencies; and engagement with KVPs. These public goods create value for money across the global HTM responses. Ensure countries retain access to these key areas, beyond their period of access to funding. Provide access to wambo.org or other pooled procurement or price determining mechanisms during and for some period beyond Global Fund eligibility for countries that lack value pricing for national procurements in open markets due to limited scale or other market factors. Also encourage, through policy dialog and partner support, the Global Fund supported countries to utilize these pricing and procurement mechanisms when national procurement regulations constrain access to value pricing under domestic financing. [Board, Secretariat, Partners].

Fine-tuning of STC Operationalization and Implementation:

Heighten emphasis on efficiency and value-for-money across all Global Fund supported components. Inculcate a culture of efficiency across Global Fund supported programs and activities. Strengthen the narrative on increasing program efficiencies in all funding requests. Work with countries individually or regionally to develop country-driven strategies and priorities for addressing efficiency during the allocation period. Continue to support allocative efficiency studies to ensure sufficient attention to scale-up of prevention activities. Ramp up attention and technical support for value for money analysis of national programs and interventions, including national drug procurement and community-level services. Provide support to countries to assess, implement and evaluate efficient health services reforms, including decentralization. Ensure KVP programs that are to be taken over under national budgets represent value for money. [Countries, Secretariat, Partners].

Sharpen focus on tools and processes for prioritization of disease responses at the country level, particularly for high-burden upper-middle and lower-middle income countries. Continue to support country-level HTM stakeholders in building a sound investment case and advocating for domestic resources within the context of the country's plans for UHC. In collaboration with partners, further improve epidemiological and financial modeling and translation of this information into priorities, plans and budgets; especially, better prioritized and realistically costed NSPs, analyses for the inclusion of HTM services in social health insurance, and national health financing strategies. [Countries, Secretariat, Partners].

Continue scaling up efforts on domestic resource mobilization, including through innovative financing mechanisms such as debt buy-downs and swaps. Prioritize increases in domestic financing for scale-up of KVP services in UMICs and LMICs where needed to address the epidemics (domestic funds and funding mechanisms). Increase the level of health financing and sustainability support from internal specialists to support Country Teams' dialog and co-financing discussions, particularly in LICs and LMICs. Undertake more joint planning and missions with the World Bank/regional banks to more fully engage with planning, budgeting and finance authorities. Better align discussions and Global Fund funding processes with national medium-term expenditure frameworks (MTEF) and other budgeting procedures. [Countries, Secretariat, Partners].

Continue to evolve the application of co-financing to meet both the intent and the requirements of the STC policy. Follow the Global Fund's successful experience in gaining commitments for increased domestic financing of the health sector and HTM component financing with improved reporting and accountability for realizing committed amounts. Continue active risk assessment and monitoring of commitments. Further work with countries to ensure co-financing reflects increased uptake of a broad range of key program elements, including KVP program costs. Consider revising commitment and reporting formats to more readily obtain up-to-date information that includes information on items funded and can be compared across time periods for the same country and across countries [Countries, Secretariat].

Expand country ownership and responsibility for STC efforts, and ensure country-centered, demand-driven Global Fund support. Continue to increase the use of national systems, including national budgeting and procurement processes, to the extent possible. Consider means of extending the level of country ownership that seems to have been built through the TRA process of identifying and addressing challenges to broader sustainability issues in non-AELAC regions. Expand the use of innovative models, such as the NSP-based model used in Rwanda, to other countries. [Countries, Secretariat, Board].

Consider additional STC indicators as part of the Key Performance Frameworks guiding the Global Fund and its country grants. Review KPIs and internal management indicators to ensure they reflect key data needed to assess STC progress. At Global Fund management level, ensure indicators are available to routinely monitor (i) RSSH strengthening, including integration and use of country systems; (ii) KVP program sustainability, and (iii) progress on co-financing commitments (mid-grant or annually) by content with easy comparison across countries. Ensure that data are routinely captured and reported. [Secretariat].

For additional consideration:

Learn from sustainability and transition efforts already underway in Global Fund countries and regions. Further share experiences within the Global Fund on working with countries to improve STC outcomes. Review STC relevant efforts covering LICs, LMICs and UMICs to identify best practices and hazards. [Countries, Secretariat, Partners].

Further align grant management and governance processes to frameworks and mechanisms that promote longer-term sustainability, and away from quick responses to reducing the disease burden. There may be inherent barriers and constraints to sustainability posed by the original grants management and governance processes, e.g., historical capture of the grant process by disease program managers may hinder robust RSSH proposals or integration across programs and systems. In addition, risk management versus sustainability continues to be a trade-off in the use of country systems. Further attention to mechanisms for mitigating risks while maximizing the use of country systems is needed. [Board, Secretariat].

Consider greater use of the CCM, the LFA, and other on-the-ground mechanisms to strengthen coordination and oversight of STC efforts. The CCMs could support strategic approaches to improve sustainability, including greater emphasis on financing and efficiency. One member could be tasked with oversight of the process. The CCM could establish a task force for sustainability and transition, and engage on these issues actively during CCM meetings. This could be reviewed under the on-going CCM Evolution project of the Secretariat. The LFA could support both capacity building and oversight for STC efforts; this may require additional or separate ToRs. [Board, Secretariat].

INTRODUCTION

Global Fund and the Context of the Review

The Sustainability, Transition and Co-financing (STC) Policy of the Global Fund was approved by the Global Fund Board in April 2016. The STC Policy was quickly operationalized and the Global Fund, in cooperation with countries and partners, began implementing the policy during the 2017-2019 allocation period. Grants reflecting key STC Policy focus areas and principles are now starting to be implemented (the majority from mid-2018) following the 2017 – 2019 allocation cycle funding request and grant-making process.

In 2018, the Office of Inspector General (the “OIG”) conducted an audit of the Global Fund transition management processes.²⁴ The scope of the audit included an examination of the effectiveness of Global Fund governance mechanisms to support transition, as well as the adequacy of key processes to operationalize the transition component of the STC Policy. The report concluded that transition processes were being applied consistent with the STC Policy and subsequent guidance.

In March 2018, the Global Fund Strategy Committee requested the Technical Evaluation Reference Group (TERG) to conduct a review of the STC Policy by early 2019. The objectives of the review are outlined in Section 2.2, below. The STC Policy is considered relevant to all countries, not just those in or projected to transition, as supported by the findings of earlier TERG sustainability reviews that highlighted the importance of considering STC as early as possible.²⁵ The TERG accepted that that STC Review should complement and not duplicate the OIG audit of transition management processes.

This review focuses on the operationalization and implementation of the key principles of the STC policy, determining the initial impact of the STC Policy at the country level, and how the implementation of the policy might be improved. The review focuses primarily on the sustainability and co-financing aspects of the STC policy and peripherally examines transition issues given the recent OIG audit.

Strategy Committee (SC) suggestions resulted in the Statement of Work also reflecting review of the extent to which STC Policy implementation is encouraging governments to assume greater responsibility for key program costs. These include procurement of essential drugs, health products and commodities; primary prevention activities; human resources for health; and service provision for key and vulnerable populations.

The review focuses primarily on STC policy implementation in middle-income countries with a high burden of disease. These programs represent a large portion of Global Fund business. This focus results in emphasis on the sustainability and co-financing dimensions of the policy and avoids duplication with the OIG audit of the transition management processes published in September 2018. However, the STC review takes into consideration key findings of the audit and ensures that the three dimensions of the STC policy continue to be interlinked.

Structure of the Report

The Report is divided into eight chapters plus an executive summary. The review provides the methodology, subsequently it looks explicitly at country program adherence to the key sustainability and transition focus areas and at application of the STC Policy principles. The report then examines how selected case study countries are addressing sustainability, transition, and co-financing requirements. The review assesses corporate actions undertaken to implement the policy. Based on the

²⁴ Office of the Inspector General (OIG). Audit of Global Fund Transition Management Processes (September 2018), available [here](#)

²⁵ Technical Evaluation Reference Group (TERG) reviews 2013 and 2015.

synthesis undertaken in the body of the report, the final chapter presents recommendations for improving Global Fund STC practices and guidance and provides final conclusions.

METHODOLOGY

Understanding of the STC policy and its implementation

The STC Policy was approved by the Global Fund Board in April 2016 followed by the STC Guidance Note in May 2017. The STC supports the overarching strategy of the Global Fund for 2017 – 2022, which recognizes four primary areas for overall Global Fund attention: maximizing impacts against HTM; building resilient and sustainable systems for health; promoting and protecting human rights and gender equality; and mobilizing increased resources.²⁶ Key focus areas of the STC Policy are embedded within the Strategy, particularly with respect to Strategic Objectives 1, 2 and 4.

The STC Policy provides additional detail on the Global Fund expectations for country programs as they move toward sustainability, manage transition and mobilize additional domestic resources through co-financing. Both Global Fund and country approaches to ensuring sustainability of disease outcomes, as well as the underlying global health and macroeconomic contexts within which the programs operate, are evolving as Global Fund country partnerships mature.

The STC Policy identifies key focus areas for country progression toward greater sustainability of Global Fund supported disease responses. These sustainability focused areas are summarized for this review as (1) stronger, costed national disease plans; (2) increased focus on health sector financing, including development of health financing strategies and strengthening of national health accounts; (3) greater use of national systems in undertaking grant financed activities; (4) greater program efficiency and optimization; and (5) gradual absorption of program costs. These five areas are not exhaustive of the issues needing attention to ensure sustainability of disease program outcomes but represent priority areas for all countries.

Key transition focus areas provide additional expectations for country programs one to two cycles ahead of transition from Global Fund financing, as well as all LMICs with less than high disease burdens and all UMICs.²⁷ These focus areas include (1) transition readiness assessment; (2) transition and/or sustainability planning; (3) directly addressing sustainability challenges in grant design; (4) increased attention to the needs of key and vulnerable populations, and (5) accelerated co-financing of all key interventions in addressing the epidemics.

Co-financing, the third element of the STC Policy, is a tool for helping countries realize and leverage domestic financing commitments. The STC Policy and the Operational Policy Note on Co-financing provide revised co-financing expectations, including increases both in government spending on health and co-financing of Global Fund-supported programs. A co-financing incentive of at least fifteen percent of the Global Fund amount allocated to the country program is also included. This amount from the allocation can be accessed with evidence of additional commitments and realization of those commitments for the disease program and/or health systems, depending on the country's income level (above previous spending levels). The amount of co-financing required and the focus of those commitments is differentiated by country income and disease burden, and increasingly focuses on either RSSH interventions that address transition bottlenecks and key and vulnerable population

²⁶ The Global Fund Strategy (2017 – 2022): Investing to End Epidemics

²⁷ Global Fund uses the latest three-year average of Gross National Income (GNI) per capita to determine eligibility given the World Bank income classifications to determine low, lower-middle and upper-middle income status. In 2018, the World Bank classifications calculated from 2017 GNI per capita estimated using the Atlas method were defined as: LIC (less than or equal to \$1005); LMIC (\$1006 - \$3955) and UMIC (between \$3956 and \$12,325). High income countries (HICs) were defined as above \$12,326.

interventions for countries with higher incomes and lower disease burdens. Additional attention is to be provided to countries that a) have a high, severe or extreme disease burden²⁸ for two or more disease components, and b) where health accounts for less than eight percent of government expenditure and/or tax revenues are lower than 15 percent of GDP.²⁹

The key principles for operationalizing and implementing all three elements of the STC Policy reflect guiding principles for the current Global Fund business model. These are:

- *differentiation* based on a country's place along the development continuum according to income level, epidemiological context, disease burden, human rights and gender contexts, and other regional, country and context specific factors;
- *alignment* to country systems including building resilient and sustainable systems for the health sector (RSSH) and integrate systems that may have been operationalized on parallel tracks;
- *predictability* of transition timing, and support for early and proactive planning so that countries can prepare for disease components that may no longer be eligible for Global Fund support; and
- *flexibility* to adapt aspects of policy to country and regional contexts for impact and to maintain services.

Objectives of the Review

The TERG commissioned this review to: (1) assess how the Global Fund has operationalized and is implementing the “Sustainability” and “Co-financing” aspects of the STC Policy, (2) understand how country programs and stakeholders are incorporating key principles and focus areas of the STC Policy into their national programs and funding requests, including strengthening sustainability, increasing domestic financing, and preparing for transition from Global Fund financing; (3) understand the extent to which the STC Policy is helping foster greater sustainability of national programs, including (but not limited to) how the co-financing policy is supporting greater domestic investment in health and strategic areas of the three diseases; and (4) document lessons learned on how STC Policy implementation and the key focus areas of the Global Fund's sustainability efforts might be further improved, at the Global Fund Secretariat and the country levels, and amongst key Global Fund partners.

The review focuses on the sustainability and co-financing elements of the STC Policy. A 2018 audit by the Global Fund's Office of the Inspector General (OIG) reviewed progress in implementing the transition elements of the STC Policy in countries facing short- or medium-term (3 to 6 years) transition from Global Fund support, with a focus on Global Fund's transition management processes. The current review is careful not to duplicate the findings of the audit on transition, and (as requested) focuses mainly on sustainability and co-financing challenges in middle-income countries with high burden of disease. This review builds on the findings from the OIG audit report on transition management processes, and from previous sustainability reviews undertaken by the TERG in 2013 and 2015. Findings from the recent TERG commissioned reviews of Resilient and Sustainable Systems for Health (RSSH) interventions and the Global Fund Partnerships were also made available to the team.

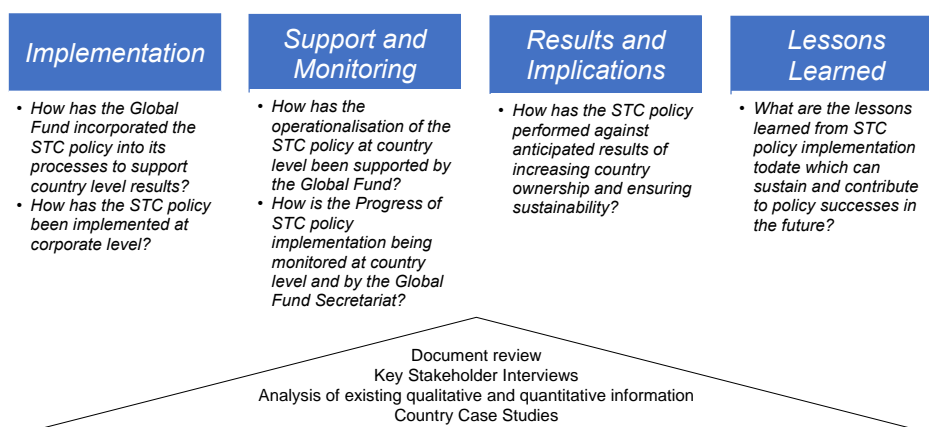
Overall Methodology

The study examines both global (“corporate” level actions that affect STC implementation) and country level implementation of the STC Policy. The Review provides descriptive overview of key corporate actions and utilizes a structured, comparative country case study approach to assess implementation at the country level. Figure 1 provides the schematic for the overall methodology.

²⁸ Please note that following the modification of the Global Fund's eligibility policy in 2019, the “extreme” and “severe” disease burden classifications have been removed; disease burdens are now classified as either “High” or “Not High”.

²⁹ Guidance Note for STC of Programs supported by the Global Fund (January 2017). Please note that the STC Guidance Note was updated in December 2019 and is available on the Global Fund website [here](#).

Figure 1. Review Framework and Summary of Key Questions



The consultant team of experts (CTE) used a mixed methods approach collecting and analyzing both qualitative and quantitative data. Data sources included document reviews, key informant interviews and both desk and field-based country case studies.

Ten case studies (countries) were undertaken, five as remote desk-reviews and five that incorporated one-week country field visits. The TERG Secretariat and Country Teams facilitated the interaction with the national programs. The CCM Secretariats assisted in organizing the agendas and the meetings on the ground. Each country case study was conducted by one CTE member accompanied by a TERG Secretariat staff. Each of the case studies examined early STC policy implementation and outcomes; assessed the understanding of country programs staff and other key stakeholders with regards to the Global Fund's focus on sustainability, transition, and co-financing. In addition, the CTE identified lessons learned and best practices; and developed recommendations for possible Global Fund action.

Country selection was undertaken through purposive sampling, based on the following criteria: largely middle income countries with high-disease burdens, but not yet scheduled for full transition from Global Fund support, with some variation on the tail ends; mix of regions, burden of disease (high-impact, core and focused countries), and cross section of disease programs to be highlighted; and country willingness to participate in the review. Within these criteria, preference was given to countries identified by the Global Fund Secretariat and Country Teams as having potential for lessons-learned in key areas of sustainability and co-financing. An additional selection criterion was to try to include countries that were part of the 2013 and 2015 TERG sustainability reviews. However, given the focus on countries nearing transition and other differences in selection criteria from the earlier reviews, the selection included only two countries from the 2013 review (Kenya and Ukraine) and one from the 2015 review (Kenya).

This methodology resulted in the selection of ten countries. These included 27 disease components, representing total grants of US\$ 1,344 billion. Ten of the 27 components were at or "near transition", i.e. projected to transition or recommended to begin early planning for transition (7 percent or US\$ 92 million of the components reviewed). The countries included 5 High Impact countries (representing 77% of the total grant amount reviewed); two Core countries (19% of total grant amount) and three Focused countries (4% of total grant amount).³⁰ Countries were geographically dispersed, with five across Africa, two in Asia, two in Eastern Europe and Central Asia, and one in Latin America and the

³⁰ The Global Fund Operational Policy Manual (8 November 2018) defines focused portfolio countries as those receiving less than US\$ 75 million; core portfolio countries are those allocated between US\$ 75 and US\$400 million; and high-impact countries are those allocated more than US\$ 400 million in the allocation period.

Caribbean. Ten of the components are highlighted by the Global Fund for transition or to prioritize transition planning (7% of total grant amount reviewed).³¹ Two components are implementing transition funding; two are expected to become ineligible in the 2017-2019 allocation cycle with the possibility of transition funding in the next; and another six programs have been requested by the Global Fund to prioritize transition planning either because they are projected to transition or because they are UMICs or LMICs with lower disease burden.³²

From mid-January through February 2019, **case studies were undertaken for Ghana, Namibia, Dominican Republic, Georgia, and Sri Lanka (desk-based), as well as Rwanda, Kenya, Vietnam, Ukraine and Côte d'Ivoire (field-based).** Key informants included various Fund Portfolio Managers, CCM members in country, and other key partners as identified for each case. These typically included ministries of finance, treasury, and health; national health insurance programs; bilateral and multi-lateral partners; civil society organizations including those supporting key and vulnerable populations; and the private sector. Documents that were reviewed included funding requests and annexes, Global Fund Grant Approvals Committee (GAC) documents, and available reports provided by the Global Fund Secretariat, gleaned in the field or found through internet searches with an emphasis on the 2017 – 2019 allocation period.³³

Members of the CTE conducted semi-structured in-depth interviews in the five field-based case study countries, at the Secretariat in Switzerland, and with key external global partners. Additionally, interviews were also held with the S&T Specialists, Country Teams and selected key stakeholders (via Skype) for several of the desk-based remote reviews. In-country stakeholders were representatives from Global Fund country structures (e.g., Principle Recipients, CCM members, LFAs), the Ministry of Health, bilateral and multilateral agencies, relevant NGOs and other stakeholders.

At the “corporate” level the review focused on actions and plans to promote implementation of the STC policy, with an emphasis on the “Sustainability” and “Co-financing” elements given the recent OIG audit of transition policy management and processes. Information was based both on written documentation provided to the CTE by the Secretariat and by key informant interviews undertaken in person (or online) at various points throughout the assignment. Findings were compared to information gleaned from the country-level studies, and analyzed with the question of “do we see a specific country-level impact?”

All CTE members focused on analyzing the case-study and corporate data in relation to the broad range of sustainability issues, the key focus areas and principles of the STC Policy, and the fifteen key study questions from the original Terms of Reference.³⁴ Initial findings were then shared with select members of the Global Fund Secretariat to support the CTE in considering conclusions and practicable recommendations.³⁵

³¹ The Global Fund (2018). Projected Transitions from Global Fund Support. The document was updated in January 2020 and is available on the Global Fund website [here](#).

³² For these six components, the Projected Transitions document notes “planning for eventual transition should be a priority and considerations for transition should be built into country dialogue, co-financing commitments, grant design, and program design.”

³³ The methodology did not include comparison of the current allocation period (2017 – 2019) with previous allocation periods given emphasis on activities since the STC Policy was approved and incorporated in the most recent period. However, given the nature of and constraints to the review, focus on the current allocation period was sufficient to gain useful insights, lessons learned and to formulate recommendations that the CTE hopes will support the Global Fund in further strengthening the movement towards ensuring sustainability of disease outcomes in its grants practices.

³⁴ Request for Proposals: TERG STC Policy Review (October 2018).

³⁵ This consisted of two one-hour sessions held at the Global Health Campus on Wednesday afternoon, March 13, 2019. Attendees, invited from across grants management and technical offices, provided direct feedback to the CTE on key findings. The sessions were particularly helpful in challenging assumptions and identifying areas for further clarification and/or more nuanced consideration by the CTE.

Constraints to the analysis

The data were largely qualitative, except for information available from secondary sources (such as macroeconomic and health sector data available from the World Bank Open Data). This reflected the fact that many country activities were only just unfolding and that there were necessary lags in the reporting of indicators from central databases (e.g., the procurement database). While the CTE often requested quantitative data on implementation and financing data while in the field, data were mostly unavailable in a useable format.

This review was not intended to assess the impacts of the STC Policy, and, therefore, did not include a statistical counterfactual. The small number of purposively selected case-studies were not designed to draw credible statistical inferences across the larger Global Fund portfolio. However, the team did examine how the STC Policy is being implemented at the country-level in selected settings and qualitatively assessed differences in implementation and outcomes across different country contexts. In addition, the CTE solicited and incorporated the expert judgments of key stakeholders and practitioners on the efficacy of the STC policy and its implementation.

Given the early stages of implementation, some aspects of the STC Policy were difficult to fully assess. This includes implementation of the grants initiated under the STC Policy and realization of co-financing commitments made under the 2017-2019 allocation cycle. Table 1, below, provides a sense for the timing of these grants. Côte d'Ivoire was approved by the Global Fund Grant Approvals Committee on September 2017, and Georgia was not yet approved at the time of the initiation of the review (i.e., early 2019).

Table 1: Global Fund Grant Approvals Committee (GAC) Date by Country and Program

GAC Date for Selected Grants							
Sept 2017	Oct 2017	Nov 2017	Dec 2017	Oct 2018	Nov 2018	Dec 2018	April and September 2019
CIV TB	CIV HIV CIV Mal Kenya HIV Kenya TB Kenya Mal UKR HIV UKR TB Vietnam HIV Vietnam TB	Vietnam Mal	Ghana HIV Ghana TB Ghana Mal Namibia HIV Namibia TB Namibia Mal Rwanda HIV Rwanda TB Rwanda Mal	Sri Lanka TB	DR HIV Sri Lanka HIV	DR TB Sri Lanka Malaria	Georgia HIV Georgia TB

Data on 2017 – 2019 allocation period made available by Global Fund

Regional grants were not assessed in this review. Catalytic Strategic Initiatives and Matching Funds were also not separately analyzed. It was not possible in the time provided to determine whether these activities are implemented in line with key STC focus areas and principles.

Not surprisingly, given the widely divergent country contexts, the case studies varied in focus and in the data collected. The case studies were largely driven by the nature of each country's STC efforts, proximity of the programs to transition and by the understandings of key informants. The case studies provided insights into a range of sustainability elements, but also encompassed substantial variation across the case studies on all but a limited range of core data.

A key constraint was determining the contribution of the STC Policy as a trigger for sustainability related actions or activities. Many of the STC efforts have been on-going and were themselves part of the organic development of the policy and its guidance. The CTE focused on the Policy as an enabler of STC focus and improved outcomes across the portfolio.

FINDINGS ON STC POLICY BY KEY FOCUS AREAS AND PRINCIPLES³⁶

Key STC Sustainability Focus Areas in Country Case Studies

The STC Guidance note recommends five focus areas for embedding sustainability into grant design and implementation. The Guidance is for all countries receiving Global Fund financing. These areas are robust, costed and prioritized NSP; development of a health financing strategy; tracking health and disease program spending; implementing through national systems; and gradual absorption of program costs. However, it is important to note that these focus areas are not an exhaustive list: one of the key principles of the STC policy is that it is implemented flexibly, with consideration for the country and regional context.

The ten case studies show good but varied progress across the five focus areas. Nine of the ten countries have costed NSPs for disease programs based on broad country consultation.³⁷ The selected NSPs reviewed are also adequately prioritized to make decisions based on available, rather than needed, funding. However, many NSPs have large gaps between the financing available and program needs. Nine of the ten countries have or are developing a national health financing strategy, inclusive of the three diseases, and all have institutionalized expenditure tracking mechanisms (e.g., national health accounts or other mechanisms), although measurement is infrequent and/or sporadic for some countries.

The Global Fund grants show uneven alignment with national programs. This is partly a result of programmatic and financial risk mitigation measures and/or incentives that favor separation of disease programs, separate project management units, external procurement, and direct relationships with program managers, rather than integration into overall health ministry activities.³⁸ Examples of good alignment include Rwanda, with NSP based budget support, and Ukraine, where the Government is developing institutions and processes as needed to internalize all disease related interventions. As programs reach transition, there is a high degree of alignment in the government executed activities. Alignment and sustainability of KVP activities in the non-state sector continue to need attention for most countries.

Key Transition Focus Areas in Country Case Studies

Transitioning programs demonstrate strong adherence to STC Policy key transition focus areas.³⁹ This is in line with findings from the OIG Audit on Transition Policy implementation. Although performance may be varied in terms of sustainability focus areas (e.g., alignment and RSSH outcomes), it is quite similar across the programs in terms of transition. All transitioning programs had undertaken a transition assessment and transition and/or sustainability planning. Transition/sustainability planning outcome and process indicators are included in updated NSP frameworks in the Dominican Republic, Georgia, and Sri Lanka. Investments for addressing sustainability challenges are included in the grants.

³⁶ As outlined in the STC Guidance Note (2017). Please note that the STC Guidance Note was updated in December 2019 and is available on the Global Fund website [here](#).

³⁷ The HIV and TB NSPs in Ukraine expired in 2018. Ukraine Cabinet of Ministers approved the National Strategy on TB, HIV and Hepatitis 2030, in Nov 2019.

³⁸ This is also related to the history of the Global Fund, in which vertical programs were established prior to strong national capacities with the goal of rapid scale-up of effective disease responses.

³⁹ Transition program grants included in the STC review were Dominican Republic TB and Sri Lanka Malaria. Six other programs have been identified by the Global Fund for priority transition and sustainability planning: Georgia HIV and TB programs, Dominican Republic TB, and all three programs in Namibia, although no timeline is given for transition from Global Fund support (after 2025). However, projected transitions are periodically updated and published by the Global Fund and components projected to transition could change as a result.

The two programs receiving transition funding for this allocation period (Sri Lanka malaria and Dominican Republic TB) project rapidly increased absorption of financing for program elements in the current grant period.

Application of Key STC Principles

Application of key principles varied given national priorities and starting points. Case study findings observed nuanced application of the STC principles across the countries.⁴⁰

Alignment

Good development principles recognize the importance of building on existing systems or processes in country to enable country ownership and improve the likelihood of sustainable impacts. This means ensuring that Global Fund programs use, or plan to use, country systems including to build resilient and sustainable systems for health (RSSH) and integrate parallel systems.

There was good alignment of Global Fund supported components with NSPs or other national health and disease planning across all case study countries. However, there was uneven alignment in use of national systems. A good example of the benefits of alignment comes from the Rwanda National Strategy Financing based budget support (see below), in which strong political will enhanced through program support has supported the country in maintaining outcomes for HIV and TB despite reduced external support.

Box 1: Rwanda NSF Based Budget Support

The Global Fund provides budget support, i.e. the Global Fund uses the National Strategy Financing (NSF) mechanism channeled as targeted health sector budget support. The NSF model is based on Joint Assessment of National Strategies (JANS), rather than on program specific funding requests. Separate capacity assessments for specific disease programs are not required, as services are integrated and utilize national systems. Country M&E and procurement systems are used, rather than separate systems for management and implementation of the Global Fund grant. Verification of results is mainly carried out using in-country mechanisms. Local Fund Agent (LFA) verification processes focus on the systems for verifying achievements from Global Fund grants. Disbursements are linked to achievement of results rather than to grant specific activities and fund utilization. The model uses existing country oversight mechanisms. The Global Fund budgeting guidelines used in other countries' grant management processes are not fully applied given the budget support setting in Rwanda.

Challenges on alignment stood out in two areas: procurement and supply chain management (PSM) and key and vulnerable population (KVP) activities. Efficient and effective PSM is fundamental to the Global Fund's fight against the three diseases and the achievement of its strategy. This is because the Global Fund's biggest investments at country level in many contexts are for health product procurement.⁴¹ In countries where the procurement and supply chain systems are weak and/or not well-developed, in order to ensure uninterrupted delivery of life-saving commodities to people in need, alternate supply chain management systems were explored and in some cases led to establishment of parallel systems (e.g., Côte d'Ivoire where purchase of health products is undertaken external to the ministry and the procurement agency, the Dominican Republic where procurement was returned to a project management unit when the national agency was unable to procure goods on time, and Kenya where diagnostic commodities are included in non-state PR grant budgets in order to circumvent constraints in the national procurement system that do not allow advance payments). Furthermore, for some countries national systems for financing KVP services through NGOs do not exist, creating challenges for alignment with in-country systems.

⁴⁰ It is important to note that the TERG Review was undertaken in early 2019. The case study findings are based on information collected in early 2019 and thus reflects program findings for the previous years (e.g., largely 2015 – 2018).

⁴¹ Procurement and Supply Chain Management at the Global Fund: Audit Report, GF-OIG-15-008, 2015, available [here](#).

Attempts to achieve target 3.3 of the Sustainable Development Goals (SDG) – i.e. to end epidemics of acquired immunodeficiency syndrome (AIDS), malaria, neglected tropical diseases and tuberculosis by 2030 – will be hampered if services fail to scale-up and sustain coverage of vulnerable and excluded populations. Despite substantial progress to date, the current programs of KVP outreach are almost entirely financed through external resources. This failure of state action reflects the many deep-seated gender-related, human-rights-related, cultural, financial, political and social barriers that such populations face. In many of the countries included in the review, the implementation of programs for KVPs is undertaken by civil society organizations and supported by the Global Fund. These organizations are often not part of the fiscal space of the government. The programs also are not integrated into government delivery mechanisms.

Two other areas stood out for progress but also the need for additional efforts: alignment to national budget processes and integration of program management. Efforts are being undertaken by the Global Fund to improve alignment with national budget processes. The issue, however, was visible in at least two countries: Côte d'Ivoire noted difficulty in fulfilling its 2018 co-financing commitments due to non-alignment of the Global Fund grant and co-financing cycles with the national budget process and as noted under 3.3.2 Flexibility, below, the current grants for Kenya are extended to run through June 2021 to improve alignment with national planning and budgeting cycles. Program management is also of note, as some countries – even in transitioning programs (e.g., DR TB) – retain separate project management units (PMUs) or project implementation units (PIUs), external to usual government program management processes.

Flexibility

The Global Fund's operationalization of the STC policy has proven to be sufficiently flexible to respond to countries with different contexts. The CTE found examples where, although key focus areas were consistently applied, the interactions were pragmatic rather than dogmatic. The following provides examples of flexibility in STC policy implementation.

- Grant cycle timing or length was sometimes amended as needed to improve alignment. For example, in Kenya, the current cycle of grants for all three diseases is for 3.5 years (through June 2021) to better align both the current co-financing and future cycles to national budget processes. A regional effort on malaria elimination in Central America and Hispaniola (RMEI) has an extended grant timeframe (five years) to allow alignment with the timeframes of other partners. The activity is designed to leverage additional financing through the InterAmerican Development Bank and other regional partners with longer loan processing and run times.
- Flexibility was observed in the pragmatic use of grant funds to achieve sustainability goals. For example, in Viet Nam a portion of the Global Fund grant financing is covering social insurance premiums for people living with HIV/AIDS who are not covered under the existing social health insurance criteria. The government plans gradual absorption of the premiums throughout of the grant. In Ukraine, a clear program for moving grant management portions from non-state to state actors to improve alignment and build country systems provides for gradual take-over of the funds by the new state over the course of the grant. In Rwanda, NFS-aligned, results-based financing of the national budget is reaping benefits for program efficiencies and disease control outcomes.
- Global Fund provides principles and recommendations for transition readiness assessments, but countries develop and apply their own tools. No single method of transition preparedness is required. Countries may apply existing tools or develop new ones appropriate to the country and program context. Similarly, countries can address their unique disease and epidemiological settings with tailored programs fit to the evidence. While the Global Fund provides a modular framework for intervention selection, decisions are made at the country level based on program needs.

- Flexibility was also evident in the range of models for measuring co-financing commitments. Some countries, such as Kenya, provide additional budget resources directly, meeting the twenty percent co-financing incentive through increasing funds in specific budget line items for procurement of drugs. Many others use a combination of direct co-financing of drugs and commodities, and some in-kind attribution for services delivery staff and facilities. Few countries meet co-financing requirements purely through attribution of in-kind expenditures.

From the country side, flexibility was repeatedly displayed in determining areas for co-financing in the ten case-study countries. Countries took pragmatic paths to demonstrating their contributions to the Global Fund supported disease programs. While largely focused on procurement of commodities, it also included absorption of grant financed staff and other program costs.

Differentiation

Differentiation of the STC policy and associated processes based on a country's place along the development continuum according to income level, epidemiological context, disease burden, human rights and gender contexts, and other regional, country and context specific factors supports maximizing the impacts from Global Fund financing. The first level of differentiation that affects STC efforts are the programmatic (e.g., high-impact, core, focused), income and disease burden categories used by the Global Fund. While country contexts vary widely, these categories help support analysis of issues that subsets of countries may have in common, such as domestic resource mobilization, allocative efficiency and financing needs.

The STC policy and subsequent guidance currently provide clear differentiation by country income and disease burden for sustainability, transition and co-financing requirements. These were further delineated with the 2018 Global Fund Projected Transition from Global Fund Support by 2025⁴², that made clear the differing expectations and requirements for LMICs with non-high disease burdens and UMICs. Access to Funding processes have also differentiated funding request formats, providing countries the option to apply for funding using a Tailored to Transition format.

Further differentiation by the Global Fund in STC operationalization in key areas could prove beneficial. For example, some key informants within the Secretariat and at country level indicated that co-financing requirements could be applied more strictly or leverage greater funds depending upon the country setting (e.g., where fiscal settings are stronger, additional co-financing could be sought). Also, greater recognition of different levels of institutional, systems and economic development in developing RSSH activities could ensure that these interventions support countries in moving forward in the systems development continuum.

Predictability

Predictability is a key tenet for external financing - and one that the short-term political processes in donor countries and agencies often fail to meet. Wherever possible, countries should have sufficient notice, time and associated resources to plan for transition. At the country level, this includes early and proactive planning for transition preparedness in countries where disease components may no longer be eligible for Global Fund support.

Countries and external partners appreciate the Global Fund's approach, using largely visible, published selection criteria for allotment of funds, requests for co-financing and transition from support. The consistent application of funding cycles is also helpful, as countries are clear on the timeframes during which funds can be utilized. The increasing alignment with budget cycles, growing streams of on-budget funding and improved and more timely reporting of health expenditures (e.g., through more frequent updates to national health accounts) from operationalizing the STC Guidance is also improving predictability of budget resources for programs during grant periods – and beyond. The early planning

⁴² Document updated in January 2020 and available on the Global Fund website [here](#)

for transition also provides greater opportunities to seek domestic resources to replace Global Fund support for key activities, as was seen in the transition plans for the Dominican Republic tuberculosis program. External partners and many country key informants commended the Global Fund for providing technical support for assessing transition readiness, and its willingness to provide a transition grant, as needed, to support countries in remedial action to ensure transition readiness.

The country allocation process also provides a level of predictability, given the relatively transparent formula for decision-making, as well as the ability to consider extenuating circumstances considering reductions from one allocation period to another. However, challenges are noted in that the Global Fund's own three-year replenishment cycle underpins the system, with countries aware that future allocations will be dependent on success in raising funds. This also means that countries are informed quite late of the actual allocation for the coming period. Country understanding of and support for this process were evident during the Kenya field visit, when counterparts repeatedly expressed their support for Kenya's early commitment to the replenishment process and to its increased contribution.

The CTE also noted that in-country respondents across the field-based case-studies registered concern at being selected for the STC Review. For many respondents, "STC" is linked more to concerns that Global Fund may be exiting financing in their country, and less to sustaining increasing coverage and outcomes.

FINDINGS ON SUSTAINABILITY

Introduction

The STC Policy covers three important areas: increasing the sustainability of disease outcomes, which is directed at all countries; transition, which in this context means the process of managing programs as Global Fund exits from financing select disease components; and the application of differentiated co-financing requirements and incentives for implementers of Global Fund grants. This section of the Report focuses on sustainability. The following sections cover transition and co-financing.

Country interest in and progress on sustainability of disease programs varies and seems to be driven by external pressures that are distinct from Global Fund activities (e.g., moving into middle income country category, or responding to reductions in PEPFAR funding). Other than for countries nearing transition, the extent to which Global Fund activities facilitate or lead such efforts is often unclear.

Many key informants seemed to be largely unaware of the STC Policy; however, some were aware of the section on sustainability in the funding request application and changes in co-financing requirements in the 2017 – 2019 allocation period.

Analytical Framework/Elements of sustainability

The Global Fund STC Policy indicates that: “Planning for sustainability requires a multipronged approach that includes investing in the appropriate resilient and sustainable systems for health (RSSH), capacity building, advocacy and service delivery interventions while at the same time evaluating options for progressively increasing domestic financing for health and for the three diseases in particular.”⁴³ The case study from Rwanda, a low-income country making good progress in addressing health issues, provides an example of the wide range of activities needed for building sustainable programs (see Box 2).

Box 2. Key steps taken by the Government of Rwanda to address sustainability issues

- Focused on integrated health services provision to find efficiencies and bring down costs, resulting in 94% of the funding need for the next implementation period being met, despite substantive decline in donor resources.
- Adopted a ‘Health Care Financing and Sustainability Policy’, which seeks to diversify and improve domestic resource mobilization through innovative financing mechanisms and public private partnerships; strengthen risk pooling and health insurance mechanisms; increase efficiency for improved quality and service delivery; and strengthen the institutional environment for sustainable financing.
- Strengthened capacity of teaching institutions to augment HRH production and decentralization of HRH management to improve district health governance and enhance local recruitment. Developed an HRH plan to gradually take financial responsibility for positions defined at the different levels by 2019.
- Consolidated management of the Community Based Health Insurance (CBHI) scheme under the Rwandan Social Security Board to enhance its effectiveness; paying premiums for the 23% of the population (the very poor).
- Incorporated RSSH components within the GF Funding Request, focussing on human resources, critical infrastructure and augmenting coverage of the CBHI.
- Committed additional investments in disease programs and health systems, which is 260% higher than requirement to access the co-financing incentive of the next allocation.

Source: Global Fund data

⁴³ The Global Fund STC Policy, 2016.

However, beyond financing issues, both the STC Policy and guidance remain imprecise regarding the parameters of sustainability or how the different elements of sustainability should be prioritized. This is partly addressed in practice by the guiding principles that allow the STC Policy to be applied with differentiation and flexibility, meaning country and/or regional contexts drive Country Teams and country selection of key sustainability variables for attention. However, this review needed a more concrete framework against which to assess sustainability.

The ST Specialists in EECA and LAC noted an article by Oberth and Whiteside (2016) that was useful in providing a framework for assessing sustainability. The framework had been used in support of regional strategic thinking. Although the original framework was developed to address HIV and AIDS programs, it is sufficiently broad to be applicable for other diseases as well. The authors lay out a “six-tenet conceptualization of what sustainability means in the HIV and AIDS response: (1) financial, (2) epidemiological, (3) political, (4) structural, (5) programmatic, and (6) human rights.”⁴⁴ The CTE used this framework as the basis for a broader view of sustainability. Key areas covered are noted in the introduction to each section.

Case Study Findings

Financing

Financial sustainability in the context of this review addresses the question: “Are there stable and diversified funding mechanisms in place to provide the needed long-term finance for the disease response?”⁴⁵ In this review, financing includes the elements that are highlighted by the Global Fund for increasing Government fiscal self-reliance for disease program costs. These are domestic resource mobilization (DRM), improved efficiency and innovative finance. Co-financing is considered a tool to address domestic resource mobilization and is a separate section in the STC Policy. Findings around the Co-Financing portion of the Policy are found in Section 6: Implementation of Co-financing.

To support governments in addressing NSP needs, the Global Fund is supporting work on expanding the fiscal space where possible.⁴⁶ Five potential sources for increasing funds for health are identified by Heller (2006): (1) macroeconomic and fiscal growth; (2) changes in budget priorities; (3) earmarking and creating new revenue streams dedicated to the particular funding need; (4) development assistance; and (5) efficiency gains.⁴⁷ This includes redirecting resources across the health sector, such as using social health insurance schemes or private insurance or private primary care to cover some of the needs for the three diseases. While macroeconomic and fiscal growth are beyond the remit of the Global Fund, the remaining four are being addressed directly by the Global Fund.

At the time of this review, the Global Fund is emphasizing four modes of action for increasing resources for the three diseases. First is work on domestic resource mobilization, including support for developing sector and disease-specific health financing strategies especially targeting countries that a) have a high, severe or extreme⁴⁸ disease burden for two or more disease components and b) where health accounts for less than eight percent of government expenditure and/or tax revenues are lower than 15 percent of GDP.⁴⁹ This includes country dialogue on increasing health resources as well as developing minimum benefits packages and undertaking disease-specific actuarial analyses for social health insurance. These

⁴⁴ Oberth and Whiteside (2016). “What does sustainability mean in the HIV and AIDS response?”

⁴⁵ Oberth and Whiteside (2016).

⁴⁶ Fiscal space is the budgetary room a government can use to provide additional resources for a given desired purpose without prejudice to the sustainability of the government’s overall financial position (Heller 2006).

⁴⁷ Saleh, Karima, Ricardo Bitran, Bernard Couttolenc, The Financial Sustainability of HIV/AIDS and Universal Health Coverage Programs in Sub-Saharan Africa: Case Studies from Côte d’Ivoire, Kenya, Tanzania, and Nasarawa State in Nigeria. 2018.

⁴⁸ Please note that as per the changes in the Global Fund’s eligibility policy in 2019, the “extreme” and “severe” disease burden classifications have been removed; disease burdens are now classified as either “High” or “Not High”.

⁴⁹ Guidance Note for STC of Programs supported by the Global Fund (January 2017). Updated in 2019 and available on the Global Fund’s website here

activities are aimed at changing budget priorities. Second, is a substantial portfolio of technical support activities to achieve efficiency gains, including work on improving both sector (cross-programmatic) and program efficiencies. Third is innovative financing to identify mechanisms to leverage new sources of financing for health, including creating new revenue streams earmarked to specific health needs and further leveraging development assistance. This includes directly mobilizing financing through Debt2Health and development partner and private sector leveraging mechanisms, as well as indirectly through discussions and support on taxation (e.g., tobacco taxes) and other means of earmarking or raising funds (e.g., HIV Funds, etc.). It also includes innovations that improve efficiencies or catalyze increased outcomes (e.g., performance or outcome-based financing). Last, is the Global Fund's use of co-financing to leverage more budget and greater fiscal attention to disease and sector specific needs.

These activities have been on-going and informed the STC Policy which was approved by the Board in April 2016. In particular, DRM and innovative financing activities have been undertaken as a result of countries facing reductions in levels of Global Fund financing after the institution of the New Funding Model (NFM) in 2014 and its increased emphasis on Willingness to Pay. However, the level of attention to all four areas (DRM, efficiency, innovative finance and co-financing) has increased as a response to the STC Policy guidance and with the refinements in co-financing that address both sector and disease-specific funding as a result of the STC Policy.

General Context

There remain large gaps between resource needs estimated under national strategic plans and available resources. For the ten countries reviewed, financing gaps for the HIV programs in the current allocation period range from zero (Sri Lanka) to 42 percent (Dominican Republic). The average across the ten countries was 20 percent. Gaps noted in the Funding Requests for the 2017 – 2019 allocation period for TB range from 10 (Rwanda) to 78 percent (Ghana), averaging 30 percent across the ten countries. Malaria faces similar shortfalls, ranging from 9 (Sri Lanka) to 51 percent (Kenya) and averaging 34 percent across the 7 country programs.⁵⁰

The scale of the response is huge in countries with extreme burdens. For example, national HIV program expenditures represent 23 and 21 percent of the national government total health expenditures in the current allocation period (2017 – 2019) in Namibia and Kenya, respectively.

Programs have ambitious goals, particularly in HIV, where countries have committed to achieve or exceed the 90-90-90 targets.⁵¹ Yet, the Global Fund Grant Approvals Committee (GAC) noted in December 2017 that these goals are not necessarily reflected in Global Fund grant performance frameworks because of “limitations of budgets in the 2017-2019 allocation period.”⁵² Kenya is already managing more than 1.1 million persons (79% of PLWHIV) on antiretroviral treatment (ARVs), with expectations that the number will increase with further progress towards the 90-90-90 goals. The GAC noted in the 2017 approval meeting that the current allocation for Kenya would be sufficient to maintain the current numbers, but scale-up may be constrained. They also noted that the Kenya Funding Request included an ART funding gap of \$65 million in unfunded quality demand (UQD).⁵³ Currently, less than 20 percent of program costs are covered by the Government of Kenya. While Kenya presents an extreme example given the high HIV burden, the issues are similar in other high HIV burden countries, e.g., Namibia and Rwanda.

⁵⁰ The consultants were unable to determine if these lower gaps were partially an artifact of better planning capacities and/or less aspirational demand given unlikely requirement.

⁵¹ The 90-90-90 target is led by UNAIDS, and represents 90 percent of those infected with HIV are aware of their status, of those, at least 90 percent are enrolled in antiretroviral therapy (ART), and among those, 90 percent have achieved viral load suppression.

⁵² Aidsplan Global Fund Observer Newsletter Issue 327: 13 December 2017.

⁵³ Aidsplan Global Fund Observer Newsletter Issue 327: 13 December 2017.

Continued scale-up of patient enrolment in ART without sufficient guarantee of durable domestic, Global Fund or other external resources, or adequate national procurement mechanisms, could adversely impact treatment retention, and increase the risk of stock-outs and drug resistance. These ambitious targets of increasing numbers of people on treatment are stretching existing budgets and could impact financing for prevention, RSSH and addressing other health issues.

Countries have high levels of dependency on external partners for financing the epidemics. External funding (Global Fund and others) is expected to cover from 20 to 95 percent of total NSP costs in the current period. This dependence is also often largely on two partners: The Global Fund and bilateral support from the US Government.⁵⁴ In 21 out of 27 programs reviewed, the Global Fund was the largest single external financier, contributing more toward the program than all other external partners combined.

External partner support as currently structured has plateaued and is likely to have downward trends, requiring absorption of any new-found fiscal capacities into maintaining existing activities. As disease programs expand to address the epidemics particularly in high burden countries, domestic funding is expected to be a larger portion of disease financing. The countries reviewed had or were likely to experience large reductions in funding from external donors. Many countries faced volatility in the level of contributions from external partners. This is exacerbated by high dependence on these resources for funding programs.

External partners and in-country informants recognized Global Fund for taking a wider, sectoral approach to health financing. Until recently, several respondents noted there had been a tendency for the Global Fund to view financing and fiscal space from the point of view of Global Fund grants (e.g., one to one replacement of Global Fund resources). Partners welcomed the Global Fund in taking a broader view of financing for the sector. However, informants noted a tendency, confirmed in the case study findings, for transition planning to become a report of dollar to dollar substitution of Global Fund financing by national budgets. There were also concerns expressed by external informants that fiscal space analyses should not be confined to single disease streams, or even to determine co-financing based solely on Global Fund support.

The Global Fund Country Teams and other Secretariat staff are engaging more deeply and at higher political levels in health financing discussions in country. Both global partner and country informants noted greater attention to health financing issues. Country Teams also reported increased engagement with ministries of finance and/or treasury departments. The more nuanced requirements on co-financing of the STC Policy and Operational Policy Note (OPN) on Co-financing mean greater engagement on broader health financing issues. For the transition countries, transition planning requires substantive engagement on sources of financing. However, beyond these Global Fund programmatic needs, health finance discussions seemed dependent on country contexts and external partners. For example, in Georgia and Ukraine Country Teams were engaged in high-level advocacy and policy dialogue for domestic resource mobilization for HIV and TB programs, which supported local advocates in calling for increases of country resources for those programs. In Kenya, the Global Fund supported the development of the draft National Health Financing Strategy and the review of the impact of incorporating the HIV and TB care under the National Health Insurance Program. This has led to Global Fund engagement in high-level policy forums, including at the Deputy Prime Minister level. Box 3 outlines engagement to date on health care financing in three of the ten case-study countries.

⁵⁴ The US Government currently is also the largest single source of financing for the Global Fund.

Box 3. Global Fund Engagement in Health Care Financing for 3 Case Study Countries

Examples of Global Fund engagement in countries include on-going health care financing efforts in three high-burden LIC and LMICs among the selected case-studies under review. This list was compiled by the Global Fund Health Care Financing team to provide data for determining where Global Fund can further catalyze domestic resource and innovative financing efforts. On-going support and engagement (as of end of 2018) include:

Kenya:

- Strategic Initiative support for Health Financing Strategy through WHO
- Support for anchoring transition planning for the three diseases to Kenya's Health Financing Strategy for sustaining effective coverage for HIV, Tuberculosis, and Malaria
- Support for actuarial evaluation to assess costs and feasibility of integrating HIV Treatment Packages Into NHIF
- Ongoing support for policy dialogue on health financing through BMGF grant
- Strategic Initiative support for National Health Accounts

Ghana

- Strategic Initiative support for Health Financing Strategy through WHO
- Strategic Initiative support through WHO for overcoming system-wide cross-programmatic inefficiencies across the (selected) HIV/AIDS, TB, malaria, EPI and MNCAH programs
- Strategic Initiative and grant support for National Health Accounts
- Ongoing support for policy dialogue on health financing through BMGF grant

Rwanda

- Historic and ongoing support for performance-based funding (PBF)
- Historic and ongoing support for community-based health insurance (CBHI)
- Investment through the budget support modality
- Ongoing support for policy dialogue on health financing through BMGF grant

Source: The Global Fund data

In countries where there is a formalized relationship with the World Bank or regional development banks, traditional partners to ministries of finance, there appears to be higher level financing discussions (e.g., around financing for malaria elimination in the Dominican Republic with the Inter-American Development Bank⁵⁵, and incorporation of the three diseases in UHC efforts in Namibia and Côte d'Ivoire). The Global Fund may also play a role in health care financing discussions even when not recognized through supporting health financing activities through partners. For example, in Rwanda, the WHO support for health financing initiatives is partially supported by the Global Fund support to WHO for such activities, although not credited in the field.

There may be unexploited opportunities for further engagement in health financing processes. For example, it was not clear that Country Teams align their interventions and visits with key budget processes, such as public discussions of the medium-term expenditure framework (MTEF). In addition, most of the countries reviewed are undertaking some level of health systems reform (e.g., devolution, restructuring of primary health care, shift from inpatient to outpatient care models, transition to social health insurance, exploring UHC options). Joint missions with the World Bank and other finance-oriented partners are being conducted in some countries, e.g. Burkina Faso and Côte d'Ivoire, and may provide greater access for senior level health finance discussions. In countries such as Ukraine and Dominican Republic, where Global Fund engagement on sustainability and/or transition is more systematic, the organization's influence seems to be much larger.

⁵⁵ The Inter-American Development Bank (IDB), the Bill and Melinda Gates Foundation and the Carlos Slim Foundation support the Regional Malaria Elimination Initiative (RMEI) in seven Central American countries and the Dominican Republic. The initiative will bring \$83.6 million in new funds and is expected to leverage over \$100 million in domestic financing and \$39 million in existing donor resources across the region by 2022 to ensure malaria remains a top health and development priority despite dwindling numbers of cases.

It is unclear whether Country Teams are comfortable taking on this expanded scope in health financing, or whether they have the necessary skills and capacities to do so. Several internal and external informants noted that sector level dialogue may require staff knowledge and skills, as well as time for building relationships and strategic interaction not traditionally included in Country Team processes oriented toward program grants management.

At the same time, it is not clear that the CCMs have the right representation within their membership as well as the sufficient depth of understanding to conduct dialog at the sectoral level. It also seems CCMs are not tasked, nor is any member accountable to the group for coordinating efficiency and value for money efforts across the programs. As indicated earlier the CCMs are not discussing issues of sustainability as part of their agenda. Although all CCMs should discuss in detail plans and approaches to sustainability, this is rarely happening. The CTE did note that many of the CCMs for case study countries include members from the Ministry of Finance. However, it is not clear whether these members play an active role in CCM discussions.

Case Study Context

Government expenditures on health remain low. For the ten countries reviewed, all had 2017 total government health expenditures equivalent to below 5 percent of GDP (the average for the ten was government health expenditure of roughly 2.4 percent of GDP). Only two case study countries had domestic general government health expenditures as a percent of overall government expenditure above 10 percent: Namibia (11 percent) and the Dominican Republic (16 percent). This means that none of the African case study countries met the Abuja Declaration target of 15 percent of total government expenditure for health in 2017. These low investment levels for health are also subject to increased competition within the health sector with countries expressing political commitments to expansion of access to health services under the broader UHC agenda.⁵⁶ Changing disease patterns, with rising, more generalized epidemics of chronic, non-communicable diseases in all countries reviewed, are likely making new demands on scarce resources, and exerting pressure in national political processes and within-sector allocation debates. The scale-up of disease programs, particularly for countries with high burden HIV epidemics, entails increasing proportions of future budgets. For example, nine of the ten case study countries are already pursuing but fall short of the 90-90-90 goals in HIV, meaning increasing costs for the program to meet these goals and eventually move toward 95-95-95.⁵⁷

Box 4 provides insights into some of the key financial sustainability issues in Namibia, a UMI country committed to UHC with severe to extreme disease burdens and declining access to donor funding.

⁵⁶ Watts, R. "ODA for Domestic Revenue Mobilization" (2018). <http://devinit.org/post/oda-for-domestic-revenue-mobilisation/>

⁵⁷ Documentation reviewed on Dominican Republic indicated that as of 2017, the Government was still reviewing the timing for implementation of the 90-90-90 goals.

Box 4. Observations on Financial Sustainability in Namibia

- High prioritization of domestic budget for health: Namibia spends comparatively more on health than its UMI peers (in 2016, 9.1% of GDP compared to an average 6.1%). At 62% of total health expenditure (THE), the government is the largest funder of healthcare in FY 2014/15. The private sector, employers, contributed 22% of THE, primarily by contributing to private medical aid schemes. Households in Namibia had the highest level of financial risk protection among the ten case studies, with 'out of pocket' spending contributing to under 11% of THE.
- Government commitment to UHC in the National Health Policy Framework 2010–2020: The GoN has increased budget allocation for health despite macroeconomic and fiscal challenges. The 'medium term expenditure framework' projects further prioritization of health from 10% of GoN budget to 12% in the current grant period.
- Decline in donor funding: Share of donor funding in THE has substantially declined from around 22% in FY 2008/09 to 6% in 2014/15. Donor funding for HIV fell from about US\$ 110 million in 2012, to US\$ 45 million in 2020. TB funding has declined from about US\$10 million in 2012 to US\$ 3 million in 2020. While increases in domestic funding have offset these declines for TB, total funding for HIV is lower than that available in 2012-2014.
- Significant funding gaps: With declining donor funding and macroeconomic constraints for increases in domestic funding, there are serious funding gaps for all major program areas that may erode gains in HIV and TB control that have been made in the last two decades. Identifying new, sustainable sources of healthcare financing will be critical, especially for HIV.
- Technical and allocative efficiencies: While the government funds a major share of the HIV response and is increasing its contributions for prevention programs for vulnerable populations, there is no domestic budget allocation for key populations such as sex-worker, men who have sex with men (MSM), and transgender programs. Namibia has one of the highest unit costs for ART. A significant percentage of this expenditure is for ARV procurement, which is double the price of those purchased in neighboring South Africa. To address that imbalance, Namibia recently revised its procurement procedures by working directly with manufacturers, with the first tender awarded to a CIPLA factory based in Uganda.

Source: TERG STC Case Study

Macroeconomic settings are mixed and have varied implications for increasing domestic tax revenues (select data and trends are provided within individual case-studies). Strong economic growth is projected for many of the countries. Average GDP growth over the past five years for the selected countries averaged from 3 to 6 percent. However, debt ratios have increased in recent years, with all countries in the sample having high debt to GDP burdens for their fiscal settings. Further analyses of the fiscal setting for the ten countries is included in each of the country case studies included in a separate document. Taking a greater role in financing these programs at current drug prices and program costs, particularly the large HIV programs, could represent quite a burden in countries with limited fiscal capacity to absorb the additional costs. Our high-level analysis of fiscal indicators indicates that only in the Dominican Republic is there likely potential to increase total government expenditure in the short-term. In all other case study countries, without policy action there is limited or no potential to increase total government expenditure in the short-term. Across the countries, any real increases are likely only to be realized through increases in tax revenue generation and/or continued economic growth, the prospects for which are uncertain. As such, any significant increase in government allocations to health would most likely require a commensurate reduction to other sectors.

Microeconomic settings also vary, with many countries reporting devolved fiscal environments in which local government authorities are managing large portions of national budgets, and often make decisions regarding local health spending. Sub-national contributions are becoming increasingly important – magnifying program risks and offering another layer in need of capacity building support. For example, part of the current Global Fund grant in Kenya is working with county governments to determine mechanisms for Global Fund financial support at the local level. In many countries, the private health sector still delivers a large portion of services, particularly for tuberculosis diagnosis and treatment, and treatment of malaria-type fevers. Funding landscapes are also increasingly complex. For example, Rwanda has community-based health, public sector provision and military health insurance, among other institutions, as part of the health financing strategy.

Domestic Resources Mobilization (DRM)

All ten countries report increasing commitments for health, and for national budget financing of the three diseases. In line with the Addis Ababa Action Agenda (2015) on financing the Sustainable Development Goals (SDG), domestic resource mobilization is expected to play a key role in expanding health financing to reach Universal Health Coverage (UHC) and disease elimination SDG sub-goals. In addition, nine of the ten countries have or are developing a national health financing strategy.

New sources of domestic health financing are being brought to bear in addressing the three diseases. For example, eight of the ten selected case study countries are using or considering social health insurance mechanisms to leverage additional financing for the three diseases. In Viet Nam, the Global Fund grant supports premium payments for key populations in the social health insurance system (see Box 5). The Government has committed to absorb these premiums over time under national resources. In Kenya, the National AIDS Commission undertook disease and financial modeling supported by the Global Fund to build the information needed to consider including HIV and TB treatment under the National Health Insurance Fund (NHIF). Development of HIV and TB packages for the NHIF is underway. In the Dominican Republic, the previously separate health services under the Ministry of Public Health and those under the social security system are being combined under provincial level management, rationalizing services and infrastructure, and including HIV and TB care under the minimum package of benefits. Social insurance mechanisms are meant to leverage domestic resources, improve equity and increase efficiency in the broader health system.

All case study countries report having institutionalized national health accounts (NHAs) or other health expenditure tracking measures.⁵⁸ None of the countries indicated in the Funding Request tick boxes that Global Fund support was sought for these efforts, although several have delayed production of NHAs for recent years. Data from current NHAs or health expenditure surveys were not credited but were presumably used in funding landscape analyses in the Funding Requests and other documents. Tracking of domestic health accounts is important to ensure commitments to tackling the diseases are met and that funds are spent, and to predict actual budget fulfilment for co-financing commitments in future fiscal cycles. However, expenditure tracking is also challenging, particularly given that most of the national health accounts are not undertaken annually. Improvements are needed in these systems, or additional expenditure tracking/budget analysis tools that can be used more often are needed.

There remain constraints to adequate increases in DRM for the three diseases. For many of the case study countries reviewed, challenges include low levels of tax collection and high external debt burdens; compounded by low prioritization for health expenditures in government budgets.

⁵⁸ Rwanda has an alternate mechanism to the NHA for expenditure tracking through the Health Resource Tracking Tool (HRTT). This web-based tool is used to routinely collect comprehensive expenditure and budget data from all the levels of the public health sector as well as from external partners and international and local NGOs. The Dominican Republic uses a different public expenditure tracking mechanism.

Box 5: The gradual uptake of HIV/AIDS, TB and Malaria services under the Social Health Insurance (SHI) scheme in Viet Nam

Over the past decade, Viet Nam has made major strides in establishing a social health insurance (SHI) scheme for its people. Subscription to the existing national health insurance program really took off with the proclamation of the national Law on Health Insurance in 2008 and its revision in 2015, leading to compulsory participation for each citizen. SHI currently covers 90% of the population, with a target of 100% coverage by 2020. The State budget covers for the poor, near poor and students (partially for the latter two groups), while others pay 4.5% of their salary (shared between employer and employee) when employed or 4.5% of the minimum salary (\$30). This covers a basic package of services that includes examination and treatment, rehabilitation, antenatal care and deliveries as well as some transport costs when being referred.

As social health insurance expands coverage, it is recognized that the key to financial and institutional sustainability of externally-financed health programs such as those funded by the Global Fund and other International partners, payments for priority disease programs may need to be aligned within the context of the national UHC framework. Anti-retroviral therapies (ARVs), viral load testing and other HIV-related services became reimbursable under the Social Health Insurance in late 2014 and by 2020 over 70% of PLWHIV will receive ARVs via the SHI. Patients supported by PEPFAR will transition to social health insurance by 2018 and those supported by Global Fund will begin transition from 2019; the first ARV treatment paid for under the SHI was offered in March 2019. Similarly, TB and Malaria services are largely covered under the SHI.

While this shows tremendous progress in terms of sustaining the outcomes of the Global Fund supported programs, there are a number of concerns that may need to be addressed in the future including: a) as the Government of Viet Nam is still the major payer with two-thirds of the contributions to the SHI, there is continued need to grow the fiscal space to ensure sustainability; b) at the same time the formal sector premium may need to be increased in the light of the additional public health programs, such as TB and HIV that now will also be covered under the SHI; c) it may also be necessary to pay for additional diagnostic services and to cover for X/MDR TB services; and lastly, d) a concerted effort needs to be made to address privacy and access concerns of key populations that are reluctant to sign up for SHI supported services. With the ongoing concurrent restructuring of general preventive medicine services and the priority disease programs at the provincial and district level being integrated into Centers of Disease Control and Prevention, thereby increasing efficiency, reducing costs and rationalizing pricing, Viet Nam is well on its way to take over and sustain externally funded programs.

Sources: WHO, WB, GF and MoH/Dept. of Planning, Finance and Health Insurance

Efficiency

The Global Fund defines efficiency as “achieving maximum *outputs* or best health outcomes for a given level of investment.” Efficiency is an important component of achieving value for money (VfM). Good VfM, as defined by the Global Fund, is achieved through maximizing the *impact* and outcomes of GF investments, that is making the best possible use of available resources to i) maximize impact on HIV, TB and malaria; ii) help build resilient and sustainable systems for health; iii) promote and protect human rights and gender equality; and iv) mobilize increased resources.⁵⁹ While the language in the STC Policy focuses on efficiency, the Global Fund practice on efficiency is more aligned with the concept of VfM. Figure 2 provides a schematic of the elements of VfM as defined by the Global Fund.

⁵⁹ VfM Presentation, Global Fund 40th Board Meeting, 14-15 November 2018, Geneva, available [here](#). Note that a Technical Brief was published in November 2019, after the finalization of this review, and includes an updated definition. It is available [here](#).

Figure 2. The Global Fund Elements of Value for Money

$$\text{VfM} = 4\text{Es} + \text{S}$$

SUSTAINABILITY

How sustainable are the financing, spending and management approaches to disease programmes and health systems?

EQUITY

- How fairly are the benefits being distributed, leaving no one behind?
- To what extent can we reach vulnerable and marginalised groups?

ECONOMY

Are we / our agents / countries procuring inputs of appropriate quality at reasonable prices?

EFFICIENCY

How well are 'we' turning those inputs into outputs and outcomes?

EFFECTIVENESS

- To what extent are those outputs having their intended effects?
- **Cost-effectiveness:** What is the intervention's impact on disease burden relative to the inputs being invested?

Source: Global Fund 40th Board Meeting, 14-15 November 2018, Geneva.

There are many ways that the Global Fund impacts value for money, including efficiency, of interventions in achieving outcomes. One key means is through impacts on the overall market for HTM commodities, through pooled procurements and market shaping activities. Another is through attention to value for money in its grant making processes. A third means is through direct technical or financial support for efficiency enhancements at the country level. Another example is indirectly through its influence on or financing to global partners.

Given the heavy weighting of medical products in HTM services, one of the key means for ensuring value for money in these programs is through improved pricing, quality and timely delivery of commodities. The Global Fund's Market Shaping Strategy is designed to work with partner organizations to ensure the health of key product markets for HTM related goods and support transitioning countries in addressing market challenges. As part of the Strategy, the Global Fund aims to use tools such as Health Technology Assessment (HTA) and cost-effectiveness analysis to ensure effective, good value procurement of quality assured (QA) products and encourage future innovation. The Global Fund's Pooled Procurement Mechanism (PPM) aggregates order volumes on behalf of participating grant implementers to negotiate prices and delivery conditions with manufacturers. In 2017, the PPM managed US\$1 billion in orders, serving grant implementers in 63 countries. The on-line procurement tool, wambo.org, leverages the PPM to provide accessible prices, increased transparency and improved reliability in the supply of medicines, health products and non-health commodities procured by national governments under Global Fund grants. The tool provides information needed to search, compare, purchase and track the delivery of transparently priced, quality-assured products, improving market visibility, ordering and delivery time. Eight of the ten case study countries utilized wambo.org for grant financed procurements. A pilot is on-going to broaden access to wambo.org for national financing, and the Global Fund Strategy Committee recently voted to expand the pilot to an additional 50 transactions (from 10).⁶⁰

⁶⁰ In furtherance of the STC policy, in GB/B37/DPO9 (May 2017), the Board authorized a pilot, limited to a maximum of ten transactions, to allow wambo.org to accept orders for health products placed by current PRs using domestic funds. The pilot was intended to test and refine the process of opening the platform to purchases funded with domestic sources (as opposed to Global Fund grant funds) and to provide operational and strategic inputs for the development of the future strategy for wambo.org. In March 2019 the Strategy Committee authorized an additional 50 transactions. In November 2019, the Board approved transactions up to a cap of USD 50 million, see Board decision GF/B42/DPO5 available [here](#).

Another set of key interventions for improving the value for money of Global Fund grants are in the funding and implementation oversight processes which aim to optimize the use of resources, ensure good value in procurement of goods and services, and an efficient mix of inputs. Tools used to achieve VfM include guidance in the allocation letters to seek efficiencies, use of costed national strategic disease plans, requirements to address sustainability and VfM in many of the funding request formats, expert review of and feedback on all technical aspects of the funding requests, and the negotiations undertaken by the Country Teams in finalizing component grants and in reprogramming funds that are not utilized. In particular, attention by the TRP to targeting of interventions, adherence to normative guidelines and use of technologies, and careful review of budgets and quantities by the Country Teams are likely to improve VfM from the grants. Further refinements in the funding request processes could encourage while supporting country ownership of greater attention to efficiency improvements.

Grant implementation processes have also been modified to increase value for money. Global Fund oversight for implementation and rigorous audit processes during implementation assure that resources are used as intended, and are designed to catch issues that may lead to funds being diverted and not being used to generate outcomes.

The STC Policy encourages further attention to improving program efficiencies. All but one of the selected countries had recent allocative efficiency modeling for the full HIV program, with disease transmission modeling and costing tools.^{61,62} These models were reflected in improved intervention selection and costing of National Strategic Plans. Many of the programs had studies done in 2016, with repeat studies being undertaken in 2019. Several countries also modeled disease transmission and program costs for the TB program. Few of the malaria programs seem to have been included in such analyses. At least one country (Côte d'Ivoire) was using geospatial modeling, supported by the World Bank, to better cost and target services. Three countries were included in on-going cross program efficiency studies (Côte d'Ivoire, Ghana and Sri Lanka).⁶³

Key informants indicated that a “culture of efficiency” is growing in HTM program implementation, but additional emphasis on efficiency and broader VfM considerations is needed.^{64,65} Given the expected downward trend of external financing as a proportion of program costs, the projected slow growth of national health budgets, and the magnitude of the task of absorbing disease response costs currently covered through external partners, improved utilization of resources will be vital to maintaining and building on achievements to date. Attention to VfM must be applied not just to Global Fund grants but also to national budget funding. Key areas for efficiency include allocation across diseases, within the disease programs and across the sector to maximize impacts on disease outcomes; appropriate selection and optimization of technologies, including drug treatment protocols and use of diagnostic tools (e.g., GeneXPert); achieving value for money in national procurement; integration of programs and considerate use of human resources, particularly given the overall scarcity of trained personnel in many countries; and appropriate monitoring and evaluation of outcomes. However, VfM-related activities must reflect practicable and effective changes. For example, overburdening a single community health worker or diagnostic laboratory to integrate all health activities into one service point may reduce costs but may also not be effective. Three areas of importance to Global Fund programs are discussed further

⁶¹ Rwanda undertook extensive modeling for the NSP based program in 2015, and regularly updates disease transmission and cost estimates.

⁶² Allocative efficiency modeling is recommended by the Global Fund in the HIV Information Note (2019) as a basis for developing funding requests. UNAIDS and other partners provide technical support. See HIV Information Note [here](#) (pp. 19).

⁶³ Information provided through key informant interviews and provision of data by corporate level experts.

⁶⁴ The Global Fund defines Value for Money along four “Es + S”: Economy, Efficiency, Effectiveness, Equity plus Sustainability. Updated Technical Brief on Value for Money is available on the Global Fund website [here](#).

⁶⁵ Secretariat technical experts and AELAC and EECA regional staff are strongly engaged in efficiency work. However, the CTE seldom found this level of attention and clarity of purpose at the country level or in documents reviewed for the country case studies.

below: better costing of NSPs, procurement of health products and commodities and prevention activities.

Table 2. Efficiency Support for Allocative Efficiency in Countries since 2016

Country	Activities
Côte d'Ivoire	<ul style="list-style-type: none"> ✓ Geospatial Analysis to assess physical accessibility to health services (primary health care as well as disease-specific services, including for HIV, TB and malaria) (2018-19) ✓ Allocative Efficiency analysis planned for all three diseases (2019) ✓ Cross Programmatic Efficiency analysis (2019) ✓ Optima: "HIV Investment in Côte d'Ivoire: Optimized allocation of resources for a sustainable and efficient response" (HIV) (2016)
Ghana	<ul style="list-style-type: none"> ✓ Cross Programmatic Efficiency analysis (2018) ✓ Potential allocative efficiency analysis (TBC)
Kenya	<ul style="list-style-type: none"> ✓ NSP with allocative efficiency analysis for 2017 – 2022. (HIV)(2016)(BMGF) ✓ Program quality and efficiency (iDSI) (2018-19) ✓ HIV NSP and Investment Case development, in collaboration with UNAIDS, Gates and other partners (2019)
Namibia	<ul style="list-style-type: none"> ✓ HIV Investment Case in collaboration with UNAIDS (Spectrum modeling 2016)
Vietnam	<ul style="list-style-type: none"> ✓ Allocative efficiency analysis (HIV, TB). This has been done last cycle and ongoing for this cycle (2016, 2019)
Sri Lanka	<ul style="list-style-type: none"> ✓ Allocative efficiency analysis (HIV). (2018) ✓ Allocative efficiency analysis (TB) (2018) ✓ Cross Programmatic Efficiency analysis (2018)
Georgia	<ul style="list-style-type: none"> ✓ Allocative efficiency analysis (HIV) (2019) ✓ Optima: "Optimizing Investments in Georgia's HIV Response" (HIV)(2016)
Ukraine	<ul style="list-style-type: none"> ✓ Allocative efficiency analysis (HIV) (2019) ✓ Value for Money in Ukraine's HIV Response: strategic investment and improved efficiency" (Optima)(2016)
Dominican Republic	<ul style="list-style-type: none"> ✓ Allocative efficiency analysis (HIV)(Spectrum)(2016)

Source: Global Fund data

Evidence suggests that program procurement for first line drugs in the case study countries is undertaken largely within competitive international pricing, with exceptions, whether procured by national agencies or through global mechanisms. Use of national systems is important for building capacity and ensuring sustainability. The Kenya Medical Supplies Authority (KEMSA) pointed to the Global Fund webpage with benchmark prices as a key source of competitive price data. In Georgia, the procurement and supply of health products for HIV and TB is managed by the National Centre for Disease Control. A provision in the State Budget Law enables NCDC to procure through PPM (wambo.org) and the Global Drug Facility (GDF). The Dominican Republic uses a regional pooled mechanism for TB under the auspices of the Pan American Health Organization (PAHO) to procure from international sources. Global Fund requirements govern procurement of health products procured with Global Fund grants⁶⁶, however risks and concerns remain on the pricing for the growing quantities of drugs procured for the programs under national resources.

In terms of allocative efficiency within the disease programs, disease *prevention* programs are often not clearly identified or costed in national budgets, and few efficiency studies cover CSO interventions that reach KVPs.⁶⁷ Where budgets were clear, these activities garnered very little funding (4.5 percent in Kenya). Positive exceptions are the HIV and TB programs in Ukraine and Georgia, where the Global Fund is supporting activities to define and cost the package of preventative services.

⁶⁶ If the outcome of a procurement process for products meeting the required specifications and standards results in a price that is higher than the relevant reference price, national or other resources may be required to pay the difference.

⁶⁷ A 2019 effort by LAC will result in an efficiency analysis of CSO delivery of KVP interventions.

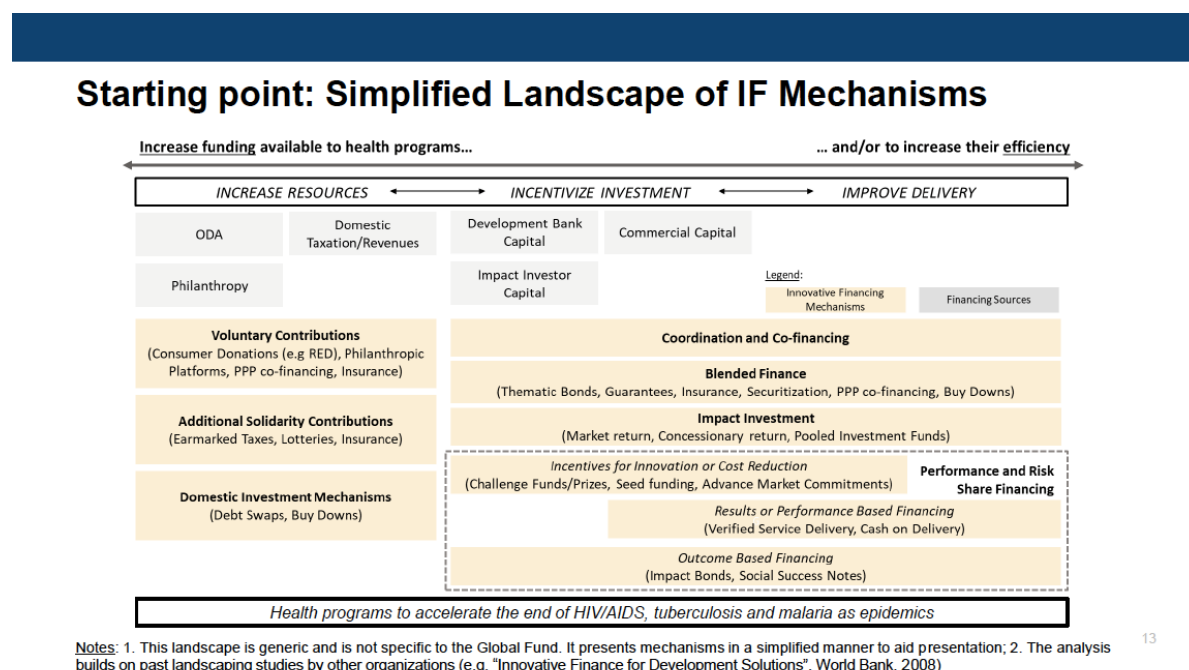
In terms of grant funding processes, the funding requests, TRP Reviews and GAC Review and Sign-off forms all addressed VfM to the extent required. The TRP ensured that normative guidance was followed, programs were sufficiently targeted, disease reduction and health services targets were sufficiently ambitious yet realistic, that the mix of inputs and budget line items seemed appropriate, and that progress was being made in domestic resource mobilization, among other assurances.

Innovative Finance

Since the April 2016 approval of the STC Policy, the Secretariat has taken steps to operationalize innovative finance (IF) and define what it means for the Global Fund. This has included extensive work with the Global Fund's Audit and Finance Committee (AFC) to clarify direct and indirect IF support. These efforts have resulted in a "[Structured Approach to Innovative Finance](#)" reviewed by the Board in November 2018 which clearly defines the focus areas of Global Fund engagement in IF, the principles upon which it should be based, and the mechanisms that will be prioritized in implementing the IF agenda. In addition, this also includes an AFC endorsed Framework for Investments in Blended Finance, which lays out specific details on Global Fund engagement in blended finance transactions (including loan buy downs).

The purpose of IF is to increase resources available for health and/or directly for the three diseases. This includes identifying new sources of revenue, bringing additional financiers to the table and/or innovations that improves efficiency of resource use. Figure 3 provides a useful schematic for considering innovative financing mechanisms. Varied IF initiatives are underway with Global Fund support. Several of the mechanisms seen (although not assessed) in the case study countries are discussed further, below.

Figure 3. Innovative Finance Mechanisms



Source: GFB/29/35. Update on Innovative Financing (May 2018)

Trust funds represent an opportunity for earmarking existing or new sources of revenue. However, the trust funds in LICS and LMICS remain constrained by limited opportunities for raising funds. Kenya has included an AIDS Trust Fund in its proposed health financing strategy.

Loan buy-downs leverage additional health resources and greater attention to the three diseases by multilateral development banks and their partners in ministries of finance, bringing new sources of funding to the health table. Most recently, the Global Fund Board recently approved a loan buy-down for the World Bank to work with the Government of India to address TB services. Mixed grant and loan funds under the Regional Malaria Elimination Initiative (RMEI) in Central America and the Dominican Republic are reducing the costs of borrowing from the Inter-American Development Bank for projects that support malaria elimination.

Debt2Health transactions may be of growing interest given the increasing debt overhang for many sub-Saharan African countries. The Debt2Health mechanism channels funds from debt repayment to investments in health.⁶⁸

Box 6. Innovative Financing in Côte d'Ivoire

The Funding Request (FR) for the 2017-2019 allocation period from the Côte d'Ivoire includes innovative funding mechanisms to address the shortfalls in government budgets and the inability to increase tax revenues. Mechanisms to be explored include levies on financial transactions or mobile telephony, public-private partnerships (PPPs) or the exchange of debt enabling funds. The FR indicates that an in-depth survey will be carried out to identify innovative new mechanisms to mobilize additional resources. The review team identified one such innovative mechanism – a Debt2Health financing initiative undertaken jointly by Côte d'Ivoire, the Global Fund and Germany from 2010. Within the framework developed by the Global Fund, Germany agreed to cancel Euro 19 Million in debt; in exchange, Côte d'Ivoire agreed to use half of that amount as additional funding for HIV. The initiative channeled money away from debt repayments and towards investments in HIV services.

Results-based financing can also provide incentives for countries to improve efficiency of outcomes. This can be seen clearly in Rwanda, where HIV program results have improved, despite large reductions in external assistance and decreased overall levels of financing for HIV/AIDS interventions.

Increasing taxes on harmful products is a possible means of raising revenues for health while also directly improving health outcomes. Such funds could be used to finance specific budget items or disease-specific trust funds. Tobacco, alcohol, sugary beverages and fatty foods have all been objects of “health” taxes. As an example, almost all countries have instituted tobacco taxes; however as noted in the ten case study countries shown in Box 7, these taxes are often too low and maximize neither health benefits nor revenues. It was not clear to the CTE the extent to which Global Fund is currently engaging directly with the case study countries on health taxes, but advising on earmarked taxes are a potential area for Global Fund to indirectly support countries in increasing resources for the health sector.⁶⁹ Some key informants both internal and external to the Global Fund Secretariat expressed concern at the capability and mandate of the Global Fund to engage on broader fiscal issues, such as taxation. Yet, working through WHO and other partners engaged on health taxes issues may provide an entrée for Global Fund to discuss earmarking of revenues for health and/or key disease programs in some countries.

⁶⁸ The Global Fund's Debt2Health program converts debt repayments into lifesaving investments in health. Under individually negotiated “debt swap” agreements, an implementing country agrees to invest in programs to fight the three diseases or strengthen health systems through the Global Fund. Germany and Australia have agreed to participate to date. This mechanism has been well reviewed and is now supported by the UHC2030 Taskforce on Innovative Financing for Health Systems. Indonesia, Pakistan and Côte d'Ivoire have benefited thus far.

⁶⁹ See “Update on Innovative Finance,” the Global Fund, GF/B39/25, May 2018.

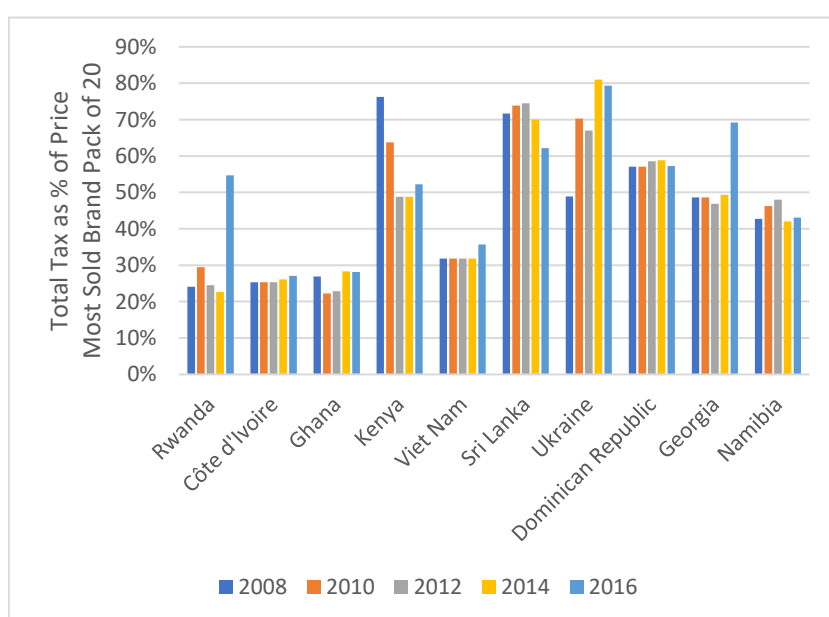
Box 7. Example for Taxation: Tobacco Excise Taxes in Case Study Countries

Figure 3 provides information on tobacco taxes in the ten case study countries, measured as the level of excise tax (specific and *ad valorem*) on a pack of twenty of the most popular brand of cigarettes in that market.

Only one of the case study countries, Ukraine, had excise taxes above the 70 percent of pack price recommended by WHO as needed to optimally reduce smoking in 2016. Rwanda and Georgia showed strong progress with large cigarette tax increases in 2016, with Rwandan taxes more than doubling the rate of previous years and Georgia nearly reaching 70 percent. Many of the other countries fall short of this goal, with three countries having excise tax rates at less than 35 percent – or half the recommended level. Three of the case study countries use soft or hard earmarks to finance health through tobacco taxes. Kenya earmarks 2 percent of the tobacco excises for the national health fund. Côte d'Ivoire has an additional tax on tobacco that is directed toward the HIV/AIDS program. Viet Nam uses 1.5 percent of the taxes on tobacco to fund smoking session programs. Outside of the case study countries, there is a growing body of experience on using tobacco tax proceeds to fund health programs, including in the Philippines, Thailand and the United States.¹

Figure 3. Total Cigarette Excise Taxes by Year Selected Countries

(Arranged in Order of Country Income per capita – low to high)



Epidemiological Sustainability

Epidemiological sustainability in this context answers the question: Is there a sufficiently rapid projected trend of declining incidence and prevalence to reach disease control goals? The Global Fund Strategy 2017-2022 places emphasis on “Ending the Epidemics.” Key informants for this review noted that elimination of the diseases is the ultimate “sustainable response,” and in that sense, sustainability has always underpinned the Global Fund’s approach. The current Strategy hedges that approach with greater emphasis on sustained responses for epidemic control. Maintaining that clarity of focus on disease control while widening the view toward achieving long-term goals is imperative for ensuring sustained disease reductions.

Findings

Globally, progress has been made toward ending the epidemics. Most countries have seen declines in disease rates for HIV and AIDS, TB and malaria. The Global Fund has likely contributed greatly to this progress. However, the case study countries reflect the broader Global Fund context in showing varied progress on tackling the diseases across the ten case studies.

New HIV infections declined between 2005, 2010 and 2017, for all countries included in the review. Similarly, a decline in AIDS related deaths was noted for all countries included in the STC review, except Georgia and Namibia which reported an increase.⁷⁰ Selected countries have concentrated epidemics among key populations. For example, for 2018 Ukraine has an estimated prevalence rate of 22.6% among people who inject drugs (PWID), 7.5% among men who have sex with men (MSM) and 5.2% among sex workers (FSWs), while prevalence in the general population was estimated at 1%.⁷¹ In Georgia, the epidemic continues to be concentrated among MSM with a prevalence rate of 16.2%.⁷²

Tuberculosis incidence largely shows slow declines in disease incidence for the past decade. Of the case study countries, Kenya, Namibia, and Viet Nam are considered to have high burdens of TB prevalence.⁷³ Namibia and Kenya also bear high burdens of HIV and TB coinfection. Current trends show slow or stagnant progress in reducing disease burdens. In addition, many countries are experiencing increasing rates of multi drug-resistant tuberculosis (MDR TB). Kenya, Ukraine and Viet Nam are considered high burden countries for MDR TB.⁷⁴ For example, MDR TB is rapidly rising in Eastern Europe. In 2015, the WHO included the Ukraine in the list of 30 high MDR-TB burden countries in the world (WHO 2015). Data from WHO in 2017 indicated that every fourth newly diagnosed case of TB in Ukraine was a drug-resistant strain.

The picture for achievement in reducing malaria in the case study countries is also mixed. After 2010, results in malaria incidence per 1000 population in the case study countries vary, with Rwanda steeply rising from 2011 until 2016 and thereafter declining, and Namibia slowly rising from a very low level in 2013. The data in Figure 4.a. below also shows progress in reducing incidence stagnating in Ghana from 2013 and a slight increase from 2017 – 2018 in Côte d'Ivoire. Malaria incidence in Kenya remains somewhat flat in the 2010 – 2017 period. The rise in three countries, despite strong efforts of Global Fund and other partners, is concerning and calls into question long-term epidemiological sustainability in these countries for this disease. On the positive side, Figure 4.b graphically provides data on the case study countries with low malaria incidence. Vietnam and the Dominican Republic show very low and largely downward trending malaria incidence in populations at risk. Success stories include Sri Lanka, which was certified free from endemic malaria transmission in 2016 and is currently in the process of transitioning from Global Fund support for the malaria program based on zero incidence of endemic disease transmission.⁷⁵ Georgia achieved zero cases of local mosquito-borne malaria transmission in 2010 and is now in the malaria elimination phase (sustaining zero local malaria transmission).⁷⁶

Programs may not be able to end the epidemics in the time frames proposed, but few NSPs provide intermediate goals or extended time frames for meeting targets. Aspirational targets help galvanize action, but may also prevent good program planning and prioritization.

⁷⁰ UNAIDS, AIDSinfo, aidsinfo.unaids.org, accessed 30 January 2020

⁷¹ *Ibid.*

⁷² *Ibid.*

⁷³ Data on tuberculosis is from the Global Fund 2018 World TB Report and the 2015 WHO Use of high burden country lists for TB by WHO in the post-2015 era

⁷⁴ Stop TB Partnership High Burden Countries.

⁷⁵ The Global Fund Eligibility Policy (2018; p. 4) states that “countries are not eligible to receive an allocation for malaria if they: (i) have been certified as ‘malaria-free’ by the WHO and are included in the official register of areas where malaria elimination has been achieved; or (ii) are on the WHO ‘Supplementary List’ of countries that are malaria-free but not certified by WHO.” Note that the Eligibility Policy was updated in 2019 and is available [here](#).

⁷⁶ WHO Europe Malaria Report, “Georgia”, available [here](#)

Some informants expressed concern that the Global Fund does not consider epidemiological trends in allocation and program transition decisions. Many countries aspire to improve economic standing, yet attaining MICs and Upper Incomes status will reduce their access to Global Fund finance, regardless of whether they are progressing in tackling the diseases. The Global Fund policy on eligibility has been extensively debated, and May 2018 revisions allow for all LICs and LMICS to be eligible for support regardless of disease burden.⁷⁷ However, the Global Fund is one of few funding agencies that consistently applies disease burden as part of the criteria in making country-level decisions on the allocation of funding. Sufficient flexibility also exists in Global Fund decision processes for consideration of funding for extreme cases.

Figure 4a. Malaria Incidence in in STC Review Countries 2010 - 2018⁷⁸

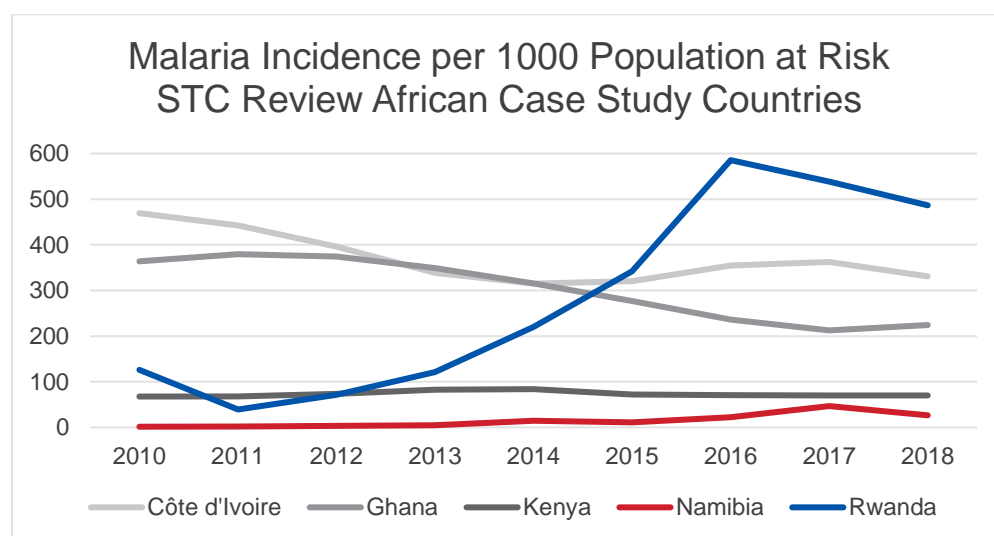
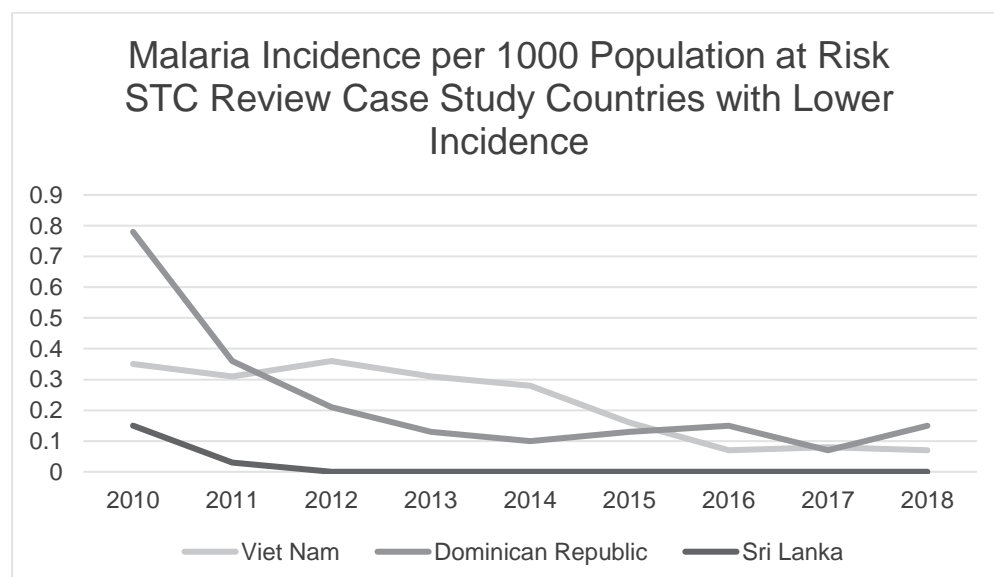


Figure 4b. Malaria Incidence in STC Review Countries 2010 - 2018⁷⁹



Source: Charts updated in January 2020 based on WHO World Malaria Report (2019)

⁷⁷ UMICs must meet disease burden criteria thresholds to be eligible for funding, with some exceptions that open or restrict eligibility,

⁷⁸ WHO World Malaria Report 2019, Annex 3-F, available [here](#)

⁷⁹ WHO World Malaria Report 2019, Annex 3-F, available [here](#)

Programmatic Sustainability

Programmatic sustainability responds to the question: “Does the specific program or intervention make sense in an integrated primary care system?”⁸⁰ Oberth and Whiteside (2016) note “... there is no model for determining programmatic sustainability and it is generally left to governments to decide which parallel systems they absorb and which ones dissolve.” The Global Fund perspective asks: “Do countries have in place the right combination of interventions at the appropriate scale to achieve impact? How are the interventions integrated into national systems (mostly but not all for health)?”

The STC Guidance commits the Secretariat to work with countries on “the sustainability of Global Fund supported programs” by, among others, “aligning requirements to ensure that Global Fund financed programs can be implemented through country systems to build resilient and sustainable systems for health.”⁸¹ The review team applied a resilient and sustainable health systems (RSSH) lens to assess progress on programmatic sustainability. The country case studies explored the alignment with already existing systems or processes in country, building on recent RSSH work undertaken by the TRP, TERG and OIG.

Findings for RSSH

There is common though varied progress towards alignment with or adoption of country health systems in the implementation of Global Fund grants, irrespective of where the country sits along the development continuum. That this is occurring across the spectrum of country capacities was underscored by Rwanda, the only LIC included in the 10-country selection. The use of NSP-aligned, results-based program funding in Rwanda results in strong alignment with government systems.

RSSH investments were primarily geared towards supporting current systems rather than strengthening such systems to ensure sustainability. This was in line with earlier findings in the TRP RSSH Review and the TERG Review on RSSH. Within RSSH elements, the following detailed observations are from the 10 case studies:

Procurement

Most of the ten case study countries have established central procurement agencies and are using central procurement systems for medicines, other health products and commodities. These national procurement agencies are also shouldering most of the procurement for grant financed drugs and commodities. All but one⁸² of the countries are procuring goods under both grant and national financing. The CTE identified HIV/AIDS and malaria health products being procured under grant financing using wambo.org for procurement in eight of the ten countries; see Table 3 below.

⁸⁰ Oberth and Whiteside (2016). The reference continues: “Piot et al. (2015) highlight that sustainability necessitates a programmatic transition from an emergency response to a long-term main-streamed approach.”

⁸¹ The Global Fund, STC Policy (April 2016)

⁸² In 2015, Ukraine made an unprecedented decision to transfer PHHP state procurement from the MoH to international organizations (i.e. UNDP, UNICEF, Crown Agents, etc.) for a transitional period until March 31, 2019, which has been extended to March 2021.

Table 3: Use of wambo.org for procurement of Global Fund financed health products in case study countries.⁸³

Country	Product						
	ARVs	Condoms/ Lubricants	ACTs/Anti- Malarials	RDTs	LLINs	Diagnostics Supplies, incl. HIV RDTs	Laboratory Supplies
Viet Nam	X	X		X	X	X	X
Sri Lanka		X	X	X	X	X	X
Dominican Republic						X	X
Ukraine	X					X	X
Georgia	X	X				X	X
Ghana	X		X	X	X	X	X
Namibia	X					X	X
Côte d'Ivoire	X	X	X	X		X	X

The level of national procurement being undertaken for the three disease is also rapidly increasing, in line with the observation that co-financing has largely focused on national financing of medical supplies (e.g. diagnostics, first line drugs and ART, bed nets). However, none of these countries have procured on wambo.org using domestic funds so far⁸⁴.

In most cases country TB procurement for both GF and government resources are channeled through the Global Drug Facility (GDF) to ensure procurement of high-quality drugs (e.g. FLDs and SLDs, laboratory supplies, reagents and GeneXpert machines and cartridges). Dominican Republic used to buy on the local market until the need arose for XDR TB medicines which they then bought from the PAHO Strategic Fund.

The GDF undertook an analysis of the impact of the STC policy on TB drugs and diagnostics procurement⁸⁵ and found that as countries co-finance or transition, national laws, rules & regulations dictate procurement practices. National procurement observations from the GDF (also noted in the STC review country case studies), included:

- Protracted tendering and contracting processes
- Failed tenders: no bids submitted, bid prices too high, service terms unacceptable
- Delays in allocation of government funds to pay which delays ordering & deliveries
- Poor service: distributors, agents, suppliers fail to meet delivery times & volumes
- Lack of clarity on roles & payor: customs clearance, import duties, in-country transport
- Inability to access concessional pricing for certain products (Xpert MTB/RIF Cartridges)
- Increased prices charged by global & local suppliers/distributors

⁸³ These represent commodities procured through wambo.org identified by the CTE in undertaking the case studies in early 2019. They may not be fully inclusive of all wambo.org related commodities in the current implementation period for these countries.








⁸⁴ The use of wambo.org with domestic funds is still in pilot phase; none of the STC review countries are among the pilot phase

⁸⁵ Tuberculosis Market-Shaping Strategy: Overview, Updates & Priority Issues from Stop TB's Global Drug Facility, Dr Brenda Waning, 2017, Chief, Global Drug Facility, Stop TB Partnership 17 October, 2017. Montreux, Switzerland

The GDF analysis noted that lack of timeliness and poor results from procurement resulted in stock-outs and poor-quality products. At least 5 of the 10 case study countries reported recent stock-outs, especially of ARVs (Namibia, Ghana, Kenya and Côte d'Ivoire) and laboratory supplies (Dominican Republic). This suggests there is further need to address forecasting, procurement and in-country distribution systems.






Figures 5 and 6 below summarize the possible outcomes when countries transition from the Global Fund to national procurement under national budget financing. While the figures were developed for TB drugs by the Stop TB Partnership, and may also apply to HIV/AIDS and malaria health products.

Figure 5. Possible outcomes when countries transition from the Global Fund to national procurement under national budget financing (TB1)

<div>  Observations on WHAT countries buy: Will NTPs Revert to Pre-GF Practices? (Meds) </div>		
Pre-Global Fund	Global Fund	Co-Financing/Transition
 <p>Multiple, single tablets and injections Not optimized, not user-friendly</p>	 <p>Fixed-dose combinations Optimized, user-friendly</p>	<p>Continue using FDCs Or, Go back to multiple tablets, irrational regimens</p>
 <p>Unknown quality status</p>	 <p>Quality-assured products</p>	<p>Continue to use Quality-Assured Products Or, Revert to products of unknown quality</p>
 <p>Expensive second line treatment (>\$5000 per treatment course)</p>	 <p>Large Price decreases (\$800 for shorter MDR regimens)</p>	<p>Continue to use optimized regimens at low prices via some type of pooled procurement Or, Pay higher prices as a single buyer</p>

Source: Stop TB Partnership (2017)

Figure 6. Possible outcomes when countries transition from the Global Fund to national procurement under national budget financing (TB2)

<div>  Observations on WHAT countries buy: Will NTPs Revert to Pre-GF Practices? (Dx) </div>		
Pre-Global Fund	During Global Fund	Co-financing/Transition
<p>Solid culture TB diagnosis & DST</p> <ul style="list-style-type: none"> Slower, less sensitive Inexpensive, materials sourced locally 	<p>Automated liquid culture TB diagnosis & DST (MGIT)</p> <ul style="list-style-type: none"> Faster, more sensitive Expensive, sole source, reliable provider (Becton Dickinson) 	<ul style="list-style-type: none"> Countries may reduce amount of liquid culture performed, reverting to solid culture for testing of patient groups of lesser priority National/regional distributors of Becton Dickinson sometimes significantly mark-up prices
<p>Microscopy</p> <ul style="list-style-type: none"> Low sensitivity Does not provide information on drug resistance US\$ 1-2 / test, sourced locally 	<p>Xpert MTB/RIF</p> <ul style="list-style-type: none"> High sensitivity Provides information on drug (rifampicin) resistance US\$ 9.98/test, sole source provider (Danaher/Cepheid), USA offering concessional prices when paid in US\$ upfront 	<ul style="list-style-type: none"> Countries may revert to microscopy, or reduce amount Xpert performed Countries may not be able to access concessional prices when national regulations require payment in local currency upon delivery; national distributors known to mark-up 50%-800%

Source: Stop TB Partnership (2017)

Ukraine illustrates the positive results from the application of the STC policy on the development and adaptation of a country's national procurement systems. The country is undertaking a health sector reform program that includes reform of procurement processes for essential medicines and other health products. Box 8 provides an overview of the key elements of procurement reform in the country, in line with the STC policy.

Box 8: Ukraine - Transition, Sustainability and Co-financing

Main achievements in 2018:

- Procurement reform. About 40% of State budget saved due to the transfer of procurement functions to international organizations.
- Established Central Procurement Agency (CPA) as a continuation of procurement reform. In 2019, the CPA successfully procured non-critical health products. For 2020 and beyond, transition of procurement from NGOs to CPA for key prioritized national programs and GF grants will increase while dependent upon CPA meeting key milestones and becoming operational.
- The State budget covered 100% of MoH calculated TB drug needs (but in accordance with old national guidelines, the State did not procure Bdq and Dlm). For HIV, the State budget covered 73% of patients receiving ART.
- Ukraine fully funded opioid substitution therapy (OST) for over 10,000 patients, representing a 100-fold increase over the number in 2005.
- Implementation of optimization strategy. Gradual withdrawal from non-recommended drugs.
- On average, 1st line drugs (TDF/FTC/DTG) cost less than US\$ 115 per year – one of the lowest levels in the region. Due to optimization of Lpv/Rtv, the ratio was decreased from 37% in 2016 to 7% in 2018, resulting in savings of almost US\$ 5.5 million.
- Use of new TB drugs (Bedaquiline and Delamanide were registered in Ukraine and included in procurement list for 2019). Preparations made for transition to new WHO recommended approaches in 2019.
- Implementation of reform of TB services and transition to an outpatient model. Optimization of beds (14548 beds in 2016 and 13 848 in 2017) at 5% reduction per year.

Source: Ukraine CCM Source (March 2019)

Many countries lack market power, and benefit from global and regional mechanisms for procuring health commodities. This can be as simple as using Global Fund publicly provided information on ARV prices (e.g., Kenya), to using wambo.org for procurements or the Global Drug Facility for TB drugs, or participating in regional pooled mechanisms, such as the PAHO Strategic Fund (e.g., the Dominican Republic procures TB drugs through this mechanism).

Information Systems

There has been a general move towards the integration of health information systems through the adoption of the DHIS2 as an integrated and interoperable platform. The Global Fund's strategic investment in the further development (funding the University of Oslo's Health Information Systems Program) and implementation of the DHIS2 (in Global Fund-supported countries) has led to the system being an interoperable platform for country information systems in 67 LICs and LMICs⁸⁶. This, in turn, has led to the adoption of the DHIS2 as the basis for the country disease programs and subsequently the basis for evidence-based planning of programs and funding requests.

As a result, it was found in the TRP/RSSH study that the substantial investment in information systems is singularly the most advanced in terms of strengthening health systems (while others RSSH investments are still supporting considerable operational costs). With the advance of electronic means of collecting and analyzing data, savings and processing speed have been achieved vis-à-vis the traditional paper-based systems, which makes the information systems more sustainable.

⁸⁶ DHIS2, "About DHIS2", <https://www.dhis2.org/about> (accessed 30 January 2020)

However, there remain programs with separate disease information systems or even parallel systems for Global Fund reporting, e.g., vertical reporting systems were still seen in the country case studies: in Viet Nam, Sri Lanka, Namibia, and Ghana. While other departments, units, or programs of the health ministries may have adopted the DHIS2, considerable resistance was indicated on the part of program managers to making disease information systems interoperable with other information systems. This inhibits the achievement of program efficiencies. For example, there were instances where direct linkages could have been made but were not made to a national lab information system or a logistics information system to improve information on 'Last-Mile' distribution or availability of drugs. While vertical systems may be cost-effective in some settings, the default should be integration given the needs of long-term sustainability, unless there is a strategic case for duplicative systems.

Never-the-less, there are also good examples. For example, some countries with components closer to transition have even explored the integration of information systems in line with national e-Governance systems such as e-Health, e-procurement, and individual medical patient record systems (with unique identifiers) (e.g., Ukraine).

Lastly, while the Global Fund, countries and external partners have made substantial investments in information systems, there has been much less attention to or investment in capacity building for monitoring and evaluation (M&E) processes and human resources. In particular, human resources for M&E are largely funded through off-budget RSSH support from the Global Fund. These are also the first positions to be deleted when allocations shrink or grants end, with few if any being absorbed into the government civil service (e.g., as was the case in Sri Lanka).

Human Resources for Health

In the 2017-2019 cycle, many of the funding requests included detailed human resources (HR) plans to increasingly absorb HR in a staggered manner; with difficult to fill or highly specialized positions absorbed last. Where these were not submitted, they were requested by the TRP or the Country Teams. While there is still considerable Global Fund investment in human resources, e.g. program management staff, technical staff and community health workers, especially in the LICs and LMICs, there is a growing trend for countries to take on commitments for HR needs for HTM beyond Global Fund funding, i.e. to be paid from government budgets. This includes shifting responsibilities for absorbing staff to local government funding.

However, there remain issues with inclusion of CSO-based staff, particularly service delivery staff who are key to achieving results, in HRH planning. Almost none of the plans recognize these workers, and the sustainability of their services and capacities is seldom considered in formal plans.

Community health workers are increasingly recognized as an integral component of the health workforce and vital to achieving public health goals. The country case studies hold interesting examples:

- Incentives for approximately 58,000 Community Health Workers (CHWs) in Rwanda are largely externally funded through performance-based grants.⁸⁷ The CHWs are organized into cooperatives that also implement income generation activities. Seventy percent of funds provided to the cooperative are earmarked for income generation activities and 30% is shared among the members. Key informants raised concerns with respect to the financial sustainability of this program. Cooperatives are not able to absorb any significant share of the costs of the community health program despite income generating activities. An additional concern raised was the lack of an institutional framework regulating the program, determining the formal duties and rights of these 58,000 health care providers, and ensuring proper oversight and quality. Key informants noted the tension between regulatory policy and the right to health and access.
- The Global Fund TB and HIV grants support the system of Community Health Volunteers (CHVs) in Kenya used to expand the reach of the health system largely for TB and HIV promotive and

⁸⁷ Rwanda HSSP IV, 2018.

preventive care. The current Global Fund allocation includes stipends and supervision costs for this cadre. However, a TRP request and Country Team negotiations during grant-making resulted in a plan for county governments to gradually absorb these incentives. The counties are making good on this commitment, with Global Fund grant financing likely to be reprogrammed to cover other county level needs according to in-country informants.

- Financing for Community Health Workers features prominently in most of the NSPs. These posts are sometimes disease-specific (e.g., not integrated into broader services delivery) and in general, plans for supervision, absorption and future funding of positions are not well specified.

Public Financial Management (PFM)

Weak PFM systems constrain effective implementation of national HTM programs. Common challenges include the lack of contracting and oversight mechanisms for non-state provision of health services, inability to provide advance payments for international commodities, inability to accrue expenditures across budget years, and problems in budget execution driven by a range of budget and treasury processes, among others. Decentralization and or fiscal devolution of health services in almost all countries under review adds an additional layer of complexity and capacity challenges to PFM.

Global Fund investments are on-budget in some countries and off-budget in others. Alignment with budget processes and cycles was better as countries neared transition, although funding for key population activities continued to be largely outside of government processes and absorption of these costs continue to lag. Where investments are on-budget, countries are reporting delays in the release of funding and implementation delays. Where investments are off-budget, countries report that the 3-year cycle and annual work plan and budgeting processes of the Global Fund are out of sync with government cycles. This makes integration of services at different levels of the health system more difficult. The on- and off budget differentiation is also reflected in the national health accounts, where it is difficult to capture/align external funding, including that of the Global Fund with overall health expenditures.

Increasingly Global Fund supported disease treatment (diagnostics and preventive services less so) is funded under a social health insurance scheme or provided by a separate government entity. However, this separation of funding streams and multiplicity of providers requires additional PSM, health information and other investments to ensure that procurement and distribution of medical supplies are coordinated across entities.

Integration of services

There is a need for greater emphasis on integration of services and program management. Few countries can afford the level of vertical programming supported by external funders in the past. Efficiency and, therefore, sustainability require integration of services and support streams where it makes sense. Possibly spearheaded by a country's desire to move towards UHC, there is a growing trend of integrating services. This takes different forms: from the transitional TB/HIV program integration (though a lot more could be done beyond testing and drug provision), to establishment of prevention packages that include services beyond the Global Fund reach, to integration with other diseases such as Hepatitis C or dengue, to 'integration' under a national social health insurance scheme as mentioned above. For example, in Georgia, the government's commitment to elimination of Hepatitis C Virus (HCV) catalyzed the integration of HIV and TB screening interventions with Hepatitis C screening services at all levels of health care. Georgia provides universal coverage with Hepatitis C treatment for the entire population, including for HIV/HCV and TB/HCV co-infected persons.

Governance (CCM)

There is a need to consider the CCMs and the way that Global Fund undertakes its support. Supported by other Global Fund initiatives, such as the *CCM Evolution Project*, it was observed that CCMs are being strengthened as the national conduit for Global Fund investments; including engagement of civil society organizations, whether international or local NGOs, and key population representative groups or community-based organizations represented on the CCM as Global Fund Principal Recipients (PRs)

or Sub-Recipients (SRs). Despite the positive engagement of the latter, several of the external partners queried the continued need for such a mechanism, especially if there is a central trend towards national government agencies being the main Global Fund counterpart with greater use of national systems⁸⁸. Questions were also raised regarding the appropriateness of the CCM as the governance structure for coordination of partners, given that these mechanisms are often driven by program managers and others who may have difficulty relinquishing “turf” for integration of programs.⁸⁹

The appropriateness of CCM as the governance mechanism in development of RSSH funding requests was also raised by external partners given that the current interventions seem to reflect the needs of the HTM programs in achieving Global Fund objectives, rather than addressing broader health systems challenges to effective HTM programs (e.g., integration of disease control programs, overarching human resources for health issues). This reflects findings of the RSSH reviews that note the preponderance of support rather than strengthening activities in Global Fund financed RSSH programs.

Partnerships (Country-level)

Different levels of external partner coordination are seen across the countries. Factors that seem to impact coordination include the level of Global Fund investment vis-à-vis other partners, the placement of the funded support within the health sector (e.g., on/off budget, separate PMUs or integrated into overall government management of the program), and the ‘strength’ of the CCM in coordinating activities. Greater alignment as countries near transition – and perhaps greater capacities in those countries – does seem to result in better donor and external agency coordination by government entities. At the same time, more aligned processes even in low income countries, such as the NSP RBF budget support instrument in Rwanda, provide governments with a better framework for donor collaboration. In Namibia, strong donor coordination has led to joint efforts between the Global Fund, PEPFAR and the World Bank in addressing HIV and TB. In Ukraine, under the UN Partnership Framework and Joint Program 2018-2022, one strategic priority is a sustainable HIV response. To that extent, the program is advocating for efficient investment and transition to domestic funding and supporting the Sustainability Strategy and Transition 20-50-80 Plan in Ukraine.

The need to engage more with the private health services sector is widely recognized, but little is done. For example, in Kenya an estimated 43% of TB cases seek first treatment in private clinics or pharmacies. However, in the case studies, little collaboration is noted on the ground, despite private sector presence on all CCMs. Particularly noticeable is the absence of private sector data across the three diseases, even in those that have integrated, interoperable information systems. An exception is the malaria and TB support by the corporate sector in Namibia (22% of program financing). The CTE is aware of exceptions beyond the case studies (e.g., tuberculosis control in India; malaria in the Philippines).

Findings for Program Management

A variety of program management structures were used across the case study countries, with different levels of alignment with country processes. In at least one country, risk mitigation seemed to be driving program management away from alignment with Government processes. Despite some of the ULMIC/UMI countries being close to transition, there were still some with a strong PMU/PIU and it

⁸⁸ As per the Global Fund’s policies, CCMs can be part of national government coordination bodies. According to the Global Fund Framework Document (2001), “The mechanism should be at the highest national level responsible for national multi-partner and multisectoral development planning. It should preferably be an already existing body. If no appropriate coordinating body exists, a new mechanism will need to be established.” However, these national structures must be inclusive and ensure a broad range of stakeholders, including civil society, key populations and those living with or affected by the diseases.

⁸⁹ Further issues were raised by external partners concerning the appropriateness of the regional coordinating mechanisms in the governance of Global Fund resources that are used at country level through regional grants (which are not covered in this review).

remained unclear how the government was to take over such arrangement. The Rwanda grants were again good examples for alignment with national processes.

Almost all countries had dual track Principal Recipients (PR) for the grants. These included a state-PR and a non-state PR. Efforts were underway in Ukraine and the Dominican Republic to strengthen mechanisms to continue to finance non-state actors as both country's HIV programs seek to improve sustainability.

The STC Policy moves the Global Fund further along the path from emergency response to building sustained programs. However, continued evolution of processes and analytical frameworks is needed to overcome the inherent barriers and constraints to sustainability posed by the original grant management and governance processes. Risk management vs sustainability continues to be a trade-off in use of country systems.

Human Rights

The key question regarding human rights sustainability is “How will the right to health be protected for populations who might be excluded from decision-making?”⁹⁰ This includes participation in decision-making, continued progress on addressing human rights-related barriers in the context of the disease responses, and sustained coverage of key and vulnerable populations by HTM prevention and treatment services.

There is wide recognition that sustaining disease impacts requires prevention and care activities that reach key and vulnerable populations. Particularly for HIV, much of this work is accomplished through community-based organizations in the ten countries reviewed. However, with exception of transition-oriented countries in EECA and LAC (e.g. Ukraine, Georgia and the Dominican Republic), there seems to be even less attention to the sustainability of community provided services, which are largely financed through external donors, than to state-provided services. These programs remain at grave risk of being underfunded and/or not continued as countries shoulder a larger portion of program costs.

Often these community-based organizations face legal and regulatory constraints to receiving funding from public sources. Either the organizations themselves lack appropriate legal status, governments have no mechanism to fund these entities for service delivery, or in many cases, legal issues and criminality codes around risk behaviors limit public funding. Others are constrained through bureaucratic processes that are not made to fit small organizations. While partially addressed in transition planning, earlier and more directed efforts are needed to ensure access to prevention and care services by key and vulnerable populations.

The review found that some countries have established or are in the process of establishing “social contracting” mechanisms for sustainable financing of primary prevention interventions for key populations.⁹¹ For example, Côte d'Ivoire and Georgia have mechanisms for contracting with non-governmental organizations. The Dominican Republic and Ukraine are also piloting approaches that include “social contracting” with CSOs to maintain promotion and prevention activities for key populations after Global Fund transition.

⁹⁰ Oberth and White (2016) note “Some funding partners are concerned about reaching key populations, such as men who have sex with men, sex workers and drug users, in contexts where the government would otherwise not provide services [and] the difficulties of funding partners promoting human rights while also encouraging country ownership in places where certain key populations are criminalised.”

⁹¹ The Global Fund (2017) STC Guidance Note defines “social contracting” as mechanisms that allow for government funds to flow directly to civil society organizations (CSOs) to implement specific activities. This can include domestic finance through contracts, grants, procurement or third-party payments, of social goods and services, e.g. health activities, is known as “social contracting”. The STC Guidance Note was updated in December 2019 and is available on the Global Fund website [here](#).

However, most countries have yet to establish the processes and legal frameworks needed to promote state funding of non-state actors for important key population interventions. Even where processes and frameworks are being piloted, constraints to these approaches are clear. For example, in Georgia, where public financing and contracting of civil society organizations does exist, the requirement for the non-state actor to provide a bond⁹² – even for a small percent of the overall contract – limits the ability of community and local non-state organizations to respond.⁹³ In other countries, “social contracting” mechanisms are in a pilot phase (Dominican Republic, Ukraine) or are underfunded (Côte d'Ivoire), and therefore lack the capacity to sustain primary prevention programs at the levels supported by the Global Fund.

Other constraints noted by key informants to “social contracting” for CSO provision of services to KPs include the fact that these services may not be perceived as critical by ministries of health, local governments or other funding authorities. Even if mechanisms are in place, there is often reluctance fund these activities through state budgets. Furthermore, these activities have often been designed with support from external partners; countries may lack the capacity to design, manage and monitor implementation of these activities.

Furthermore, the case study countries already show limited or inadequate coverage and lack scale-up plans for addressing primary HIV prevention for key populations - even with Global Fund support. In all ten countries data showed inadequate coverage of primary prevention for key populations, even with Global Fund support. For example, although not projected to transition by 2025, Ukraine is planning and implementing key elements for transition and has pledged to utilize national resources to support NGO-run programs. However, the current coverage of harm reduction programs in Ukraine, which has an HIV prevalence rate of 22.6% among people who inject drugs (PWID), is too low to impact the epidemic in this key population. Harm reduction programs distributed just 84 needles and syringes for PWID per year in 2017 (showing only minimal progress since 2011, when that figure stood at 75 needles and syringes per PWID per year), and the government-supported Opioid Substitution Therapy (OST) program covered less than 5% of PWID.⁹⁴ In addition the only clear plan for scale-up was in Viet Nam with the Opioid Substitution Programming for PWID.

Finally, the review found that Global Fund supported interventions that work to address human rights barriers to accessing health services tend to be cut as countries near transition, with financing and contracting mechanisms taking priority in this period. It was also noted by key informants that country sustainability efforts do not generally include plans to address legal barriers to services for key populations, such as criminalization.

In-country NGO PRs and CSOs have recommended that additional effort be given to sustainability of key population interventions. Suggestions include peer learning around sustainable financing with organizations in other countries (including CBOs in developed countries), earlier dialog with governments on CSO financing, and increased attention to efficiency of service delivery.

Structural

Issues of structural sustainability can be constructed as constraints on demand. The key question: “Is the social and environmental context enabling for a long-term effective response?”⁹⁵

A key concern is that as countries achieve higher targets, those who are left behind (e.g., missing TB cases or those not included in 90-90-90) may be among the most marginalized in terms of income and

⁹² Important to note that as of final review of the TERG STC Review (December 2019) exemptions from the bond requirement are being granted during the tendering process in order to reduce the impact on CSOs.

⁹³ In Georgia a majority of service provider CSOs find it difficult to meet the requirements of the Public Procurement Law to present a bank guarantee of 1-2% of the total budget of a tender, or another form of insurance, with a tender.

⁹⁴ UNAIDS, *Health Rights and Drugs: Harm Reduction, Decriminalization and Zero Discrimination for People who Use Drugs*. 2019.

⁹⁵ Oberth and Whiteside (2016). The authors go on to note: “Gill et al. (2006) emphasize that a sustainable response to AIDS requires looking beyond securing the financial and physical resources needed, to also focus on structural barriers to access.”

access to services. Beyond issues of discrimination, this could relate to poverty, inequity, residence in remote rural areas or in urban slums, or cultural issues surrounding household decision-making that mean unequal access to health services or information on disease prevention for some family members, or acceptance of gender-based violence norms that put girls and women at risk. These structural barriers may prevent people from having the knowledge or agency to protect their health, or to give full expression to demand for health services. While much of the discussion around program implementation focuses on provision of services (the supply side), it is also important to consider those who are not accessing services. The costs and difficulty of reaching these populations can also be much larger than those of the previous efforts.

The case studies presented various social and environmental challenges to program sustainability – but also held some positive examples. Good examples include linkages with the social protection program in Kenya to ensure food and income support for MDR TB patients, included in the allocation amount and in unfunded quality demand (UQD). Kenya also requested and received USD 5 million in matching funds for reaching adolescent girls and young women (AGYW) – a particularly vulnerable population group in the Kenyan HIV epidemic – and USD 4 million in human rights matching funds. Universal Health Coverage (UHC) pilots in Kenya, partially supported through Global Fund grant activities, include removal of user fees for the first tiers of health service. This is already resulting in a large increase in health services demand in those counties in the first year of the pilot. Similarly, in Georgia, the introduction of the Universal Health Care Program (UHCP) has expanded coverage and improved equity overall in the health system, while also providing an opportunity to develop a more effective, integrated model for TB service delivery. With the UHCP, many households near the poverty line can access necessary health services for which they were previously not covered. Georgia has also made significant progress in improving financial access to health services under the UHCP by reducing out of pocket expenditures (OOPE) for services.

Political

Assessing political sustainability requires that we address the questions: “Will the diseases remain on the policy agenda? Is the legal and policy environment conducive for an effective response?”

There was evidence of strong political commitment for UHC, and to some extent, to the three diseases in most of the case study countries. Political leaders are visible in global fora calling for additional attention to HTM. They are also advocating for UHC and health reforms at the national level. Countries are also expanding committing budget line items and financing to Global Fund co-financing commitments.

There is growing recognition amongst the STC review countries that the legal and policy environment impacts access to services in myriad ways. These include laws, policies, and regulatory institutions that impact the vulnerability of those affected as well as the environment for program management and response. The latter include legal barriers to international procurement, poor public financial management needed for constructive tendering, and redundant or ineffective drug regulatory authorities.

TRANSITION FROM GLOBAL FUND SUPPORT

The Sustainability, Transition and Co-financing (STC) Policy defines transition as the mechanism by which a country, or a country component, moves towards fully funding and implementing its health programs independently of Global Fund support, while continuing to sustain the gains made and scaling up programs as appropriate.⁹⁶ The transition part of the policy establishes a proactive approach, principles and framework for promoting effective transitions.⁹⁷ The objective of Global Fund transition activities is to support countries in addressing transition challenges and preparing for component exit from Global Fund financing, while sustaining and accelerating health system and disease outcomes.

Context

The Global Fund Secretariat has focused much of its initial attention and effort in operationalizing the STC Policy on transition efforts. Changes in Board approved eligibility criteria and allocation processes from 2012 defined and accelerated the number of component transitions based on national incomes and disease burdens.^{98,99} Internal strategic processes in developing the 2017 – 2022 Strategy as well as independent TERG sustainability reviews in 2013 and 2015 highlighted the need for the Global Fund to prioritize work with countries to better manage country-component exit from its financing.¹⁰⁰ Partly as a result, the 2016 STC Policy codifies expectations and processes for consistent management of transition. The subsequent January 2017 STC Guidance Note provides recommendations for how countries should prepare for transition, including assessing transition readiness and having in place a strategy for transition.¹⁰¹ The Guidance Note also provides the requirement that countries applying for transition funding submit a transition work-plan, noting that ideally, transition planning should start several years ahead of projected exit from Global Fund financing.¹⁰²

This attention to early transition planning has required a great deal of Global Fund's STC attention to be focused on UMI countries and to LMI countries with non-high burden of disease. This has enabled the Secretariat to "catch-up" to ensure transition assessments and plans were in place for those country-components already transitioning, and to support assessment and planning in those country-components nearing transition as well as those recommended to prepare for transition.¹⁰³ As of 2018, the Secretariat was working closely with countries to conduct transition readiness assessments (TRAs)

⁹⁶ GF/B35/04 – The Global Fund STCPolicy, April 2016

⁹⁷ OIG (September 2018). Audit Report: Global Fund Transition Management Processes. The two agreed management actions (AMAs) from the audit have been closed as of April 2019 or earlier.

⁹⁸ GF/B30/DP05: Revision of the Policy on Eligibility Criteria, Counterpart Financing Requirements and Prioritization of Proposals for Funding from the Global Fund (November 2013). Revisions to the eligibility policy (May 2018) allow for all low and lower-middle income to be eligible regardless of disease burden. Countries categorized as UMIC based on income must meet disease burden criteria thresholds, with some exceptions which open or restrict eligibility for UMICs.

⁹⁹ Projected Transitions from Global Fund Support (2018) noted 12 components in 11 countries becoming ineligible during the 2014 – 2016 allocation period with access to final transition funding in 2017 - 2019; 7 components in 5 countries likely becoming ineligible in the 2017 – 2019 period, and 11 components in 7 countries between 2020 and 2025. In addition, an additional 25 LMI countries with low disease burdens and 27 UMI countries were identified that should prioritize transition planning. However, projections are updated periodically and country status may change. Please note that this document was updated as of January 2020 and is available on the Global Fund website [here](#).

¹⁰⁰ OIG (September 2018). Audit Report: Global Fund Transition Management Processes. The two agreed management actions (AMAs) from the audit have been closed as of April 2019 or earlier.

¹⁰¹ Guidance Note: Sustainability, Transition and Co-financing of programs supported by the Global Fund (Jan 2017). Please note that the Guidance Note was updated in 2019 and is available on the Global Fund website [here](#).

¹⁰² The Global Fund (March 2018). Projected Transitions from Global Fund Support by 2025 indicates planning should begin ideally 10 years ahead.

¹⁰³ In addition, seven countries were reported by key informant interviews (KII) to have elected to use the Tailored to Transition format for application in the 2017 – 2019 allocation period.

or TRA equivalents in nearly 30 countries, covering approximately 60 disease components.^{104,105} For many country-components, these processes are undertaken as “sustainability” assessments and plans to increase self-reliance and prepare for reduced external support in general, as the timeline for exit from Global Fund financing is not known.

To support these efforts, five sustainability and transition (ST) specialists have been assigned to the Eastern Europe and Central Asia, South East Asia, and Latin American and Caribbean Country Teams, the regions most impacted by earlier transitions and transitions in the 2017 – 2019 and 2020 – 2022 allocation cycles. Internal and partner training on STC has also had a strong focus on transition.¹⁰⁶

An important element of Global Fund support for transition planning was the development of three TRA tools with support from external consultations in 2016 and 2017: a tool to assess HIV and TB programs and health systems aspects of transition readiness; a malaria-specific tool given the nature of the disease; and a diagnostic tool for sustainable financing of CSO services. These instruments address critical issues of transition – and sustainability – planning. Although the Global Fund does not require countries to use the specific format, the prototype serves to give an example of the robustness of the analysis expected. To strengthen technical support to countries in undertaking TRAs, the Global Fund is also collaborating with key partners, including UNAIDS and USAID, that finance technical assistance for these efforts.

To further support transition planning, the Global Fund produced a list of components in 2016 “Projected Transitions from Global Fund Support by 2025,” based on projected improvements in income classifications, which is updated annually by the Global Fund Secretariat¹⁰⁷. The subsequent list makes expected transitions more transparent and predictable by identifying components that are transitioning or likely to transition between 2017 and 2025, and recommends that all LMI countries with non-high disease burdens and all UMI countries prioritize planning for transition.

In September 2018, an audit was conducted by the OIG on the Global Fund’s management of transition processes in line with the STC Policy.¹⁰⁸ The findings were generally positive, with recognition of some remaining areas for attention. The audit recognized that transition is primarily “a country process supported by the Global Fund. As such, factors such as the political willingness, the level of commitment or the legal framework of countries, which are at different maturity levels, are key enablers of successful transition... these factors are country led and beyond the Secretariat’s direct control.” The reduced leverage of the Global Fund with reduced investment in transitioning components was also noted, resulting in increased need for focused engagement “on the part of all stakeholders, including governments, the Global Fund Secretariat, the Board, partners, donors and civil society organizations.” Box 9 provides key findings from the audit report. These findings are relevant across the elements of the STC and are incorporated into and supported by the findings of the TERG STC Review.

¹⁰⁴ The Global Refund recommends that countries use the TRA or “equivalent” tool. Varying country contexts mean that some countries may find advantages in using different tools for assessment. This also provides opportunity for learning from different formats. For example, some countries with strong NSPs use the format for updating those strategies to assess transition challenges. In another example, one country is piloting a “transition-oriented” Public Expenditure Review with WB to support analysis of transition challenges. Source: Internal communications with key informant.

¹⁰⁵ Internal communication with key informant.

¹⁰⁶ OIG (September 2018). Audit Report: Global Fund Transition Management Processes.

¹⁰⁷ Please note that the Transition Projections list was updated as of January 2020 and is available on the Global Fund website [here](#).

¹⁰⁸ OIG (August 2018). Audit Report: Global Fund Transition Management Processes. Available on-line [here](#). The two greed management actions from the audit have been completed as of April 2019.

Box 9. Key Findings OIG Audit Report: Global Fund Management of Transition Processes

Key Achievements and Good Practices

Approval of the STC policy. The Global Fund is one of a few donor organizations to develop and implement a policy that outlines the principles and framework for effective transition from its support. This has increased both transparency and predictability for countries and components that are likely to transition. It has also encouraged early planning and stakeholder engagement to address transition challenges.

Improved Secretariat oversight to support transition planning. The Secretariat has instituted a Steering Committee, led by the Head of Grant Management and including all relevant divisions, to oversee implementation of the STC Policy. The Management Executive Committee has identified implementation of the policy as one of its key strategic priorities and has defined key STC deliverables, timelines, measures of success and accountabilities. Key performance indicators are also monitored at the Secretariat level to track progress on implementation.

Improved and tailored funding application and grant making processes to support transition. The Secretariat has enhanced the processes and tools to support transition. The funding application process is now tailored, with a specific funding request for transition applicants. Strategic Information and Sustainable Financing (SISF) experts, included in the Technical Review Panel, review funding requests and provide guidance on transition activities and risks. At grant approval stage, country teams are required to indicate how the STC policy is taken into consideration in designing the grant. Relevant tools, such as the transition readiness assessment and a diagnostic tool for public financing of civil society organizations, have also been developed to support transition planning.

Key Issues and Risks

Identification of alternative mechanisms to support countries post transition. Transition challenges such as access to quality-assured medicines can affect gains made in countries post transition. There is an opportunity for the Board and Secretariat to explore ways to support transition through mechanisms other than grant funding. For instance, the Global Fund could leverage existing arrangements to allow these countries to procure medicines and health products through the Fund's Pooled Procurement and wambo.org platform... The OIG acknowledges that the Secretariat and/or the Board can only make these mechanisms available while decisions to use them are country led.

Improvement required in monitoring transition grants. Standard grant indicators alone are not sufficient for measuring the performance of specific transition activities. As a result, transition activities are currently captured in the Work Plan Tracking Measures of the Grant Performance Framework. Whilst there is an existing quality assurance process for the Performance Framework, there is limited control to ensure that all key transition activities as per the transition work plan are captured in the Work Plan Tracking Measures. As a result, transition activities are inconsistently captured and the progress of these activities could be overlooked during the annual funding decision-making process, where the grant's performance is fully assessed by the Secretariat. There is a need to define a formal and systematic approach to monitor the performance of transition grants and to ensure that transition-related challenges are promptly identified and mitigating actions put in place."

Source: OIG (September 2018). Audit Report: Global Fund Transition Management Processes

The Secretariat's Eastern Europe and Central Asia and Latin America and Caribbean regions (EECA/LAC) have built extensive experience and expertise on transition and sustainability planning. These regions largely contain middle income countries that are moving toward UMICs and high-income categories and have lower disease burdens. Almost all currently eligible countries in these two regions either have components that have transitioned or are projected to be transitioning from Global Fund

support; or the Global Fund has recommended they begin sustainability and transition planning during the 2017–2019 period.¹⁰⁹

Both external partners and key country informants expressed concerns regarding the Global Fund’s tendency to define transition as graduation from Global Fund support. Informants noted that country programs face transition from other external partners, as well as within the program when elements are moved to government financing.

Case Study Findings

Ten of the twenty-seven disease components in the ten case study countries are identified by the Global Fund as in, or “near transition”, i.e. projected to transition or recommended to begin early planning for transition. The designation and projections for transition from Global Fund support are based on country national per capita income category and disease burden.¹¹⁰

- As of the writing of this report, two of the selected components are ineligible for future Global Fund support based on Global Fund eligibility criteria of current country income and/or low burden of disease.¹¹¹ Sri Lanka was certified to have eliminated endemic transmission of malaria in 2016. A final transition grant in the 2017 – 2019 allocation cycle is oriented toward sustaining elimination. The Dominican Republic has made sufficient progress in tackling tuberculosis and in economic growth to be no longer eligible for program funding. A final transition grant in the current allocation cycle addresses TB program sustainability challenges.¹¹²
- As of the writing of this report, two case study components were expected to become ineligible during the 2017 – 2019 allocation period, with possible access to transition funding in 2020 – 2022. Sri Lanka’s HIV and TB components are projected to become ineligible in the current allocation period given projected movement into UMI country classification.
- As of the writing of this report, six case study components are included on the Global Fund list of components that should prioritize transition preparedness and transition planning.¹¹³ These are in UMI countries (Dominican Republic HIV; Georgia HIV and TB; and Namibia HIV, TB and malaria).¹¹⁴

The ten components were covered in four of the five desk review case studies. No field visits were selected for countries with components in transition. The total amount of grants for these components represents seven percent of the total grant amount across the ten case study countries (US\$ 92,345,615 of a total of US\$ 1,342,534,031). This was in keeping with the terms of reference for the STC Review that requested focus on middle income countries with high burden of disease.¹¹⁵ Ukraine has undertaken

¹⁰⁹ Please note that there are various countries and disease components where there is a focus on transition preparedness which are not included in the projected transitions document, and other programs in the LAC and EECA regions where transition preparedness is not actively emphasized formally by the Global Fund, including Haiti and Kyrgyzstan. For those countries recommended to begin planning, the recommendation is to begin sustainability and transition planning or incorporate sustainability and transition into existing planning.

¹¹⁰ Projected Transitions from Global Fund Support by 2025 – Projections by Component (March 2018 Update).

¹¹¹ Global Fund Eligibility Policy, as set forth in Annex 2 to GF/B35/06 – Revision 1 and approved by the Board in April 2016 under decision point GF/B35/DPO7. The method uses an average of available GNI per capita data (World Bank Atlas Method) over the latest three-year period to determine a country’s income classification. The latest available disease burden data are provided by headquarters of UNAIDS for HIV and WHO for tuberculosis and malaria. Annex A of the Eligibility Policy provides disease burden indicators and thresholds used to determine eligibility. However, transition projections are updated periodically and may change.

¹¹² Non-eligible countries may be included under regional efforts when it is strategic to do so. Source: Global Fund guidance, including STC Guidance Note.

¹¹³ Projected Transition from Global Fund Support by 2025 – Projections by Component (March 2018 Update)

¹¹⁴ The Dominican Republic is already ineligible for support for the malaria program. However, the country is included in regional elimination efforts (RMIE) supported by the Global Fund in the current allocation cycle.

¹¹⁵ In a Working Paper on Transition (July 2018), the Center for Global Development projects that components likely to transition from the Global Fund by 2040 represent only a small portion of the portfolio, and only 3.6% of the current total Global Fund allocation.

transition and sustainability planning, and was selected as a field based case-study. However, the country has not been identified by the Global Fund as a priority for transition planning.

A key finding of this portion of the review is that the Global Fund processes for transition were consistently applied in the transitioning components in this allocation cycle. Countries had undertaken transition assessments, had transition plans and had included transition workplan (TWP) indicators in the NSPs or other strategic documents. Countries proposed different structures for monitoring of the transition and sustainability workplans (e.g., possible contracting of an NGO in Ukraine).

Spin-off effects were evident in most of the review countries and regions with transitioning components. For example, Ukraine is undertaking early preparation for sustainability and future transition of its HIV and TB programs, although components supporting these programs have not been identified in the Global Fund transition projections.¹¹⁶ The DR has developed a sustainability strategy for the HIV response.

- Countries benefit from regional technical consultations on sustainability and transition planning. Many interviewed stakeholders from Ukraine and Georgia (EECA countries) stated that regional technical consultations on transition planning for harm reduction programs, co-organized by the Secretariat of the Global Fund and the European Harm Reduction Network (EHRN) in 2013, and on transition and sustainability of HIV and TB responses organized in 2015, provided significant technical support to countries from the region for better sustainability and transition planning. The latter resulted in a draft Framework for Sustainability and Transition for countries transitioning from Global Fund support in the EECA region with a matrix of four key transition areas: policy, governance, finance, and programs. Currently, all countries in the EECA region are undertaking or have undertaken transition and sustainability planning. The EECA case study countries, Ukraine and Georgia, have already developed formal sustainability and transition plans and have started to implement them. The LAC team has provided similar attention to sustainability and transition for countries in Latin America and the Caribbean.
- Effective national coordination is essential for effective management of the transition process and to ensure long-term sustainability of disease outcomes (including the planning and implementation of the transition process). This is well recognized both in Ukraine and Georgia. The Georgia CCM established a Policy Advisory Advocacy Committee (PAAC) with the mandate to identify the challenges during the transition process and propose measures for addressing them. The PAAC has led development of the Sustainability and Transition Plan (STP) in Georgia and is overseeing its implementation, while capacity of NGOs is built for monitoring the implementation. In Ukraine the newly established Public Health Centre (which is a governmental PR) is coordinating sustainability and transition planning and implementation and may contract an external agency (NGO) for monitoring its implementation. The Global Fund was instrumental in setting up those process by creating the space for governments and civil society to jointly engage in the national/global response planning and coordination; building NGO capacity for monitoring the transition plan implementation; and in building capacity for the governmental and non-governmental sectors to interact constructively with each other.
- Transition of preventive services seems to be the most challenging area in the process. Many countries still lack mechanisms for contracting NGOs/CSO, and where in place, detailed contracting procedures for CSO/NGOs in the health sector are lacking, or financing is

¹¹⁶ During the 2018-2021 allocation cycle, Ukraine is considered High-Impact given the amount of funding provided in this allocation period. It was also categorized by the Global Fund as a country with a Challenging Operating Environment (COE), which allows Global Fund greater flexibility in considering contextual circumstances in programming and grants management. See the Global Fund Challenging Operating Environments Policy (April 2016). Please note that for the 2022-2025 allocation cycle Ukraine is now classified as a Core country.

inadequate (CIV). In Ukraine, there are ongoing efforts to define the contracting model for CSOs/NGOs to be applied from July 2019 (as stated in their Transition Plan). Two different contracting models were piloted in 2018, however a final model is not yet agreed and approved. In Georgia, stakeholders pointed that although mechanisms are in place to contract CSOs, the latter are constrained from participation in government tenders due to the Public Procurement Law which requires a bank guarantee of 1-2% of the total budget of a tender, or another form of insurance as a bond.

- Case study evidence indicated that multi-country regional grants provide value-added for sustainability and transition when they focus on advocacy for policy change (especially related to laws around HIV and human rights), sustainability of KP programs, and health system strengthening. In EECA countries the Global Fund, through its partnership with WHO, is supporting the TB Regional EECA Project (TB-REP) for health system strengthening for effective TB¹¹⁷ programs, to translate existing good practices at the country level into the implementation of people-centered models of TB care, and to replicate them across Eastern European and Central Asian countries. In LAC, a multi-country grant is supporting Caribbean countries to address sustainability of HIV services for key populations.

Box 10. Government of Sri Lanka (GoSL) Malaria Program: Steps in Transition

- A key focus of the transition process for the GoSL has been the dependence of the program on the Global Fund for support for human resources (HR). The 2014 – 2016 allocation grant initially supported about 134 staff. As per the HR transition plan, GoSL is committed to absorbing these staff.
- The TRA and transition grant (2017 – 2019 allocation) take further steps toward integration of the malaria program into the general health system. The grant supports inclusion of key elements of the malaria program in primary health care, which is being restructured by the ministry of health with the support of the World Bank, the Asian Development Bank and the Global Fund. In 2018, the Global Fund financed analytical work in collaboration with WHO to improve cross-programmatic efficiency and to develop an essential package of services to support PHC restructuring. A roadmap is also laid out to transfer remaining Global Fund activities to GoSL budget: training and routine entomological surveillance will be scaled down but fully funded through domestic resources by 2019.

Source: TERG STC Review Case Study

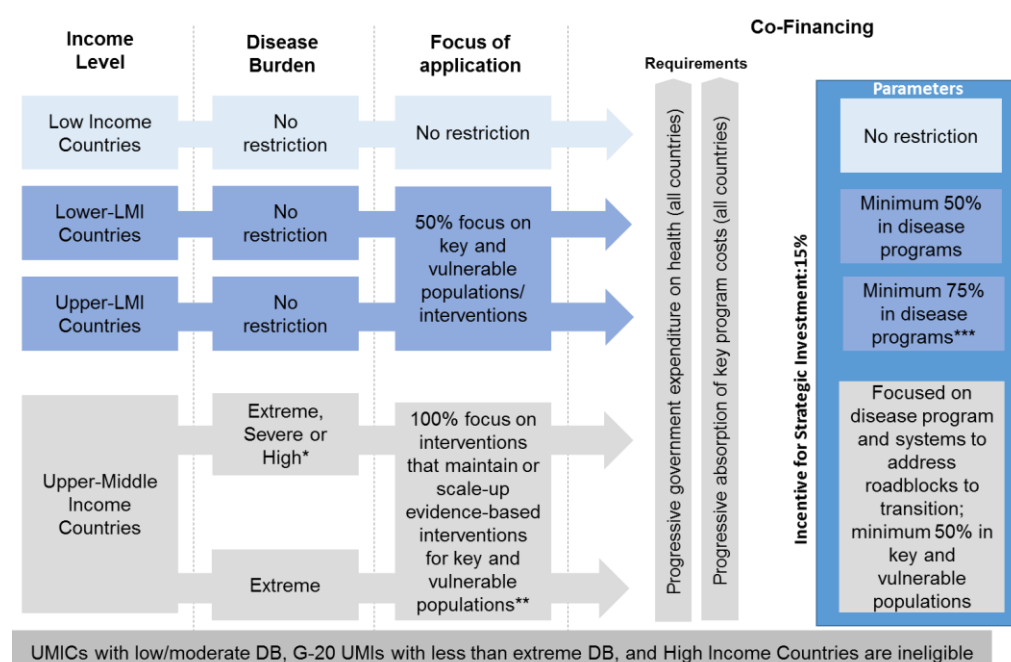
¹¹⁷ TB Regional EECA Project (TB-REP) is aiming to reduce hospitalization and increase ambulatory care. A specific people-centered TB model of care was developed at the regional level and will be further adapted to the country's needs during 2018-2020.

IMPLEMENTATION OF CO-FINANCING

Introduction

Increasing domestic investment in health systems and HIV, TB, and malaria disease-specific programs is crucial to addressing the full cost of the response to the three diseases. To increase country ownership and build the sustainability of programs, a revised co-financing policy was introduced under the STC Policy. The co-financing piece of the STC Policy aims to further encourage overall increases in domestic investments for the health sector and the three diseases as well as progressive uptake of program costs of Global Fund supported programs. To this end, the revised co-financing approach i) further differentiates the co-financing requirements by income classification and disease burden, ii) has as a specific focus leveraging domestic resources for health/UHC in countries with high disease burden and low domestic health investment, and iii) provides access to a co-financing incentive. Figure 7, below, is extracted from the 2017 Guidance Note on STC¹¹⁸. It outlines both differentiated programmatic and co-financing requirements by country income classification and disease burden.

Figure 7: Differentiated Application Focus of Co-Financing Framework across income and disease burden contexts¹¹⁹



* Small Island Economies are eligible if they have a low or moderate disease burden. ** As per the STC policy, UMI countries can include investments for RSSH interventions that are critical for ensuring transition readiness as identified through a transition readiness assessment. UMI countries may also include technologies or innovations that represent global best practice. *** 'Low' or 'moderate' burden country components are encouraged to show a greater share of domestic contributions that will address systemic bottlenecks for transition and sustainability.

The Global Fund links discussion of co-financing with broader domestic resource mobilization. While the Global Fund supports/encourages countries to undertake health care financing strategies, allocation efficiency studies, and other technical efforts to support better decision making for the health sector and across the three diseases, co-financing requirements mean allocating actual budget for health and

¹¹⁸ Please note that the updated version of the STC Guidance Note, published in 2019, now includes an updated graphic to reflect changes in the Global Fund's eligibility policy. It is available on the Global Fund website [here](#).

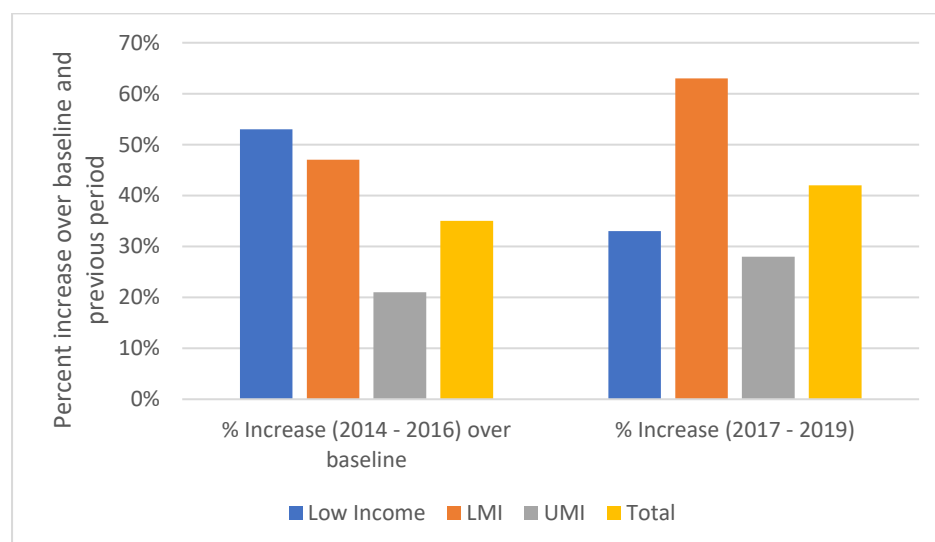
¹¹⁹ The Global Fund (January 2017) Guidance Note Sustainability, Transition and Co-financing of programs supported by the Global Fund.

for the specific programs. However, the absence of a counterfactual makes it difficult to determine whether the requirements leverage additional resources over what would have been provided.

The new co-financing requirements resulted in significant additional minimum government commitments than would have been required under the previous Willingness to Pay policy. A 2017 internal Global Fund review noted a “58% increase in *additional minimum required domestic* commitments after upward revision of incentives.” The base level of incentive (15%) was increased to require larger amounts based on country context in 36% of all Global Fund supported countries.¹²⁰

Countries are clearly taking on more responsibility for financing all three diseases, with accelerated co-financing in LMI and UMI countries, and for HIV and TB. In particular, LMICs are responding with increasing commitments for uptake of program costs. Figure 8 provides a graphic display of the percentage increase in financing for NSP related activities, comparing funds provided in 2014 – 2016 with the pre-allocation period baseline, and the percentage increase between actual amounts for 2014 – 2016 and committed amounts in the 2017 – 2019 allocation periods. The data is from the Global Fund Health Financing Team and represents information on most of the Global Fund recipient countries.¹²¹

Figure 8. Increase in Domestic Co-Financing for HTM by Country Income Category Compared to Baseline and Previous Allocation Period



Source: The Global Fund data 2018.

Low income countries are increasing their level of co-financing, but commitments in this allocation period represent a smaller increase than in the previous period – that is a slower rate of increase. This is likely a result of large increases in the previous period and slower increases for malaria, a disease that particularly affects low income countries. However, it is worth noting that these figures are based on aggregate amounts, and not country-specific data. This means that they will be biased towards changes in large, High-Impact portfolio Global Fund implementers, such as Kenya. Co-financing requirements between periods will also change given reductions in component grants, and the numbers may partially reflect such changes. In addition, the 2017 – 2019 figures represent commitments, not actual provision of co-financing.

¹²⁰ GF/B37/17, Global Fund Board meeting in Kigali, Rwanda, May 2017.

¹²¹ The information is based on the Global Fund’s review of co-financing in 233 out of 276 programs.

Co-financing Context

The vertical nature of some Global Fund grants leads to program specific requirements for co-financing, without necessarily recognizing the co-financing commitment requirements from other external partners, or competing needs within the health sector.

Internal key informants indicated that the level of flexibility in application of the co-financing policy left authorities and responsibilities unclear, e.g., how directive can staff be in co-financing discussions and where is final decision-making. Both internal and some country-based informants indicated that co-financing could be used more strategically to leverage program funding, for example, to provide earlier transition of funding to KVP primary prevention services and that in some countries, funding requirements could be larger.

External partners noted that fiscal and co-financing landscape analyses should be done on the sectoral level, rather than by program or in association with specific grants. It was noted that this often does not seem to be the case, particularly given the component specific requirements. There were also several observations that the Country Team may not always have sufficient bandwidth to focus on strategic use of co-financing, as the Fund Portfolio Managers and finance specialists often cover more than one country, and a great deal of time is spent on ensuring efficient use of grant resources and resolving challenges to grant absorption. In some circumstances, co-financing becomes an accounting issue, rather than leverage for STC, and often results in increased commodity procurements under national budgets. While having budget line items instituted to pay for commodities is critical to sustainability, more clearly defined differentiation of co-financing expectations by country could leverage additional STC results in terms of advancing government commitments to a broader range of interventions (e.g., early adoption of program costs for KP prevention and outreach).

It was also noted that it is difficult to track the extent to which Global Fund co-financing requirements add to countries' overall fiscal burden. Co-financing requirements are typically negotiated directly with countries under the broad auspices of the STC Policy and for the CTE, were found summarized in the GAC memorandum. However, to some external and in-country observers the process by which these negotiations take place and the outcome of the negotiations in terms of country-by-country co-financing requirements seemed opaque, and data was difficult to obtain.

The use of country-specific methodologies in defining co-financing amounts and differentiation in co-financing requirements between countries means that it is difficult to compare and synthesize the co-financing data made available at either the country or Global Fund Secretariat level.

A good practice is the recognition of reprogramming of cost-savings to HTM programs as co-financing. This provides incentives for improvements in value for money while preserving resources for the sector. However, it also complicates year to year assessment of co-financing increases through National Health Accounts and other expenditure surveys.

Case Study Findings on Co-financing

Co-financing commitments across the ten case-studies indicate increased financing for the three diseases. However, lack of conformity in the data (e.g., information on items financed, availability of line item figures) means cross country comparison is difficult, if possible. Verifying both commitments and amounts spent remains a labor-intensive endeavor that requires specific knowledge of the country's fiscal setting and counterpart choices.

Across the ten countries co-financing guidelines seem to be applied as provided in the OPN on Co-financing, as detailed in Global Fund Guidance Note on the STC in Figure 7, above. Negotiations, including identifying co-financing commitments, were completed on 2018 – 2020 program grants in at least 9 of the 10 countries prior to start of the STC Review. All countries committed sufficient amounts

of co-financing to meet the Global Fund requirements, as well as meeting the focus requirements for KVP programs.

At the time of the writing of this report, there has been very little experience to date on fulfillment of the 2017 - 2019 commitments. Two of the case study countries (Côte d'Ivoire and Kenya) noted difficulties in fulfilling initial year amounts. The former due to lack of alignment with national budget processes, meaning funds would flow only in the following year; the latter sees prospective issues due to difficulties in public financial management associated with national procurement (the procurement authority is unable to work on an accrual basis, thereby creating issues if invoices cannot be paid before the June 30 end of the fiscal year).

For the ten case-studies, co-financing represented as additional budget is largely used for procurement of important health products and commodities, including opioid substitution therapy for PWID programs. This may reflect the importance of procurement in the underlying grants and in these programs more generally. Even as countries near transition, non-commodity program costs for KVP programs are often not included in co-financing, remaining to be absorbed during the transition grant. There were exceptions, particularly in countries with sustainability and transition assessments and planning (e.g., DR, Ukraine). In some settings, the uptake of KP programs results in the Government delivering the service with potential drawbacks for access (e.g., Viet Nam's transition from large-scale PEPFAR financing and Sri Lanka).

Box 11. Government of Sri Lanka (GoSL) Gradual Absorption of HIV/TB Program Costs

In the current HIV grant provision is made for a mid-term review of the NSP 2018-2022 and the implementation of a Transition Readiness Assessment to be undertaken to review finances, plans for continuation of services and policies working with KPs once the global fund transition takes place. Regarding the latter, the MoH is already absorbing and expanding its activities for KPs, taking them over from the NGO PR.

The TB grant, a program continuation, does not specify conducting a TRA, but does include an End-term program review and NSP preparation for the 2021-2025 period. Meanwhile government commitment towards sustainable TB control is increasing and several steps have been taken in terms of absorbing GF supported technical staff in government positions, procurement of ancillary drugs and rifampicin, assuming procurement of First line drugs from the beginning of 2019 and partially procuring lab reagents, consumables and equipment (other than GenXpert) through GoSL funds.

Source: TERG STC Review Case Study

In-country informants seemed cognizant of the co-financing incentive, but largely unaware of the requirement to increase the overall resources for the health sector. Upon review of the OPN, the consultants found the co-financing requirements complicated and involved, with differentiation and flexibility in implementation further complicating discussions and making cross country comparisons difficult. As understated in a 2018 AIDSPAN newsletter: "There appears to be some confusion among in-country stakeholders regarding the Global Funds STC Policy."¹²²

¹²² Garmaise, D. "Global Fund's Co-Financing Policy," AIDSPAN: 3 April 2018. The article provides an overview of the OPN in order to inform in-country stakeholders of the differentiated policy.

OPERATIONALIZATION OF THE STC POLICY AT CORPORATE LEVEL

Internal Efforts

The Global Fund is supporting implementation of the STC Policy throughout its business processes. The STC Policy is reflected across the organization – from grant making to Country Team activities. Transition and sustainability work in several regions have preceded and fed into development of the policy, with implementation already underway when the policy was approved. These regions (particularly EECA and LAC) have continued to pioneer strategic efforts on STC at the regional level. The STC Policy is reflected in the overall Leadership and Oversight of the Global Fund, in its processes and guidance, priorities for internal capacity building, technical support, global partnerships and monitoring, assessment and evaluation. The following provides a sense of the level of internal activity underway to operationalize the STC Policy, although the list is by no means exhaustive in coverage.

A full range of guidance has been provided for operationalizing the STC Policy.¹²³ However, further clarification of the overarching framework for sustainability may be useful. The guidance to date is particularly concrete for transition planning processes (as noted in the OIG audit in September 2018) and, to a lesser degree, for operationalizing the co-financing policy. The guidance regarding expectations on sustainability is somewhat less clear, with focus on financing, but a broad range of topics included in the STC Guidance Note (2017). In addition, other Global Fund efforts are providing additional support and insights for STC Policy roll out. Examples include the RSSH Guidance and the current work under the CCM Evolution Initiative. In addition, at the time of the writing of this report there are plans for development of disease-specific annexes to the STC Guidance note to further detail considerations related to sustainability¹²⁴. These should include greater emphasis on technical and programmatic efficiency.

Secretariat actions strengthened attention to STC in the grant-making process for the 2017 – 2019 allocation period. Further strengthening for the next cycle is needed. This included referencing STC focus areas in the country allocation letters and operationalizing the differentiated application formats with greater attention to sustainability and a specific Funding Request format for transition funding. The Grant Approvals Committee Review and Sign-off forms were revised to provide specific issues on key sustainability issues, including domestic resource mobilization, procurement and human resources included under the grants. The TRP was also strengthened for review of the revised funding requests with the addition of a cadre of strategic investment and sustainable finance (SISF) experts.

Internal capacities for STC have been enhanced through re-allocation of staff positions, expansion of mandates and training. A senior-level health financing manager was added to the Health Financing Team in 2018 to strengthen the level of policy and implementation support. The Team has also taken on greatly expanded activities related to STC, including support to Country Teams and internal committees for DRM; critical support to Country Teams in the negotiation of commitments, verification and reporting of co-financing commitments and their realization; and innovative finance; among others. The Team provides technical support within the Secretariat and to countries, both directly and through Global Fund Strategic Initiative funded technical assistance agreements with key partners (e.g., the WHO Health Financing Team, among others).

¹²³ Key documents include the STC Guidance Note; the Operational Policy Note (OPN) on Access to Funding; the OPN on Co-Financing; disease-specific information notes.

¹²⁴ In December 2019 the Global Fund Secretariat published an updated version of the STC Guidance Note which includes TB and Malaria specific annexes, as well as HPM, HMIS, and “Social Contracting” annexes. An updated version of the Guidance Note is expected to be published in early 2020 with the addition of an HIV annex.

Five sustainability and transition specialists have been assigned to key fund portfolios where transition issues are foremost due to income or disease burden classifications, e.g., AELAC, including countries in Eastern Europe, Asia, and Latin America and the Caribbean (LAC). These five specialists support Country Teams in managing transition processes in country programs already identified for transition from Global Fund support, and in promoting actions to improve long-term sustainability and domestic resource mobilization across the portfolios. These specialized staff support the “mainstreaming” of STC focus into the core work of the regional teams and Country Teams overall, an important element of STC Policy implementation – boosting efforts in EECA, LAC, and SEA. A summary of EECA activities included in Box 12 shows the range of activities being strategically undertaken at the regional level to support successful transition. A similar range of activities was reported by the LAC team.

Box 12. Summary of sustainability and transition activities in Eastern Europe and Central Asia (EECA)

Conceptual work: EECA team developed regional strategies for sustainability and transition (2014-2017 and 2020-2022) based on EECA transition case studies, transition assessments on specific topics in the EECA portfolio, and technical consultations on transition to domestic funding of HIV and TB responses.

High-level advocacy and policy dialogue for domestic resource mobilization: Advocacy resulted in increased domestic resources for TB and HIV programs. Developed a framework for “social contracting” with UNDP and other partners. Developed an intervention-based co-financing framework (as outlined in the EECA Investment Guidance) and is engaging on country-level health reforms to support a sustainable response to HIV and TB. Examples include the integration of HIV and TB services into mandatory health insurance schemes in Azerbaijan, Moldova, and Armenia and PHC/UHC reform in Ukraine and Moldova.

Cross-programmatic and within program efficiency improvements: Global Fund supported countries to improve value for money in HIV and TB programs through: cross-programmatic efficiency reviews, such as recently undertaken in Georgia; allocative efficiency exercises, e.g. Optima modeling across the region; HIV treatment optimization in Moldova, Uzbekistan, Ukraine, Tajikistan, Georgia; revision of TB and HIV diagnostic algorithms in Turkmenistan and Armenia; revision of TB models of care, which resulted in reducing hospitalization rates for new TB cases in the region from 74% (2015) to 56% (2017); task shifting, including development of “social contracting” mechanisms in Montenegro, Ukraine, Moldova, and Kazakhstan; and procurement platform strengthening, including addressing national procurement, regulatory, and registration challenges to accessing quality affordable drugs.

Grant management actions: Integrated transition plans into grant designs including 1) sliding-scale targets and budgets, 2) systems strengthening and hand-over measures, 3) special conditions in the grant confirmations, and 4) workplan tracking measures. Monitoring the realization of specific co-financing commitments. Integrated PIU functions into national processes and structures, e.g. moving NGO contracting to the national AIDS Center in Azerbaijan and Armenia; moving the procurement functions from UNDP to MOH in Belarus; integrating the HIV prevention databases into national reporting, as in Moldova and Belarus.

Source: EECA Department, The Global Fund, March 2019

The Global Fund has also developed and is implementing an internal training course to increase staff capacities on thematic areas important for strengthening sustainability, including increasing domestic financing and preparing for transition from external financing. The STC Course is on-going and has already trained (as of the writing of this report) more than 150 of Secretariat and key partner agency staff. Participants rated the course very highly in discussions with the CTE. Some staff did note the need for increased skills in health financing and broader health dialog with responsibilities for expanded country engagement on these topics. In addition, partially in response to the 2018 OIG Audit of Global Fund Management of Transition Processes, the Secretariat updated an STC training plan which outlines additional on-going capacity efforts for STC related themes.

In addition to country component grants and Secretariat engagement and support, the Global Fund also funds a range of catalytic investments to further leverage progress in key areas. Catalytic investments

in the 2017 – 2019 allocation cycle included a program of Matching Fund grants, Multi-country Grants and Strategic Initiatives. These activities were targeted at addressing program challenges, including areas critical for achieving and sustaining outcomes. The following case study countries were awarded a total of nearly \$75 million in Matching Funds to address:

- HIV: KP impacts (CIV, Ghana, Kenya, Ukraine, Viet Nam, Zimbabwe)
- HIV: Programs to remove human rights-related barriers to health services (CIV, Ghana, Kenya, Ukraine)
- HIV: Addressing the needs of adolescent girls and young women (Kenya, Zimbabwe)
- TB: Finding missing TB cases (Kenya, Ukraine)
- Resilient and sustainable systems for health (RSSH): Data systems, data generation, data use (CIV, Ukraine)

The Sustainability, Transition and Efficiency Strategic Initiative (STE-SI) funds technical support across several STC areas. In particular, the initiative funds partner activities on health financing, national health accounts and programmatic and allocative efficiency. It also funds technical assistance for transition readiness assessments and transition planning, addressing specific transition challenges like procurement and public financing of CSOs (“social contracting”), and strategic domestic advocacy in limited portfolios, as well as a range of other activities in support of increased sustainability.

Global Fund is also aligning its global partnerships toward STC issues. The Global Fund has included sustainability and transition in agreements with the WHO, UNAIDS and the development banks; is collaborating on transition planning processes and “social contracting” with USAID and UNAIDS; and is fostering new partnerships for sustainability through the internally funded STE-SI, including with OECD to strengthen MOF and MOH networks. The Global Fund is also partnering with the World Bank and the World Health Organization on regional health financing and sustainability courses for country partners, pilot versions of which have now been completed in Lao, Central America, and Armenia. In addition, the Global Fund is participating in global efforts to align external health funding partners in a more consistent approach to sustainability, transition and financing of health systems (e.g., UHC 2030).

Global Fund has already achieved some success in harnessing regional partnerships to focus on pragmatic areas of sustainability and transition. For example, as part of the LAC strategic plan for promoting sustainability and supporting transition, the LAC STC specialists have a plan for region specific partnership activities. The plan, taking advantage of Global Fund’s global partnership and adding regional partners for 2018/2019 is provided in the slide presented in Box 13.

Box 13. LAC Regional Partnerships for Sustainability and Transition

S&T specialists work in LAC

Enhanced external partnerships- 2018/19

PAHO:

- Continue joint missions that include S&T dimensions
- Prepare and participate in the WHO-GF meeting on preparing countries for GF transition (Georgia, Sept 18)
- Engagement with PAHO Strategic Fund on access to commodities
- Strategic support to multi-country grants
- Find synergies with PAHO on biannual plans 2018/19

UNAIDS:

- Continue collaboration on the development of HIV sustainability strategies for Guyana, Dominican Republic and Jamaica
- Strategic support to multi-country grants

USAID:

- Continue collaboration on the development of HIV sustainability strategy and social contracting mechanisms for Guyana, DR and Jamaica
- Further collaboration on the work with private sector/regional fund

TB Caucus:

- Presentation to Chairs of Health Parliamentary Committees
- Regional event on TB Laws
- Engagement of LAC MPs and civil society pre and post-HLM

UNDP:

- Continue close collaboration on social contracting (DR, Panama, etc.)
- Engage on their role in transition as development partner (beyond PR)

World Bank:

- Flagship courses (Central America, Caribbean, and South America)

STOP TB Partnership:

- Engagement on the preparation of LAC civil society for the HLM
- Collaboration on multi-country ToR focused on S&T issues

Mexican Government:

- Organization of regional meeting on social contracting

OECD:

- Engage in the preparation and implementation of 2nd meeting of the MoF-MoH network

Regional Civil Society Platform (CRG SI):

- Joint efforts to sensitize civil society on STC policy (webex, joint events, policy briefs) and engagement in TWPs
- Coordinated technical assistance planning and rollout of social dialogues

Private sector:

- Organized trainings on private sector engagement in the Caribbean (with PS team)
- Guyana-Exxon
- Digicel- Jamaica/regional level

IDB:

- Develop a good understanding of opportunities & synergies between RMIE and GF malaria grants to strengthen sustainability of the malaria responses
- Identification of opportunities for further collaboration in specific countries

UN Economic Commission for LAC (ECLAC): To be defined

The Global Fund Le Fonds mondial El Fondo Mundial Глобальный фонд 全球基金 الصندوق العالمي 12

Source: Global Fund LAC Department

The case studies in this TERG STC review also noted good examples of partnerships in the field. For example, working with the WB on geospatial modeling to improve allocative efficiency in Côte d'Ivoire, partnerships in Ghana and Namibia around health financing reforms, among others. However, there were also indications that cascading this alignment to partnerships with global agencies at the country level is still needed in some cases. For example, in Kenya a new RMNCAH effort financed by the World Bank, UNICEF and other partners fails to identify PrEP, PMTCT, TB or malaria services or indicators in its performance matrix, a case of separate responsibilities by partner.

Recent assessments and evaluations by the Global Fund and associated independent bodies have also focused on sustainability and transition issues. The Technical Evaluation Reference Group (the "TERG") conducted two thematic reviews on sustainability in 2013 and 2015 which provided substantial input into the development of the STC Policy. The TERG has commissioned this review with a focus on the implementation of the policy. The 2018 report to the TERG on the Prospective Country Evaluation (PCE) includes a synthesis of sustainability activities across the PCE countries as one lens for assessing country progress. Recent TERG reviews of RSSH activities and Partnerships should provide important recommendations for improving the sustainability of program achievements. Other independent efforts include the August 2018 Office of the Inspector General (OIG) Audit of the Global Fund Transition Management Processes, with findings largely strongly supportive of Global Fund actions, as well as the OIG's expanded attention to sustainability issues in individual country and other audits. In addition, the CCM Evolution Initiative of the CCM Hub should also provide useful insights for sustainability.

Processes are in place for internal learning, oversight and course correction for STC Policy impacts. Although this review is not an audit and does not serve in this function, the CTE had access to key Secretariat staff engaged in internal mechanisms for STC implementation, as well as staff undertaking various elements of STC work across the internal architecture. In addition, the CTE reviewed public documents and some internal documents provided by Secretariat staff to illustrate specific points. Key elements of this internal orientation include:

- The Board is keenly aware of the importance of the topic and continues to highlight STC implementation progress annually in its meetings.

- Management gives attention to the topic, particularly through an STC Steering Committee led by the Head of the Grants Management Department and including a wide range of Secretariat leadership. A Senior Project Lead position is dedicated to the STC work at the corporate level. An annual workplan (which was not shared with the CTE) for the Steering Committee supports STC implementation priorities across the organization.
- A Steering Committee on Domestic Resource Mobilization and Innovative Finance led by the Finance Department has also been set up, with broad, cross-Agency representation.

Monitoring

Many of the needed indicators for determining progress on STC goals are already being collected in the form of the Global Fund's Key Performance Indicators (KPI) and Strategic Initiative indicators (SI). This is a result of the overlap between the intent of the STC Policy and the Global Fund's overall strategy, Ending the Epidemics (2017 – 2022).

The Policy and the subsequent guidance largely lack description of and/or quantitative targets for medium term objectives or endpoint goals, other than end-point achieving health treatment or disease reduction targets.

Additional indicators could include qualitative or disaggregated co-financing data, data on integration of services and commodity costs for national budget procurements.

OVERALL STC CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Overall, the Global Fund seems to be successfully transforming the organization to focus on STC. Building on the earlier experiences of the AELAC teams, the previous Willingness-to-Pay policy, and the TERG sustainability reviews (2013, 2015), the Fund developed a pragmatic policy approach consistent with its key principles of flexibility, alignment, predictability, and differentiation. Implementation at the Secretariat level and in the regions and countries where components are transitioning or preparing to transition seems strong.

However, the CTE perceived a large difference in the level of strategic thinking and ownership of the STC processes evident in documents and key informant interviews between countries that had undertaken transition and sustainability planning and the countries that were yet to move forward with comprehensive TRA type assessments. Similar differences were noted in focus across Global Fund regional divisions between those targeting transition planning and others. While it is important not to underestimate the level of effort needed to support lower capacity countries with high disease burdens in implementing large Global Fund grants, it is important that *sustainability* of the disease outcomes be further prioritized by countries and within the Secretariat even in those regions where no or few countries are planning for transition. This will require further internal capacity building, modifications in Secretariat staff scope and responsibilities, developing new tools that support better country-led sustainability assessment, and refining the Global Fund's internal strategic processes that support sustainability actions. In addition, the STC Review case studies underscore a number of remaining challenges that require attention and effort from the Global Fund, external partners and countries across the portfolio.

Internal attention and effort are now needed to further the agenda on sustainability, building on these earlier successes. The challenges are great. Achievement of disease goals will require leveraging resources from multiple sources, including external donors. Ensuring the countries are maximizing outcomes with available financing will be key to continuing scale-up and sustainability of outcomes.

The review provides a broad range of findings and recommendations, mirroring the broad range of relevant topics. Recommendations are summarized in the Executive Summary and provided below, and discussed at greater length throughout the individual sections of the document. Key recommendations (underlined) have been provided in four categories: Overall, Priorities for Increased Attention, Fine-tuning of STC Operationalization and Implementation, and those for Additional Consideration. Suggestions for operationalization are included underneath the key recommendations (bulleted), and suggested key implementers [in square brackets] have been noted.

Recommendations

Overall:

Further strengthen efforts to operationalize and implement the STC Policy.

- Continue to prioritize and monitor successful transition for country disease components exiting or on a path to exit from Global Fund financing.
- Continue to build internal capacities, evolve grant-making processes, and maintain attention to sustainability in grant implementation.
- Continue efforts to increase efficiencies and value for money in grant negotiations.

- Fine-tune accountabilities, work plans and incentives, as needed, across the organization, and with grantees, contractors and partners to ensure that they are fully consistent with prioritizing the *sustainability* of disease outcomes.
- Ensure adequate staff time, capacity and attention are available to strategically implement the STC Policy.

[Global Fund Board, Secretariat, and related bodies (OIG, TRP, GAC, TERG)]

Priorities for increased attention:

Prioritize and strengthen efforts to address impediments to the scale-up and sustainability of effective HIV, TB and malaria services for KVPs across the portfolio.

- Intensify efforts to promote domestic or alternate financing and “social contracting” mechanisms for CSOs and human rights advocacy that support primary prevention and compliance adherence activities, even at early stages in the process toward self-reliance.
- Continue efforts to improve the enabling environment for KVP services.

[Countries, Secretariat, Partners]

Further address health systems weaknesses that impact the sustainability of disease outcomes.

- Implement the new RSSH Roadmap (March 2019) to target investments that address sustainability challenges, including differentiation across the systems development continuum and increasing strengthening vs. support activities.
- Urgently expand system efforts in three areas: (i) diagnose and address constraints to effective national procurement and supply management, (ii) address public financial management constraints to program implementation under increased domestic financing; and (iii) address constraints to integration of programs and systems, seeking greater efficiency and effectiveness in health services delivery, health information, human resources for health, program management and governance.
- Consider providing guidance internally and to countries regarding rationalizing program management costs.

[Countries, Secretariat, Partners]

Continue to create and ensure access to Global Public Goods in key areas, especially market shaping for key drugs, diagnostics and commodities; knowledge around building program efficiencies; and engagement with KVPs. These public goods create value for money across the global HTM responses. Ensure countries retain access to these key areas, beyond their period of access to funding.

- Ensure countries retain access to these key areas, beyond their period of access to funding.
- Provide access to wambo.org or other pooled procurement or price determining mechanisms during and for some period beyond Global Fund eligibility for countries that lack value pricing for national procurements in open markets due to limited scale or other market factors.
- Encourage, through policy dialog and partner support, the Global Fund-supported countries to utilize these pricing and procurement mechanisms when national procurement regulations constrain access to value pricing under domestic financing.

[Board, Secretariat, Partners]

Fine-tuning of STC Operationalization and Implementation:

Increase attention to sustainability assessment and planning in high-burden, lower-middle income countries.

- Encourage and support country-level sustainability planning for all countries.
- Consider expanding successful internal regional STC efforts to cover all regions: Assign S&T specialists to the remaining regions.
- Modify grant applications to reflect greater attention to sustainability assessment and planning.
- Develop regional frameworks, strategies, and priorities for addressing sustainability.
- Modify the current transition readiness assessment methodology to better serve broader sustainability assessment in these settings, with a greater emphasis on systems strengthening, efficiency and value for money, and addressing constraints to scaling up and sustaining KP and human rights activities.
- Increase coordination with PEPFAR, the President's Malaria Initiative (PMI) and other donors to ensure sustainability planning considers the broad context of external support.

[Countries, Secretariat, Partners]

Heighten emphasis on efficiency and value-for-money across all Global Fund-supported components.

- Inculcate a culture of efficiency across Global Fund-supported programs and activities.
- Strengthen the narrative on increasing program efficiency in all funding requests.
- Work with countries individually or regionally to develop country-driven strategies and priorities for addressing efficiency during the allocation period.
- Continue to support allocative efficiency studies to ensure sufficient attention to scale-up of prevention activities.
- Ramp up attention and technical support for value for money analysis of national programs and interventions, including national drug procurement and community-level services.
- Provide support to countries to assess, implement and evaluate efficient health services reforms, including decentralization.
- Ensure KVP programs that are to be taken over under national budgets represent value for money.

[Countries, Secretariat, Partners]

Sharpen focus on tools and processes for prioritization of disease responses at the country level, particularly for high-burden upper-middle and lower-middle-income countries.

- Continue to support country-level HTM stakeholders in building a sound investment case and advocating for domestic resources within the context of the country's plans for UHC.
- In collaboration with partners, further improve epidemiological and financial modeling and translation of this information into priorities, plans and budgets; especially, better prioritized and realistically costed NSPs, analyses for the inclusion of HTM services in social health insurance, and national health financing strategies.

[Countries, Secretariat, Partners]

Continue scaling up efforts on domestic resource mobilization:

- Prioritize increases in domestic financing for scale-up of KVP services in UMICs and LMICs where needed to address the epidemics (domestic funds and funding mechanisms).

- Increase the level of health financing and sustainability support from internal specialists to support Country Teams dialog and co-financing discussions, particularly in LICs and LMICs.
- Undertake more joint planning and missions with the World Bank/regional banks to more fully engage with planning, budgeting, and finance authorities.
- Consider innovative financing mechanisms such as debt buy-downs and swaps.
- Better align discussions and Global Fund funding processes with national medium-term expenditure frameworks (MTEF) and other budgeting procedures.

[Countries, Secretariat, Partners]

Continue to evolve the application of co-financing to meet both the intent and the requirements of the STC policy.

- Follow the Global Fund's successful experience in gaining commitments for increased domestic financing of the health sector and HTM component financing with improved reporting and accountability for realizing committed amounts.
- Improve reporting and accountability for realizing committed amounts; consider revising commitment and reporting formats to more readily obtain up-to-date information that includes information on items funded and can be compared across time periods for the same country and across countries.
- Continue active risk assessment and monitoring of commitments.
- Further work with countries to ensure co-financing reflects increased uptake of a broad range of key program elements, including KVP program costs.

[Secretariat]

Expand country ownership and responsibility for STC efforts, and ensure country-centered, demand-driven Global Fund support.

- Continue to increase the use of national systems, including national budgeting and procurement processes, to the extent possible.
- Consider means of extending the level of country ownership that seems to have been built through the TRA process of identifying and addressing challenges to broader sustainability issues in non-AELAC regions.
- Expand the use of innovative models, such as the NSP-based model used in Rwanda, to other countries.

[Countries, Secretariat, Board]

Consider additional STC indicators as part of the Key Performance Frameworks guiding the Global Fund and its country grants.

- Review KPIs and internal management indicators to ensure they reflect key data needed to assess STC progress.
- At Global Fund management level, ensure indicators are available to routinely monitor (i) RSSH strengthening, including integration and use of country systems; (ii) KVP program sustainability, and (iii) progress on co-financing commitments (mid-grant or annually) by content with easy comparison across countries.
- Ensure that data are routinely captured and reported.

[Secretariat]

For additional consideration:

Learn from sustainability and transition efforts already underway in Global Fund countries and regions.

- Further share experiences within the Global Fund on working with countries to improve STC outcomes.
- Review STC relevant efforts covering LICs, LMICs and UMICs to identify best practices and hazards.

[Countries, Secretariat, Partners]

Further align grant management and governance processes to frameworks and mechanisms that promote longer-term sustainability, and away from quick responses to reducing the disease burden.

- Address inherent barriers and constraints to sustainability posed by the original grants management and governance processes, e.g., historical capture of the grant process by disease program managers may hinder robust RSSH proposals or integration across programs and systems.
- In addition, risk management vs sustainability continues to be a trade-off in use of country systems. Further attention to mechanisms for mitigating risks while maximizing use of country systems is needed (e.g., NSP based programs and performance-based grants).

[Board, Secretariat]

Consider greater use of the CCM, the LFA, and other on-the-ground mechanisms to strengthen coordination and oversight of STC efforts.

- The CCMs could support strategic approaches to improve sustainability, including a greater emphasis on financing and efficiency. One member could be tasked with oversight of the process.
- The CCM could establish a task force for sustainability and transition, and engage on these issues actively during CCM meetings.
- The LFA could support both capacity building and oversight for STC efforts; this may require additional or separate ToRs.

[Board, Secretariat]

Recommendations by Thematic Area

THEMATIC AREAS	RECOMMENDATIONS	AGENT	HIGHEST PRIORITY
Co-Financing	<i>Continue to evolve the application of co-financing to meet both the intent and the requirements of the STC policy.</i> To follow the Global Fund's successful experience in gaining commitments for increased domestic financing of health sector and HTM component financing, <ul style="list-style-type: none">• Improve reporting and accountability for realizing committed amounts; consider revising commitment and reporting formats to more readily obtain up-to-date information that includes information on items funded and can be compared across time periods for the same country and across countries;• Continue active risk assessment and monitoring of commitments;• Further work with countries to ensure co-financing reflects increased uptake of a broad	Countries, Secretariat	

	<p>needed to address the epidemics (domestic funds and funding mechanisms).</p> <ul style="list-style-type: none"> • Increase the level of health financing and sustainability support from internal specialists to support Country Teams dialog and co-financing discussions, particularly in LICs and LMICs. • Undertake more joint planning and missions with the World Bank/regional banks to more fully engage with planning, budgeting and finance authorities. • Consider innovative financing mechanisms such as debt buy-downs and swaps. • Better align discussions and Global Fund funding processes with national medium-term expenditure frameworks (MTEF) and other budgeting procedures. 		
Financing and Service Provision for Key and Vulnerable Populations (including “social contracting”)	<p>Prioritize and strengthen efforts to address impediments to the scale-up and sustainability of effective HIV, TB and malaria services for KVPs across the portfolio.</p> <ul style="list-style-type: none"> • Intensify efforts to promote domestic or alternate financing and “social contracting” mechanisms for CSOs and human rights advocacy that support primary prevention and compliance adherence activities, even at early stages in the process toward self-reliance. • Continue efforts to improve the enabling environment for KVP activities. 	Countries, Secretariat, Partners	X
Access to Affordable Health Products and Procurement	<p>Continue to create and ensure access to Global Public Goods in key areas, especially market shaping for key drugs, diagnostics and commodities; knowledge around building program efficiencies; and engagement with KVPs. These public goods create value for money across the global HIV, TB and malaria responses.</p> <ul style="list-style-type: none"> • Ensure countries retain access to these key areas, beyond their period of access to funding. • Provide access to wambo.org or other pooled procurement or price determining mechanisms during and for some period beyond Global Fund eligibility for countries that lack value pricing for national procurements in open markets due to limited scale or other market factors. • Encourage, through policy dialog and partner support, the Global Fund supported countries to utilize these pricing and procurement mechanisms when national procurement regulations or market conditions constrain access to value pricing under domestic financing. 	Board, Secretariat, Partners	X
Ongoing learning and monitoring of STC progress	<p>Learn from sustainability and transition efforts already underway in Global Fund countries and regions.</p> <ul style="list-style-type: none"> • Further gather and share experiences routinely within Global Fund on working with countries to improve STC outcomes. • Review STC relevant efforts covering low, lower-middle and upper-middle income countries to identify best practices and hazards. <p>Consider additional STC indicators as part of the Key Performance Frameworks guiding the Global Fund and its country grants.</p>	<p>Countries, Secretariat, Partners</p> <p>Secretariat</p>	

	<ul style="list-style-type: none"> Review KPIs and internal management indicators to ensure they reflect key data needed to assess STC progress. At Global Fund management level, ensure indicators are available to routinely monitor (i) RSSH strengthening, including integration and use of country systems; (ii) KVP program sustainability, and (iii) progress on co-financing commitments (mid-grant or annually) by content with easy comparison across countries. Ensure that data are routinely captured and reported. 		
Other	<p><i>Consider greater use of the CCM, the LFA, and other on-the-ground mechanisms to strengthen coordination and oversight of STC efforts.</i> The CCMs could support strategic approaches to improve sustainability, including greater emphasis on financing and efficiency:</p> <ul style="list-style-type: none"> The CCMs could support strategic approaches to improve sustainability, including a greater emphasis on financing and efficiency. One member could be tasked with oversight of the process. The CCM could establish a task force for sustainability and transition, and engage on these issues actively during CCM meetings. The LFA could support both capacity building and oversight for STC efforts; this may require additional or separate ToRs. <p><i>Further strengthen efforts to operationalize and implement the STC Policy.</i></p> <ul style="list-style-type: none"> Continue to prioritize and monitor successful transition for country disease components exiting or on a path to exit from Global Fund financing. Continue to build internal capacities, evolve grant-making processes, and maintain attention to sustainability in grant implementation. Continue efforts to increase efficiencies and value for money in grant negotiations. Fine-tune accountabilities, work plans and incentives, as needed, across the organization, and with grantees, contractors and partners to ensure that they are fully consistent with prioritizing the <i>sustainability</i> of disease outcomes. Ensure adequate staff time, capacity and attention are available to strategically implement the STC Policy. 	<p>Board, Secretariat</p> <p>Global Fund Board, Secretariat, and related bodies (OIG, TRP, GAC, TERG)]</p>	

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