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Abbreviations and Acronyms

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

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

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

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Executive Summary

Introduction, objectives and scope

The Strategic Review 2020—commissioned by the Technical Evaluation Reference Group (TERG)—was carried out between December 2019 and August 2020. It had three Main Objectives:

- **Main Objective 1:** To assess the outcomes and impact of Global Fund investments against the goals and objectives of the 2017–2022 Strategy at its mid-term.
- **Main Objective 2:** To assess operationalization and implementation of the current Strategy.
- **Main Objective 3:** To provide an evidence-informed rationale for integrating lessons learned during the first half of the 2017–2022 Strategy, and how to position the Global Fund within the global field of health development organizations in its post-2022 strategic cycle.

Main Objective 1 focused on assessing progress towards Strategic Objectives (SOs) 1, 2 and 3:

- **SO1:** Maximize disease impact
- **SO2:** Build resilient and sustainable systems for health (RSSH)
- **SO3:** Promote and protect human rights and gender (HRG)

Main Objective 2 assessed how well the Global Fund business model is working to operationalize and implement the current Strategy at its mid-term, including consideration of progress against SO4 (mobilize increased resources).

Main Objective 3 drew on learning from across the scope of the review to identify recommendations and suggest approaches for strengthening implementation during the remaining period of the current Strategy, and for consideration in the development of the next strategy.

Across the Main Objectives, 25 Strategic Review Questions (SRQs) were agreed, with a number of sub-questions covering a wide range of themes and topics of relevance to the Global Fund Strategy and business model. These SRQs are presented in Section 3.2 of the main report.

Methodology

The SRQs were divided into seven topic-specific analytical modules – outcomes and impact; value for money (VFM); funding model; monitoring, evaluation and learning (MEL), oversight and risk management; partnerships; sustainability, transition and co-financing (STC); and recommendations and future positioning. This helped to structure our team internally, with each module being led by a specialist consultant, and focus the review's enquiry on the priority issues within the scope of work.

SR2020 employed a mixed methods analytical approach that is theory-based, designed to enable an understanding of whether the theory of change (ToC), as developed for this review and presented in Section 5 of the main report, is working as intended. This has involved three main data collection approaches (extensive review of existing secondary data; key informant interviews and focus group discussions with the Secretariat, partners and global health leaders, including Global Fund Board members; and a structured case study approach in 11 countries) and a range of analytical methods. A comprehensive description of the methodology and approach is presented in the agreed Inception Report submitted in January 2020.

In conducting this review, we encountered a number of limitations, not least due to COVID-19, which hampered access to some key stakeholders, conducting the country case studies and the SR2020 team working arrangements. Although we have sought to include a wide range of country experiences in the evidence used for this review, a limitation arises from how representative the countries studied are to the wider portfolio which restricts our ability to draw conclusions on how findings may apply to other settings. Another limitation relates to the availability of data on results. This review comes at the mid-point of the Strategic period, but most grants and initiatives influenced by it started in 2018, and there is often very little information on the outcomes and impact of Global Fund investments from this point onwards (e.g. due to time lags). Despite the limitations, in all cases, we feel that we have an acceptable or strong level of evidence to justify our findings and conclusions.

Findings

Main Objective 1: Outcomes and impact of Global Fund investments

This section considers progress against SOs 1, 2 and 3, drawing on progress reporting against the relevant Global Fund Strategy Key Performance Indicators (KPI) and wider evidence collected as part of the review. It provides the basis for high-level conclusion 1, and identifies the critical factors which explain how and why progress is or is not being made, including those related to the business model. In doing so, it provides a link to Main Objective 2 and high-level conclusions 2 and 3.

SO1: Maximize disease impact. Good progress has been made towards SO1 in terms of scaling-up a number of key interventions across diseases which has contributed to substantial reductions in mortality. However, significant gaps remain in scaling up interventions to achieve targets for reducing new cases/infections. The review's analysis confirms that the Secretariat's reporting of progress towards SO1 targets is accurate. Key Performance Indicator (KPI) 1 tracks performance against the Strategy impact targets. This is comprised of:

- **Lives saved:** The Global Fund Strategy aims to save 29 million lives across the three diseases between 2017 and 2022. The Secretariat reports that it is 'on track' to do so with an estimated 9.9 million lives saved in 2017 and 2018. Progress has been much faster in Global Fund portfolio countries for HIV (deaths declined 17% between 2015 and 2019) than TB (deaths declined 2.9% between 2015 and 2018) or malaria (deaths declined 9.2% between 2015 and 2018).
- **New infections/cases:** The Global Fund Strategy aims to reduce new infections/cases by 38% across disease between 2015 and 2022. The Secretariat reports that achievement of this target is 'at risk' with a decline of 7% between 2015 and 2018 and a further 16% decline projected to 2022. Progress has been faster in Global Fund portfolio countries for HIV (new infections declined 13.7% between 2015 and 2019) than TB (new cases declined 11.2% between 2015 and 2018) or malaria (new cases increased 4.4% between 2015 and 2018).

KPI 2 tracks performance against the Strategy service delivery targets. This is comprised of seven indicators for HIV, six for TB, and four for malaria. The Secretariat report progress through an optimistic projection for all indicators (under which almost all service coverage targets will be met or are within reach) and a conservative projection for a sub-set of indicators (under which a number of service coverage targets are considered 'at risk' or 'off track'). The review's analysis suggests that the conservative projections present a more realistic assessment of potential achievement of the Strategic target. This highlights that strong progress has been made to scale up a number of interventions, including testing and treatment, which link to the good progress made in reducing mortality. Further progress is however required to improve the quality of care, as indicated by weaker progress against targets for ART retention, TB TSR and increases in global malaria deaths. The data also highlight slow progress in scaling up prevention interventions, which is related to the insufficient progress made against the strategic target for reducing new infections/cases.

Multiple factors hinder progress against what was intended, most notably in relation to health system weaknesses, human rights and gender specific vulnerabilities and barriers to accessing services, as well as resourcing issues. These are issues that should in theory be addressed to the extent feasible through support under SOs 2, 3 and 4. These are all critical components of sustainable disease responses, but over which the Global Fund has limited control. Nonetheless, the review highlights that Global Fund grants can often be designed without sufficient focus on these issues to attain results, which is linked to a set of incentives created by the business model – see below and under Main Objective 2.

SO2: Build RSSH. Despite progress in some areas, the Global Fund's contribution to strengthening health systems to support gains against SO1 and make substantive progress towards UHC, and by implication contribute to programmatic sustainability, has been limited. The Global Fund invests in RSSH to ensure sustainable, equitable and effective delivery of three disease and wider health

services, thereby contributing to UHC and more broadly to health security. The KPIs do not provide a holistic assessment of progress in this regard. The review's analysis, and as reported through KPI 6, does, however, suggest that some gains have been made in some areas. Most notably, this relates to the two areas which account for the majority of RSSH investments: strengthening data systems for health and countries' capacities for analysis and use; and strengthening global and in-country PSM systems. However, even in these areas there is strong evidence to suggest that substantial challenges still exist which limit the health impact of Global Fund investments. The COVID-19 pandemic is further demonstrating the ongoing weakness of health systems and the fragility of previous gains made against the three diseases.

A number of factors help explain why limited progress has been made towards this SO, including country contextual factors, as well as important factors related to the business model. These are explored in findings under Main Objective 2, and summarized under high-level conclusion 1.

SO3: Promote and protect HRG. There has been limited progress in addressing equity, human rights and gender issues across the Global Fund portfolio, albeit with variation by geography, disease and KVP group. The KPIs do not provide a holistic assessment of progress towards this SO. Significant inequities exist in access to health services and health outcomes across the portfolio and particularly by KVP group. These inequities act as a significant constraint to the achievement of SO1 and are driven by social, economic, political, demographic and geographic factors. These issues are difficult to address and require engagement in issues over which the Global Fund often has limited influence. There have nonetheless been gains in scaling up service coverage, including for those who face discrimination and/or other structural barriers, in part facilitated by Global Fund support for technology and service innovations and targeted interventions to KVPs. However, evidence from this review suggests that the factors driving observed inequities often do not receive sufficient attention in grant and program design, and wide variations in health service access and health outcomes still exist within and across countries. These variations and the factors that drive them help explain why slow progress is being made towards to some areas of SO1.

Progress against gender objectives has been muted. Performance against the KPI focused on gender and age equality (KPI 8, targeting a reduction HIV incidence in women aged 15-24 years old), is currently below target, reported by the Secretariat as 'at risk'. The review's analysis suggests that while progress is being made in some programmatic areas, there is weak progress in other areas and Funding Requests often leave critical issues unaddressed.

Investments in human rights have increased significantly in a sub-set of countries, particularly where specific additional financial and technical support has been provided, with some emerging evidence of positive results being achieved in these countries as reflected by KPI 9. This points to the merits of employing targeted approaches in this area. However, there is little evidence of similar gains being made across the wider portfolio, including in countries where there are substantial issues.

The most critical explanatory factors for a lack of progress and investment in HRG appear to relate to political will, particularly where specific KVP groups are criminalized and/or addressing structural barriers to accessing services would be politically unpopular. This review also suggests that various aspects of the business model can help to explain why limited progress has been made towards this SO. These are explored under Main Objective 2, and also summarized under high-level conclusion 1.

Main Objective 2: Operationalization and implementation of the Strategy

This section presents the key findings on how well the business model is working to operationalize and implement the current Strategy for the achievement of the SOs. The scope of work covered a range of themes and topics, which have been clustered under the following headings. Building on findings from Main Objective 1, this provides the basis for high-level conclusions 2 and 3.

Funding model: The review's assessment of the funding model suggests that it works reasonably well to ensure that resources are allocated to provide guidance on how to design grants to maximize disease impact. Strengthened guidance has also been made available on how to design grants to

meet SOs 2 and 3, alongside catalytic investments to boost financial allocation and technical assistance to these areas. In spite of these efforts, the funding model still fails to ensure that Funding Requests are prioritized and grants are designed to address all SOs simultaneously. Most notably, this is related to:

- often highly aspirational, untargeted and/or unprioritized NSPs, which serve as a weak foundation for developing a Funding Request, particularly where, in combination to this, HRG and RSSH needs are not well articulated within NSPs
- weak guidance, including from technical partners, on how to prioritize under resource constraints: (a) between geographies, populations and intervention mixes; and (b) across SOs
- technical partners that are often not well placed, unable or unwilling to influence prioritization, and weak mechanisms to engage other partners that are
- Global Fund-supported modelling and efficiency analyses not yet being embedded and fully utilized, or extended to all countries
- an unwillingness by the Secretariat to insist on certain strategic priorities being addressed in grant design (although acknowledging that doing so might have unintended consequences)
- the political nature of prioritization decision making, which can override VFM considerations.

The funding model's lengthy grant development and approval processes also mean that CCMs and other engaged stakeholders are keen to avoid iteration and/or clarifications from the TRP and GAC. The result is a strong incentive to design grants that do 'more of the same' in terms of interventions, service delivery models and grant implementation arrangements, rather than pursuing bolder programming.

Technical partnerships: There are wide ranging concerns over whether partners are sufficiently supporting countries to optimally design and implement Global Fund grants. Despite efforts by the Secretariat to strengthen partner engagement, there are still issues of weak coordination and transparency of technical support investments, mixed capacity and quality of support provided by partners, and weak oversight and accountability mechanisms for results.

The review's evidence identified a number of important explanatory factors including uneven partner capacity and lack of funding to undertake Global Fund work at a level expected, and a multiplicity of agendas and interests at country level which can constrain engagement with Global Fund issues. In addition, partner mandates often do not fully align to the entire scope of the Global Fund Strategy. This most often affects RSSH and in some cases HRG. This review has also highlighted partnership 'gaps' in a number of strategically important areas, most notably to bring expertise for prevention and RSSH programming, as well as partnering with the private sector.

Further, there is evidence to suggest that while partners have a clear mandate to engage in NSP and Funding Request development processes, and the CCM model is adept at facilitating engagement at this stage, this is not the case for grant implementation processes. As such, there can be less engagement in processes to unblock bottlenecks, strengthen oversight, and manage risk.

Analysis against the SR2020 ToC demonstrates that these issues act as significant constraints to the Global Fund business model and its ability to translate the Strategy's priorities into effective grant design, implementation, and impact at the country level.

MEL and grant oversight: The Secretariat has introduced a range of measures designed to strengthen its approach to performance measurement over time. However, the lack of an overall framework or strategy for MEL has created a series of issues. Most notably, these relate to:

- A lack of integration of MEL activities which take place at multiple levels—corporate, region, country, grant, thematic—and across the many different parts of the Secretariat involved in the operation of the MEL system. In particular, there is a lack of coordination in the commissioning and use of evaluation, and a lack of clarity regarding the appropriate division between internal and independent evaluation.

- An organizational commitment to learning lessons on the enablers and barriers to success, but the lack of processes to promote a learning culture that draws on monitoring data and wider evidence (including evaluations) on what works and why.
- Gaps in the coverage of the MEL system that relate to SOs and/or critical enablers. Most notably, these relate to health technology utilization, RSSH, HRG, partnership coordination and TA investments, innovation, and achievement of VFM.
- Weak incentives for implementers to improve program performance. This is related to the use of indicators and targets that mostly focus on national level outcomes and impacts. While Global Fund grants contribute towards these, they typically have limited influence over whether targets are achieved or not. As such, the indicators are a weak proxy for grant performance and yet are used to determine grant-ratings, which results in an annual funding-decision. This process is a core element of the Global Fund's performance-based funding model, but in practice creates little incentive to increase grant performance and weak 'penalties' for poor performance.

Analysis against the SR2020 ToC indicates that these issues create strong incentives for stakeholders to design grants that prioritize activities that are: (a) comparatively easier to implement and/or absorb funds; (b) directly measured through the MEL system; and (c) able to make a measurable contribution to national indicators in a short time-frame. As such, the incentives are to deprioritize those areas that are not directly measured, are more difficult and take time to implement and achieve results. There is evidence of the Secretariat starting work to remedy these issues, including through a review of the MEL approach and redefinition of the grant-rating system.

Balancing fiduciary and programmatic risk: The Global Fund rightly promotes well-designed risk management controls that enable the achievement of programmatic results. Nevertheless, the Global Fund has been criticized in recent years for an inconsistent and imbalanced approach to managing the trade-offs between fiduciary risk concerns and the risk-taking necessary to pursue achievement of its programmatic mission, particularly in riskier environments.

Significant steps have been taken to promote a more balanced approach in this regard, in particular through new policies and processes designed to ensure that an appropriate amount and type of risk is tolerated for the achievement of programmatic results. While external stakeholders continue to view the Global Fund as risk averse, the steps taken are generally perceived as positive within the Secretariat. However, evidence from this review suggests that opportunities to apply more flexible approaches and instill processes to proactively encourage appropriate risk-taking have not been adopted. This suggests that changing the organizational culture, and external stakeholder's perceptions of that culture, from one that has been focused more often on fiduciary controls takes time and will require specific attention.

Analysis against the SR2020 ToC indicates that the implication of this is to create incentives for stakeholders to design grants that prioritize activities that are well tested and comparatively easier to implement and/or absorb funds.

Procurement and market shaping: Linked to the significant scale up of biomedical/facility-based services, including testing and treatment, across the portfolio, the Global Fund has delivered significant value in the market-shaping space directly under its control. Strong improvements have been made in health technology availability and affordability, with market-shaping successes across product categories and contributions to broader health product management. Evidence from this review suggests that issues outside of the Global Fund's direct control, such as on pricing, quality and supply security in domestically financed procurement can be dealt with inconsistently across the portfolio, but offer great opportunity for further VFM gains.

Efficiency in implementation: Cross-portfolio program efficiency appears to have increased over time alongside considerable efforts to increase both allocative and technical efficiency, albeit with widely recognized opportunities for further gains. These efforts are however mostly related to SO1 and SR2020 analysis shows that interventions that seek to strengthen health systems and address

HRG-related barriers can be deprioritized throughout grant implementation. This occurs through lower levels of absorption leading to budgetary shifts away from these areas within individual grants, and portfolio optimization mostly prioritizing interventions in support of SO1.

STC: The review's assessment of the implementation of the STC Policy is that good progress is being made across countries towards financial sustainability, in part related to the operationalization of the STC Policy and the co-financing requirement specifically. The COVID-19 pandemic does, however, represent a significant threat to these gains in the short-, medium-, and long-term.

Ensuring programmatic sustainability of health programs and services remains a challenge and necessitates leveraging political will and engagement in issues over which the Global Fund has limited control. Much work has been done to galvanize commitment to making progress in this area and agreeing on a set of actions to further embed sustainability within the Global Fund's approach. This represents significant progress, although the approach may not be sufficient and/or fully appropriate in all contexts. For instance, a more nuanced approach may be required in decentralized and devolved settings. It is acknowledged that making progress in this area will require significant time. Nonetheless, findings from this review suggest that examples of where countries have made substantive progress in planning for, designing and implementing grants that build towards programmatic sustainability are limited to a relatively small proportion of the portfolio.

Conclusions

The review conclusions are clustered around three high-level conclusions which relate to the review findings across Main Objective 1 and 2.

High-level conclusion 1: There has been mixed progress towards the Global Fund SOs:

- **SO1:** Good progress has been made towards SO1 in terms of lives saved, but significant gaps remain in scaling up interventions to achieve targets for reducing new cases/infections.
- **SO2:** Despite progress in some areas, this is uneven and most Global Fund investments in RSSH are used to support operational costs for the three disease programs rather than strengthening health systems to make substantive progress towards UHC and programmatic sustainability.
- **SO3:** There has been limited progress in addressing equity, human rights and gender issues across the Global Fund portfolio, albeit with variation by geography, disease and KVP group.

COVID-19 appears likely to reverse some of the gains made. Alongside the need to substantially accelerate progress in all areas to meet 2030 goals, 'more of the same' will not be sufficient. More attention to addressing the underlying policy and socio-economic drivers of the epidemics is required as part of an approach that places increased emphasis on sustainability and equity.

SO1: Despite progress in reducing mortality, overall progress has been constrained by insufficient prioritization of effective prevention interventions, the continued presence of health system issues and inequities in access to essential services. Critical to the substantial progress made in reducing mortality has been the significant scale up of biomedical/facility-based services, including testing and treatment. The Global Fund has been at the forefront of global efforts in this regard, providing significant levels of global financing for health technologies, and helping to drive strong improvements in health technology availability and affordability. Further progress will however require improvements in program quality, as indicated by weaker progress against targets for ART retention, TB TSR and increases in global malaria deaths. Many areas where progress is off track are centered around prevention interventions, which is related to the insufficient progress made against the strategic target for reducing new infections/cases. Along with the continued presence of health system issues and inequities in access to essential services, this suggests the need for some rebalancing of priorities and investments moving forward. This will necessarily be influenced by the new reality imposed by COVID-19, which is seriously interrupting service delivery in many countries.

A significant explanation for a lack of contribution by the Global Fund against SOs 2 and 3 is that insufficient funding has been channeled to the right types of activities.

SO2: While a significant proportion of Global Fund resources are allocated to RSSH (USD 0.5 billion per year), two-thirds of this is used to support operational costs for the three disease programs rather than strengthening health systems more broadly. This is the case even in countries relatively far along the development continuum suggesting that there is little differentiation of RSSH support. Evidence from this review suggests that Global Fund investments in RSSH can only be expected, at present, to be making a marginal contribution to the objectives of building RSSH that would enable progress towards UHC and contribute to programmatic sustainability.

One major reason for this is due to there being insufficient funding to simultaneously fund essential disease program costs and strengthen all aspects of health systems (for which the resource needs are huge and well beyond what the Global Fund alone can provide). Other reasons include a lack of clarity on the overall purpose of and need for RSSH investments, stemming from divergent viewpoints on this issue among the Board and wider partnership¹ and historically weak technical guidance in this area. Relatedly, RSSH receives less prioritization and focus, as compared to SO1, across various aspects of the business model, including Funding Request/Grant-Making, grant implementation, and monitoring, evaluation and learning (MEL) processes, as well as partner arrangements.

SO3: Substantial inequalities exist in access to and utilization of services and health outcomes across the Global Fund portfolio including by geography, disease and KVP group. These are driven by a range of factors, including economic status, age, sex, level of education, geographic place of residence as well as context specific dimensions such as ethnicity, disability, migratory status. Addressing these issues is challenging and there has been limited progress in doing so to date, albeit with variations by geography, disease, and KVP group.

Investments in HRG and to reduce inequalities among specific population groups have historically been low. This is partly due to difficulties in targeting interventions to these groups, stemming from a lack of strategies, policies and plans to address their needs, weak population size estimates, and a mixed understanding about what works and why. Where there is evidence, the business model does not work to ensure that these are systematically addressed in grants. For gender specifically, Funding Requests often leave critical issues unaddressed. In terms of human rights, dedicated financing and technical assistance has helped to significantly increase the level of investment and strengthen programming in a sub-set of countries, with some emerging evidence of positive results. Investments have also increased in middle-income countries, which can be partly attributed to having a specific KPI focused on this area.

A specific issue that may be hampering the adoption of a consistent approach across the portfolio relates to different understandings and interpretations of what equity means, both within the Secretariat and among partners. Specifically, a widely held view is that equity involves trade-offs with efficiency or effectiveness, for instance where geographies or population groups are prioritized. This represents a dangerous misunderstanding of equity, which is concerned with giving everyone equal access to services based on need in order to improve efficiency, effectiveness and achieve impact.

Mixed progress towards the Global Fund's three SOs does not suggest the need to shift the organization's focus away from these areas, but does suggest the need to evolve the business model. There is strong evidence that the most critical barriers to achieving disease impact relate to issues with prioritization and implementation, health system weaknesses, equitable access to services and HRG-specific vulnerabilities. There is much uncertainty in relation to the eventual health, economic and political impact of the COVID-19 pandemic. While the pandemic ultimately looks set to make the scale of the challenge ahead all the more difficult, these pre-existing barriers are likely to remain the most pertinent issues for the Global Fund in the next strategic period.

As such, the current SOs 1, 2 and 3 remain highly relevant. While the Secretariat has constantly sought to evolve its ways of working and introduce specific mechanisms to try to address these challenges, analysis against the SR2020 ToC indicates that the business model as a whole is still not

working to systematically support the design and implementation of grants operating at country level that consistently and simultaneously meet SOs 1, 2 and 3.

The context within which the Global Fund operates continues to evolve and is likely to be less supportive of the organization’s strategic targets in the short- and medium-term. This has implications for how the Global Fund delivers against the SOs in the future. Due to the predominance of the COVID-19 pandemic and its domestic and international health, social and economic impacts, current rates of progress against the SOs are likely to be affected, and this may necessitate a reprioritization of Global Fund resources for the current and next strategic period. For instance, this may include greater priority to fragile health and community systems and the poorest and most vulnerable communities, whose economic circumstances exacerbate their susceptibility to COVID-19 but also HIV, TB, and malaria.

High-level conclusion 2: The evidence clearly shows that the Global Fund’s business model has continued to evolve during the period of the current Strategy and has strengths in several areas. However, to date, the model still does not deliver solutions to a number of long-standing challenges, that primarily relate to coordination of action across multiple objectives and how to achieve evidence-informed prioritization when stakeholders at both international and country level have diverging levels of capacity and differing priorities.

There are several clear strengths in the current business model that should be built upon. This necessarily involves care being taken not to undermine these strengths through unintended consequences of reform in other aspects of the business model. These include:

- The Global Fund’s market-shaping work has continued to deliver strong performance under the current Strategy and is a main driver of economies achieved by the Global Fund. This includes strong improvements in health technology availability and affordability across product categories and contributions to broader health product management. Further gains could be made through support to strengthen domestically financed procurement.
- Using a range of tools and processes, the Secretariat has sought to increase absorption, allocative and technical efficiency, with some evidence of efficiency gains across the portfolio over time. This has included growth in the technical skills of the Secretariat, the use of Matching Funds and Multi-Country Approaches to ensure strategic priority areas are prioritized, as well as Strategic Initiatives, notably to support a range of modeling exercises designed to supplement updated technical guidance to better inform country prioritization processes, and the addition of the Strategic Investment and Sustainable Financing cadre within the TRP. There are however opportunities to refine, expand and better utilize many of these efforts for further gains.
- The Global Fund’s support for innovation—both new technology scaling as well as service delivery innovations (e.g. differentiated testing strategies, community-led responses)—has enabled more tailored interventions to meet KVP needs, as well as improved impact across diseases. Further efforts are however required to ensure that these are scaled up.
- There has also been good progress in supporting countries to increase domestic funding, although we anticipate substantial risks to both financial sustainability associated with the COVID-19 pandemic and its impact on the global economic situation.

Despite greater technical guidance and support to improve allocative efficiency, a number of business model mechanisms do not work consistently across the portfolio to ensure that grants are sufficiently prioritized to maximize disease impact, while also making necessary progress towards HRG and RSSH, and equity and sustainability more generally. Findings from across the review suggest that prioritization is a significant issue affecting both how resources are allocated across sub-national geographic areas, population groups and intervention mixes, and across activities that respond to the each of the SOs. Prioritization decisions are influenced by a range of country contextual factors. Evidence suggests that Global Fund mechanisms, like for other donors, can

struggle to generate political commitment to meet all of the Global Fund’s strategic priorities. Further, the political nature of prioritization decision making can often override VFM considerations. Prioritization is also influenced by a number of different components of the Global Fund business model. Most notably, this relates to the funding model and role technical partners in supporting prioritization decision making, the MEL system, and ongoing perceptions among many country stakeholders of the Global Fund being risk averse. Together, these business model components create a set of incentives for country stakeholders to design grants that:

- do ‘more of the same’ in terms of interventions, service delivery models and grant implementation arrangements that are well tested, rather than pursuing bolder/innovative programming;
- prioritize activities that are comparatively easier to implement and/or absorb funds; and/or
- focus on programmatic areas that are directly measured through the MEL system, and where a measurable contribution to national indicators can be made within the three-year grant lifecycle, allowing for time-lags in data.

In practice, analysis against the SR2020 ToC suggests that this leads to a prioritization of biomedical/facility-based services, mostly focused on scaling up treatment; and weaker prioritization of activities to scale up prevention programming and address HRG-related barriers, and strengthen health systems. As such, the review suggests that there is a strong link between observed progress towards the SOs and the set of incentives created by the business model to influence prioritization.

The interaction of the business model and national contexts is still not effectively prioritizing the design of grants and disease responses that build towards programmatic sustainability. Ensuring programmatic sustainability of health programs and services is challenging and requires significant time and engagement in issues that are outside of the Global Fund’s direct control but that it can influence. There has been considerable progress made by the Secretariat in working with the various Board sub-committees to agree and take forward a series of actions that seek to further embed sustainability within the Global Fund’s approach. Findings from this review suggest there are examples of where countries have made substantive progress in planning for, designing and implementing grants that build towards programmatic sustainability, but these are limited to a relatively small proportion of the Global Fund portfolio. Critically, related to findings under Main Objective 1, making further progress will require prioritized efforts to strengthen CSO and community-led systems to provide these services; address inequities and HRG barriers; and strengthen health systems. These are all fundamental components of a sustainable disease response that are at present receiving insufficient attention. A separate emerging challenge to planning and making progress on sustainability relates to an increasing trend towards decentralization/devolution which may require a shift in policy approach.

High-level conclusion 3: The Global Fund business model does not always work to create strong and clear incentives for partners and other stakeholders to improve program results. Opportunities to do so through the structuring of contracts, arrangements, and processes are often missed.

The Global Fund business model does not always work to create strong and clear incentives for partners and other stakeholders to improve program results. This primarily relates to the design of the MEL system. Firstly, there are some significant gaps in the coverage of the MEL system which, as well as partly explaining why these areas receive less attention, can also help explain why less progress is made in these areas. Most notably, these ‘gaps’ relate to RSSH, HRG, partnership coordination and TA investments, innovation, and achievement of VFM (by which we refer to a rounded assessment of economy, efficiency, effectiveness, equity and sustainability). As such, in line with the conclusions above on prioritization, the review suggests that there is a strong link between observed progress towards the SOs and the design of the MEL system.

Secondly, the Global Fund's approach to assessing grant performance relies heavily on indicators that measure progress towards national level outcomes and impacts. While Global Fund grants contribute towards national level outcomes and impacts, grants typically have limited influence over whether results at this level are achieved or not. As such, the indicators are a weak proxy for grant performance and yet are used as a core element of the Global Fund's performance-based funding model. In practice, this creates little incentive to increase grant performance and weak 'penalties' for poor performance.

Opportunities to strengthen performance management are insufficiently used. The review suggests that contracts, arrangements, and processes with partners are often not structured to incentivize desired behavior and performance in line with the Secretariat's expectations. This applies to incentivizing grant performance and ensuring that grant investments achieve better value, and also often in the structuring and management of contracts with partners based on the quality of the outputs delivered.

Main Objective 3: Recommendations on future directions

Building on the review findings and conclusions, and discussion with the Secretariat and TERG, this section summarizes the review's recommendations on future directions. Strategic recommendations 1 and 2 focus on actions that should be implemented now. Strategic recommendations 3, 4 and 5 focus on what should be reflected in the next strategy.

A more detailed set of operational level recommendations, including who should take responsibility for implementation, are presented in the main report.

Strategic Recommendation 1: Start now to strengthen the processes by which geographies, populations and intervention mixes are prioritized in NSPs and Funding Requests to ensure that Global Fund investments are evidence based and reflect an appropriate balance across the SOs, VFM criteria and organizational ToC.

The review shows that opportunities are missed to increase impact within disease programs and grants through a lack of prioritization and targeting of intervention mixes across sub-national geographies and population groups, including for RSSH and HRG, that build toward sustainability. As a result, the Global Fund's overall effective contribution is not maximized. This is because the systems, processes, and tools that drive the design of national programs and Funding Requests still do not deliver the evidence-based prioritization needed for fully efficient, effective, equitable and sustainable outcomes.

Acknowledging the importance of country ownership, finding this balance in evidence-based prioritization will require:²

1. Having a clear approach to tackling this issue.
2. Stronger and more specific guidance from the Secretariat and technical partners to encourage prioritized decision-making in resource-constrained settings and the tools to allow quantitative and qualitative VFM assessment of options
3. Processes that support countries to adopt and scale innovations in technology, service delivery and targeted interventions to help ensure access to KVPs and encourage more adoption of innovative solutions
4. Mechanisms that are appropriate, capacitated and financed to develop NSPs and Funding Requests at country level
5. Greater attention to and prioritization of particular service delivery modalities (e.g. CSO, community systems, private sector) that can sustain services, build capacity and create an enabling environment that leads to impact
6. Processes at country level that draw upon the expertise of communities closest to the epidemics to identify innovative, yet context-appropriate and sustainable solutions that target the underserved.

Strategic Recommendation 2: Strengthen the partnership's focus on achieving results as a priority during the remainder of this Strategic period, as the basis for enhancing impact from the start of the next strategic period.

The review highlights that the Global Fund business model does not always work to create strong and clear incentives for partners and other stakeholders to improve program results. Opportunities to do so through the structuring of contracts, arrangements, and processes are often missed. Instituting a strong focus on results should extend beyond the Secretariat, where recent reforms are intended to address this issue, to technical and other partners working at country level. This will involve strengthening the mechanisms for partner and stakeholder engagement, quality assurance, monitoring, evaluation and learning, as well as grant oversight.

Strategic Recommendation 3: An important new emphasis in the next strategy should be on strengthening the Global Fund's ability to adapt to the range of possible contexts that it might operate in post COVID-19.

The rapid emergence of COVID-19 has shown how a global pandemic can affect virtually every aspect of implementing the Global Fund Strategy; and how the Global Fund partnership is able to respond to such a threat. Our limited evidence on the Global Fund's initial response is that it has been smart, swift and focused. Nevertheless, a practical consequence will be the difficulty in differentiating the causes of any under-performance against the strategic targets due to shortcomings in the current Strategy and operationalization of the business model from those associated with COVID-19. This will also make setting new targets, which rely on stability and predictability in the broader context difficult. This needs to be recognized in reviewing the Global Fund's future performance.

More significant, the consensus view is that the immediate health and medium- and long-term economic, financial and health systems impacts of COVID-19 will be large. How significant these impacts will be cannot easily be predicted as they will be contingent on responses by multiple stakeholders. Development of the next strategy should therefore include a significant focus on testing the resilience of the Global Fund strategy and business model under multiple scenarios. Scenario planning, a strategy development tool that has been used and refined over several decades, should therefore be incorporated into the process of developing the next strategy.

Strategic Recommendation 4: The current SOs 1, 2 and 3 should remain at the forefront of the next strategy. However, the next strategy should make it clear that the SOs are mutually dependent with each critical to achieving the other. The business model should adapt to shift the priorities within each SO and enhance coherent management across the three.

Our conclusions show that the current SOs 1, 2, and 3 (see below) remain critical for delivering effectively against the Global Fund's mission. Key areas where the new strategy needs to ensure greater prioritization in line with the three SOs are:

- a) **Maximize impact against HIV, TB, and malaria (SO1):** Enhanced delivery requires greater prioritization of prevention programming to reduce new infections/cases and more focus on ensuring equitable outcomes through prioritization of progress in low performing geographies and programmatic areas, and among specific population groups.
- b) **Build RSSH (SO2):** The next strategy should clearly specify what is required from a health system in order to ensure financial and programmatic sustainability. Based on this, the strategy should then identify what is realistic and within the scope of the Global Fund to achieve and where this might link to the efforts of others operating in this space. This should include consideration of whether all the current operational objectives are relevant and necessary; whether new areas may merit inclusion, for instance in relation to global health security; and where the Global Fund offers comparative advantage and should focus efforts.
- c) **Promote and protect HRG (SO3):** The need to effectively address human rights and gender equality as critical components of disease responses is a recognized and long-standing challenge for the Global Fund. The next strategy should nonetheless seek to intensify the

focus on these priorities, including by drawing on lessons from the catalytic investments in this area which suggest that dedicated funding and technical assistance can yield gains. Consideration could also be given to focusing the SO more broadly on ‘achieving equity’ since this might more explicitly emphasize the linkages to other the SOs. Alternatively, equity could be framed as a principle underpinning the entire strategy.

To promote more equal management across the SOs, the next strategy should make clear that the SOs are mutually dependent, with each critical to achieving the other. More collaborative ways of working will be imperative to ensure progress against the SOs, particularly SOs 2 and 3, which require significant multi-sector coordination and joint working. The Global Fund’s engagement through the Access to COVID-19 Tools (ACT) Accelerator, may offer lessons and/or set a precedent for future co-working arrangements between governments, scientists, businesses, civil society, philanthropists and global health organizations.

Finally, we recommend that the current SO4—to mobilize increased resources and achieve VFM in their use—should be positioned as a strategic enabler alongside the Global Fund business model and role of partnerships.

Strategic Recommendation 5: For the next strategy, position programmatic and financial sustainability for the three disease responses as a high-level strategic priority and ensure mechanisms are in place to operationalize this priority.

This could include making sustainability a strategic objective and/or the overarching goal to which other SOs contribute. This would be effective at signaling its importance to the Secretariat, partners and country stakeholders, and communicate that it should not be treated as a siloed issue but requires a meaningful and coherent approach across the full scope of the Global Fund’s work. Consideration should be given to broadening the definition of sustainability used by the Global Fund beyond just the three diseases to incorporate the expected benefits of investments to other health agendas/sectors. This would be helpful in clarifying and ensuring that the Secretariat and partners project a common position on the need for the Global Fund to invest in health systems strengthening. Such an approach would also allow the Global Fund to demonstrate a strong commitment to supporting wider global health agendas, including UHC, global health security and the SDGs).

The Board will need to consider how and whether framing sustainability in the manner suggested can be complimentary to the objective of disease elimination, which this review suggests is increasingly unrealistic in the short- and medium-term, particularly for HIV and TB. As such, there may be merit in framing these goals in a nuanced manner.

At a minimum, we would expect meaningful progress against this priority to require a number of changes to how the business model supports prioritization in NSPs and Funding Requests. Areas of focus should include how the present model supports prioritization of strengthened CSO and community-led systems, investments for KVP and prevention programming, addressing HRG and equity barriers, and strengthening health systems. This will be challenging in what is another well recognized difficult area for all funding agencies and would require partners and countries to support and agree to make hard decisions. Furthermore, its delivery might require accepting a reduction in short-term results delivered when the consequences of COVID-19 would already be depressing progress against the Global Fund’s strategic targets.

1 Introduction

The Global Fund Technical Evaluation Reference Group (TERG) commissioned a consortium comprised of Euro Health Group (EHG), Itad and the University of California San Francisco (UCSF) to conduct the Strategic Review 2020 (SR2020), the statement of work (SoW) for which is provided in Annex 1.

This final report presents our findings from the data collection and analysis work carried out between February and May 2020, and in response to extensive comments received from the Secretariat and TERG in June, July and August 2020 on the first and second draft reports.

The report is structured as follows:

- Section 2 sets out the purpose and objectives
- Section 3 describes the approach
- Section 4 presents limitations
- Section 5 sets out the Theory of Change (ToC) employed for this review
- Section 6 presents our findings
- Section 7 presents our overall conclusions
- Section 8 sets out areas for recommendations.

The report is supplemented by the following annexes (Vol 2):

- Annex 1: Relevant sections of the request for proposals
- Annex 2: Full listing of review questions
- Annex 3: People met
- Annex 4: Supporting material for findings
- Annex 5: ToC tables by module
- Annex 6: Bibliography
- Annex 7: Country summary reports

2 Purpose and objectives

The SR2020 is designed to assess progress made during the first three years of the Global Fund Strategy 2017–2022 to provide learning and suggest approaches for strengthening implementation during the remaining period of the current Strategy, and for the development of the next strategy. This review draws on the strategic reviews conducted in 2017 (SR2017) and 2015 (SR2015).

The SR2020 had three main objectives:

- **Main Objective 1:** To assess the outcomes and impact of Global Fund investments against the goals and objectives of the 2017–2022 Strategy at its mid-term.
- **Main Objective 2:** To assess operationalization and implementation of the current Strategy.
- **Main Objective 3:** To provide an evidence-informed rationale for integrating lessons learned during the first half of the 2017–2022 Strategy, and how to position the Global Fund within the global field of health development organizations in its post-2022 strategic cycle.

To meet these objectives, the SR2020 drew on the myriad of information already available across a range of topics and themes of relevance. This included reporting of progress against key performance indicators (KPIs) and studies commissioned by the Secretariat, TERG-commissioned thematic reviews and the Prospective Country Evaluations (PCE), and the work of the Office of the Inspector General (OIG). This extensive database of knowledge was reviewed with a view to identifying well-evidenced options for the Global Fund to move forward.

3 Approach

3.1 Structuring the work

Our approach to SR2020 involved clustering of the wide range of issues raised in the RfP around seven topic-specific analytical modules which helped to structure our team internally and focus our enquiry on the priority issues within the scope of work. These were outcomes and impact; value for money (VFM); funding model; monitoring, evaluation and learning (MEL), oversight and risk management; partnerships; sustainability, transition and co-financing (STC); and recommendations and future positioning.

SR2020 employed a mixed methods analytical approach that is theory-based, designed to enable an understanding of whether the theory of change (ToC), as developed for this review – see Section 5 – is working as intended. This has involved three main data collection approaches (extensive review of existing secondary data; key informant interviews and focus group discussions with the Secretariat, partners and global health leaders, including Global Fund Board members; and a structured case study approach in 11 countries) and a range of analytical methods.

We have shared multiple iterations of this report with TERG and Secretariat stakeholders and taken time to incorporate the significant amount of feedback received. This has included a workshop with the Secretariat focused on discussing the review conclusions and options for recommendations.

A comprehensive description of the methodology and approach is presented in the agreed Inception Report submitted in 2020.

3.2 Strategic review questions

Within each workstream we have clustered the various strategic review questions (SRQs) into seven topic-specific modules (see Table 1).³ The modules are broadly mapped onto our interpretation of the Global Fund's 2017–2022 ToC (see Figure 2).

The clustering of SRQs into modules was designed to enable us to understand how and whether different components of the ToC are working, while also allowing a clear line of sight from the generation of findings against the SRQs up to high-level strategic questions, and finally to the generation of recommendations.

It is, however, important to highlight the interrelated nature of many of the issues being assessed, which has required cross-modular working in many instances, and cross-referencing between findings sections.

Table 1: Strategic review questions by Main Objective

Module	Strategic review question (SRQ)
Main objective 1	
1: Outcomes and impact	<ul style="list-style-type: none"> 1: What are the trends during the period 2010 - 2018 in service delivery, coverage and quality outcomes and impact indicators that can be identified through further disaggregation of Global Fund KPIs; country data; modeling; and country case studies, to strengthen understanding of performance? 2: What are the key factors that have enabled and/or hindered achievement of these targets by region, population group, or other contextual factors? 3: What are the trends in significant areas that correspond to Strategy sub-objectives that are not directly covered by the KPIs? 12: To what extent are Global Fund investments addressing structural barriers faced by programs leading to more effective national program implementation and contributing to national outcome targets? In which areas should the Global Fund strengthen its support to address structural barriers to improve program outcomes? Have there been unintended consequences (positive and negative)?

Main objective 2	
2: VFM	<ul style="list-style-type: none"> 9: How successful has the work undertaken by the Global Fund to enhance grant absorption been in increasing absorption? Are there investment areas where absorption is higher or lower? Has the work to enhance grant absorption led to more quality and impactful programs in-country? What are the barriers to implementation that could affect absorptive capacity and how can these be addressed? 10: Are Global Fund investments (Grants and Strategic Initiatives) focused on the most appropriate interventions to deliver the most impact and the best VFM, in practice and according to country context? How could this be improved? 11: To what extent are the Global Fund's procurement mechanisms and market-shaping efforts contributing to the VFM of Global Fund investments? How likely is it that any economies and efficiencies that are realized through these efforts, will be sustained post-transition?
3: Funding model	<ul style="list-style-type: none"> 6(R): To what extent do the Global Fund's Funding Model, policies, their operationalization and key Secretariat processes (including the allocation letter, Funding Request development materials and guidance, Funding Request development process, Technical Review Panel (TRP) guidance, Grant Approval Committee (GAC) approval, grant implementation and grant revisions including portfolio optimization) appropriately position the Global Fund partnership to deliver the Strategy's objectives? 7: To what extent are the Global Fund's Funding Model, policies and key Secretariat processes supportive of country priorities (National Strategic Plans and Health Sector Plans) and able to appropriately influence national health and disease program planning and implementation? 8: To what extent have the catalytic investments achieved their aim in catalyzing investments for greater impact? 14(R): How effective has the Global Fund's Funding Model, its policies and processes (including the allocation letter, Funding Request development materials and guidance, Funding Request development process, TRP guidance, GAC approval, grant implementation and revisions including portfolio optimization) been in supporting countries build resilient and sustainable systems for health (RSSH) and deliver impact on the ground? How can they be strengthened? 15(R): How effective has the Global Fund's funding model, its policies and Secretariat processes been (including the allocation letter, Funding Request development materials and guidance, Funding Request development process, TRP guidance, GAC approval, grant implementation and revisions including portfolio optimization) in: <ul style="list-style-type: none"> protecting human rights, especially with respect to key populations including men who have sex with men (MSM), transgender, people who inject drugs (PWID), sex workers and prisoners? promoting gender equality to ensure that the rights of women, men, girls and boys are equitably protected? <p>How can impact in these areas be strengthened?</p>
4: MEL, oversight, and risk	<p>Monitoring, evaluation and learning (MEL) and oversight</p> <ul style="list-style-type: none"> 4: How appropriate are service coverage targets in the country cases used for this analysis relative to the amount of funds invested by the Global Fund, the government and partners? 13: Is the way that the Global Fund monitors and provides oversight to its investments on a country level adequate, appropriate and done in the most cost-effective way possible? How does this vary across country typologies, e.g. Challenging Operating Environments (COEs)? How could this be improved? 25: To assess any gaps in the current suite of KPIs in measuring the impact of the Strategy and to suggest any information/indicators to more comprehensively assess the impact of the Strategy going forward. <p>Balancing fiduciary and programmatic risk</p> <ul style="list-style-type: none"> 5: What progress has been made in strengthening programmatic assurance to inform trade-off decisions between mitigating fiduciary and programmatic risk so that the grants achieve maximum impact? How can this be improved?

5: Partnerships	<ul style="list-style-type: none"> • 19: To what extent is the Global Fund’s partnership model, as set out in the Partnership Strategy, working as intended at the country level? How can this be strengthened? • 20: For areas where the Global Fund has only limited influence or less control, what are the enabling factors, barriers and recommendations for actors in the Global Fund partnership for ensuring that grant implementation is supporting achievement of the Strategy and more effective national disease and wider health programs? • 21: To what extent does the Global Fund use opportunities for collaboration and synergies with other entities at global and country level?
6: STC	<ul style="list-style-type: none"> • SRQ16a(R): To what extent are Global Fund investments being designed and implemented most efficiently and synergistically alongside investments through other sectors or areas of health with complementary aims or investment pathways? How could this be strengthened? • SRQ16b(R): To what extent are human immunodeficiency virus (HIV), tuberculosis (TB), and malaria services being integrated in efficient, effective, equitable, and sustainably delivered packages of health services demonstrating a step-wise movement along a development continuum? • 17a(R): How has the co-financing policy been operationalized, and what have been the successes and challenges of implementation? • 17b(R): How effective has the Global Fund been in supporting the move toward increased domestic funding via the co-financing requirement or other efforts? What more can be done to support these efforts? • 17c(R): What evidence is there that the Global Fund has affected country-level decision-makers to ensure that Global Fund grants have not displaced domestic resources for health and what measures could the Global Fund take (either singularly or in collaboration with partners) to mitigate this risk? • 18a(R): What have been or will be the consequences for community-based organizations (CBOs)/civil society organizations (CSOs)/non-governmental organizations (NGOs) as Global Fund support has been or will be withdrawn? How can CSOs/CBOs/NGOs be strengthened to ensure that key and vulnerable populations (KVP) needs are met both currently and in the future? • 18b(R): What are the key barriers to programmatic sustainability and how can they be addressed? • 18c(R): What are, have been, and will be the implications of the Global Fund’s ability to manage risk as countries transition? • 18d(R): What are the additional lessons learned from the Sustainability, Transition, and Co-financing (STC) Policy and what are its implications for the future strategic direction of the Global Fund?
Main objective 3	
7: Recommendations and future positioning	<ul style="list-style-type: none"> • SRQ22: To what extent are the SOs, Global Fund policies and programs aligned with, supportive of and contribute to the Sustainable Development Goals (SDGs), UHC objectives as well as with new initiatives such as the global health security agenda and the AMR initiative? • SRQ23: What recommendations would strengthen the implementation of the current Strategy and deliver against its outcome and impact targets, including by actors in the Global Fund partnership and by relevant thematic areas (region, population etc.)? • SRQ24: What new and emerging themes or drivers impact the three diseases and in building resilient and sustainable health systems, and are critical to understand success and to inform the next Global Fund Strategy?

4 Limitations

In conducting this review, some limitations were encountered:

- The SR2020 team had completed much of its literature review and KIIs, and half of the country case studies by the time the Secretariat closed its doors to business in mid-March. After this point, the team understandably faced issues in accessing information and stakeholders for interviews (notably from the Supply Operations Department since March), conducting case studies, and with working arrangements of team members, which meant on-going team analysis was conducted virtually. Further, COVID-19 has added complexity to the environment in which the Global Fund operates and our assessment, creating additional workload for the team. While the team tried to mitigate the effects of this as much as possible, the TERG's deadlines have been fixed and the process for writing this report has been condensed.
- **The limited representativeness of countries analyzed has constrained the review's ability to draw conclusions on how findings may apply to other settings.** Given the highly variable contexts in which the Global Fund operates and the different nature of Global Fund support across countries there is no 'typical' country for case study. The sample of case studies agreed with the TERG was purposeful, representing a range of geographies and mix of experiences. To mitigate potential underrepresentation, we sought to expand the breadth of country experiences, where possible, by conducting focus group discussions with Health Product Managers (HPMs) (on market shaping and supply chain) and Fund Portfolio Managers (FPMs) (e.g. on sustainability and MEL issues), including data from TRP reviews across all countries and including data from other evaluations such as the PCE, OIG reports and other literature.
- **Availability of data on results.** SR2020 comes at the mid-point of the strategic period, but most grants and initiatives influenced by it started in 2018. Difficulties were encountered in obtaining information on the outputs, outcomes, and impacts of Global Fund investments for this strategic period (i.e. from 2017 onwards). This is related to both time lags for information on results but also due to a number of gaps in the information that is collected. Nevertheless, the team has done its best to assess and consider the appropriateness of the Global Fund's positioning and readiness to produce the desired outcomes.

In light of these issues and to ensure stakeholders are aware of the impact of these limitations on our findings, we have provided an indication of the strength of evidence on which the findings are based. Table 2 presents our approach to ranking the strength of evidence.

Table 2: Approach to ranking the strength of evidence

Ranking	Definition of strength of evidence
1	The finding is supported by multiple data sources (good triangulation), which are of strong quality.
2	The finding is supported through (moderate triangulation) by multiple data sources of lesser quality, or by fewer data sources of higher quality.
3	The finding is supported by few data sources (limited triangulation) of lesser quality.
4	The finding is supported by very limited evidence (single source) or by incomplete or unreliable evidence. In the context of this prospective evaluation, findings with this ranking may be preliminary or emerging, with active and ongoing data collection to follow up.

5 Theory of Change

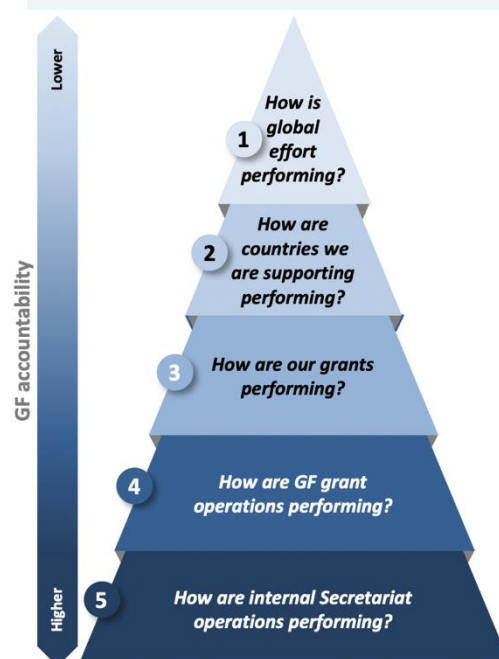
While the 2017–2022 Strategy refers to changes that the Global Fund Board would like to see, it does not articulate a clear ToC that links changes in the way the Global Fund works to accelerated program impact. The first task for the SR2020 team, therefore, was to devise a ToC retrospectively. The purpose of the ToC is to set out how changes in the way the Global Fund operates will deliver desired outcomes and to highlight the assumptions and risks that underlie the causal pathway. As such, the SR2020 ToC was developed from a review of Global Fund and other documentation, and in consultation with key Secretariat staff, to make explicit the key linkages that underpin the business model and Strategy.

Figure 2 shows a diagrammatic representation of the ToC, as understood by the SR2020 team having discussed with various members of the TERG and Secretariat. The ToC is underpinned by a series of underlying assumptions (provided in Annex 5). In line with best practice for evaluations dealing with highly complex contexts, we structured these assumptions around a Context-Mechanism-Outcome framework which helped the team unpack causality in the Global Fund Strategy and operations in more detail, and guide data collection. A comprehensive description of the methodology and approach is presented in the agreed Inception Report submitted in 2020.

The team mapped the seven analytical modules (and SRQs) to the ToC and in doing so set out how the different aspects of the business model relate to each other and lead to the achievement of outcomes.

The team also mapped different steps along the ‘Conifer of Control’ (a Secretariat construct designed to reflect the Global Fund’s level of control over different processes and the achievement of results along the causal pathway—see **Error! Reference source not found.**) to the ToC which was a helpful tool to enable alignment to the Secretariat’s thinking.

Figure 1: Global Fund Conifer of Control



Box 1: Overarching theory of how the Global Fund works to accelerate program impact

The overarching theory starts with the way in which: (a) countries apply for, access, receive and implement grant resources—i.e. the funding model; (b) the STC Policy procedures and practices support countries to strengthen financial and programmatic sustainability; and (c) the Global Fund monitors, oversees and assures grant implementation. These are mechanisms which relate directly to Modules 3, and 4 for of the review’s analysis, respectively, for which the Global Fund has a high degree of control over what happens—as such, we consider that these correspond to level 5 of the Conifer of Control.

The ToC articulates the important role of partners which act as a mechanism to support countries in translating the Global Fund’s systems, policies, processes and priorities into grant design and implementation decision-making, as well as supporting a range of other functions (e.g. related to M&E, oversight and assurance). This relates to Module 5 of the review’s analysis, for which the Global Fund has a moderate degree of control over what happens—this corresponds to level 3 of the Conifer of Control.

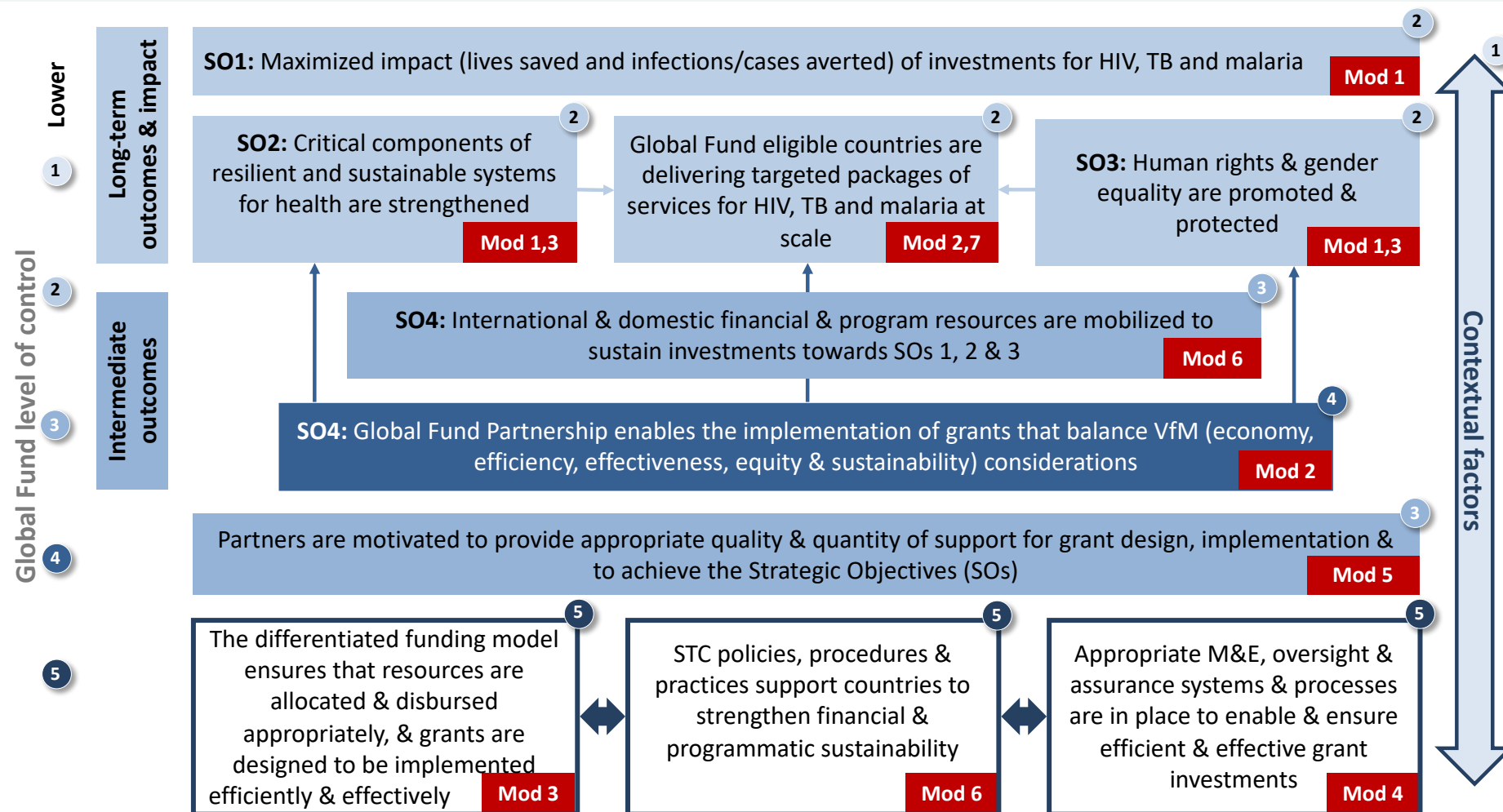
The Global Fund’s systems, policies, processes and priorities, and the role of partners in translating these to the country level, lead to two intermediate outcomes, both of which relate to the achievement of Strategic Objective 4, related to the extent to which:

- *The Global Fund Partnership enables the implementation of grants that balance efficiency, effectiveness, equity and sustainability considerations:* This relates to Module 2, for which the Global Fund has a reasonably strong degree of control over what happens—as such, this corresponds to level 4 of the Conifer of Control.
- *International and domestic financial and program resources are mobilized to sustain investments towards Strategic Objectives 1, 2 and 3:* This partly relates to an intended outcome of the STC Policy and Module 6 for our analysis, for which the Global Fund has a moderate degree of control over what happens—as such, this corresponds to level 3 of the Conifer of Control.

These intermediate outcomes (as influenced by Global Fund systems, policies, processes and priorities, and the role of partners) lead to the achievement of longer-term outcomes and impact (i.e. the SOs) over which the Global Fund has relatively little control. This is in part due to the presence of contextual factors. As such, we consider that this condition corresponds to level 2 of the Conifer of Control.

Contextual factors are also considered and are important to the achievement of Strategic Objectives, but over which the Global Fund has very little/no control, corresponding to level 1 on the Conifer of Control. For simplicity, these factors are not detailed in the ToC diagram but are detailed in the Context-Mechanism-Outcome tables provided in Annex 5.

Figure 2: SR2020 team interpretation of the Global Fund's 2017–2022 theory of change

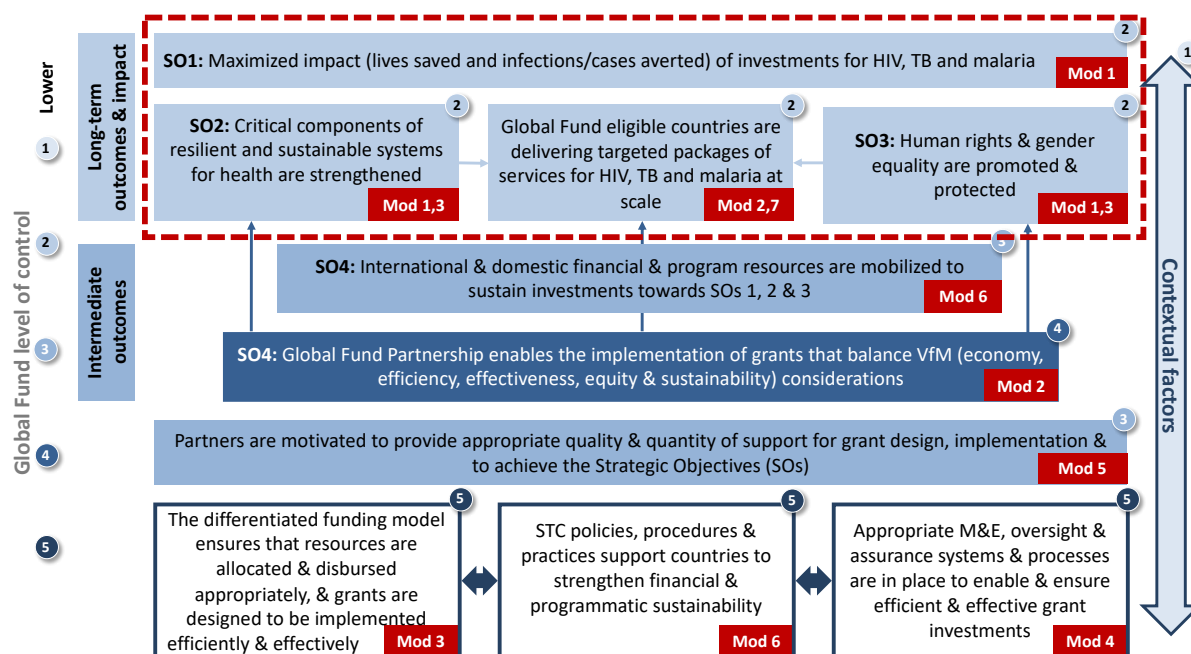


6 Findings

6.1 Main objective 1: Outcomes and impact of Global Fund investments

This section is concerned with assessing progress towards SO1 (maximize disease impact); SO2 (build resilient and sustainable systems for health (RSSH)); and SO3 (promote and protect human rights and gender equality). As illustrated by the red dotted line in Figure 3, this is concerned with the upper portion of the ToC.

Figure 3: Illustration of where outcomes and impact ‘sit’ in the SR2020 ToC



This section includes our response to a number of SRQs, with some issues covered under multiple sub-sections, as set out in Table 3.

Table 3: Response to SRQs by section

SRQ	Section with response included
1, 2, 3, 12	Section 6.1.1: Progress to SO1
1, 2, 3, 12, 17b	Section 6.1.2: Progress to SO2
1, 2, 3, 12	Section 6.1.3: Progress to SO3

This section also presents evidence on outcomes in relation to a number of SRQs (i.e. 6, 12, 14, 15, 16, 17 and 18) that are related to the business model and explored in more depth in section 6.2.

Table 4 presents a summary of the review’s high-level findings for SO 1, 2, and 3

Table 4: Main Objective 1 high-level findings

High-level findings	Strength of evidence
<p>SO1: Good progress has been made towards SO1 in terms of scaling-up a number of key interventions across diseases which has contributed to substantial reductions in mortality. However, significant gaps remain in scaling up prevention interventions to achieve targets for reducing new cases of HIV, TB and malaria. Progress is however highly variable by geography and population group. The review's analysis highlights three strategic considerations for the Global Fund as it looks forward:</p> <ul style="list-style-type: none"> • Significant scale up of service coverage is needed to meet most country-level and Global Fund Strategy targets by 2022. Making these gains will be hampered by COVID-19. • Even if current Global Fund Strategic targets are met, progress will need to significantly accelerate from 2023 onwards in order to meet the 2030 Sustainable Development Goal (SDG) to end the HIV, TB and malaria epidemics by 2030. • Significantly more funding will be required to meet 2030 elimination goals. <p>Multiple factors hinder progress against SO1, including limited investment in prevention activities and KVPs, health system weaknesses, human rights and gender (HRG) specific vulnerabilities and barriers to services, and resourcing issues. These are issues that should in theory be addressed to the extent feasible through support under other SOs.</p>	<p>Evidence is strong, comprising multiple data sources, thereby allowing for full triangulation.</p>
<p>SO2 and broader sustainability considerations: Good progress is being made across countries within the Global Fund portfolio towards financial sustainability, but progress towards programmatic sustainability is slower and more mixed.</p> <p>The Global Fund invests in RSSH to ensure sustainable, equitable and effective delivery of three disease and wider health services, thereby contributing to universal health coverage (UHC) and programmatic sustainability. There have been some gains in some areas, notably for data systems and PSM, which account for the majority of RSSH investments. However, overall, the review's analysis suggests that while investments in RSSH have increased dramatically over time, these mostly support operational costs for the three disease programs rather than strengthening and supporting the sustainability of health systems more broadly. As such, the Global Fund's investments in RSSH can only be expected to be making a marginal contribution to the objectives of building RSSH to enable progress towards UHC and build towards programmatic sustainability.</p>	<p>Findings supported by multiple data sources of reasonable quality.</p>
<p>SO3 and broader equity considerations: The review highlights uneven progress in addressing equity issues across the portfolio, driven by social, economic, demographic and geographic differences, which often do not receive sufficient attention in grant and program design. These issues are, however, difficult to address and require engagement in issues further up the Conifer of Control.</p> <p>There have nonetheless been notable gains in scaling up service coverage, including for those who face discrimination and/or other structural barriers, in part facilitated by Global Fund support for technology and service innovations and targeted interventions to KVPs. There are, however, still wide variations between and within countries.</p> <p>Progress against gender objectives has been muted. Despite progress in a number of areas (e.g. to scale up funding and implementation of activities to address gender-based violence (GBV) among adolescent girls and young women (AGYW)), there is weak progress in other areas (e.g. preventive malaria strategies) and Funding Requests often remain gender blind leaving critical issues unaddressed.</p> <p>Investments in human rights have increased significantly in a sub-set of countries, particularly where specific additional financial and technical support has been provided, with some emerging evidence of positive results being achieved. This points to the merits of employing targeted approaches in this area. However, there is little evidence of similar gains being made across the wider portfolio.</p>	<p>Findings supported by multiple data sources of reasonable quality.</p>

6.1.1 Progress towards SO1

Analysis conducted as part of this review corroborates the Secretariat’s high-level reporting of progress towards SO1 – i.e. that good progress has been made towards the strategic target for lives saved, but much more limited progress has been made in reducing new infections, while progress towards service coverage targets is mixed. However, the design of some Key Performance Indicators (KPIs) may obscure actual progress and likelihood to achieve the Strategy targets. To assess progress toward SO1, a detailed review of the methodology used by the Secretariat was conducted to calculate and report on progress toward KPIs 1 and 2. Data was triangulated to compare progress toward ‘global plan’ targets (i.e. Fast-Track Strategy to end the AIDS epidemic by 2030, WHO End TB Strategy, and WHO Global Technical Strategy for Malaria (2016–2030))⁴; progress toward Global Fund targets using both ‘optimistic projections’ (assumes achievement of country-level targets) and ‘conservative projections’ (assumes that recent progress will continue through to the last year where each country specific target is agreed, usually 2020); and regression analysis to project current trends through to 2022. The analysis is presented in Annex 4.i.

At the level of impact (i.e. mortality and incidence), the analysis suggests that much greater progress is being made in some countries than others, and more in HIV than for TB and malaria – see below. These nuances are not captured by the reporting of progress on the KPI 1 target but are included in the Secretariat’s recent reporting of disaggregated progress.

For service coverage, the analysis suggests that the optimistic projections of progress towards KPI 2 presented by the Secretariat are often too optimistic⁵, while the conservative projections are more realistic (although can be too conservative in some instances)⁶. Where conservative projections are not provided (i.e. for those indicators with non-modelled targets), there is a risk that progress towards these targets is being overstated⁷. The Secretariat’s reporting is usefully disaggregated in recent reports to illustrate variation in progress by country for each indicator. Interpreting this progress across the portfolio and different projections for decision making, as required from the Board, requires a sophisticated knowledge of the KPI design and reporting methods.

Comparing across these data points highlights three themes which are important to consider when interpreting results and their implications for the next strategic period:

- Significant scale up of service coverage is needed to meet most country-level and Global Fund Strategy targets by 2022. Making these gains will be hampered by COVID-19.
- Even if current Global Fund Strategic targets are met, progress will need to significantly accelerate from 2023 onwards in order to meet the 2030 Sustainable Development Goal (SDG) to end the HIV, TB and malaria epidemics by 2030.
- Significantly more funding will be required to meet 2030 elimination goals.⁸

Much progress has been made in reducing mortality associated with the three diseases; however, progress has been slower for TB and malaria. The Global Fund Strategy aims to save 29 million lives across the three diseases between 2017 and 2022. The Secretariat reports that it is ‘on track’ to do so with an estimated 5.1 million lives saved in 2017 and 4.8 million in 2018. However, this masks some nuances and diverging performance between diseases:

- **HIV:** Globally, AIDS-related deaths have declined 39% since 2010 (1,000,000 in 2010, 830,000 in 2015 and 690,000 in 2019) which is close to the global plan target of 500,000 HIV-related deaths per year by 2020. Estimates suggest that AIDS-related deaths declined 17.0% between 2015 and 2019 in Global Fund portfolio countries. If this trend continues, we would anticipate a decline of 29.8% by 2022.
- **TB:** Globally, deaths from TB declined by 13% between 2010 and 2015 and by 11.7% between 2015 and 2018. This is far short of the global plan target of 35% by 2020. Estimates suggest that deaths from TB declined 2.9% between 2015 and 2018 in Global Fund portfolio countries. If this trend continues, we would anticipate a modest decline of 6.7% by 2022.
- **Malaria:** Globally, deaths from malaria declined by 21% between 2010 and 2015, and 9% between 2015 and 2018. This is well below the global plan target of a 40% reduction in

deaths between 2015 and 2020. Estimates suggest that deaths from malaria declined by 9.2% between 2015 and 2018 in Global Fund portfolio countries. If this trend continues, we would anticipate a decline of 21.4% by 2022.

There has been significantly less progress in reducing new infections/cases across all three diseases, with evidence of progress slowing. The Secretariat estimates that new infections/cases of HIV, TB and malaria have declined by 7% between 2015 and 2018 and projects a 16% decline in new infections/cases if current progress continues. The Secretariat rates this progress as ‘at risk’ to meet the Global Fund Strategy targets, although the low projection for new cases falls below the range for the Strategy target.⁹ Again, progress varies by disease:

- **HIV:** Globally, new infections declined 9.5% between 2010 and 2015 (from 2,100,000 to 1,900,000) and 10.5% between 2015 and 2019 (from 1,900,000 to 1,700,000). This progress is well below the global plan target of 500,000 new infections per year by 2020. Estimates suggest that new HIV cases declined 13.7% between 2015 and 2019 in Global Fund portfolio countries.¹⁰ If this trend continues, we would anticipate a 24.0% decline in new HIV cases in Global Fund portfolio countries between 2015 and 2022.
- **TB:** Globally, new TB cases increased 18.2% between 2010 and 2015 and declined by 6.3% between 2015 and 2018. This progress is far short of the global plan target of a 20% reduction by 2020. Estimates suggest that new TB cases declined 11.2% between 2015 and 2018 in Global Fund portfolio countries. If this trend continues, we would anticipate a 26.2% decline in new TB cases in Global Fund portfolio countries between 2015 and 2022.
- **Malaria:** Globally, malaria cases declined by 13% between 2010 and 2015 but increased by 4% between 2015 and 2018. Progress is, however, going well in elimination settings.¹¹ Estimates suggest that malaria cases increased by 4.4% between 2015 and 2018 in countries it supports. If this trend continues, we would anticipate a 10.2% increase in malaria cases between 2015 and 2022.

If countries meet their targets for scale up of service coverage (optimistic projection), then almost all Global Fund targets for KPI 2 will be met. However, actual progress in scaling up service coverage (used for the conservative projection) is slower than required to meet current Global Fund Strategy targets for many indicators, and significantly below the SDG target to end the epidemics by 2030. Of note, the Global Fund has not created conservative projections for non-modeled indicators under KPI 2. A summary by disease is presented below, with more detail (including our analysis of non-modeled indicators) provided in Annex 4.i.

For HIV, if all countries meet their grant targets, almost all Global Fund Strategy service coverage targets will be met or within reach. In contrast, using the conservative projection based on current progress, the Secretariat rate many as ‘at risk’.¹² Through the optimistic projection as of the end of 2018, Global Fund Strategy targets for the proportion of PLHIV who know their status, the number and proportion of PLHIV who are on ART, number of voluntary medical male circumcisions, percent of pregnant women on ART and percent of patients on ART retained in HIV care at 12 months will be met or within reach (within the uncertainty range). Only percent of new HIV-positive patients on IPT is rated as ‘off-track’. In contrast, if all countries continue recent progress toward achievement of modeled country targets (i.e. conservative projection), only the target for number of voluntary medical male circumcisions (a particular focus area of the Gates Foundation and PEPFAR, which is the predominant funder) will be met. However, our regression analysis suggests these projections may be overly conservative and that most targets would be met or within reach (except percent of patients retained in HIV care at 12 months and percent of new HIV patients on IPT).¹³

For TB, if all countries meet their grant targets (optimistic projection), then all Global Fund Strategy service coverage targets will be met or within reach. However, based on current trends (conservative projection), only targets for TB case notification and TB treatment coverage will be met. Through the optimistic projection, Strategy targets for number of TB cases notified, TB treatment coverage, treatment success rate, number of MDR/RR-TB cases notified, MDR/RR

treatment success rate and percent of HIV/TB patients on ART will be met or within reach. However, using the conservative projection, only the modeled targets for number of TB cases notified and TB treatment coverage will be met. The target for the number of MDR/RR cases notified is rated as 'off track'. Our regression analysis reaches similar results as the conservative projection.

For malaria, if all countries meet their grant targets (optimistic projection), then most Global Fund Strategy service coverage targets will be met. However, based on current trends (conservative projection) targets for both LLIN distribution and IRS households reach will be 'at risk'. Through the optimistic projection, Strategy targets for number of LLINs distributed, number of IRS households and percent of febrile children under five (5) tested for malaria will be met. Only the target for percent of pregnant women who receive three doses of IPT will not be met. In contrast, using the conservative projection the targets for number of LLINs distributed and number of IRS households will not be met, but will be within reach. Our regression analysis reaches similar results to the conservative projection for number of LLINs distributed and number of IRS households reached, although our analysis suggests that these targets may not be met. However, campaigns for both LLIN distribution and IRS are cyclical and many countries have planned these campaigns for later in the grant cycle. This could explain the difference in our observed results.

Progress against impact and service coverage targets varies widely by geography and population group. Our detailed analysis is presented in Annex 4.i, summary observations are as follows:

HIV

- **Region:** Progress toward HIV targets has been stronger in regions with greater total resources, more generalized epidemics (e.g. in East and Southern Africa (ESA) as compared to West and Central Africa (WCA) and other regions). The Eastern Europe and Central Asia (EECA)¹⁴, Middle East and North Africa (MENA) and Latin America and Caribbean (LAC) regions continue to experience increases in HIV-related deaths and new HIV cases.
- **Population group:**
 - **Children:** Substantial progress has been made in reducing deaths and new cases, particularly in the ESA region, however, children still lag behind in access to ART.
 - **AGYW:** Significant progress has been made globally in preventing HIV transmission to AGYW and in engaging HIV-infected AGYW in testing, care and treatment.
 - **Men:** 90-90-90 targets look less likely to be achieved for men, although this varies by region.
 - **KVPs:** More than half (62%) of new infections are among KVPs (MSM, PWID, prisoners, sex workers and transgender people) and their sexual partners. While knowledge of HIV status and treatment coverage has increased the coverage of prevention programs ranges widely (from 26% to 77%) across regions and KVP group. Treatment coverage also ranges from 53% among transgender persons to 75% among MSM.

TB

- **Region:** Incidence, mortality and progress vary dramatically across countries. The EECA region and all countries in Africa have experienced declines in deaths that are on track to approach or meet 2030 elimination targets. In all other areas/regions there has been less progress in reducing deaths from TB and new TB cases, which are not on track to meet 2030 elimination targets. In Global Fund portfolio countries, average treatment coverage is highest (at least 75%) in Latin American countries (LAC) and MENA, and lowest in WCA.
- **Population group:**
 - **Men** are over-represented in number of new cases, but do not differ from women in their probability of diagnosis/treatment or mortality from TB.
 - **Children** are not over-represented in number of new cases, but are less likely than adults to be diagnosed/treated and more likely to die from TB.

- **KVPs:** Structural barriers affect service access of vulnerable populations (i.e. migrant populations, miners and prisoners). However, there is very limited data to monitor service coverage and burden of disease in these populations.

Malaria

- **Region:** In WHO-defined high impact countries, there was a 12% decline in cases between 2010 and 2018, over half of which were in the Democratic Republic of Congo (DRC) and Nigeria. In Global Fund portfolio countries, between 2015 and 2017, malaria cases increased substantially in LAC (9%), slightly in ESA (0.2%) and declined in WCA, MENA and Asia in Global Fund portfolio countries; While deaths increased in LAC but decreased in all other regions (Asia = -18.0%; WCA = -13.6%; ESA = -6.8% and MENA = 6.7%). In Nigeria, despite low IPTp, SMC and pediatric treatment coverage, as well as low ITN utilization and increased numbers of cases in 2018, mortality has fallen dramatically (from almost 153,000 deaths in 2010 to about 95,000 deaths in 2018). In elimination settings, seven additional countries reported no indigenous cases of malaria since 2015 – this is ‘on track’ to meet the Global Technical Strategy target of ten additional countries by 2020.
- **Population group:**
 - **Pregnant women:** In sub-Saharan African countries with moderate to high malaria transmission, prevalence of exposure to malaria infection during pregnancy was estimated as 29% in 2018. However, ITN utilization varies widely by country – while over 75% of pregnant women slept under ITNs in Mali, Benin and Mozambique, this was below 50% in many countries and lowest in Angola (23%) and Zimbabwe (6%). IPTp3 coverage increased from 2% in 2010 to 31% in 2018, with variations across countries.
 - **Children under five:** This is the most vulnerable group affected by malaria. From 2000 to 2017, malaria mortality in children under five decreased significantly, although still accounted for 67% of all malaria deaths worldwide in 2018. ITN coverage has increased significantly, although one in four children in sub-Saharan Africa still live in a household without any protection from an ITN or IRS.¹⁵

Barriers to progress against Strategic Objective 1

The review identified enablers, challenges and approaches which factor into the disease responses across the Global Fund portfolio. The factors were categorized and mapped according to those which are: (a) epidemiological and programmatic—categorized by prevention, diagnosis and treatment; and (b) cross-cutting factors, including those related to health systems, resourcing levels as well as structural barriers (socio-cultural, environment and political factors). Figure 4 presents the factors and the extent to which they enable or hinder progress against SO1, and are feasible for the Global Fund business model to address or influence.¹⁶

Factors over which the Global Fund has lower ability to leverage include:

- the need for new tools (requiring R&D investment) is limiting progress
- structural barriers requiring socio-cultural influence or cross-sector working
- co-morbidities influencing disease outcomes (e.g. diabetes, smoking as risk factors for TB)
- program areas over which the Global Fund has no influence (e.g. climate change, biological threats or conflict).

Achieving gains in the areas within the lower left-hand quadrant (i.e. higher up the Conifer of Control) requires reliance on partners or possibly adaptations to the Global Fund business model or ways of working. Factors in the lower right-hand quadrant are those more amenable to Global Fund influence (i.e. further down the Conifer of Control) and where the Global Fund has already stepped up efforts but further and continuing effort is required.

Overall, the figure captures the point that the Global Fund has been relatively more successful in enabling results within areas amenable to its control or influence, while showing that many

fundamentally important factors that hamper progress against SO1 (and others) are not as easily influenced.

Enabling factors that have supported progress across the three diseases include:

- access to more effective drugs
- increased testing capacity; improved surveillance
- better data and reporting, resulting in appropriate stratification informing the response strategy
- increased or sustained coverage with some prevention interventions
- increased use of differentiated and more effective testing and service delivery approaches
- effective use of community systems and responses in some settings
- political will, country leadership, and sustained domestic and international funding

Multiple factors hinder progress in the three diseases including:

- **In HIV**, primarily weak prioritization of disproportionately affected KVPs resulting in low coverage of HIV prevention and testing services; lack of KVP size estimates and tailored responses; variable adherence; continuing low viral load testing coverage despite large investments; PMTCT cascade weaknesses; limited access of children to EID, ART (and sub-optimal formulations); and, less funding allocated to prevention.
- **In TB**, the main issues are the lack of diagnostic access and effective case finding interventions to find missing cases; relatively constrained budgets; slow up-take of new regimens and limited drug susceptibility testing access hampering MDR treatment adherence and success rates; low preventive therapy coverage; sub-optimal engagement of private sector and primary health care service providers in TB; continuing low access to bacteriological diagnosis despite large investment; continuing need for better treatment and diagnostic tools.
- **In malaria**, challenges are variable coverage and use of vector control; need for improved data to enable stratification; resource limitations; need for new malaria control tools; low coverage of IPTp3; over-treatment with ACTs; limited uptake of tools for severe malaria management; limited tools to manage biological threats; substandard and falsified products.

Finally, there are cross-cutting enabling and hindering factors which are more or less common to all three diseases, a key enabling factor being government and partner commitment and sustained funding to the disease response. Cross-cutting hindering factors are numerous. Annex 4.i provides the full details of these factors as well as case study material and supporting evidence.



6.1.2 Progress towards SO2 and broader sustainability goals

Good progress is being made across countries within the Global Fund portfolio towards financial sustainability, but progress towards programmatic sustainability is slower and more mixed.

Between 2002 and 2017 domestic health expenditures increased more than fivefold, which appears to be driven mostly by growth in GDP rather than significant reprioritization of health versus other sectors. This trend has been observed even in severely resource-constrained environments, and irrespective of where countries sit along the development continuum. Domestic investments in the three diseases have also increased over the same period, driven mostly by TB and HIV, with modest increases in funding for malaria. Analysis conducted as part of the STC Thematic Review and supported by evidence from this review suggest that there is limited fiscal space in many countries to increase domestic funding further, with many stakeholders noting daunting fiscal and economic challenges and ongoing funding gaps for the disease responses.¹⁷ The implications of COVID-19 on financial sustainability and future domestic funding for health and the three diseases are as yet unclear, but emerging evidence suggests that gains made against the three diseases over the past 10-15 years risk being reversed as a result of the economic, long-term effects of the pandemic.

The limited available evidence on progress being made towards UHC (which can be considered loosely as a proxy for sustainability) suggests that this is also driven by GDP growth, but also, critically, the way that health spending is channeled – i.e. progress made where funds are channeled through social health insurance and government schemes but not non-profit and private insurance schemes.¹⁸ Analysis of the World Bank UHC index, as of 2017, shows that Global Fund ‘core’ countries typically have the lowest UHC score and ‘focused’ countries have the highest score, although ‘high impact’ countries made the most progress towards UHC between 2015 and 2017.

As highlighted in Section 6.2.6, the use of Global Fund resources to ensure sustainability of health programs and services remains a challenge. This is despite the issue having been reviewed several times previously, and agreement by the Secretariat, TERG, TRP and OIG to implement a series of ‘joint’ recommendations to address sustainability and other key related challenges.^{19,20} However, as correctly noted by the Global Fund Secretariat, many sustainability and transition challenges depend fundamentally on issues far up the Conifer of Control – i.e. political will and policy decisions at the national and subnational level – over which the Global Fund has limited ability to influence. Nonetheless, to make progress, this review highlights the continued importance of strengthening RSSH, focusing on the capacity of government institutions/agencies, cross-programmatic efficiencies and the appropriate integration of health systems and equitable service delivery (at the primary health care level or otherwise) and addressing a lack of government ownership, accountability, and support for KVP programming. The review also highlights the growing significance of decentralization/devolution of government responsibilities and accountability for delivering health programming which can have implications for sustainability.

The Global Fund invests in RSSH to ensure sustainable, equitable and effective delivery of three disease and wider health services, thereby contributing to UHC. The Global Fund invests around USD 0.5 billion per year in RSSH (see Annex 4.xii) and is the largest multilateral provider of grants to health systems strengthening.^{21,22} While this represents a significant proportion of the Global Fund’s overall portfolio, this is a tiny fraction of the estimated USD 371 billion needed annually from now until 2030 in order to strengthen health systems to achieve UHC.²³ Progress in this area should be considered in this context.

While investments in RSSH have increased dramatically over time, these mostly support operational costs for the three disease programs rather than strengthening health systems more broadly or contributing to systems sustainability, irrespective of where countries sit along the development continuum. On average, 15% of grant funding is budgeted for RSSH.²⁴ This is split across RSSH components,²⁵ which appears to depend on where countries sit along the development

continuum and what is being supported by other development partners (which is not always clear in Funding Requests), but with no clear patterns observed across countries.

Granular analysis of the RSSH budgets for country case studies, which builds on the TRP's analysis of RSSH investments in the 2017–2019 funding cycle using the 4S framework, shows that around 65% of RSSH investments are used for health systems *support*—i.e. payment for recurrent costs of the Ministry of Health (MoH)/Principal Recipients (PRs)/disease programs (salaries, support supervision, meetings, travel, TA from technical partners)—while the remainder is designed to *strengthen* health systems, ensuring that the country achieves more equitable and sustained improvements across health services and health outcomes.^{26,27,28} We note that if we were to include the Secretariat's determination of 'contributory' RSSH investments, around 90% of RSSH investments should be considered as health systems support. Emerging evidence from the 2020–22 Wave 1 Funding Requests suggests that these patterns are consistent across funding cycles, with little evidence of investments being used to build upon those from the previous grant cycle. Further, analysis suggests that RSSH investments are still used for systems support activities even in countries relatively far along the development continuum, such as in the Dominican Republic, an upper-middle-income country which would be expected to be preparing for transition. As such, this suggests that there is little differentiation of RSSH support based on where countries sit along the development continuum. Annex 4.xii provides more detail.

Evidence from interviews with global health leaders suggests that many supporters of the RSSH agenda are critical of the current situation. However, all acknowledge that the Global Fund's role in RSSH is, and has always been, a divisive issue. More specifically, it is seen as a prerequisite for long-term success and sustainability by some and as a distraction from the Global Fund's core mission by others. Moving forwards, the only real point of consensus suggested by the interviews is that there is a need for greater clarity as to what the Global Fund does and how decisions on RSSH funding are reached.

Despite limited funding for health systems strengthening compared to global need, some gains have been made. The evidence base on the outcomes and impact of Global Fund RSSH investments is weak, in part due to a lack of data generated by the MEL system. Below is a high-level assessment of progress against each of the seven Operational Recommendations of the 2017-2022 Strategy, based on available data:

- *Strengthen community responses and systems (10% of total budgeted NFM2 RSSH investments):* Despite the critical role communities play in delivering health services, recognized in the Strategy and which often feature prominently in NSPs, this area has received limited attention. Funding appears to have been used mostly to establish community health worker schemes rather than looking at a more comprehensive community systems approach (e.g. using community mechanisms and structures to mobilize, advocate, support and monitor key and affected populations). As such, we consider that the achievement of outcomes and impact in this area is likely to have been minimal.
- *Support reproductive, women's, children's and adolescent health, and platforms for ISD (12% of total budgeted NFM2 RSSH investments):* ISD and quality improvement includes both integration of health systems and program services. In terms of integrating health systems functions, there is very little quantitative evidence to suggest that progress is being made. However, anecdotal accounts speak of progress through RMNCAH clinics, iCCM and the AGYW initiatives despite the limitations of highly verticalized systems and processes (e.g. for MEL, laboratory systems, community systems and PSM). The Secretariat has however made significant progress in articulating how the Global Fund can make a more meaningful contribution to this objective through the RSSH Roadmap. There is evidence to suggest that progress is being made to enhance program service integration in some areas, particularly for HIV and TB program services.²⁹ (see Annex 4.xiii for more detail).

- *Strengthen global and in-country PSM systems (20% of total budgeted NFM2 RSSH investments):* This area receives particular attention by the Secretariat, partners (including through substantial TA funds managed by the Supply Chain Department and Strategic Initiatives (SIs)) and country stakeholders, which has supported the expansion of medicines and commodity distribution systems to 'last mile' facilities. This progress is reflected through KPI 6b which shows strong performance against targets to ensure uninterrupted availability of essential health products at service delivery points. However, this remains an area that is continually plagued with challenges – mostly high up the Conifer of Control – which threaten the value and health impact of Global Fund investments in health technologies.³⁰
- *Leverage critical investments in human resources for health (14% of total budgeted NFM2 RSSH investments):* HRH resources have been used to provide additional workforce to support the implementation of disease programs (and in some cases manage Global Fund grants and report on progress) both at national, local and community levels, primarily through salary support. This support is often important to the ongoing management and implementation of services. However, evidence suggests that these posts are often disease-specific, rather than being integrated into broader services delivery. In addition, plans for supervision and the future funding of these positions is not well specified in NSPs or Funding Requests which ultimately inhibits accountability as well as long-term sustainability.
- *Strengthen data systems for health and countries' capacities for analysis and use (40% of total budgeted NFM2 RSSH investments):* In line with the funding prioritization of this area and the significant attention it receives from other partners, there have been substantial improvements in the quality and availability of data. Particular gains have been made to expand DHIS2 as an interoperable information system platform for the integration of different disease information systems. This progress is reflected through KPI 6e which shows that more countries are reporting disaggregated data for relevant indicators by age and gender; and KPI 6d which shows a significant increase in the number of High Impact and Core countries with fully deployed and functional HMIS³¹; and progress made across all countries in the KPI cohort. However, as above, there is also evidence that more could be done in this area, both to improve the quality and utilization of routine data. This progress is hampered by a number of factors, including electricity and internet connections, and human resource capacity which affect COE countries in particular.
- *Strengthen and align to robust national health strategies and national disease-specific strategic plans (1% of total budgeted NFM2 RSSH investments):* Funding, much of which comes through bilateral set asides, has been used to support the development of NSPs and engage in program formulation and monitoring through CCMs, as well as Global Fund governance support. KPI 6f reports strong alignment of Funding Requests to NSPs although findings from this review reflect the continued need to strengthen and improve NSP quality.
- *Strengthen financial management and oversight (2% of total budgeted NFM2 RSSH investments):* Weak financial systems for budgeting, accounting, auditing, contracting, and oversight continue to hinder the effective and efficient implementation of Global Fund supported programs. Analysis suggests that most of the funding is allocated to ensure accountability of Global Fund grant resources rather than supporting the broader financial systems. This may be partly explained by the fact that responsibility for financial management rests with the Ministry of Finance or Auditor General who typically do not have strong relationships with stakeholders engaged in Global Fund processes and grants. The related KPI 6c does not helpfully show progress in this area across the portfolio but does show that a small number of high priority countries (5 in 2019) completed public financial management transition efforts and demonstrated improved financial management capacity.

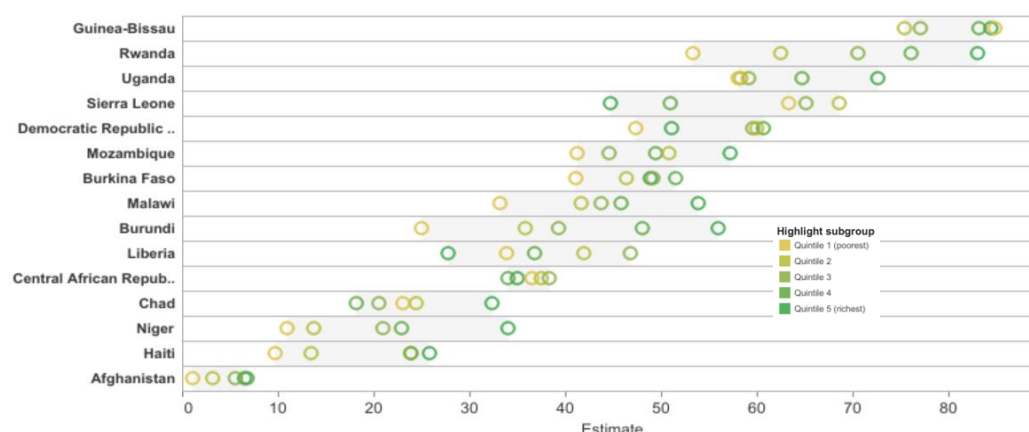
Annex 4.ii provides more detail.

6.1.3 Progress toward SO3 and broader equity goals

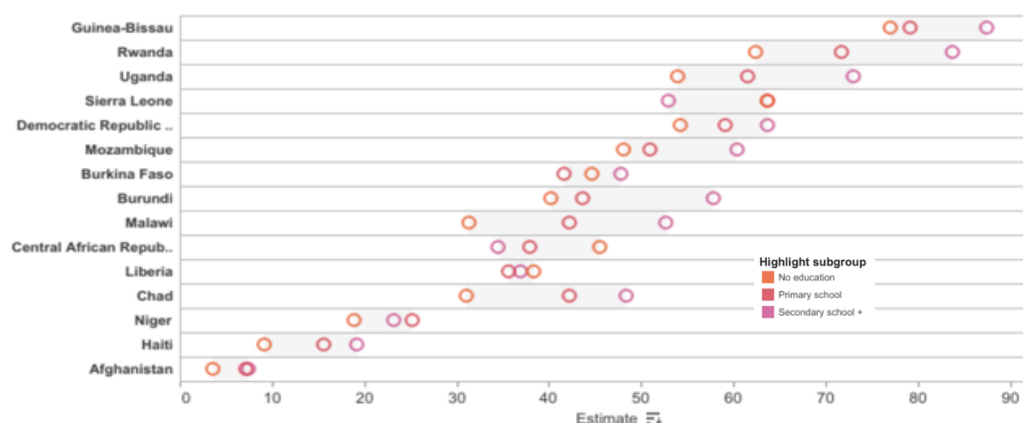
Equity is central to the Global Fund’s Strategy and critical to achieving disease goals. The VFM Technical Guidance defines equity as ‘to ensure everyone has a fair opportunity to attain the full potential for health and well-being, with no person disadvantaged due to social, economic, demographic or geographic differences.’³² Equity is a core dimension of the Global Fund's VFM framework, and promoting gender equality and human rights (SO3) is one crucial way to address inequities. The Community Rights and Gender (CRG) Department works to mainstream equity into the Global Fund’s work, including to close gaps in gender equity, remove human rights-related barriers to services especially for key and vulnerable populations, and strengthen community monitoring, among others.³³

The review highlights uneven progress in addressing equity issues across the Global Fund portfolio, including by geography, disease and KVP group. Most recent data from the WHO Global Health Observatory Health Equity Monitor shows that substantial inequalities exist in access to health services and health outcomes across and within countries. These inequalities are driven by economic status, age, sex, level of education, geographic place of residence, as well as context-specific dimensions, such as ethnicity, disability and migratory status.³⁴ These factors also have a substantial bearing on access to and/or utilization of services for the three diseases. Figure 5 presents the proportion of pregnant women in low income countries sleeping under an insecticide-treated net by (a) wealth quintile; (b) level of education; and (c) place of residence.

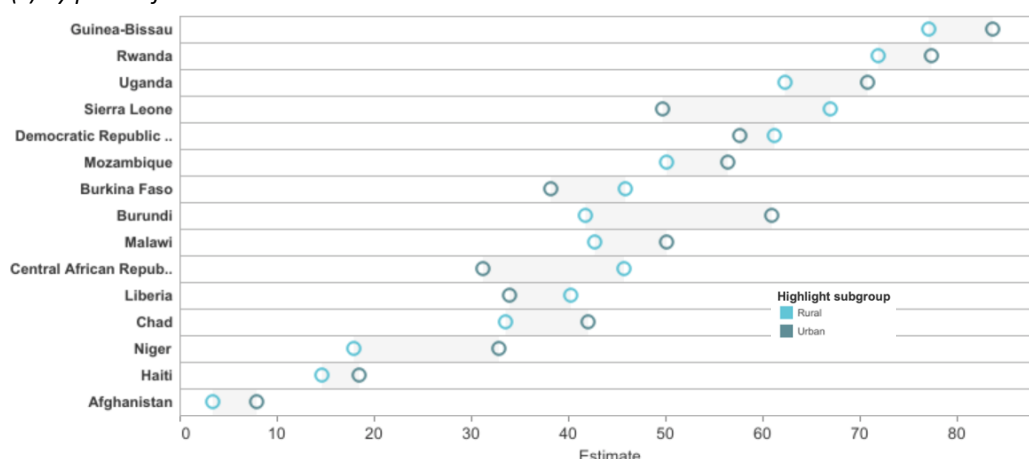
Figure 5: Estimated proportion of pregnant women sleeping under an ITN in low income countries
(a) by wealth quintile



(b) by level of education



(c) by place of residence



As noted in section 6.1.1, at the global level, substantial inequalities remain between population groups for all three diseases. For HIV, AGYW account for one in four new HIV infections in sub-Saharan Africa, and the target for KPI 8 to reduce HIV incidence among this group by 58% between 2015 and 2022 is 'at risk', with only a 20% reduction as of mid-2019. Also for HIV, KVPs (MSM, PWID, prisoners, sex workers, and transgender people) and their sexual partners account for 62% of new adult HIV infections globally; the level of TB among some KVPs, such as prisoners, is up to 100 times higher than that of general population,³⁵ while malaria disproportionately impacts pregnant women and children under five, with up to 10% of maternal deaths caused by malaria in sub-Saharan Africa.³⁶ In-depth analysis at the country level conducted through the PCE highlights the substantial inequalities in access and utilization of services for the three diseases that exist in many countries, as illustrated in Box 2.

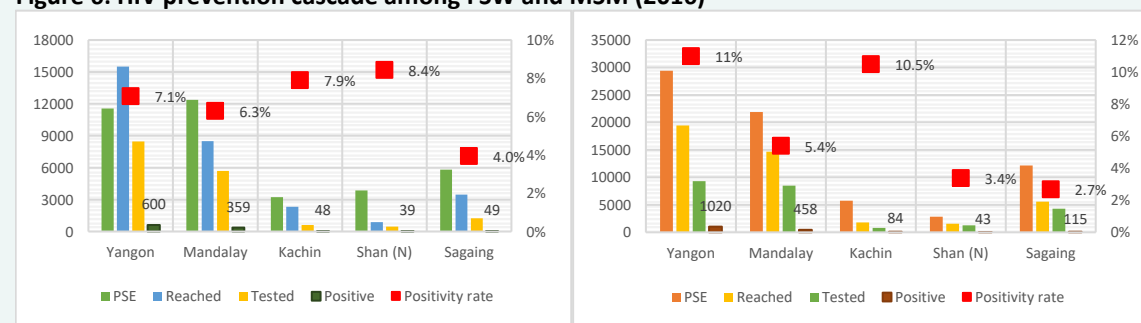
Box 2: Addressing the needs of KVPs in Myanmar

The Myanmar 2018 PCE Annual Report showed that national ART coverage scaled up over time to 66% in 2017 with substantial differences between men (55%) and women (79%) and sub-national areas.

As illustrated in Figure 6 for FSW and MSM using 2016 data, there were substantial inequalities along the HIV prevention cascade in sub-national areas (analysis restricted to five high priority states/regions):

- A high proportion of the population size estimate was not reached in most states/regions
- The proportion of those reached that were tested varied significantly
- The testing positivity rate varied significantly.

Figure 6: HIV prevention cascade among FSW and MSM (2016)



More generally, assessments of VFM conducted through the PCE found weaker progress toward equity objectives than other elements of VFM.³⁷ The review's evidence underscores the continued inequities in accessing health services and gender and human rights-related barriers that are impacting on the achievement of the Strategy's objectives. This has also been laid bare by the impacts of COVID 19 which has exposed the failure of health systems to address the needs of particularly vulnerable populations, such as migrants and refugees, among others.

Review analysis also suggests that equity considerations and technical guidance on these issues is further advanced for HIV than TB, with malaria trailing (despite significant recent progress, as evidenced in the 2019 technical brief: *Malaria, Gender and Human Rights*; and a new CRG malaria tool developed by Roll Back Malaria—the Malaria Matchbox).³⁸

KIs noted that the lack of appropriately disaggregated data and understanding of the barriers to assessing health services and the determinants of health and three disease outcomes is a critical restriction to prioritizing equity in programming decision-making.

The rest of this section focuses on progress toward specific areas of the Strategy—i.e. in relation to scaling up services to KVPs; gender equality; and human rights.

The Global Fund’s support for technology and service innovations and targeted interventions helps to ensure that KVPs are able to access the services they need, but more could be done. Since 2018, investment for HIV prevention among KVPs has increased, particularly for sex workers, PWID, and MSM, prisoners, and transgender persons. Targeting interventions to these groups is however difficult due to a range of factors, including a lack of strategies, policies and plans to target and address KVP needs, and weak population size estimates (often due to a reliance on bio-behavioral surveillance studies that can lead to under-estimates of HIV prevalence).^{39,40} Irregular collection of data and methodological changes also challenges analysis of the results of implementation and perpetuates a lack of understanding about what works and why, which hampers prioritization decision making. This is critical for many KVPs that face a range of barriers to accessing services.

A number of new technologies have been introduced and/or scaled up with Global Fund support which are designed to better reach KVPs and address barriers to access. For example, use of differentiated testing strategies including HIV self-testing kits means that KVPs are better able to access HIV testing; community-led responses are often more effective in reaching those facing structural barriers to services; prioritizing TB interventions in high TB incidence areas such as informal settlements; and prioritizing poorer communities and harder-to-reach populations and identifying strategies to reach them with malaria prevention tools.

The PCE also found strong evidence of programs using evidence-based strategies to increase coverage and improve targeting of KVPs, particularly in HIV programs and at the subnational level. However, the level of ambition set by targets is often low and coverage levels for KVPs remained low in most PCE countries. The focus of these activities was also on KVP service coverage and outcome targets rather than specific interventions to reduce human rights or gender-based barriers, which the analysis showed remained significant in all countries.⁴¹

Progress against gender objectives has been somewhat muted. Significant progress has been made in several areas, notably in the collection and reporting of gender-disaggregated data, in access to PMTCT services⁴² and in interventions to address GBV, especially in HIV Funding Requests.⁴³ Furthermore, to support action against gender-based inequalities, the Global Fund has more than quadrupled investments to reduce new HIV infections for AGYW in sub-Saharan Africa through investments in community-based prevention programs, as well as global level initiatives such as HER (HIV Epidemic Response).⁴⁴ However, funding for IPT for pregnant women appears to have reduced from USD 7.7 million budgeted in 2016 to USD 4.1 million in 2019. Coupled with low LLIN coverage in pregnant women (Figure 5), the main preventive strategies to control malaria in pregnant women do not appear to be sufficiently prioritized to meet needs, especially in resource poor settings.

A gender review of Funding Requests for the 2017–2019 funding cycle found that gender tends to be secondary to, or subsumed under, more general prevention programs (i.e. adolescents and out of school youth) and human rights programs that tend to be gender blind.⁴⁵ For example, ‘know your rights’ legal interventions rarely, if ever, address critical gender issues such as GBV and marital rape. The Global Fund lacks a framework to compare gender-responsiveness across funding windows and for this reason measuring progress can be challenging. Further, a lack of granularity, even in the detailed budgets that accompany Funding Requests, makes it difficult to determine whether

countries have budgeted the necessary components, or the full package of services—or at a minimum, the services proposed in the Funding Request. Another review conducted by the Secretariat in 2019 found that *‘historically very few [HIV] funding proposals identified GBV as a barrier to accessing services or provided relevant data, and that most funded activities related to standalone trainings or activities with little measurable impact.’*⁴⁶

Investments in human rights have increased significantly in a sub-set of countries where specific support has been provided, but less so in other countries where there are also substantial issues.⁴⁷

Although gains have been made against HIV-related stigma and discrimination, discriminatory attitudes toward people living with HIV remain extremely high in many countries.⁴⁸ Furthermore, a lack of data on results in this area restricts analysis of progress being made. Data from the UNAIDS Laws and Policies database, while focused on HIV only and showing some progress in many areas, indicates the scale of the problem at hand – see Box 3. To address issues of stigma and discrimination in health care settings, the Global Fund has increased funding to decrease discrimination and increase the quality of care by training care providers in human rights and ethics. For example, in Uganda, the Global Fund supported the community-based organization Uganet to provide human rights and medical ethics training for 450 health workers, with a focus on young key populations.⁴⁹

The OIG estimated that across the portfolio the Global Fund invested USD 123 million to remove human rights-related barriers through the 2017–2019 funding cycle (excluding service provision programming for KVPs).⁵⁰ Analysis of CRG-related investments, including KVP services, suggests that CRG-related investment peaked in 2017, that they are heavily concentrated in HIV, and they represent just ~1% of the total portfolio.

This is higher in middle-income countries, where human rights-related investments increased fourfold between the 2014–2016 and 2017–2019 funding cycles for HIV and TB. Some key informants attributed this to the establishment of KPI 9b in 2017, focused on the percentage of HIV, HIV/TB and TB grants dedicated to reducing human rights barriers and targeting KVPs in middle-income countries. The target for KPI 9b to increase investment in programs to remove human rights-related barriers for HIV and HIV/TB grants in 71 countries was also exceeded. This has been linked in part to the Breaking Down Barriers (BDB) SI (USD 1.74 million) which is supporting 20 countries to conduct baseline human rights assessments and develop 5-year implementation plans for comprehensive programming to remove human rights-related barriers. During the 2017–2019 funding cycle, USD 45 million in Matching Funds was made available for these 20 countries, of which 90% dedicated additional grant funding and/or domestic funding to remove human rights-related barriers. This resulted in a sevenfold increase in investments in these countries.⁵¹ Some countries, which have completed their baseline assessment, have already used them to design their NFM3 grant proposals – for example Mozambique, Nepal and Ghana have designed and invested in programs to address human rights-related barriers.⁵² Initial results from mid-term assessments of the BDB initiative in

Box 3: Summary of evidence from the UNAIDS Laws and Policies database on the presence of human rights barriers across countries (2019)

- Less than a third of reporting countries had: laws protecting against discrimination on the basis of HIV status (with around one third criminalizing drug use and sex work); documented barriers to justice for KVPs, people living with or affected by HIV; have a complaints procedure, or procedures/systems to protect and respect patient privacy or confidentiality; and have specific mechanisms in place to promote access to justice.
- Less than half of countries have specific violence protections for KVPs and PLHIV; and a national plan/strategy addressing gender-based violence/violence against women that includes HIV.
- Less than 50% of 195 countries reported that training programs have been implemented in the past 2 years for: PLHIV and KVPs on their rights; healthcare workers on HIV-related human rights and non-discrimination; preventing violence for police and other law enforcement personnel. Lack of funding was reported as by far the biggest barrier to providing these training sessions.

another three countries (Ukraine, Philippines, and Sierra Leone) suggest that while there are still substantial issues that need to be addressed, progress is being made toward implementing comprehensive programs to remove human rights-related barriers. This reflects the positive reporting against KPI 9a which measures the extent to which comprehensive programs are established to reduce human rights barriers to access, albeit in a small subset of countries. This is impressive and points to the merits of a targeted approach that utilizes additional funding.

Nonetheless, analysis suggests that investments overall in HRG are uneven and remain a real challenge for the Global Fund. For the countries not participating in the BDB, which include many high-impact countries and where there are substantial human rights-related issues, only 29% invested grant funds toward removing human rights-related barriers, and these were typically small.⁵³ As such, there to be a portfolio-wide approach to strategically differentiate investments to ensure that a supportive/enabling environment to achieve and sustain impact is worked towards over time. Box 4 highlights the experience of Ethiopia.

Box 4: Failing to address human rights for MSM in Ethiopia

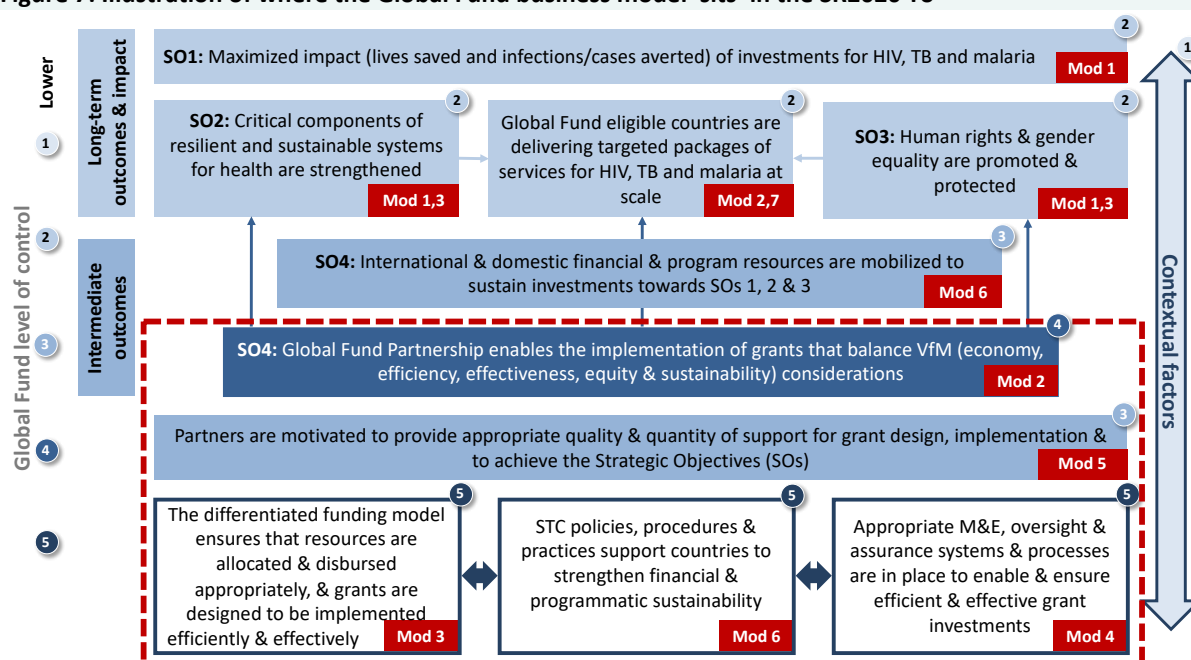
Ethiopia is a high-impact country well known for denying that MSM exist in the country, and the absence of programming for this key population. Despite repeated efforts on the part of the TRP, the GAC, the Secretariat, partners, and the global community to address this denial, signed grants for the 2017–19 funding cycle include no funding for evidence-based prevention programming for MSM (or transgender or PWID populations), and investment in the removal of human rights-related barriers remains minimal (0.3% of its HIV allocation).

There are a number of challenges to advancing equity. As highlighted above, the scale of the problem is huge and tackling it requires addressing the social determinants of health and the significant stigma and discrimination that continues to inhibit access to and utilization of health services – all issues further up the Conifer of Control. There is also a lack of effective systems to monitor and report on the total funding and results of investments in removing HRG and socio-economic barriers.⁵⁴ There also appear to be different understandings and interpretations of what equity means, both within the Secretariat and among partners. Specifically, it is a widely held view that equity involves trade-offs with efficiency or effectiveness, for instance where geographies or population groups are prioritized. This represents a dangerous misunderstanding of equity, which is concerned with giving everyone equal access to services based on need in order to improve efficiency, effectiveness and achieve impact.

6.2 Main Objective 2: Operationalization and implementation of the 2017-2022 Strategy

This section is concerned with how well the Global Fund business model and partnership enable the optimal design and implementation of grants that balance VFM considerations and maximize impact against the Strategic Objectives (section 6.1). As illustrated by the red dotted line in Figure 7, this relates to the lower portion of the ToC, and those mechanisms, policies and processes where the Secretariat has the greatest level of control over what is in place.

Figure 7: Illustration of where the Global Fund business model ‘sits’ in the SR2020 To



This section includes our responses to a number of SRQs, with some issues covered under multiple sub-sections, as set out in Table 5.

Table 5: Response to SRQs by section

SRQ	Section with response included
6, 7, 8, 10, 14, 15	Section 6.2.1: Funding model
11	Section 6.2.2: Procurement and market shaping
9, 10	Section 6.2.3: Efficiency in implementation
4, 5, 13, 25	Section 6.2.4: MEL, oversight and balancing risk considerations
16, 19, 20, 21, 22 23	Section 6.2.5: Partnerships
17, 18	Section 6.2.6: Operationalization of the STC Policy

Table 6 presents our high-level findings across these sections.

Table 6: Workstream 2 high-level findings

High-level findings	Strength of evidence
Funding model: The funding model works reasonably well to ensure that resources are allocated and guidance is provided to country stakeholders on how to design grants to maximize disease impact. However, a range of factors can lead to Funding Request submissions that are insufficiently prioritized. This includes weak prioritization guidance, weak or insufficient prioritization in NSPs, the founding document for Funding Requests; the political nature of prioritization decision making; flexibility by the Secretariat on the priorities and expectations for grant design; and the Funding Request/Grant-Making process itself. Progress has been made to increase the level of prioritization placed on RSSH and HRG in some areas (e.g. Secretariat guidance, Funding Request/Grant-Making processes and tools, TRP composition, catalytic investment) but less so in other areas (e.g. linkage to these issues in NSPs, prioritization guidance, Secretariat articulation of priorities through allocation letters, portfolio optimization).	Evidence is strong, comprising multiple data sources, thereby allowing for full triangulation.
Procurement and market shaping: The Global Fund delivers significant value in the market-shaping space directly under its control, with strong improvements in health technology availability and affordability. This also includes market-shaping successes across product categories and contributions to broader health product management.	Evidence is strong, comprising multiple data sources, thereby

High-level findings	Strength of evidence
Evidence suggests that issues outside of the Global Fund’s direct control, such as on pricing, quality and supply security in domestically financed procurement can be dealt with inconsistently across the portfolio, but offer great opportunity for VFM gains.	allowing for full triangulation.
Efficiency in implementation: Cross-portfolio program efficiency appears to have increased over time alongside considerable efforts to increase both allocative and technical efficiency. There are however widely recognized opportunities for further gains and more could be done to expand, embed and utilize these efforts (e.g. to improve health technology delivery and utilization and improve efficiency of program management and service delivery models).	Strong evidence, allowing for full triangulation.
<p>Technical partnerships: There are wide ranging concerns over whether partners are sufficiently supporting countries to optimally design and implement Global Fund grants. Despite some examples where arrangements work well and a number of steps have been taken to strengthen partner engagement (e.g. through the Partnership Engagement Initiative, Strategic Cooperation Frameworks), there are still issues with coordination, accountability, and transparency of how TA is delivered at the country level. There are also challenges to operationalizing working relationships between partners for RSSH at the global level as there is no working forum (such as a Situation Room) in which to address RSSH issues as they relate to the diseases.</p> <p>Synergies and collaborations: There is significant overlap of concomitant goals between the Global Fund Strategy and UHC, SDG and wider health goals. While the Global Fund is collaborating more closely with other organizations in pursuit of these goals, the objectives and rationale for how these collaborations drive impact at country level are not always clear. There is also partnership engagement ‘gaps’ in strategically important areas, such as the private sector, prevention and RSSH.</p>	Evidence is strong, comprising multiple data sources, thereby allowing for full triangulation.
MEL, oversight: There is currently no overall framework/strategy for monitoring, evaluation and learning (MEL), and these functions are not well joined up. There are also gaps in the monitoring and evaluation data collected that relate to strategically important areas (e.g. RSSH, HRG, partnerships/TA investments, innovation) which may partly explain why these areas of the Strategy receive less attention. There is also evidence that the systems in place to determine grant ratings based on achievement of programmatic targets do not place strong incentives on implementers to achieve results in line with the principle of performance-based funding	Evidence is strong, comprising multiple data sources, thereby allowing for full triangulation.
Balancing fiduciary and programmatic risk: Significant steps have been taken to promote a more balanced approach to managing the trade-offs between programmatic and fiduciary risk. While external stakeholders continue to view the Global Fund as risk averse, the steps taken are generally perceived as positive within the Secretariat. However, changing the organizational culture from one that has been focused more often on fiduciary controls takes time and will require specific attention.	Findings supported by multiple data sources of reasonable quality.
<p>Operationalization of the STC Policy:</p> <p>Agreement by the Secretariat, TERG, TRP and OIG to implement a series of ‘joint recommendations’ represents significant progress in defining an operational approach to guide continued STC Policy implementation. This includes long-term sustainability planning alongside the other pillars of the Global Fund’s work on sustainability. Evidence suggests that this approach is being prioritized in some countries but is not yet happening across the whole portfolio, and may be inappropriate in some decentralized/devolved settings. A particular challenge relates to ensuring the sustainability prospects of CSOs such that they can continue to provide services and KVP programming. Despite some positive examples, the sustainability prospects for these organizations are often tenuous.</p> <p>The co-financing requirement continues to evolve from a compliance mechanism to focusing on broader organizational goals and objectives. This is being successfully operationalized, but as the requirement becomes more prescriptive on what co-financing can be utilized for, and in light of the current macroeconomic situation, countries may face greater compliance challenges.</p>	Evidence is strong, comprising multiple data sources, thereby allowing for full triangulation.

6.2.1 Funding model

As per the SR2020 ToC, the funding model is critically important for the implementation of the Global Fund Strategy. It supports the strategic investment of resources based on high-quality, country-owned national strategies and aims to maximize the impact of investments by working with all partners to design and implement grants that deliver on the Global Fund's Strategic Objectives. This section examines the extent to which some of the principal mechanisms, policies and processes of the funding model are working to position the Global Fund partnership to facilitate achievement of the SOs. This addresses SRQs 6, 7, 8, 10, 14 and 15.

The Secretariat has provided stronger and more directive guidance to countries on the need to ensure that Global Fund priorities are addressed, but more so for disease impact than RSSH or HRG. A review of allocation letters across the 2017–2019 and 2020–2022 funding cycles suggests that the latter contain clearer and more direct messaging on: the need to ensure disease investments align to technical guidance; priorities and expectations for the grant design; the importance of investing in health and community systems, and HRG; sustainability priorities, including the need to increase domestic resources; and expectations for implementation arrangements, including around PR selection. However, this messaging is often high level, particularly for RSSH and HRG issues, without specifying exactly what issues need to be addressed. For example:

- In most cases the allocation aims are directed at the provision of targeted and/or essential services for KVPs. However, the focus is not specific, allowing space for countries to define (or avoid identifying) KVPs (e.g. MSM in Ethiopia; TB among men in Vietnam). These priorities are also mostly 'suggested' or 'recommended' to be focused on but not 'required' and as such can be ignored.
- The allocation letters for the 2017–2019 cycle included a suggested percentage of the allocation to be used for RSSH purposes, but guidance for 2020–2022 funding cycle is more vague, where RSSH investments are 'welcomed' but with no suggested investment range.

The Secretariat's technical guidance for RSSH and HRG has improved. This includes a Core Information Note: Building RSSH through Global Fund Investments, a guidance note for developing RSSH Funding Requests at the same level as those for HIV, TB and malaria, and several RSSH-related technical briefs. For HRG, guidance has been strengthened but there is a more limited range of technical briefs and tools.⁵⁵ Despite these developments, the guidance is still ambiguous in a number of areas and could easily be interpreted differently in its application as per KIs.⁵⁶ Case study findings also point to mixed awareness, utilization, and appreciation of this guidance at country level, implying an important and continued role for Country Teams and partners in relaying and influencing priorities in grant design processes. This includes the need for a regular familiarization with the different guidance notes for Secretariat staff.

The Global Fund and its partners strongly influence the development and content of NSPs, but these often do not: (a) represent an actionable or prioritized plan; (b) link to wider health system developments and sector plans; and/or (c) address all of the Global Fund's strategic priorities. NSPs are used as the foundation for developing a Funding Request, strongly encouraged by the Global Fund, and often receive significant funding and technical assistance (TA)⁵⁷ for their development. There is a body of evidence to show that country experiences in developing NSPs vary. KIs noted that some countries use the NSP development process as a genuine opportunity to rethink and internalize best practice for designing strategic plans, and others see it as a 'tick box' exercise to serve Global Fund purposes. There is evidence from NFM1 and NFM2⁵⁸ that the timing of country NSP processes often change to fall in line with the Global Fund application windows. Case studies and KIs indicate that for NFM3, NSP review, country dialogue and Funding Request development has frequently taken place in short succession, following receipt of the allocation letter, and often requiring TA at short notice.⁵⁹ The review findings endorse those of previous studies⁶⁰ which highlight the disruption caused by the Global Fund three-year grant cycle to national processes, which evidence suggests can contribute to a disconnect between NSPs and FRs.

A range of stakeholders noted that NSPs are often aspirational and reflect multiple partner and country stakeholder interests but lack the political commitment or funding to support implementation. There is significant Global Fund partnership engagement and TA investment in strengthening NSPs which is not reflected in the current KPI.⁶¹ Documentary and KII evidence from NFM2⁶² and more recent NSP reviews point to an improving but overall mixed picture in terms of NSP quality. While there have been important improvements in epidemiological modeling, situational analysis, and integrating health systems and financial sustainability considerations, weaknesses remain with identifying changes needed to make programmatic progress toward targets, and information on prioritization decisions when resources are constrained.

There is some evidence that NSPs do not adequately consider human rights⁶³ (although there are exceptions, Box 5) or health systems issues as they relate to the implementation of proposed disease interventions. Indeed, the success of many interventions in NSPs are predicated on well-functioning health systems, which is often not the case, but because there is little discussion of health sector weaknesses and plans in NSPs, it is difficult to determine whether the planned interventions can feasibly be implemented as intended. This can weaken Funding Requests, as RSSH is usually required to be integrated in disease Funding Requests, yet there is no detailed plan upon which to base RSSH interventions (health sector plans are often too high level).

Box 5: Ukraine strategic plan for removing human rights-related barriers to HIV and TB services

Ukraine was one of the first countries to develop and approve a strategic plan for removing human rights-related barriers to HIV and TB services (approved in May 2019). The plan provides a comprehensive overview of current programs to reduce barriers and defines a vision for scale up in the future.

Three sub-working groups were established with mandates to monitor human rights barriers; develop proposals for legal and policy change to address these barriers; and to mobilize and conduct advocacy for adoption and implementation of the legal and policy proposals, and for reducing stigma and discrimination. They are involved in developing the Funding Request for the 2020–2022 cycle.

The development of separate strategic plans to remove human rights is part of the BDB initiative by CRG. 20 countries will develop such plans based on CRG baseline studies. Funding for these plans comes from a Strategic Initiative and UNAIDS.

The BDB initiative has enjoyed high-level political support from the Ukrainian government and there is evidence of integration of human rights programs into state programs.

Weak prioritization guidance and the often political nature of prioritization decision making also affects the design of Global Fund Funding Requests. WHO provides clear normative guidance in relation to which interventions and health products are recommended. However, there is limited guidance on how to prioritize in order to arrive at an allocatively efficient intervention mix within the available resource envelope. Evidence from this review supports the conclusions of the TRP lessons learned for 2017-2019 and indicates that a lack of guidance on prioritization, weak or insufficient prioritization of NSPs, and flexibility by the Secretariat on the priorities and expectations for grant design, contributed to NFM2 Funding Request submissions that were insufficiently prioritized. This is true for all disease, but particularly malaria— see Box 6.⁶⁴

In response to this issue, the 2019 HIV and TB Global Fund technical guidance notes have become more directive, providing a set menu of impact-maximizing interventions that applicants should be prioritizing (although the equivalent for malaria is still the least directive about prioritization).⁶⁵

Funded by the Sustainability, Transition and Efficiency (STE) SI, several types of modeling have been employed to inform NFM3 allocation decisions across diseases, populations, geographies, and intervention mixes.⁶⁶ However, these models have been least applied in malaria programs where they are most needed (i.e. due to having the largest funding gaps and the weakest technical guidance).⁶⁷ Further, weak mechanisms are in place to ensure that findings are discussed and

incorporated into decision-making processes. For instance, and while acknowledging that modeling does not necessarily answer all of the questions related to prioritization⁶⁸, there is no requirement for the country dialogue process to include discussions around the issues raised through the modeling analysis; no process for the Country Teams and the STE leads to track or follow up on the influence of the analysis on decisions; and no penalties if the modeling advice is ignored. Except in a few instances, the outputs of the modeling have not been made readily available to the TRP or independent evaluators (as experienced through SR2020 and the PCE), inhibiting use and comparison of the data.⁶⁹

Box 6: Prioritization decision making for malaria

During NFM1 and 2, insufficient resources in malaria grants meant that countries were unable to do what was epidemiologically indicated and choices needed to be made, in terms of budget allocation to case management, surveillance, chemoprevention and vector control, as well as within each of those categories. Prioritization guidance has been weak and even where WHO's guidance speaks specifically to vector control, it does not address the implication of the growing resistance to pyrethroids, which means that universal net coverage no longer provides full protection. The prioritization tension has been most evident around IRS, as it is an extremely costly and cost-effective intervention, and guidance is unclear about deployment of IRS and nets in the same geographical area. Country capacity and partner support, from WHO AFRO, was viewed as weak and the tools that would enable prioritization are quite sophisticated and not widely used.

There are a number of examples of where modeling, including that funded through the STE-SI, has not been relied upon to inform the Funding Request, again particularly for malaria (e.g. DRC and Uganda Wave 1 NFM3 Funding Requests).

TRP composition has evolved to reflect and support the four SOs and there is evidence that the body plays an important role in influencing and validating grant design to meet these objectives.

The TRP has a long-standing RSSH cross-cutting group which engages alongside disease experts to review Funding Requests. For review of 2020–2022 Funding Requests, two new cross-cutting groups were formed—one for HRG, and the other on Strategic Investment and Sustainable Financing (SISF)—with appropriate specialists onboarded. Review evidence and analysis suggests that the TRP's analyses and outputs⁷⁰ focus on all four SOs, and their findings are regularly cited in Secretariat and Board thinking/outputs, indicating their influence across diseases, HRG and RSSH issues.

However, this review has identified challenges in the TRP review process related to: (1) the timing of the review; and (2) how and whether recommendations are addressed.

- First, although the amount of time allocated for TRP review has increased substantially since round-based applications, it still remains constrained. There is an increasing emphasis placed on TRP KPIs that overwhelmingly favor timely delivery, but are not designed to measure quality—thereby setting up perverse incentives to prioritize speed over quality. In addition, the Secretariat and Country Teams may be motivated to push Funding Requests through a rapid approval process to support absorption and avoid the additional burden on stakeholders associated with iteration.
- Second, analysis of TRP forms and reports shows that similar issues frequently emerge across funding cycles, suggesting that recommendations are not always acted upon. The OIG's 2019 Annual Report to the Board found “inconsistent incorporation of TRP” feedback in the design of the grants, with KIs also indicating that TRP members regularly raise concerns in this regard in plenary review discussions. Although the exact scale of the issue is unclear, it could nonetheless undermine the purpose of the TRP, and underscores the importance of more systematic tracking and follow-up. We note that the Secretariat is currently making efforts to improve the systematic tracking of TRP recommendations and how they are actioned.

Portfolio optimization is helping to ensure that Global Fund resources are utilized within funding cycles but appears to shift funds toward interventions targeting the three diseases rather than RSSH and HRG. As above, portfolio optimization intends to reallocate additional or unutilized funds

across the portfolio and has been applied across the grant cycle. These additional funds are used to invest in countries' unfunded quality demand (UQD) register/prioritized above allocation requests (PAAR) to support further implementation of the Strategy. Since 2017, the Secretariat has put in place criteria and processes involving Country Teams, technical partners and GAC to review absorption, conduct regular grant revision exercises and approve decisions regarding which countries receive additional funding through portfolio optimization and for what purpose. Prioritization criteria for portfolio optimization and financing UQD are: maintaining Global Fund-supported essential life-saving services and programs; potential for increased measurable impact; and strategic investments to strengthen sustainability.⁷¹

The review's analysis of activities/interventions supported with funds allocated through portfolio optimization for case study countries shows that a significant proportion was allocated to interventions aimed at scaling up prevention and/or treatment for HIV, TB and malaria, with very little allocated specifically to RSSH or HRG (see Annex 4.ii).⁷² An important reason why this might happen is related to the strong incentives on PRs to increase absorption, particularly from the grant mid-point onwards when many grant revision exercises are finalized.⁷³ RSSH and HRG are often among the lowest absorbing areas and it could conceivably be considered risky to integrate and initiate new activities within existing grants that are up and running, particularly in these low absorbing areas. This finding echoes analysis of the spike in expenditure in 2017, caused in part due to the incentives created by portfolio optimization, where a majority (~60%) of the 'additional' expenditure was used for health commodities and technology (which can incur expenditure but need not be used immediately); 15% for HIV prevention; and 15% for program management.

Catalytic investments⁷⁴ have increased the level of focus and attention on strategically important areas, including RSSH and HRG, but only partly achieved the aim of catalyzing investments for greater impact. Review analysis shows that catalytic funding has served to increase focus and attention on strategic priority areas where further progress is required, including RSSH and HRG, and that most but not all investments have been designed to facilitate a 'catalytic' outcome:

- **Matching Funds** seek to leverage additional financial resources, including from the core allocations, for identified areas of strategic importance. Review analysis suggests this has only happened for two out of the six areas (HIV AGYW and TB missing cases). There have been particularly low levels of investment in one area (human rights), grant budgets falling in some areas over time, and some instances of Matching Funds being allocated to countries with already very large allocations to these areas. Box 7 provides a spotlight on the TB missing cases Matching Funds using evidence from case studies.
- **Multi-Country Approaches** support innovative/improved programming to areas that would not otherwise have received such attention through country grants. Review analysis suggests that grants have largely been designed in this manner and offer significant added value.
- **SIs** are focused on improving country responses in strategically important areas, with some examples of innovation (e.g. introduction of new LLINs and RTS,S malaria vaccine). There is a less clear rationale for how some other areas are intended to be catalytic—for instance it is unclear how the work under the SI on PSM diagnosis and planning (i.e. diagnose issues and develop and implement strategies for supply chain systems) intends to be catalytic over and above what could be funded through the grant allocation if this was a country priority.

The amount of investment and the number of countries accessing catalytic funding are only a small fraction of the overall portfolio and have not been sufficient to meet the ambitious goals of catalytic funding. It is also unclear in some instances, particularly for some Matching Funds and SIs, why activities have not been funded through existing grant mechanisms, which would avoid substantial transaction costs.⁷⁵

There have also been several challenges to operationalizing the three catalytic funding pots that have hampered results, including late Board approval, lack of coordination with core allocations and across catalytic investments, weak country proposals, a lack of M&E data, and stringent requirements for grant revisions of Matching Funds, as compared to the core grants. These issues are detailed in Annex 4.ix.

Box 7: Spotlight on TB missing cases Matching Funds

To reach the global TB targets, there has been a major push to find missing cases using one or a combination of: (a) active case finding within fixed health care facilities, thus the push to increase the number and proportion of facilities offering TB services; (b) private provider engagement; and (c) community screening using community actors.

USD 10 million in Strategic Initiative funding and USD 115 million in Matching Funds was made available to 13 priority counties in 2017–2019 to support a wide range of activities. Some of these appear to be innovative and specific to the missing cases challenge (e.g. latent TB e-health monitoring tool and the Global PPM meeting to enhance private sector engagement in TB). Others appear to be funding general support to the entire TB program, which would comprise part of a partner’s mandate (e.g. TA to 13 countries during the reporting period to implement and scale interventions to find the missing people with TB as well as technical support to scale up diagnostics; support to NSP development in ten countries and preparation for the Global Fund planning cycle). Two of the SR2020 country cases studies received catalytic funding for TB missing cases: Pakistan and Kenya. In Kenya, considerable effort (KICK-TB) has been made to expand the case finding activities through innovative mechanisms but as of yet the yield of new cases has not significantly increased. Pakistan experienced delays in receiving Matching Funds and since has seen declines in case notification rates (2018–2019) and as has yet to see any impact from the catalytic investments.

6.2.2 Procurement and market shaping

This section presents findings in response to SRQ11.⁷⁶

The Global Fund’s market-shaping work has continued to deliver strong performance under the current Strategy, and is a main driver of economies achieved by the Global Fund.⁷⁷ The Global Fund has taken a more deliberate market-shaping role over time⁷⁸ and is now effectively leveraging its significant market share in key product categories—utilizing sourcing expertise and relationships with suppliers, partners and countries—to directly and indirectly influence health product markets.⁷⁹

By consolidating demand from LMICs and procuring high-quality commodities in bulk and at favorable prices through the Pooled Procurement Mechanism (PPM), VFM is achieved—see Box 8.⁸⁰ The 2019 Market-Shaping Strategy (MSS) Mid-Term Review (MTR) found that the Global Fund’s Supply Operations Department has driven strong improvements in availability and affordability as well as broader market-shaping successes across product categories. These gains have been made through

Box 8: PPM scale, scope and performance – key statistics

- Approximately 50% of Global Fund resources go towards health commodity purchase such as bed nets, condoms, diagnostic tests, and medicines.
- In 2019, 59% of budgeted health products were procured through the PPM, amounting to approx. USD 870 million.
- In 2019, USD 174 million of savings were achieved through PPM, exceeding the annual savings target (KPI12b) of USD 115 million.
- 85% of PPM orders were delivered on time and in full (OTIF) in 2019, also exceeding internal target.

*category-specific strategies...to guide sourcing and market-shaping activities; tenders and implementation of long-term framework agreements using a performance-based approach to manage suppliers; clearly defined and reported metrics for PPM spend; comprehensive transaction data; and partnerships with other major procurers.*⁸¹

The Global Fund has played a major role in enabling several underutilized or new innovations to be introduced and scaled. Examples include early infant diagnosis testing, pediatric antiretrovirals

(ARVs), improved adult ARV regimens, and seasonal malaria chemoprevention. SIs are also channeling funding for HIV self-testing; pyrethroid (PBO) nets; and the RTS,S malaria vaccine.

The Global Fund's contribution to market-shaping objectives has, however, been limited by:

- Internal arrangements and information flows within the Secretariat⁸², although new ways of working initiated under the SMC scale-up have helped Health Product Managers (HPMs) and Supply Operations to now work more closely on forecasting prior to supply negotiations.
- The ability to define product standards where WHO guidance leaves room for interpretation.⁸³
- The principle of country ownership, which—as currently operationalized—means that the Global Fund does not require countries to choose VFM maximizing technologies (e.g. optimize ARV regimens, select all oral TB regimens, select a 12-week rather than a 6-month latent TB infection medication, etc.).
- The market shaping strategy and its review processes operating in parallel to the overall Global Fund Strategy, creating a disconnect, which this review observed, between the role of Supply Operations on strategic purchasing (goal of the market shaping strategy) and the achievement of overall VFM (goal of the Global Fund Strategy).

More detail is provided in Annex 4.iii.

There has been a long-term trend toward increased domestic funding of health commodities, which increased from 2017–2019 under the implementation of the STC Policy. Prior to the NFM1 in 2014, 27% of eligible countries were procuring 100% of first line ARV treatments with domestic funds, compared to 38% now and a further 39% partially procuring first line ARVs. At present only 23% of countries which are 100% reliant on Global Fund resources.⁸⁴ For TB, prior to NFM1, 53% of eligible countries were procuring 100% of first line TB drugs with domestic funding compared to 60% now with a further 10% of eligible countries partially procuring first line TB drugs. This trend also seems likely to continue into the next allocation cycle (2020–2022) with more than half of the allocation letters making specific reference to increased uptake of drugs (ART, ACTs, TB) and other health products (vector control and diagnostics) as a priority area for country dialogue discussions.⁸⁵ This is part of a deliberate approach by the Secretariat to foster greater uptake of program costs as part of the Global Fund's efforts to strengthen sustainability under the STC Policy. Reducing country dependency on the Global Fund for health products is particularly important to enable the continued use of Global Fund resources for both scaling up service provision and investing in other critical priorities.

There are challenges with domestic procurement and/or financing of health products in many countries. SR2020 triangulated several sources of Secretariat data⁸⁶ and found that at least 38⁸⁷ countries have experienced challenges with domestic financing and procurement during this strategic period; this is excluding any general procurement or supply chain issues that are common in almost every country. Challenges include paying above-market prices for first line drugs; weak quantification systems and/or long government procurement processes causing stock-outs; and late and partial government counterpart payments resulting in procurement delays and stock-outs.⁸⁸ Annex 4.iii provides country examples.

Although not part of the scope of this review, it is noted that current efforts to extend the Global Fund's PPM approach to non-grant financing through the Wambo.org platform could be used to alleviate some of the issues noted above.

Domestic procurement issues are not systematically identified or addressed by internal Global Fund systems and processes. The Global Fund has processes in place to identify, mitigate and manage risks with domestic finance/procurement (e.g. Integrated Risk Tool, Transition Readiness Assessment, and country review meetings). However, there is no systematic, portfolio-wide synthesis to understand the extent of the challenges. When an issue is identified for a single country, there can be weak follow-up and accountability to ensure that mitigating actions are taken in a way that

addresses the root cause of the problem.⁸⁹ An example from the Pakistan case study showed that the TRP anticipated challenges with domestic finance and procurement of TB first line drugs (FLDs) and recommended mitigating actions, but recommendations were not actioned with negative consequences (see Box 9).

Despite domestic procurement being a Board priority, with KPI6a designed to capture intelligence on this subject, there has been a delay in agreeing to the scope and measurement methodology of this indicator. According to the most recent definition proposed for KPI6a, none of the 38 experiences mentioned above will be captured, because the proposed scope focuses on large volume countries—and those where there is significant Global Fund funding (either absolute amount or share of grant budget) going to health products or RSSH PSM—rather than on smaller, weaker and transitioning countries.

Box 9: Challenges to domestic finance and procurement of TB first line drugs in Pakistan

During NFM2, Pakistan committed to gradually taking over the procurement of first-line TB drugs from 50% in 2018, to 70% in 2019, up to 80% in 2020. The TRP's review in 2017 acknowledged the risks arising from insufficient assurance of provincial governments' contribution to TB funding, and advised several actions to (a) enable greater visibility of progress in spending against plans, and (b) to assess financial and procurement capacity at province level. The CCM discussed the issues but did not agree to make any changes based on the TRP's recommendations, a stance accepted by the Country Team. Based on KIs the Country Team acknowledged they were aware that release of PC-1 funds for TB FLDs would be unlikely and a choice was made to be ready with mitigating strategies—following closely with 6 monthly reviews with partners, ensuring a higher amount of buffer stocks and re-programming to cover the deficit. As a consequence a supply chain diagnostic in late 2019 identified that provincial procurement remained weak due to: lengthy procurement times and budget constraints; the price of locally purchased FDCs were 50% higher than Global Drug Facility prices; tender quality requirements were either non-existent (risking compromised quality) or too restrictive (limiting competition). In addition an OIG audit (April 2020) found that the government procured only 19% and 12% of the medicines in 2018 and 2019 resulting in the Global Fund stepping in to procure medicines to prevent a nationwide stock-out.

While the Global Fund does pre-emptively support capacity development in domestic procurement⁹⁰ the approach taken to risk mitigation differs across the Secretariat, linked to the lack of a corporate policy which defines the Global Fund's role. Country Teams decide whether to recommend health product uptake as part of the co-financing commitment recommendation in allocation letters. Evidence from this review suggests that this is often done without input from the Sourcing Team, with KIs noting that better coordination might encourage a more nuanced rather than blanket recommendation about how such a transition might take place. KIs also noted that there is a lack of focus on portfolio-wide analysis to determine which countries should be taking up x% FLDs to raise the overall contribution of domestic finance across the entire portfolio. When a challenge is expected to occur, the most common approach to mitigating identified risks with domestic procurement is to influence factors within the control of the Secretariat—pre-emptively overstocking pipelines; reprogramming grants to cover shortages; and calling on Supply Operations rapid supply mechanism that responds to emergency orders (see Annex 4.iii). There is currently heterogeneity in the approaches taken by Country Teams and a diversity of views within the Secretariat on the role of the Global Fund, including that the Global Fund has no role in influencing what the government does with its own funds, and that the Global Fund has a responsibility to try and influence continued patient access to quality-assured health products in the programs it supports. According to one KI 'If we have a quality assurance policy for medicines, how can we support a program where there's domestic financing for products and we're not confident in quality of those products?'

6.2.3 Efficiency in implementation

This sub-section incorporates findings against SRQs 9 and 10, focusing on efficiency trends and drivers from both a service delivery and system-wide perspective. We also examine GeneXpert utilization and grant absorption data as key indicators of implementation efficiency.

6.2.3.1 Cross-portfolio efficiency

There is evidence to suggest that cross-portfolio efficiency has increased over time, although further gains are necessary and achievable. Reporting against KPI 4 suggests that 88% of the disease programs assessed have shown efficiency gains (i.e. a decrease in cost per life saved or infection averted over the 2017–2019 allocation period).⁹¹ HIV programs have shown the most solid gains, while only a few TB programs have been flagged for inefficiency concerns. Far fewer malaria programs have been assessed to date. There are, however, many caveats⁹² to the analysis (e.g. it does not include the private sector) and it should be interpreted with caution. PCE modeling and qualitative analysis consistently found a generally positive and improving relationship between the utilization of inputs and achievement of outputs at the national level over time, particularly for HIV and malaria.⁹³

This review's evidence indicates that further efficiency improvement is required, and possible, through a more agile, expert, data-driven approach to the selection and design of interventions (i.e. recognizing the issues with prioritization flagged above). This is likely to be possible through a more granular understanding of disease epidemiology, more rigorous analysis of context, and better understanding of bottlenecks and obstacles to service uptake and delivery.

Efficiency gains at the aggregate, portfolio level arise from efficiency improvements in country programs, which are a function of choices about (a) which services and accompanying health products to provide, where and to whom – i.e. allocative efficiency;⁹⁴ and (b) how to provide those services,⁹⁵ including who should deliver them and what governments' role should be – i.e. technical efficiency. The former is dealt with above and the latter is discussed below.

6.2.3.3 How to provide services efficiently (i.e. technical efficiency)

Under the current Strategy, the Global Fund has expanded important work to understand the drivers of service delivery unit costs. Cost variation is evident for service delivery at health facilities across and within countries⁹⁶ and it has long been recommended for the Global Fund to engage in unit costing work.⁹⁷ Through the STE SI, technical efficiency analysis is being funded in counties, a large component of which is focused on analyzing unit costs of service delivery. There has been investment in costing infrastructure to acquire the basic understanding of cost elements of service delivery to enable improved benchmarking across countries.⁹⁸ The Global Fund has a comparative advantage to engage LFAs to support this line of work as costing is now a part of the omnibus LFA contract.

Although the Global Fund finances pilot work related to cross-programmatic efficiency as part of the STE-SI, implemented in partnership with the WHO, **there has been relatively less work to look at overall system efficiency, including the Global Fund's role in enabling and/or hindering this.** Several system-wide stumbling blocks have become more pressing during the current Strategy:

- **Adapting implementation arrangements to devolved and federal structures was identified as a significant challenge affecting efficiency and effectiveness of grant implementation in SR2020 cases studies.** For example, the central disease programs in Pakistan have no authority over provincial level activity contributing to confusion over roles, which in turn has affected coordination, supervision and reporting, and has hampered the Secretariat's ability to monitor and enforce co-financing commitments. The case is similar in Nepal resulting in challenges with the flow of commodities, funds, and reporting of programmatic and logistics data. In Kenya the devolution of health services to 47 counties affects health providers' roles and functions as well as the procurement and ability to account for finances. The resulting challenge in devolved contexts is that the national-level PR, and by implication the Global Fund, has less influence on the implementation of grants, as well as ability to enforce guidelines, safeguard quality of service, supervise work with beneficiaries, and monitor co-financing commitments. It is not evident that the current business model is entirely ready for

working with devolved entities in a way that balances achieving results with minimizing transaction costs.

- **Avoiding possible false economies of government as service implementer (to be distinguished from government as PR).** Shifting *PR-ship* from UN agencies and international NGOs (INGOs) to government is encouraged where financial probity allows and where government stewardship is strong. There are recent examples of this shift with the justification that ownership and sustainability can be improved as well as costs reduced with government as implementer. In Bangladesh, however, the government plans to take on increased responsibility for HIV service delivery to KVPs—shifting part of the grant functions and funds from an experienced NGO PR, despite studies showing that KVPs are unwilling to visit public healthcare facilities for sexually transmitted infection (STI) services due to experiences of discrimination and lack of privacy. Thus, the ‘false economy’ in this case relates to the potential drop in effectiveness of reaching KVPs with a quality service, despite the potential savings of relying on services provided through pre-existing fixed government facilities. SR2020 has observed a similar faulty logic in the PSM space, where some view that the sustainability goal is defined as all governments conducting their own procurement,⁹⁹ or operating the supply chain directly, whereas it may make more sense for the government to be operating only some of the PSM functions (e.g. forecasting, product selection), while contracting out other functions.
- **Private sector providers are making a contribution especially in TB case finding and case management, although the efficiency of different models is unclear.** In several countries, the Global Fund is supporting established TB PPM models which are contributing well to TB case finding and case management. However, there has been little work to evaluate the cost-effectiveness, quality and equity achieved through the different models. In Pakistan, comparable activities implemented by the two TB PPM Principal Recipients in the same provinces showed that program management and service delivery costs per case notified were USD 89 for one PR, and USD 138 for the second, a 36% variance.¹⁰⁰ Additionally, attention to private sector engagement was identified as a missed opportunity in several SR2020 case studies – Ethiopia, Viet Nam, Eswatini. Knowledge about which models work best in different contexts is important for scaling existing programs as well as to support introducing appropriate models in new countries.

6.2.3.4 Spotlight on GeneXpert—proxy for efficiency of turning inputs into service outputs

The GeneXpert is a critical support to the diagnostics armamentarium, particularly for TB.

GeneXpert is growing in importance as it a) facilitates molecular testing to start DR-TB patients on the new all oral regimen, b) used to rule out active TB when initiating TB preventive treatment and c) can be used for viral load testing in HIV. These changes will provide the opportunity to improve utilization of existing machines but also places further demand on scarce diagnostics that will also be in demand for COVID-19 testing.¹⁰¹

Despite significant investment in GeneXpert, machines remain scarce and underutilized due to a lack of complementary investments. Given the substantial investment in GeneXpert during NFM1 and 2 (USD 420 million),¹⁰² and its strategic importance to the Global Fund, it represents a good ‘tracer’ technology to look at as a proxy for health technology utilization and wider efficiency. That said, only one in ten diagnostic centers in Global Fund-eligible countries is equipped with molecular testing.¹⁰³ Issues with GeneXpert utilization are also consistently noted by the TRP and other analyses (e.g. peer-reviewed and gray literature, OIG, SR2020 case studies (see Box 10). As noted in the 2018 TRP RSSH Lessons Learned report,¹⁰⁴ under-utilization of GeneXpert is likely due to a lack of support for complementary health system needs (e.g. to ensure that policy, guidelines, diagnostic algorithms, cascade trainings and supervision, connectivity solutions, recurrent budgets for cartridges, maintenance, spare parts and supplies, sample transport systems, etc. are all in place)—systems needs which are not consistently allowed for in Funding Requests. Also, GeneXpert utilization is not

monitored in the grant performance framework or as a KPI, which means that this important investment is not being looked at in a systematic way across the portfolio.

Box 10: Observations on GeneXpert utilization – SR2020 case studies

- **Pakistan:** With 400 GeneXperts, low utilisation (<25%) is attributed to non-adherence to the WHO-recommended diagnosis guidelines of using the machines for drug susceptibility TB testing; shortages in cartridges at public sector facilities during 2018–2019; machines being located at the district capitals, with limited reliable mechanisms to transport samples from lower levels to district capitals for confirmed diagnosis, contributing to high clinical diagnoses and potentially missing cases at the lower level. GeneXpert utilisation at public hospitals is influenced by fact that hospitals close at 2pm – distances and opening hours influence utilization.
- **Ethiopia:** Low access to GeneXpert machines in relation to population size; disruptions in the supply of cartridges; inadequate sample transportation system; module failure and lack of decentralized maintenance – all factors which have contributed to a rapid decrease in TB detection rates.
- **Kenya:** There are only about 200 GeneXpert machines in Kenya, but over 4000 health facilities where TB can be preliminarily diagnosed or suspected. Sub-health stations that do not have GeneXpert must send the sputum or the patient to the centre that does (to follow national policy guidelines). This creates queues and blockages and may delay diagnosis in places, either through overloaded machines that cannot process tests quickly, or the transport system, which is expensive, samples are easily corrupted, or patients may choose not to travel. Insecure cartridge supply may also affect this at subnational level. The transport of sputum system is expensive and requires government facilities to handle petty cash, which is challenging.
- **Eswatini:** The Joint end term review HIV/TB/STI—October 2019 determined that there are a total of 28 GeneXpert sites for the diagnosis of TB with transition to GeneXpert MTB/RIF Ultra and ultra-cartridges in some facilities. The GX-Alert system was reported to be in place but was not in use due to inadequate connectivity in most facilities. The turnaround time (TAT) for results in the GeneXpert sites was found to be the same day and utilization rate was 37% in 2017.

6.2.3.5 Absorption

Although we recognize the limitations of using absorption (i.e. expenditure as a proportion of budget) in isolation as a proxy for implementation efficiency, it is helpful to provide an understanding of what for, and how well, Global Fund resources are budgeted and spent. A more complete response to SRQ9 is provided in Annex 4.vii.

Absorption increased dramatically in 2017 and 2018, although still varies substantially between investment areas.¹⁰⁵ Analysis of financial data provided by the Secretariat shows that:¹⁰⁶

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

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

Triangulating across the Secretariat's analysis of absorption for the period 2015 to 2017, as presented to the Board in May 2019,¹⁰⁷ and our own analysis of absorption for the period 2018 to mid-2019, we find that absorption is: **higher** (i.e. consistently above 80%) for commodities than non-commodities, and for program management, human resource and indirect/overhead costs; **mixed** (i.e. highly variable but typically goes no higher than 70–80%) for prevention interventions and RSSH; and **lower** (i.e. consistently around 60% or less) for interventions addressing human rights issues, PSM costs, travel costs, living support, and communications costs.

The observed increases in absorption are largely attributable to a few key processes/initiatives introduced by the Secretariat. More specifically:¹⁰⁸

- **Grant application:** The introduction of differentiated processes by country context for Funding Requests, review, Grant-Making, and approval processes shows that absorption in the first year of grant implementation increased for all application types, except for the Tailored NSP pilot category.
- **Portfolio optimization:** Appears to have been particularly effective at grant closure, where the incentives posed by this mechanism significantly influenced the spike in expenditure/absorption in 2017.¹⁰⁹
- **Analysis of absorption:** SR2017 noted that historically data on absorption was of poor quality and rarely analyzed. The PCE, supported by analysis conducted for SR2017 and this review, suggest that the introduction of the Grant Operating System, Modular Framework and revised Progress Update and Disbursement Request (PU/DR) process, have helped to improve the quality of data on absorption, which is now much more closely scrutinized. Stakeholders did, however, note that the analysis could go further and be more strategically deployed—i.e. to focus on the high value areas and/or ‘drivers’ of absorption, which could then be targeted for remedial action and/or TA.
- **More flexible documentation requirements:** For the NFM2 cycle, the Secretariat moved away from the use of Condition Precedents toward management actions and work plan tracking measures. These are more flexibly applied with disbursements often not contingent on the actions being completed therefore implementation can continue and absorption is not affected.

A number of other measures have also been introduced to respond to well-known issues affecting absorption, although it is unclear how and whether they are working. This includes: the qualitative adjustment process to the allocation methodology¹¹⁰; introduction of the Risk Appetite Framework, designed to balance financial and programmatic risk considerations more actively; partner engagement and provision of TA; and strengthening of RSSH.

A number of aspects of the business model remain problematic for absorption. Most notably related to budgeting, grant start-up processes, grant revisions, implementer capacity, the COE Policy flexibilities, and the three-year funding cycle.

6.2.4 MEL, oversight, and balancing risk considerations

This section is concerned with how and in what contexts the Global Fund MEL, oversight and programmatic assurance mechanisms (i.e. the performance framework, PU/DR, role of partners through the CCM, LFA and the OIG, etc.) work to incentivize high performance (and discourage unwanted behavior) to enable the achievement of the intermediate outcome—i.e. where Global Fund grant investments offer VFM. It is split into two sub-sections, the first on MEL and oversight, addressing SRQs 13 and 25; and the second on programmatic assurance, addressing SRQ5.

6.2.4.1 MEL and oversight

The Global Fund has invested significant effort in recent years to strengthen performance measurement systems and is continuing to target areas for improvement. The Secretariat has introduced a range of measures designed to strengthen its approach to performance measurement, including:

- establishment and continued development of the modular framework—a standardized set of core indicators, common to many national data systems, to guide the selection of grant KPIs
- completion of the Accelerated Implementation Management (AIM) project and integrated Grant Operating System, enhancing visibility of data and processes across the grant lifecycle
- development of a new Performance and Accountability Framework (PAF), providing a comprehensive view of the Secretariat’s key business processes and links with the Strategic Objectives, along with metrics and accountabilities to track performance

- development of the KPI accountability framework, assigning accountabilities for Strategic KPIs and outlining the interdependencies between KPIs and key business processes
- launch of the Strategic Framework for Data Use for Action and Improvement initiative to strengthen capacity to collect, analyze and use data at national levels.

In addition, steps have been taken to improve the management utility of performance data and better integrate performance data into management decision-making:

- strengthening of a one-stop data portal and dashboards for data on grant and country performance to support management decision-making within the Secretariat
- clear effort to use the Strategic KPI framework to engage and illuminate Board discussions about performance
- more active use of KPI data within the Secretariat, such as quarterly reporting against the new PAF to the Management Executive Committee, more systematic reviews of progress through the Country Portfolio Review process, use of Enterprise Portfolio Reviews triggered by underperformance in KPIs, and greater efforts to cascade and embed performance metrics in the work of teams and individuals.

Moreover, the Global Fund is continuing to identify areas for further strengthening. The Secretariat has embarked on an internal review of its approach to MEL including conducting a diagnostic assessment of the current MEL function, exploring how benchmarked organizations in health and development perform MEL and looking at a future approach.

The Global Fund lacks an overall framework and strategy for MEL. This is a notable omission especially since the Global Fund currently faces, and will continue to face, numerous and highly varied demands for information. Additionally, important aspects of the Global Fund's business model¹¹¹ make the choices regarding why, what and how to assess performance complicated. The Global Fund operates in varied and challenging environments, making timely learning essential, but the number of subject areas to explore could be boundless. Without a clear vision and objectives to guide these choices, there is no guarantee the approach will remain fit for purpose as it develops.

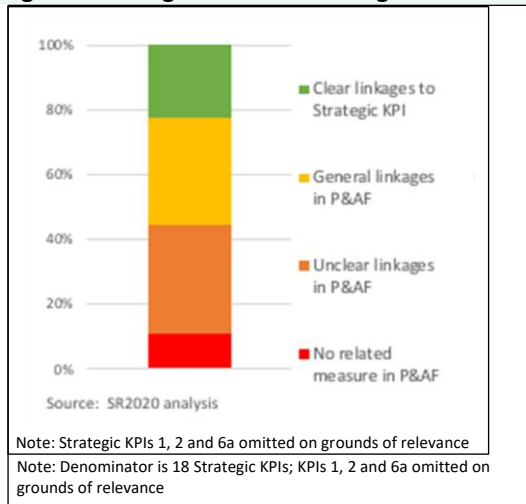
Both the TERG and Secretariat initiated reviews highlighted several limitations in the current approach to MEL, but importantly the Secretariat identified the need to develop an overarching framework to guide MEL going forward.¹¹² SR2020 has identified four key limitations in the current approach that will need to be considered as the development of the framework is taken forward: integration of MEL efforts; approach to learning; gaps in M&E coverage; and incentivizing improved performance.

The Global Fund's approach to MEL is comprehensive but activities are not fully integrated and there are issues with coordination across the Secretariat. Activities take place at multiple levels—corporate, region, country, grant, thematic—and more than 12 functional areas of the Secretariat are actively involved in the operation of the MEL system. At the country level, monitoring and oversight for investments is extensive. While the roles of the different actors are generally understood and delineated, the various activities are not well integrated. The commissioning and use of evaluation activities is particularly problematic. Multiple teams currently commission or implement different forms of evaluation studies for different purposes. The Secretariat's own analysis points to a lack of coordination at times leading to overlap and duplication, limited timeliness/utility, lack of systematic prioritization and a lack of clarity regarding the appropriate division between internal and independent evaluation.¹¹³

However, these concerns are not limited to evaluation activities. We identified instances of a lack of clarity and inconsistencies with respect to roles, responsibilities and accountabilities for monitoring, reporting, quality assurance, and follow-up.¹¹⁴ For example, SR2020 analysis found evidence of limited compliance in Focused Countries and COEs with the policy for streamlined performance frameworks at grant level.¹¹⁵ Connections between key monitoring frameworks used by the Global

Fund—i.e. the Strategic KPI framework, the PAF, and grant-level performance frameworks—are limited or inconsistent (see Figure 8).¹¹⁶ Additionally, the linkages between the routine monitoring system and internal evaluative studies are not clear.

Figure 8: Linkages between Strategic KPIs and measures in the PAF



The lack of integration is also evident in the *ad hoc* approach in the system. For example, a recent Advisory Report by the OIG found that the roll-out of SIs under catalytic investments over the 2017–2019 allocation period was not accompanied by a structured approach to monitoring and evaluating the performance of implementing partners.¹¹⁷ Similarly, an OIG Advisory Report examining grants in Western and Central Africa¹¹⁸ found that there was no clear process for regular monitoring of TA provided through Global Fund grants. The *ad hoc* approach is also evident in evaluation funding: despite being recognized as a core function, important evaluation work/commissioning—such as the TERG PCEs and thematic reviews, MECA

evaluations, and the provision of technical support to program reviews—is funded by a series of strategic projects and not from a core operating budget. In principle, the TERG is responsible for reviewing MEL plans within the Secretariat but in practice it lacks the resources to play this role.¹¹⁹

The Global Fund is committed to learning about success but the processes to promote a learning culture are not yet embedded. KIs with Secretariat staff point to a strong emphasis by senior management on the importance of knowledge management and better sharing of knowledge about what works. Nevertheless, progress made in this regard has been predominantly in strengthening the insights obtained from monitoring data—typically in aggregate form, in terms of how countries are performing against targets, cross-sectionally and longitudinally. Much less progress has been made in institutionalizing an understanding of what works and why—typically the realm of evaluation.

KIs pointed to the lack of a systematic approach to lesson-learning and sharing. Previously, it was mandatory for Funding Requests to demonstrate how lessons from relevant evaluations had been incorporated. Much is known locally but the sharing of that knowledge appears reliant on the personal inclinations of individual Country Teams or Fund Portfolio Managers. For many staff, their engagement with the MEL system is predominantly one of compliance, ensuring that required information or tasks are delivered on time.

This lack of systematic lesson-learning and sharing is largely corroborated by the Secretariat’s own analysis, which points to:¹²⁰

- variable quality of evaluation outputs
- inconsistent dissemination of evaluation findings to teams and no central repository for Secretariat-led evaluations
- no formal system of accountability for follow-up in response to evaluation findings (equivalent to the management actions agreed and tracked in response to OIG audits)
- lack of an organizational culture of learning from evaluation
- insufficient resourcing of the TERG to fulfill its function to facilitate organizational learning through its evaluations.

The Secretariat is currently running an internal initiative—Programmatic Key Insights—designed to strengthen organizational learning. It is focused on extracting greater value from the information already in its systems. This is an important first step but in the context of the new MEL framework—and the Secretariat’s ambition to place learning as a primary objective of the M&E effort—it will be

essential to consider how the need for actionable information is serviced by performance data from the full suite of its monitoring and evaluation activities.

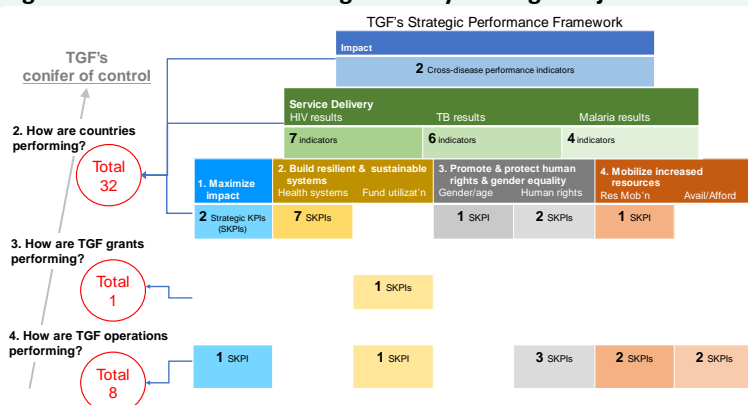
The Strategic KPI Framework covers most important aspects of the Global Fund’s Strategy but gaps remain. All performance measurement frameworks have limitations, for reasons of cost-effectiveness but also because some important aspects of performance are hard to capture with indicator-based approaches—such as the effectiveness of prevention activities, aspects of treatment quality, the results of RSSH investments, etc. Nevertheless, significant gaps and limitations have been identified in the current corporate performance framework with respect to RSSH and HRG.^{121,122} The plan to address these hard-to-measure aspects through systematic use of thematic/evaluative activities, however, has not in practice been implemented. Nor have other elements of the Global Fund’s monitoring system been used to address the gaps.

- At the organizational level, most of the business process metrics relating to RSSH and HRG in the PAF either lack sufficient specificity to link strongly to the SOs or focus on the implementation of activities rather than the quality of the processes.
- At the grant level, a number of shortcomings have been identified in the design and application of the modular framework for effective monitoring of investments in RSSH.¹²³ For HRG, a relatively high proportion of HIV-related indicators in the modular framework are gender specific or gender disaggregated (around 70%) but the proportion drops significantly for TB (less than one third) and malaria (less than one quarter).¹²⁴ There are no indicators in the modular framework directly relating to human rights in spite of the fact that nearly 50 interventions in the framework address human rights issues.

Other notable gaps in the system relate to ‘innovation and differentiation’ and ‘mutually accountable partnerships’. These are identified as ‘strategic enablers’ and key to the successful implementation of the Strategy but they are not systematically incorporated into the MEL system. There are no Strategic KPIs that relate to these enablers, and while the PAF does identify coordination of partnerships and external relations as a key business process, metrics to track performance have not yet been developed. Innovation is only addressed in the framework in the context of specific change initiatives under supply chain strengthening and financing.

The shift in the Global Fund’s focus from its operations to collective outcomes and impacts was made for good reason but has had consequences for accountabilities and incentives for performance across the partnership. The main purpose of M&E is not to report performance but to improve it, and the shift in focus to collective outcomes has supported the Global Fund’s efforts to engage partners in more strategic dialogue about results. However, there are important gaps in accountability for performance in the way the current system has developed. At the corporate level of the Secretariat and Board oversight, the design of the current Strategic KPI framework is heavily weighted toward aggregate global results (see Figure 9). Recent steps to disaggregate progress data (sensitively) by country is a positive development but nevertheless, as Figure 9 shows, over 75% of the Fund’s Strategic KPIs relate to the progress that countries are making (Level 2 on the Conifer of Control (see Figure 9)).¹²⁵ While it is entirely appropriate that the Global Fund should maintain a clear eye on this measure of success, in all but a limited number of cases, measuring countries’ progress has significant limitations in terms of holding the Fund accountable for its performance.

In contrast, less than 5% of the Strategic KPIs relate to how the Global Fund’s investments are performing (Level 3 on Conifer of Control) while the remaining 20% relate to how the Global Fund’s operations are performing (Level 4). Nor is this accountability imbalance addressed by the new PAF, given that performance under that framework is reported to the Management Executive Committee and not the Global Fund’s Board.

Figure 9: Distribution of Strategic KPIs by Strategic Objective and level of control

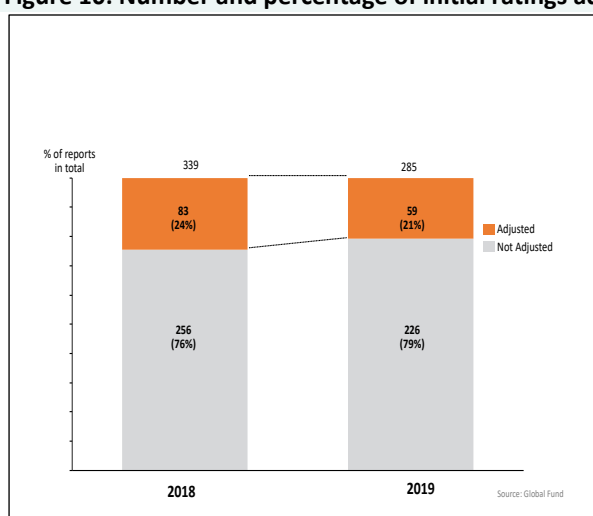
At the level of individual grants, performance ratings are a key part of the annual funding decision process, itself a core element of the Global Fund's performance-based funding model. However, ratings are determined largely by performance against national-level indicators and targets. Individual grants typically have limited influence over the achievement of their targets. Furthermore, data for some national-level indicators may involve a 12-month lag compared to the grant reporting/assessment period. This weakens the actionable links between results and grant performance and reduces the incentives for implementers to improve performance. This disconnect between the grant operations/PR performance and national performance targets is compounded by limitations in the development of grant performance frameworks:

- KIs cited cases of performance frameworks that include indicators unrelated or no longer relevant to the grant; targets set for grants that were dependent on commitments by other partners; and a situation where a decline in incidence in a country perversely resulted in underperformance against service delivery targets given the concomitant fall in need/demand.
- Important elements of interventions may be completely omitted from the performance framework (e.g. human rights), reflecting wider measurement challenges. For example, previous OIG analysis of 27 grants found that nearly 30% of the budget was not reflected in the performance framework.¹²⁶

The annual funding-decision process does, in principle, allow for qualitative adjustment to the indicator-based ratings to reflect grant management issues, though the effectiveness of this mechanism is unclear.

- Absorption data can be considered but in practice it is a weak proxy for grant implementation performance and effectiveness: inappropriate and inconsistent budgeting across countries make simple comparisons between planned and actual expenditure problematic; in many grants, the relationship between expenditure and programmatic results may be non-linear and subject to different lag times; differences in measurement methods also affect the relationship. Previous OIG and TERG assessments describe problems correlating expenditure and programmatic performance.^{127,128,129,130}
- Detailed guidelines regarding the application of management issues for qualitative adjustment are not elaborated, and the available guidance currently in the Operational Policy Manual is out of date.
- In practice, for the majority of cases, grant ratings are not actually adjusted: typically, between 75–80% of grant ratings are in line with the initial indicator-determined ratings (see Figure 10).¹³¹

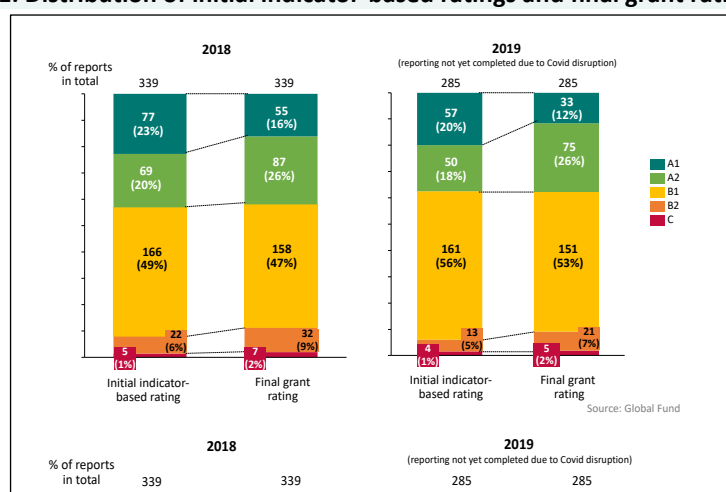
The extent to which the grant-rating exercise provides a performance sanction or incentive is also unclear.

Figure 10: Number and percentage of initial ratings adjusted for management issues

- It is true that for the 20–25% of grants where ratings are adjusted, the vast majority (75–80%) are adjusted downwards. Nevertheless, even after adjustment, 90% of grants are typically rated ‘adequate’ (B1) or better, enabling funding to be provided as planned (see Figure 11).¹³²
- In the limited number of cases where the final grant rating implies a reduction in funding, it is not clear whether the reduction necessarily occurs. The indicative funding range may not in practice be affected by any downward adjustment to the final rating for qualitative factors. When a funding decision is made that falls outside of the indicative funding range

(either above or below), managers no longer receive a warning message and are no longer required to provide a justification on the system.

- Interviewees also indicated that the Global Fund does not routinely track the effect of performance ratings on annual funding decisions.
- Finally, while the annual funding-decision mechanism can in principle penalize poor performance, it offers limited scope to reward, given that PRs cannot be awarded more than agreed-upon budgets. To overcome this constraint, budgets/targets would need to include significant ‘stretch’ components. However, the national nature of targets and potential risks arising from missing over-ambitious targets make it more likely that the current mechanism incentivizes caution.

Figure 11: Distribution of initial indicator-based ratings and final grant ratings

The Secretariat has a priority initiative underway to redefine the grant-rating system. A key aim is to drive performance accountabilities more systematically through the process, based on a clearer distinction between national program and grant-level implementer performance. However, whether these changes will result in future grant rating directly influencing performance-based funding decisions is less clear. In addition, the Global Fund has trialed Payment for Results approaches in a number of countries¹³³ and these experiences should also feed into the reform of the approach to grant assessment. Payment for Results has the potential to strengthen performance incentives in the right circumstances, but it is not a panacea and can be associated with perverse/unintended outcomes.

6.2.4.2 Balancing fiduciary and programmatic risk considerations

Significant steps have been taken to promote a more balanced approach to managing the trade-offs between programmatic mission and fiduciary risk. The Global Fund rightly promotes well-designed risk management controls that enable the achievement of programmatic results. Nevertheless, the Global Fund has been criticized in recent years for an inconsistent and imbalanced approach to managing the trade-offs between fiduciary risk concerns and the risk-taking necessary to pursue achievement of its programmatic mission, particularly in riskier environments.^{134,135,136}

The Secretariat and Board have taken steps to address these concerns, including:

- Development of the Operational Policy on Challenging Operating Environments (January 2017) which identifies the main risk for the Global Fund in fragile states, as not achieving its mission and includes flexibilities to encourage teams to find innovative solutions to operational challenges.
- Inclusion in the Operational Policy on Risk Management across the Grant Lifecycle (January 2017; revised June 2018) of the principle of ‘Accepting risk when necessary: Defining the amount and type of risk the Global Fund is willing to accept in pursuit of its Strategic Objectives’.
- Establishment of the Portfolio Performance Committee (2018) and associated Country Portfolio Review process with the explicit aim of reviewing risks and risk trade-offs and supporting decision-making regarding management’s acceptance of selected risks.
- Establishment of a corporate Risk Appetite Framework (May 2018) to support alignment of expectations across key stakeholders regarding the Fund’s risk tolerance including dialogue at Board level about risk and better evaluation of risk trade-off decisions.

In addition, the Secretariat has strengthened risk management and assurance systems generally to enable more mature engagement on decisions regarding risk trade-offs. This has included:

- increased collaboration between front-line business functions and risk oversight functions
- improved systems and tools—including the 2018 deployment of the integrated risk management tool to address previous fragmentation and enable more systematic understanding of risk
- greater elaboration of risk management policies, standards and methods
- increased engagement of the Board through discussions on risk oversight matters.

Despite these processes, procedures and guidance, evidence from the PCE and this review suggest that the Global Fund is widely perceived as risk averse.¹³⁷

The steps taken to manage risk are generally perceived as positive internally within the Secretariat but changing the organizational culture will require specific attention. The Secretariat is positive about the progress being made on balancing fiduciary controls against nuanced programmatic needs, and this view was generally corroborated during interviews with Secretariat staff.^{138,139,140}

The Secretariat has made a U-turn when it comes to risk management—trying to put more focus on programmatic achievements. SR2020 interviewee, March 2020

But the review also found evidence that the increased flexibility to develop more context-appropriate responses are not being fully exploited.^{141,142} SR2020 analysis supports this finding: analysis of a sample of countries found limited to no uptake of the policy encouraging streamlined performance frameworks in both Focused Countries and Challenging Operating Environments.

Interviews with Global Fund staff revealed a general perception that approval processes for flexible ways of working are time consuming and bureaucratic, to the point where staff were discouraged from seeking variations unless essential. The review also found evidence of inconsistent understanding among staff about the approvals process itself. It should be noted, these general

experiences were in contrast to the flexibilities introduced rapidly in response to COVID-19, for example with respect to reporting delays.

Interviewees largely welcomed the opportunity for substantive review and discussion provided by the Country Portfolio Review (CPR) process, but evidence suggests the CPR process is not yet fully effective in driving organizational change. A number of interviewees pointed to the high burden involved in preparing for the reviews and difficulties in obtaining clear, timely decisions in response to the 'asks' put forward by Country Teams.

More generally, the impression provided by interviews with Secretariat staff is that progress has been greater in enabling administrative flexibility in the face of operational challenges than promoting programmatic innovation. Similarly, processes to encourage appropriate risk-taking in these settings are perceived as generally reactive, responding to issues as they arise; whereas staff felt more anticipation could serve the Global Fund's aims better. A related observation is that while the Global Fund has demonstrated willingness to support innovation in the face of problems, it may be less willing to vary its approach (i.e. lighter touch) in high performance–low corruption settings.

6.2.5 Partnerships

Effective partnerships are fundamental to the Global Fund's way of working and a critical enabler to support implementation of the Strategy.¹⁴³ As a funding body without a country presence, the Global Fund's contribution to ending the three diseases relies on partners operating in the middle of the Conifer of Control to support country level impact. As articulated in the SR2020 ToC, technical partnerships are positioned as enablers of the SOs and play critical roles in translating the Strategy's priorities into effective grant design, implementation, and impact.

The partnership picture is complex, dynamic, and evolving. There are different understandings and definitions of partnerships¹⁴⁴ and a plethora of partnership modalities and arrangements exist with varying degrees of transparency and intrinsic control by the Global Fund Secretariat. Global Fund and UN technical partnerships often have broader engagement frameworks which support partnership through the 'unfunded mandate' or through more transactional relationships with funding attached. With global technical partners, multiple arrangements occur at different geographical levels (HQ, regional, country) and across technical and country-facing teams, adding to overall complexity.

There are wide-ranging concerns over whether technical partners are sufficiently supporting countries to design and implement grants that will significantly impact epidemics to achieve global disease goals by 2030. During the review period alone, the partnership model has been the subject of at least five reviews which identified, for improvement, long-standing partnership issues at global and country levels; weak coordination of technical support; weak transparency of investments (e.g. bilateral set-aside funds; grant funding for TA); a lack of effective oversight and accountability mechanisms for results; the need for greater alignment of technical and development partnership engagement at global and country levels; and capacity constraints and quality of support provided by partners.¹⁴⁵

This section is structured into three sub-sections: (a) recent developments that have taken place at Secretariat level to strengthen partner engagement;¹⁴⁶ (b) the extent to which partnerships are working at country level; and (c) synergies and collaborations. This review adds to the extensive body of independent evidence concerning partnerships and many of the findings, conclusions and recommendations endorse those found in other reviews.

6.2.5.1 Steps to strengthen partner engagement

In response to clear messages from the Global Fund leadership on the need to strengthen partner engagement, the Secretariat has reviewed global level partnership engagement mechanisms – e.g. the Partnership Engagement Initiative (PEI) and Strategic Cooperation Frameworks (SCF) – to better support Global Fund partnership working and impact at the country level.

The PEI has helped unpack the complexity of partnerships and filled some important gaps necessary for strengthening partnership engagement. In 2019, the Secretariat reprioritized partnership engagement and developed a high-level, time-bound initiative (PEI) accountable to the Executive Director.¹⁴⁷ The PEI aims to strengthen performance and engagement with partners across internal operations, and in doing so, started to address recommendations for partnership improvement from recent evaluations. The departure point for the PEI was a deep dive into the challenges and opportunities for partner engagement out of which six actions were developed to improve partner performance (see Box 11).

The PEI was an important and overdue initiative which has helped unpack the complexity of Global Fund partnerships at the Secretariat level and has filled gaps necessary to inform and develop strategies to engage partners more effectively. The key issues going

forward are how to strengthen and sustain the operationalization of the PEI work, including in the light of COVID-19. More broadly, there is less evidence that the drive for strengthened partner engagement is being accompanied by broader changes within the Secretariat—the capacity (numbers, and variability of interest/effort) of Secretariat staff available for partner engagement having been raised in previous reports and most recently in the OIG Audit.¹⁴⁸

Efforts are being made to improve transparency of funding to and from a range of partners, and through different arrangements, but challenges remain with data accuracy, monitoring and impact of investments. The PEI provided an analysis of *estimated* funding flows (USD 725 million, 2017–2019)¹⁴⁹ (see Annex 4.x) through different partner modalities and arrangements including varying levels of transparency and control of funds by the Global Fund. This analysis provides a high-level overview and indication of the scale of Global Fund partner investment (e.g. from bilateral, multilateral and other partners; and to technical partners via grants and SIs). There is some evidence that this data is being used to inform partner engagement strategies, e.g. opening up conversations and reconciling funding through the Global Fund/WHO strategic cooperation mechanism and improving coordination with bilateral set-side partners. Options are also being developed to increase the transparency of funds, e.g. through the use of centralized funding disbursements to some partners – a mechanism informed by the Global Fund/Green Light Committee Agreement with StopTB and GAVI Partnership Engagement Framework models. This has the potential to increase Secretariat visibility, transparency and accountability of funds at country level.

However, there are ongoing data challenges which make it difficult to track investments to grant implementing partners beyond sub-recipients and monitor the scope, status and impact of partner investments. These issues stem from weak integration of data systems at the Secretariat level, limited levels of intrinsic control by the Secretariat of grant and set-aside funding sources, different abilities for partners to share data, and use of broad budget categorizations in the modular framework (e.g. for TA).¹⁵⁰ Current grant and Strategy level performance frameworks also do not include indicators to ‘formally’ monitor investments (e.g. pre-identified TA funded through grants).

There is evidence of improved coordination between technical, bilateral and multilateral partners at the global level to support and broker country needs for TA. There is evidence that some

Box 11: Six no regret moves to improve partner engagement

1. Identify, segment, and map key set of Partners (10–15)
2. Build current relationship map for key set of Partners, document current coordinating process and identify simple/fit-for-purpose relationship management (e.g., Global Relationship Managers and Team)
3. Implement systematic screening of SIs in advance of GAC approval with respect to PE value-for-money/business case (incl. performance indicators)
4. Increase investment transparency for key set of Partners in Grants by reviewing and updating current budgetary framework
5. Assess need for pre-qualified Partners for TA services based on strategic/Programmatic importance (this has evolved to focus on improving transparency and coordination of bilateral Set Asides (‘enabling future move’)
6. Implement use of standard arrangements reflecting clear objectives and indicators of performance across SIs and Partners in Grants

Secretariat departments (such as TAP, External Relations and GMD) are improving coordination with global partners to enhance the match between the demand and supply of TA. Bilateral meetings and disease Situation Rooms take place regularly although the evidence is mixed as to how effective these are for resolving grant implementation issues through linked support at country level.¹⁵¹ Moreover, there is no RSSH Situation Room. RSSH issues are currently discussed and tackled separately in each disease Situation Room, although efforts are being made albeit inconsistently to address this through bringing together co-chairs of disease Situation Rooms to discuss RSSH. Evidence from KIIs highlights the difficulties for RSSH to establish a common working relationship or even just coordinate efforts given the multiple dimensions of health systems (e.g. information systems, human resource supply chain and governance, community systems strengthening). Furthermore, experts in the different agencies may not be at the same 'level', having different levels of independence and decision-making which makes it difficult to move along together.

For HIV, bilateral set-aside technical support mechanisms coordinate among themselves at global level to some extent – for instance, UNAIDS TSM, GIZ and Expertise France shared country draft TA plans to ensure coordination and this went well until the departure of a key individual. Nothing similar was noted for TB or malaria.

Evidence from this review endorses findings from previous reviews indicating that partner engagement in the Secretariat is spread across multiple divisions/departments with different responsibilities for partner relationship management including for managing TA (e.g. CRG and RSSH teams manage their 'own' SIs through contracts with partners). Whilst this structure reportedly enables Country Teams and country partners to work more dynamically together and reduces reporting, it also reduces potential for synergies across the teams. Some bilateral partners reported on the inconsistencies of country/Country Team relations with partners and on the need for more capacity within the Secretariat to manage coordination (which currently lies with a small team in TAP) suggesting the need for more staff and systematic standards to be applied in how the Secretariat engages with partners. Evidence points to a gap between the aspirations for greater partner engagement as outlined in the PEI, and capacities within the Secretariat.

The Global Fund does engage very closely with UNAIDS, WHO and UNICEF with various pieces but much more coordination is needed in providing TA in a timely, joined up way for countries. This is an outstanding problem. KII UN partner.

SCFs between the Global Fund and some technical partners are supporting mutual accountability and transparency at the global level. Since 2018, the Global Fund has signed two SCFs with WHO and UNAIDS (others also exist, e.g. with UNITAID and StopTB) to improve collaboration and communication at global, regional, and country levels. These frameworks support a wide range of Strategy-related policy, technical, programmatic, and thematic areas but have specifically identified joint programmatic priorities as common objectives. There is no direct funding attached to the SCFs but they can provide a conduit to other funding modalities, such as SIs (e.g. WHO's finding missing TB cases, support to data collection improvement, malaria interventions and others). The Global Fund/WHO SCF has developed an Action and Results Matrix with indicators and progress assessed through the global Steering Committee's joint review processes. This is the first time that such a matrix exists and is being held up as an innovative development, to be rolled out with other agreements.

The review's assessment is that there is some value in having these global agreements. The process of establishing the SCF with WHO, although not pain free, was important in helping convey understanding of respective mandates, e.g. in RSSH and the joint review process is enabling conversations on more sensitive issues such as investment transparency and the performance and effectiveness of operations and staff. The Action and Results Matrix, although still a weak tool for performance and accountability, is reported to have introduced new thinking and is nudging the

partnership closer to mutually accountable action and reporting, and this has brought out issues for improvement.

However, operationalizing these frameworks at regional/country level appears to be problematic.

As a modality for improving and operationalizing partner engagement at regional and country levels the SCFs seem to have mixed profile and traction. Case study evidence pointed to patchy knowledge, visibility, and engagement with the WHO and UNAIDS SCFs at country level. These challenges stem from issues with cascading globally agreed frameworks into operational agreements with regions (and countries) which are less under the control of HQ and operate with greater autonomous leadership and accountability. However, the most *significant* problem with operationalizing the SCFs is the absence of strategic level funding attached to the modality, as evidenced by AFRO's request for USD 60 million to implement a range of actions.

There is commitment to supporting the Global Fund but the bandwidth of capacity is limited and people won't work without extra funds; you have to recognize that funding for targeted set of actions with agreed metrics would make a difference. KII, Secretariat

Some country offices are often understaffed or have staff but with wrong expertise and are not fit for purpose, yet it is difficult to change them. Do partners respond the way they should? Not always because they can't due to staff, capacity and incentive issues. KII, bilateral partner

6.2.5.2 Extent to which Global Fund partnerships are working at country level

Global Fund technical partnerships work well for some things, in some country contexts. Country case study findings demonstrate a mixed picture with some UN and bilateral partners working well for some areas of the Strategy and the grants, and less well for others. Review findings suggest bilateral and UN technical partnerships (principally PEPFAR, WHO, UNAIDS) are broadly working well in supporting national planning processes particularly NSP and Funding Request development¹⁵² and for sustainability and transition planning in some countries (e.g. in Ukraine) but the picture is less clear for grant implementation (e.g. to unblock bottlenecks, strengthen oversight, and manage risk).

TA is being delivered through a plethora of mechanisms, but often lacks coordination, accountability, quality, and transparency. The ability to provide high-quality TA and engagement expected in SCFs is at times frustrated by weak capacity, lack of money or a multiplicity of agendas at country level. Levels of technical capacity are widely acknowledged as patchy in some WHO and UNAIDS offices and this affects engagement; conversely, (or sometimes within those same offices), there are individuals that play a central role in coordination, facilitation or provision of technical support, for example, the provision of some long-term TA (e.g. malaria advisors in many PMI-supported countries).

Evidence from recent Funding Request development showed the continuing presence of international short-term TA on many writing teams as important, although this is gradually being replaced or supplemented with local TA (e.g. Kenya) and is working well in some places. However, and despite efforts to harmonize the supply of TA at global level, competition exists between the many sources of bilateral technical support mechanisms in areas such as securing and contracting a small pool of quality (French speaking) consultants and using differential fee rates, etc. Evidence from this review and the PCE point to high transaction costs of poorly coordinated, and duplicative TA which can occur at certain points in the Global Fund grant cycle, particularly the NSP development and Funding Request processes. Evidence from Kenya, Cameroon, Viet Nam, and PNG highlighted ongoing issues of weak coordination and/or duplication of effort, lower quality of TA (often noted as 'unfinished' TA reports or reports that are never circulated widely) and problems associated with a lack of transparency and demand-driven TA.

Countries waited until they received their Allocation Letters in Dec before starting planning. They are putting the cart before horse. Jumping into Funding Requests without a thorough review of

NSPs, funding landscape and prioritization exercise. These processes are not always being followed. KII, provider of TA.

Everyone has to go through the NSP and Funding Request at the same time; it's disruptive and everything stops and removes focus on current grants. KII country case study

There are also issues with longer-term TA which can be funded through grants. Currently post holders report to the organization in which the position is located (e.g. WHO) rather than to the PR or Global Fund. While this arrangement might work well in some cases, the performance and accountability of the post funded by the grant is largely out of the control of the Global Fund.

There is evidence of Global Fund technical and bilateral partners at country level being active on the CCMs. Kenya's system of large, well-coordinated, broadly participatory technical working groups for each disease that feed technical information and decisions to the CCM is seen as a largely successful model. Many countries use variations on this system. Case study evidence highlights the important role played by the Secretariat to support the CCMs (e.g. through the CCM Evolution initiative) and some bilateral partners in reforming and strengthening the CCM structure and performance. This is important for all functions, including planning and monitoring of short and long-term TA funded by the Global Fund and partners.¹⁵³ However, the review's evidence lead us to conclude that the CCM is not the right vehicle through which to address the lack of planning for TA, the starting point of which should be the national programs.

USG is a key partner in supporting the Strategy in some countries. PEPFAR/PMI and Global Fund's partnership appears to be more solid and effective than under the previous Strategy (see Box 12) in the review's case study countries where PEPFAR and PMI are active. In addition to the continuing policy of having Global Fund Liaison Officers in many of the large PEPFAR countries, the USG invests a significant amount in TA even in those countries where PEPFAR is transitioning support (such as Viet Nam). This support (TA) is largely channeled to other organizations (WHO/TB and RB Malaria, UNAIDS, StopTB, TB-Care, UNICEF and others), with projects ranging from short-term missions for the countries' program benefits (such as joint program reviews, the development of the NSPs and Funding Requests) to the placing of long-term resident technical advisors in the national disease programs. KIIs at country level confirm the broad ToR of these advisors enable useful coordination and collaboration at national level that ultimately strengthens the Fund's Strategy and will increase impact.

There is limited evidence of partner engagement with the private sector at country level.¹⁵⁴ Private sector TB providers in Viet Nam, Eswatini, Ethiopia, Dominican Republic, Philippines, and Kenya do not routinely report diagnostic or even treatment data to the national program or national laboratories, despite continuing evidence that many and sometimes a majority of patients go to the private sector as a first stop for treatment. That said, there is some evidence of opportunities to strengthen PPM efforts. For instance, the Challenge Fund/Kick-TB in Kenya is using civil society and private sector innovation to improve linkages to public sector efforts for increasing case finding; and Coca Cola, Standard Bank and the Malaria Fund are committing private sector funds in Eswatini including for targeting AGYW. While in Pakistan a private sector PR is reportedly adding stability, expertise, innovation and oversight to the malaria program, and PPM is a major contributor to overall TB notification, comprising 31% of overall case notifications in 2017. But few other examples

were available, and even these examples were not yet showing outcomes as they were in the early stages of implementation.

Box 12: Examples of Global Fund/USG collaboration

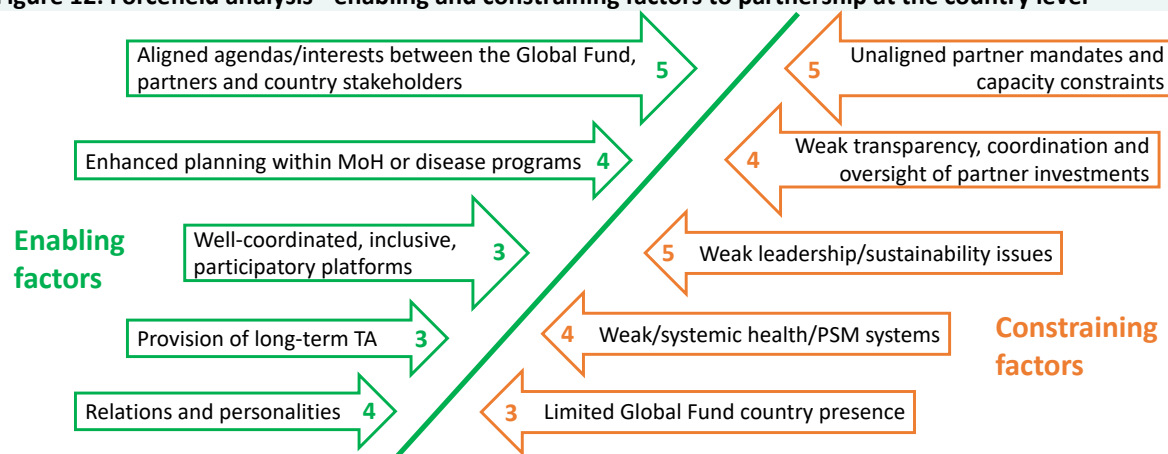
There are a number of examples of engagement to ensure alignment and harmonization of funding along with programmatic priorities and TA for KVP programming. For example, the Global Fund's work with USAID and CDC on the Key Populations Investment Fund (KPIF) which aims to scale up community-based monitoring (CBM) for KVP programming and strengthen the capacity of KVP led groups and organizations. Also, via USAID's funding for FHI/Linkages (KVP initiative in PEPFAR-supported countries) to deliver TA on strategic information and programming which were widely perceived as beneficial by the country stakeholders.

Evidence from our case studies includes:

- **Cameroon:** PEPFAR and Global Fund are working on a geographic implementation plan which divides the country into donor-specific zones where prevention programming in five districts overlapped. The respective PRs/Implementing partners signed a letter of intent defining responsibilities, aligning their tracking systems by harmonizing their unique identification codes and ensuring access to a full package of services for all beneficiaries.
- **Eswatini:** A positive indication of willingness to improve alignment between Global Fund and PEPFAR was shown by the invitations to the FPM, PRS and key populations to the COP20 meetings in South Africa. This invitation was extended to all Fund Portfolio Managers for the jointly affected countries.
- **Ethiopia:** Strong evidence for PEPFAR and PMI engagement in NSPs and early discussions of alignment of investments in Funding Request (PMI/Global Fund 'One Plan' for malaria); engagement and influence in CCM reform and provision of long-term capacity support to CCM (oversight and compliance officer, Treasury Advisor for FMS). USG implementing partners widely viewed as dynamic, capable teams.
- **Kenya:** Both PMI and PEPFAR are building on years of strong collaboration with Global Fund and were actively engaged during the NSP development for all diseases and early development of Funding Requests. Multiple surveys, evaluations and audits done by US partners are shared across all Global Fund-interested parties – recent examples include an audit of KEMSA, and the KENPHIA, 2020 (HIV seroprevalence population survey).
- **Viet Nam:** The invitation of the FPM to attend the COP2020 meetings in South Africa, and the strong liaison between USG partners and Global Fund to enhance the TB strategy, and PEPFAR's funding of a skills audit of the CCM to support reform of that body all illustrate the ongoing strength of the PEPFAR/Global Fund engagement in a country where PEPFAR itself has withdrawn its funds from service provision in its planned transition from Viet Nam.

There are a range of both enabling and hampering factors for partnerships at the country level. The evidence for this is based largely on the case studies as well as interviews with the Country Teams and various informed technical partners. As expected, many of these endorse findings reported in the Partnership Thematic Review. We summarize this work, which is presented more fully in Annex 4.x, through a forcefield analysis framework in Figure 13. Each of the factors presented have been weighted in the form of a score based on their relative importance to the functioning of partnerships at the country level, where five is the most important and one the least.

Figure 12: Forcefield analysis - enabling and constraining factors to partnership at the country level



6.2.5.3 Synergies and collaborations

There is significant overlap of concomitant goals between the Global Fund Strategy and UHC, SDG and wider health goals. Yet the actual contribution of the Global Fund to these wider development agendas is under appreciated. This is due in part to a lack of evidence on progress being made in RSSH and addressing equity issues. More specifically:

- **UHC:** The Global Fund contributes to progress toward UHC through its business model of raising and disbursing resources for the three diseases and strengthening health systems, which enable the efficient and equitable provision of wider health services. However, as noted above, RSSH investments are not always designed in this manner and results in this area are not tracked. There are nonetheless examples of countries making program decisions and commitments that will enable progress towards UHC in the medium- to long-term.¹⁵⁵
- **SDGs:** The Global Fund's Strategy is generally aligned with and designed to ensure investments contribute towards SDGs 3 and 5, although again there is little measurement of progress beyond the three diseases. The Global Fund's commitment to the Global Action Plan (GAP) has helped to define and formalize the scope of its contribution, particularly in relation to sustainable health financing, and foster collaboration between partners at the global and country level.
- **Emerging Issues in Health Security (AMR, climate change, COVID-19):** In considering future directions for the Global Fund there was little evidence, apart from KIIs, upon which to evaluate and make definitive conclusions on whether and how the Global Fund can and should 'take on' the AMR agenda or engage with health-related climate change issues. However, the rapid emergence of COVID-19 provided an opportunity to examine how a global pandemic can affect virtually every aspect of implementing the Global Fund Strategy; and how the Global Fund partnership is able to respond to such a threat. As noted in Annex 4.xiv, this response has been smart, swift and focused.¹⁵⁶ Despite this, the immediate health impact and medium and long-term economic, financial and health systems impacts will be significant.^{157,158} The experience highlights the importance of an organizational strategy and way of working that not only contributes to three disease impact, but also engages with partners working across different sectors to build RSSH and overcome the many barriers that restrict access to health services.

All of these areas require a multi-organizational, international effort. Close collaboration with other development organizations is required to draw on respective comparative advantages and ensure best use of what funds are available.

The Global Fund is collaborating more closely with organizations but needs to be clear on objectives and actions of collaboration and how these drive impact at country level. There are numerous examples of the Global Fund and UN, bilateral and multilateral and non-governmental/foundation partners collaborating more closely to leverage each other's expertise for Strategy implementation. For instance, to develop synergies that drive grant efficiencies and impact, and also in areas with shared agendas and challenges (e.g. COVID-19, and the SDGs).¹⁵⁹ Although this is positive, the challenge is keeping track of partnership engagement and involvement, and ensuring these developments bring genuine change at country level, while also adhering to the Principles of Partnership.¹⁶⁰

Partnership 'gaps' remain in a number of strategically important areas. These include:

- **The private sector:** The Global Fund has created some space for private sector participation through in-kind contributions¹⁶¹ and more clearly in terms of financing the Global Fund itself, and to a lesser extent in countries. Like other donors, systematically integrating private sector partners into national health systems and related processes is challenging, requiring specific interventions which will vary country by country, yet private sector engagement is widely perceived to be a critical gap in scaling up disease outcomes and in promoting local

innovations. This is important also for exploring innovations and learning from private sector companies (e.g. for behavior change programs, google digital for malaria stratification, etc.).

- **Prevention partnerships:** There are concerns about the effectiveness of HIV prevention programs and the slowing rate of incidence reduction, with inadequacies in partnerships being frequently cited. These include partnerships targeting AGYW—there is some consensus that addressing AGYW involves multi-sector partnerships which take time to operationalize.
- **RSSH partnerships:** There is evidence for relatively strong partnerships working to improve country procurement and supply chains (e.g. JSI in Ethiopia); health care financing (in some places, in collaboration with the World Bank) but gaps remain. The most regularly cited being expertise for human resources for health planning, integration of services, leadership and governance, and community systems strengthening, an area which does not naturally ‘sit’ with technical partners.

6.2.6 Operationalization of the STC Policy

The Global Fund’s definition of sustainability ‘focuses on the ability of a health program or country to both maintain and scale up service coverage to a level, in line with epidemiological context, that will provide for continuing control of a public health problem and support efforts for elimination of the three diseases, even after funding from the Global Fund or other major external donors comes to an end.’¹⁶² For health programs and three disease services specifically, the root causes and potential barriers to sustainability have been explored in previous reviews and include: (a) overdependence and reliance on Global Fund financing for key interventions; (b) unclear financial resources in transition contexts; (c) limited country ownership over the transition process, including lack of advanced planning; (d) lack of political will to address the underlying issues that affect transition preparedness; and (e) continued epidemiological challenges and programmatic gaps.^{163,164}

Many of these challenges relate to issues far up the Conifer of Control, over which the Global Fund has limited ability to influence, and which require significant time to demonstrate progress. Agreement by the Secretariat, TERG, TRP and OIG to implement a series of ‘joint recommendations’ to guide continued STC Policy implementation represents significant progress in defining an operational approach.^{165,166} This includes planning for and working towards sustainability by all countries regardless of where they sit on the development continuum.¹⁶⁷ Methods to ensure that sustainability is embedded throughout the program cycle closely mirror the four SOs with a focus on analyzing the feasibility of national governments to assume full financial and programmatic responsibility in the future.¹⁶⁸

Findings in this section seek to build on those made in previous reviews by exploring how the STC Policy is being operationalized to facilitate progress.

Box 13: A sample of key findings on Global Fund operationalization and implementation of the STC Policy from previous reviews

- The Secretariat has put in place clear operational guidance and revised grant-making processes to effectively support STC 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. the OIG and TRP) are building 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 operationalizing, country-led sustainability efforts beyond AELAC countries.

In line with the focus of SRQs 17 and 18, this section is split in sub-sections on planning for sustainability, co-financing, and engagement of CSOs/CBOs/NGOs.

6.2.6.1 Planning for sustainability

There is wide acceptance of the need to prioritize long-term sustainability planning across the entire portfolio, but there are challenges to meeting this objective. There are substantial barriers to building programmatic sustainability, not least related to political will, over which the Global Fund has limited ability to influence. Review evidence suggests that the timely implementation of Transition Readiness Assessments and the development of sustainability plans are mainly limited to those regions with STC Specialists and which have been prioritized for transition preparedness. For example, in Georgia, Ukraine and other EECA countries, Transition Readiness Assessments were done very early in the transition planning process, which not only allowed them to develop sustainability plans, but also allowed them to incorporate those recommendations into their own NSPs. Similarly, in Guyana, which has had an unexpected shortened timeline for transition with the discovery of its oil reserves, the Global Fund was able to support its in-country counterparts to mobilize the TA needed to ensure that the Transition Readiness Assessment was completed by end 2019. This was not the case in other country case studies (regardless of where they are on the transition continuum) such as Ethiopia, Namibia, and Malawi where little to no evidence of progress was mentioned by KIs, including Country Team members. As one KI noted, ‘...the only time this issue (sustainability) comes up is when the Funding Request is being put together...’ and another noted country stakeholders are ‘...living on a prayer.’

Decentralization/devolution may require a shift in approach to sustainability planning. This review’s evidence points to decentralization requiring a modification of the previously centralized approach for sustainability planning, which often also requires substantial capacity building, as well as working with multiple (sometimes non-integrated) health systems components.

6.2.6.2 Co-financing

The Global Fund’s efforts to encourage countries to increase their uptake of grant program costs and interventions have shown signs of success, but challenges remain. The Global Fund requires increasing domestic commitments to health for accessing its grants and, as such, has facilitated many initiatives to engage stakeholders on domestic financing above and beyond the co-financing requirement. Some of these include support for the development of health financing strategies, investment efficiency workshops, conducting Transition Readiness Assessments, encouraging the use of National Health Accounts, and exploring with other development partners blended financing mechanisms. Domestic funding for health and three diseases has risen substantially to 2017 and there have been very few instances of countries/components failing to make sufficient commitments to access the full allocation for the 2017-2019 allocation period (although compliance with those commitments is still to be assessed for most components). There are however significant challenges to raising domestic funding further, linked to fiscal space and related to the COVID-19 pandemic. For example, in Eswatini, government revenues continue to decline while government expenditures increase. Similarly, in Ukraine the analysis of fiscal indicators indicates that without any monetary policy action there is no potential to increase total government expenditure in the short-term, and that any increases are likely to be realized only through increased tax generation and/or continued growth in GDP, which is highly uncertain. In these scenarios, any increased allocation to health would most likely require a reduction to other sectors. What this has implied for countries (e.g. Malawi), where the fiscal space for health is severely constrained, is to look at potential efficiency gains. There is some emerging evidence of this happening in practice. For example, in many Asian and EECA countries there have been substantial declines in donor funding, but, according to KIs, coverage has not correspondingly declined because of domestic resources and realized efficiencies. This is supportive of analysis conducted through the PCE on HIV in Cambodia.¹⁶⁹ These gains may, however, be short term and should not be assumed in all contexts—in Uganda, substantial support is

being provided by the Global Fund Secretariat and other partners to unlock innovative domestic plans, without which one stakeholder noted ‘business will continue as usual’.

Tracking and monitoring co-financing is challenging. These issues will likely increase with decentralization/devolution of health sectors and as the Global Fund becomes more prescriptive in how it defines strategic outputs. Previous reviews, supported by reporting against KPI 9c and wider evidence from this review, note the need to revise reporting formats for co-financing commitments to more easily obtain timely information on the items funded under the requirement.^{170,171} Some of the challenges include a lack of systems in place to validate self-reported domestic commitments and the inability to track commitments at a sufficient level of detail, both of which are related to countries using their own budgeting systems, also limiting cross-country comparison. Additionally, data quality issues (validity, integrity, precision, reliability, and timeliness) remain a significant concern. Evidence from case studies suggests that this is improving in some countries.¹⁷²

Evidence collected for this review confirmed these observations and noted some additional emerging difficulties in tracking co-financing commitments. For example, in Ethiopia, Pakistan, and Papua New Guinea, the decentralization/devolution of budgetary decisions has made tracking the use of funds very challenging and, in some instances, the central government could not hold the lower-level administrative units sufficiently accountable, especially if regional authorities were not aware of central-level commitments. Since the Global Fund has neither in-country presence nor the human resources needed to address this issue, innovative solutions had to be found such as in Lao PDR where the Global Fund is partnering with the World Bank as its project will engage at the provincial level. Similarly, in Cameroon (currently non-compliant) several mechanisms have been established for monitoring the co-financing requirement, including a dedicated bank account, a co-financing monitoring committee, and ensuring interventions are targeted and traceable.

As the co-financing requirement becomes more prescriptive, countries may face greater compliance challenges. Under the STC Policy, all country components eligible to receive an allocation from the Global Fund must comply with co-financing requirements to access their allocation.¹⁷³ Historically, this requirement was positioned as a simple compliance mechanism; however, with the development of the STC Policy and subsequent guidance note, the aim is to incentivize co-financing for strategic impact by investing in priority areas. There is evidence that this is working.¹⁷⁴ As countries move along the development continuum, expectations are set for progressively higher co-financing of disease programs and key program components. During the 2020-2022 Funding Request and Grant-Making process, countries will need to show evidence of having met co-financing commitments from the 2017–2019 allocation period. Failure to realize previous commitments or provide evidence of these commitments can result in the reduction of grant funds and/or reductions in future allocations.¹⁷⁵

Stricter compliance to co-financing will need to balance domestic ambitions with Global Fund expectations. According to KIIs, in all countries during earlier periods the co-financing amounts were mostly dedicated to purchasing health commodities and then human resources for health and infrastructure. Now, in some countries (e.g. Ukraine, the Dominican Republic) and for some components, co-financing is also dedicated to preventive services and elements of domestic funding are allocated for CSOs to continue or scale up provision of prevention services. These new modalities, which countries may normally be hesitant to fund with domestic resources, require engaging earlier in potentially difficult conversations to improve the chances for both near-term success and long-term sustainability in meeting agreed-upon strategic goals.

The Global Fund’s ability to leverage increases in domestic financing is mostly limited to the three diseases with more senior/broader engagement needed for wider health sector financing discussions. Devolution/decentralization will also make these discussions more transaction intensive. While the recent STC Guidance Note and its annexes provide important and valued guidance to STC discussions, this is not thought by stakeholders to be sufficient in and of itself. Rather, ongoing,

robust, and continuous engagement with both Ministries of Health and Finance were seen by many stakeholders as necessary to ensure sustainable domestic financing for health. This would require engagement from not just the Global Fund STC specialists and Country Teams, but also senior leadership in conjunction with other development partners presenting a ‘unified voice’. This approach, it is believed, would greatly assist in capturing the attention of government stakeholders. This view was also highlighted through interviews with global health leaders who emphasized the importance of approaching STC issues in a collective manner. While there were several examples in the country case studies of the Global Fund failing to do this and, thus, countries adopting a ‘business as usual’ attitude, there were also some positive examples, including the use of national dialogues to strengthen high-level engagement.¹⁷⁶

Ideally, CCMs would be another forum for this engagement given the presence of development partners, civil society, and government officials; however, most CCMs have yet to evolve into this strategic role. Finally, concern was expressed that the Global Fund with constrained human resources will not be able to sufficiently engage in these discussions for many countries, if budgeting and programming authorities are decentralized and, therefore, the Secretariat will have to become more reliant on partners with in-country presence and, ideally, with programming and contacts at lower administrative units.

There is no evidence to suggest that the Global Fund grants result in wide-spread and large-scale displacement of domestic resources for health. However, this finding should not be considered definitive and a more thorough future examination of this issue is warranted. The STC Policy and other country guidance is explicit in that the Global Fund grants are not to be used to replace existing domestic funding and, indeed, require co-financing, increases in overall health spending, and for countries to consistently absorb more program costs. Other organizations, such as GAVI, which have examined the potential displacement of domestically financed health interventions and programs only pointed to the potential of this occurring.¹⁷⁷ A limited number of Fund Portfolio Managers, mainly covering sub-Saharan Africa, noted that displacement of domestic resources may have occurred, but also stated that they would need additional support (e.g. health financing staff, LFAs, OIG, etc.) to confirm this assumption.

6.2.6.3 Engaging CSOs/CBOs/NGOs to support sustainable outcomes

Sustainability of the Global Fund support for CSOs to continue providing services and KVP programming, in general, is tenuous at best. There are substantial barriers to service provision, many of which are further along the Conifer of Control and can be outside the Global Fund’s manageable interest. Several studies and workshops have examined the sustainability of Global Fund support for CSOs and KVP services.^{178,179,180} Indeed, the STC Policy and subsequent guidance notes were developed, in part, to address some of the CSO and KVP concerns, such as the lack of adequate planning and integration with national systems, raised in earlier studies.^{181,182} These challenges apply across other development partners, such as GAVI¹⁸³ and PEPFAR,¹⁸⁴ which have recognized that their investments in CSOs and KVPs are fragile.

The evidence collected for this review highlights that many of the same structural barriers and issues which hamper sustainability are further along the Conifer of Control, over which the Global Fund has limited influence and/or capacity to address. These include: (a) engrained cultural norms, including stigma and discrimination, which make, in some cases, even initiating discussions around KVPs challenging;¹⁸⁵ (b) perceived ‘competition’ between the state and non-state actors for accessing funds and providing services; (c) a lack of capacity by both host-country governments and CSOs to sufficiently interact with each other technically, managerially, and financially; (d) an inherent conflict of interest between civil society’s advocacy/watchdog role and that of being a provider of services; (e) legal frameworks within countries which make KVP engagement implicitly unacceptable; and (f) the unclear value-added of CSOs by their corresponding governments and a conflation of INGOs (perceived as expensive) versus local NGOs.

All of these concerns highlight the need for early and wide engagement of CSOs and KVPs to plan for a sustainable future for KVP programming, including services, and the national response in the absence of external resources. The challenges are significant, yet there are also many potential opportunities to affect program effectiveness and sustainability.

Despite these limitations, the Global Fund has and can continue to influence the sustainability of services provided by CSOs and KVP programming through its various policies and processes (e.g. NSP development, country dialogue and Funding Requests, STC Policy) and in some instances has played an instrumental role in moving this agenda forward. The Global Fund plays an important role in supporting critical CSO contributions to the fight against the three diseases and has taken positive steps to ensure KVP programming is sustained, with mixed success:

- **NSPs and country dialogue:** Funding Request processes (underlain by CSO and KVP involvement in the development of NSPs and participation on CCMs) are widely seen as entry-points for raising relevant issues, particularly grant objectives that explicitly relate to civil society advocacy and strengthening (e.g. for some multi-country approaches). However, findings from the RSSH Thematic Review and data from the UNAIDS Laws and Policies database suggest that grants are frequently designed without adequate input from communities or KVPs.¹⁸⁶ Further, evidence suggests that the extent to which these issues are addressed can be muted where, for instance, there are issues of competition for funds between state and non-state actors, and a lack of recognition of the respective roles and contributions that different partners bring. Finally, even when there is a willingness by host-country governments to engage with civil society, mechanisms to program, manage, and oversee their domestic resources are lacking, nor do CSOs necessarily have the capacity to comply with financial and reporting requirements (see below).
- **Increasingly prescriptive guidance on Global Fund expectations:** Multi-country approaches, with explicit objectives defined upfront, have been instrumental in supporting KVPs for HIV, with USD 50 million provided to support KVPs and sustainability across several regions in the 2017–2019 funding cycle. Also, the Global Fund can and does request that upper and lower-middle-income countries nearing transition and with low disease burdens increase their focus on the sustainability of interventions for KVPs; and countries or components approaching transition should implement grants through country systems, which includes CSOs.¹⁸⁷
- **Internal and partner coordination for programmatic decision-making:** There is substantial evidence to suggest that that CSO and KVP considerations are still not sufficiently integrated into program decision-making processes, and that there continues to be insufficient coordination among partners on these issues (e.g. with instances of partners unexpectedly withdrawing CSO funding). Steps have been taken in this regard, including the CRG and STE SIs, CRG Accelerate Initiative, and partner engagement around these issues.

In spite of substantial issues, country case studies and KIs suggest that progress is being made. Both the Ethiopia and Eswatini case studies point to strong evidence of national programs trying to better reach some KVPs evident in both their NSPs and Funding Requests using epidemiological evidence. Similar progress has been made in Ukraine where a legally binding and fully financed transition plan allows for limited domestic resources to be utilized for CSOs and NGOs to provide KVP services. Even in Uganda, where some KVPs are deemed illegal, progress has been made to conduct a baseline assessment for human rights and establish a technical working group to develop a national equity plan. More generally, the Global Fund has continued to support CSOs in their engagement in Transition Readiness Assessments and in the development of work plans to monitor implementation of the plans, as well as, engagement in national dialogues regarding service integration, UHC, and providing technical support for advocacy activities and continued capacity building.

The sustainability of CSOs via social contracting may not be broadly applicable and social contracting has its own set of sustainability issues; flexible approaches are needed. There can be a

tendency for stakeholders to focus on social contracting (i.e. public financing of civil society service provision) despite evidence that this can pose risks and not be appropriate in all settings. Evidence from this review points to the need for flexibility in assisting CSOs to plan for the sustainability of services and not to rely solely on social contracting. Many of the challenges are well known and often relate to the inability to legally register or the lack of a legal framework for social contracting; being limited in what services they can offer; issues of cash flow and forward funding requirements (i.e. a reimbursement system); the need for long-term planning; the lack of technical and managerial capacity; and, perhaps most importantly, uncertain political environments. Even Latin America and Caribbean countries which have been at the forefront of social contracting still face many struggles. In one country, the government ‘pushed back’ on establishing a formal relationship and saw social contracting as a possible hinderance in its epidemic response, even though it recognized civil society’s value. In Mexico and Argentina, which have been used as examples of successful social contracting, their governments have currently halted those programs. Finally, a number of KIs noted that unless these efforts are seen as being initiated internally, there will always be a perception that social contracting (and other civil society involvement) is an external-led effort and a lack of trust in the true value-added of CSOs.

There are, however, examples of where both social contracting and other models have been successfully implemented; though, again, the replicability of these results is uncertain. For example, in Georgia, there is a requirement on NGO pre-payment for participating in the governmental tenders; however, the legislation provides flexibility in waiving this requirement if certain conditions are met (past performance). Similarly, in Moldova, there is currently a Global Fund-supported pilot to finance CSOs to provide a basic package of preventive services via contracting with the national Health Insurance Fund. In Mauritius, there previously was a 2% corporate social responsibility tax on business with 75% of the funds going to small CSOs to address SDGs. This initiative has been recently reconstituted as a foundation with the potential for it to work with CSOs. And, in the MENA region there is ongoing work on examining alternative funding models (e.g. crowdsourcing, private sector funding, etc.) for CSOs. All of these examples demonstrate a need for flexibility and an approach which is responsive to CSOs needs rather than assuming that social contracting or any other method will be a panacea for CSO sustainability.

7 Conclusions

This section presents the review conclusions. These are clustered around three high-level conclusions which relate to the review findings. Specifically, high-level conclusion 1 and the more detailed conclusions within it are derived from findings under Main Objective 1 of the review. Findings from across the different components of the business model explored under Main Objective 2 inform high-level conclusions 2 and 3.

High-level conclusion 1: There has been mixed progress towards the Global Fund Strategic Objectives:

- **SO1:** Good progress has been made towards SO1 in terms of lives saved, but significant gaps remain in scaling up interventions to achieve targets for reducing new cases/infections of HIV, TB and malaria.
- **SO2:** Despite progress in some areas, this is uneven and most Global Fund investments in RSSH are used to support operational costs for the three disease programs rather than strengthening health systems to make substantive progress towards UHC and programmatic sustainability.
- **SO3:** There has been limited progress in addressing equity, human rights and gender issues across the Global Fund portfolio, albeit with variation by geography, disease and KVP group.

COVID-19 appears likely to reverse some of the gains made. Alongside the need to substantially accelerate progress in all areas to meet 2030 goals, ‘more of the same’ will not be sufficient. More attention to addressing the underlying policy and socio-economic drivers of the epidemics is required as part of an approach that places increased emphasis on sustainability and equity.

SO1: Maximize disease impact

The Global Fund has played a significant role in the scale-up of key interventions across diseases which has contributed to substantial reductions in mortality.

- For HIV, progress has been made in increasing the proportion of PLHIV who know their status, in improving rates of PMTCT and treatment coverage, and in reducing new infections in children and HIV-related deaths. Progress has been stronger in regions with more financial resources and more generalized epidemics (i.e. ESA vs WCA and other regions). Service coverage is greater for women, particularly pregnant women, but lags behind for men, children and KVPs (of which, treatment coverage is highest among MSM and lowest among transgender women).
- For TB, many countries have substantially improved their treatment coverage rates, and some their case notification rates. The Global Fund Strategy targets will be met if all countries meet their grant targets, but case finding over the next two years needs to be significantly increased to achieve the targets. Treatment coverage is highest in LAC and MENA and lowest in WCA. The treatment success rate for drug-sensitive TB is high but not yet reaching the ambitious Global Fund Strategy target. Men are over-represented in the number of new cases, but do not differ in their probability of diagnosis/treatment. Children are less likely to be diagnosed/treated and more likely to die compared to adults.
- For malaria, there has been good progress toward elimination objectives with seven additional countries reporting no indigenous cases of malaria since 2015 (Global Technical Strategy target of 10 additional countries by 2020). In high-burden settings, deaths have declined, and incidence has remained stable.

There has been insufficient progress in scaling up interventions to achieve targets for reducing new cases of HIV, TB and malaria. Further, current rates of progress towards SO1, which are likely to be significantly affected by the COVID-19 pandemic, are insufficient to meet the 2030 SDG goals to end the epidemics. There is cause for concern in a number of critical programmatic areas, particularly in some geographic areas and among some population groups, which have been identified by the Secretariat as priorities for the Global Fund moving forward:

- New HIV infections are declining but incidence remains high in some geographic contexts and KVP groups (e.g. ESA and WCA regions and among AGYW; as well as among pockets of KVPs in sub-national areas within countries), coinciding with declines in global and Global Fund investments in HIV prevention in recent years. Progress will need to be substantially accelerated to meet the 2030 goals.
- There is much slower progress in reducing new cases and deaths for TB, and there is still a large gap between estimated TB cases and those that are diagnosed and treated, particularly in WCA and among children. Also, the MDR-TB treatment success rate is only 56%, far off the Global Fund Strategy target.
- For malaria, while deaths have declined, there is substantial regional variation. Malaria cases and deaths have increased since 2015 in high-burden settings and LAC, cases have remained stable in ESA and cases and deaths have declined in all other regions. Infants, children under five, pregnant women and migrants remain at increased risk of severe disease and death, but we have limited information on the impact of disease on migrant populations. There has been limited change since 2015 in prevention coverage and utilization with only 50% of at-risk populations in sub-Saharan Africa protected by long-lasting insecticide nets in 2018.

In summary, further progress will require improvements in program quality (as indicated by weaker progress against targets for ART retention and TB TSR), and substantial scale up of prevention interventions to reduce new infections/cases.

Multiple factors hinder progress against the three diseases. These include health system weaknesses, HRG specific vulnerabilities and barriers to services, as well as resourcing issues—all critical components of a sustainable disease response and all issues relating to factors further up the Conifer

of Control. Nonetheless, these are issues that should in theory be addressed to the extent feasible through support under SOs 2, 3 and 4. Current rates of progress and the continued presence of these issues suggests the need for some rebalancing of priorities and investments moving forward. This will necessarily be influenced by the new reality imposed by COVID-19, which is seriously interrupting service delivery in many countries.

SO2: Build RSSH

Progress against the seven RSSH Operational Objectives of the 2017-2022 Strategy has been limited and uneven. Health systems issues continue to act as significant barriers to achieving SO1 targets. While noting that the Global Fund provides a small fraction of the global resource needs to strengthen health systems (and yet is the largest multilateral grant maker in this area), progress against the seven Operational Objectives of the 2017-2022 Strategy has been limited and uneven. The strongest progress appears to have been made in strengthening data systems for health and countries' capacities for analysis and use, as well as global and in-country PSM systems. These two areas account for the majority of RSSH investments. There is also evidence of some progress being made to support reproductive, women's, children's, and adolescent health, and platforms for integrated service delivery; and in strengthening and aligning to robust national health strategies and national disease-specific strategic plans, although substantial further progress is required in both of these areas. Weak progress has been made in strengthen financial management and oversight, leveraging investments in human resources for health, and in strengthening community responses and systems.

Health systems issues were frequently cited through the review as bottlenecks to making further progress towards SO1, including in relation to data systems and PSM, the areas where most progress has been made.¹⁸⁸

SO3: Promote and protect HRG

There has been limited progress in addressing equity, human rights and gender issues across the Global Fund portfolio, albeit with variation by geography, disease and KVP group. Substantial inequalities exist across the Global Fund portfolio, including by geography, disease and KVP group. These are driven by a range of factors (e.g. economic status, age, sex, level of education, geographic place of residence, as well as context-specific dimensions, such as ethnicity, disability and migratory status) and have a substantial bearing on access to and/or utilization of services for the three diseases. Making progress in these areas is particularly important to the Global Fund given that AGYW account for one in four new HIV infections in sub-Saharan Africa, and KVPs (MSM, PWID, prisoners, sex workers, and transgender people) and their sexual partners account for 62% of new adult HIV infections globally; the level of TB among some KVPs, such as prisoners, is up 100 times higher than that of general population; while malaria disproportionately impacts pregnant women and children under five, with as many as 10% of maternal deaths caused by malaria in sub-Saharan Africa.

Limited progress has been made against gender objectives. Performance against the KPI focused on gender and age equality (KPI 8, targeting a reduction HIV incidence in women aged 15-24 years old), is currently below target, reported by the Secretariat as 'at risk'. The review's analysis suggests that while progress is being made in some programmatic areas (e.g. to scale up funding and implementation of activities to address GBV among AGYW), there is weak progress in other areas (e.g. to prioritize preventive strategies to control malaria) and Funding Requests often leave critical issues unaddressed.

Investments in human rights have increased significantly in a sub-set of countries, particularly where specific additional financial and technical support has been provided, with some emerging evidence of positive results being achieved in these countries as reflected by KPI 9. This points to the merits of employing targeted approaches in this area. However, there is little evidence of similar gains being made across the wider portfolio, including in countries where there are substantial issues.

A significant explanation for a lack of contribution by the Global Fund against SOs 2 and 3 is that insufficient funding has been channeled to the right types of activities. For SO2, while a significant proportion of Global Fund resources are allocated to RSSH (USD 0.5 billion per year), two-thirds of this is used for health systems *support*—i.e. payment for recurrent costs of the Ministry of Health (MoH)/Principal Recipients (PRs)/disease programs (salaries, support supervision, meetings, travel, TA from technical partners)—while the remainder is designed to *strengthen* health systems, ensuring that the country achieves more equitable and sustained improvements across health services and health outcomes. This is the case even in countries relatively far along the development continuum suggesting that there is little differentiation of RSSH support. One major reason for this is due to there being insufficient funding to simultaneously fund essential disease program costs and strengthen health systems (for which the resource needs are huge and well beyond what the Global Fund alone can provide). Findings from across the review suggest that this is also the result of a lack of clarity on the overall purpose of and need for RSSH investments, stemming from divergent viewpoints on this issue among the Board and wider partnership¹⁸⁹ and historically weak technical guidance in this area. Relatedly, RSSH receives less prioritization and focus, as compared to SO1, across various aspects of the business model, including Funding Request/Grant-Making, grant implementation, and MEL processes, as well as partner arrangements.

For SO3, investments in HRG and to reduce inequalities among specific population groups have historically been low. This is partly due to difficulties in targeting interventions to these groups, stemming from a lack of strategies, policies and plans to address their needs, weak population size estimates, and a lack of understanding about what works and why. Investment has nonetheless increased, particularly for HIV prevention among KVPs since 2018, and a number of new technologies have been introduced and/or scaled up with Global Fund support which are designed to better reach KVPs and address barriers to access. However, the focus of these activities is usually on KVP service coverage and outcome targets (which are often low) rather than specific interventions to reduce human rights or gender-based barriers, which analysis shows remain significant in all countries. For gender specifically, analysis shows that Funding Requests often remain gender blind leaving critical issues unaddressed. In terms of human rights, investments across the portfolio remain low, with little evidence of investments being strategically differentiated to ensure that a supportive/enabling environment to achieve and sustain impact is worked towards over time.

The most critical explanatory factors for a lack of progress and investment in HRG appears to relate to political will, particularly in countries where specific KVP groups are criminalized and/or addressing structural barriers to accessing services would be politically unpopular. As it is currently operationalized under the principle of country ownership, even when there is evidence of significant HRG issues negatively impacting programmatic results in a country, the business model does not work to ensure that these are addressed in grants. As such, they can be ignored. Addressing the determinants of inequity also often requires significant time and engagement to understand and operationalize approaches. While the business model can disincentivize investments in these areas (see high-level conclusion 2), there is evidence of the Secretariat taking a more proactive approach to combining additional catalytic investments with technical assistance leading to some gains.

Another issue that may be hampering the adoption of a consistent approach relates to different understandings and interpretations of what equity means, both within the Secretariat and among partners. Specifically, it is a widely held view that equity involves trade-offs with efficiency or effectiveness, for instance where geographies or population groups are prioritized. This represents a dangerous misunderstanding of equity, which is concerned with giving everyone equal access to services based on need in order to improve efficiency, effectiveness and achieve impact.

Mixed progress towards the Global Fund's three SOs does not suggest the need to shift the organization's focus away from these areas, but does suggest the need to evolve the business model. There is strong evidence that the most critical barriers to achieving disease impact relate to issues with prioritization and implementation, health system weaknesses, equitable access to

services and HRG-specific vulnerabilities. There is much uncertainty in relation to the eventual health, economic and political impact of the COVID-19 pandemic. While the pandemic ultimately looks set to make the scale of the challenge ahead all the more difficult, these pre-existing barriers are likely to remain the most pressing issues for the Global Fund in the next strategic period.

As such, the current SOs 1, 2 and 3 remain highly relevant. These are all long-standing challenges over which the Global Fund has limited control and insufficient resources to achieve everything. While the Secretariat has constantly sought to evolve its way of working and introduce specific mechanisms to try to address these challenges, analysis against the SR2020 ToC indicates that the business model as a whole is still not working to systematically support the design and implementation of grants operating at country level that consistently and simultaneously meet SOs 1, 2 and 3.

The context within which the Global Fund operates continues to evolve, and is likely to be less supportive of the organization’s strategic targets in the short- and medium-term. This has implications for how the Global Fund delivers against the SOs in the future. Most notably, the COVID-19 pandemic is challenging health and community systems and the provision of treatment and prevention programs. It is likely to roll back many of the gains made in recent years and highlights the fragility of the systems on which these gains were made, and how dependent these gains are on strong and resilient health systems. In particular, it represents a particular threat to the poorest and most vulnerable communities, whose economic circumstances exacerbate their susceptibility to COVID-19 but also HIV, TB, and malaria. The medium- to long-term implications of the pandemic are as yet unclear but it seems certain that the scale of the Global Fund’s challenge ahead will become all the more difficult.

High-level conclusion 2: The evidence clearly shows that the Global Fund’s business model has continued to evolve during the period of the current Strategy and has strengths in a number of areas. However, to date, the model still does not deliver solutions to a number of long-standing challenges, that primarily relate to coordination of action across multiple objectives and how to achieve evidence-informed prioritisation when stakeholders at both international and country level have diverging levels of capacity and differing priorities.

There are a number of clear strengths in the current business model that should be built upon. This necessarily involves care being taken not to undermine these strengths through unintended consequences of reform in other aspects of the business model. These include:

- The Global Fund’s market-shaping work has continued to deliver strong performance under the current Strategy and is a main driver of economies achieved by the Global Fund. This includes strong improvements in health technology availability and affordability across product categories and contributions to broader health product management.
- Using a range of tools and processes, the Secretariat has sought to increase absorption, allocative and technical efficiency, with some evidence of efficiency gains across the portfolio over time. This has included growth in the technical skills of the Secretariat, the use of Matching Funds and Multi-Country Approaches to ensure strategic priority areas are prioritized, as well as Strategic Initiatives, notably to support a range of modeling exercises designed to supplement updated technical guidance to better inform country prioritization processes, and overall heightened attention to VFM by the TRP, including with the addition of the Strategic Investment and Sustainable Financing cadre.
- The Global Fund’s support for innovation—both new technology scaling as well as service delivery innovations (e.g. differentiated testing strategies, community-led responses)—has enabled more tailored interventions to meet KVP needs, as well as improved impact across diseases.

- There has also been good progress in supporting countries to increase domestic funding, although we anticipate substantial risks to both financial sustainability associated with the COVID-19 pandemic and its impact on the global economic situation.

There are further opportunities for national programs and grants to improve VFM and achieve more impact which need to be fully leveraged through the funding model and wider business model.

- There are opportunities for further VFM gains to be made by countries, particularly in areas where the Global Fund has less control (e.g. on pricing, quality, and supply security in domestically financed procurement, as well as new technology uptake/selection, health product delivery and utilization).
- The review's analysis suggests that modeling and efficiency analyses have yet to be embedded and used by countries in all settings—for instance, there is mixed progress in prioritizing investments in prevention activities and in the selection of geographies, populations and intervention mixes.
- Despite Global Fund support for innovation in new technology scaling as well as service delivery innovations to enable more tailored interventions to meet KVP needs, many have yet to be scaled up in many countries (e.g. opiate substitution treatment (OST) for PWID and pre-exposure prophylaxis (PrEP) and HIV self-testing for MSM and TG).
- Progress in prioritizing sustainability, including for CSO service provision and KVP programming, needs further consolidation; there is a strong need to build on progress to date and ensure this work is fully mainstreamed and utilized at the country level.

Despite greater technical guidance and support to improve allocative efficiency, a number of business model mechanisms do not work consistently across the portfolio to ensure that grants are sufficiently prioritized to maximize disease impact, while also making necessary progress towards HRG and RSSH, and equity and sustainability more generally. Findings from across the review suggest that prioritization is a significant issue affecting both how resources are allocated across sub-national geographic areas, population groups and intervention mixes, and across activities that respond to the each of the SOs.

Prioritization decisions are influenced by a range of country contextual factors. Evidence suggests that Global Fund mechanisms, like for other donors, can struggle to generate political commitment to meet all of the Global Fund's strategic priorities. Evidence from this review suggests that this is a particular issue for HRG, sustainability, KVP and CSO programming. Further, the political nature of prioritization decision making can often override VFM considerations. This suggests that efforts, driven by political economy analysis, should be made to strengthen political engagement to leverage Global Fund priorities.

Prioritization is also influenced by a number of different components of the Global Fund business model. Most notably:

- *NSPs as foundation documents for Funding Requests:* Although there is some evidence of improvements in the quality of NSPs, they are still often too aspirational in relation to available resources for implementation, and often propose interventions that are not prioritized. NSPs can be weak foundational documents for Funding Requests as they lack adequate consideration and granularity of detail, including for human rights and RSSH. There is a particular disconnect with RSSH as disease NSPs are not necessarily informed by, and linked to health sector and sub-sector plans (such as supply chain, data systems, and HRH).
- *Funding Request and Grant-Making:* Firstly, as for NSPs, countries receive weak guidance, including from technical partners, on how to prioritize activities and budgets in resource-constrained settings. As such, prioritization decisions can be made quite subjectively. Secondly, the time-consuming nature of developing and approving grants creates a strong incentive for CCMs and other engaged stakeholders to avoid iteration and/or clarifications

from the TRP and GAC. As such, there is an inherent incentive to do ‘more of the same’ in terms of interventions, service delivery models and grant implementation arrangements.

- *Role of partners in-country structures to influence prioritization:* Review findings suggest that in some contexts technical partners are unable or reluctant to proactively influence prioritization due to capacity issues, mandate concerns, and political sensitivities in-country and/or unwillingness to challenge the status quo, which could be seen as encroaching on the principle of country ownership. Further, CCMs can also lack the required independence and/or political gravitas necessary to influence prioritization, and the capacities and/or reach to engage diverse and multisectoral partners necessary to address RSSH and HRG barriers.¹⁹⁰
- *Design and focus of the MEL system:* The Global Fund uses mostly national level outcome and impact indicators to monitor grant performance. Given the three-year grant lifecycle, stakeholders are incentivized to focus on programmatic areas where measurable progress can be made very quickly. There is also an incentive to deprioritize areas where progress is not measured – most notably, this includes RSSH and HRG. To compensate for issues with using outcome/impact indicators (see high-level conclusion 3), a heavy reliance is placed on the use of financial data – i.e. expenditure and absorption – for grant oversight purposes. However, this also creates strong incentives to prioritize investments in areas that are easier to plan for and implement, such as commodities, human resources, and TA.
- *Risk management to balance trade-offs between programmatic mission and fiduciary risk:* Despite positive steps taken by the Secretariat to improve internal processes, continued effort is required to encourage appropriate risk-taking and promote programmatic innovation. Moreover, the Global Fund is still widely perceived by country stakeholders as risk averse which creates incentives to design grants that focus on what is well tested, rather than pursuing bolder/innovative programming.
- *Utilizing the role of the TRP to improve grant design:* The analysis highlights the value and importance of the TRP in evaluating the technical merit and strategic focus of Funding Requests. However, it is unclear whether and how the concerns and recommendations raised by the TRP review are comprehensively tracked through to action in a systematic manner by the Secretariat.

In practice, analysis against the SR2020 ToC suggests that this leads to a prioritization of biomedical/facility-based services, mostly focused on scaling up testing and treatment; and weaker prioritization of activities to scale up prevention programming and address HRG-related barriers, and strengthen health systems. As such, the review suggests that there is a strong link between observed progress towards the SOs and the set of incentives created by the business model to influence prioritization.

The interaction of the business model and national contexts is still not effectively prioritizing the design of grants and disease responses that build towards programmatic sustainability. Ensuring programmatic sustainability of health programs and services is challenging and requires significant time and engagement in issues that are outside of the Global Fund’s direct control but that it can influence. There has been considerable progress made by the Secretariat in working with the various Board sub-committees to agree and take forward a series of actions that seek to further embed sustainability within the Global Fund’s approach. Findings from this review suggest there are examples of where countries have made substantive progress in planning for, designing and implementing grants that build towards programmatic sustainability, but these are limited to a relatively small proportion of the Global Fund portfolio.

Critically, related to findings under Main Objective 1, making further progress will require prioritized efforts to strengthen CSO and community-led systems to provide KVP and other services; address inequities and HRG barriers; and strengthen health systems. These are all fundamental components of a sustainable disease response that are at present receiving insufficient attention. A potential constraint to this relates to differing views among the Board, Secretariat and other stakeholders on what the Global Fund should be aiming to achieve in terms of sustainability and consequently the degree to which the Global Fund should prioritize health systems strengthening.¹⁹¹ A separate

emerging challenge to planning and making progress on sustainability relates to an increasing trend towards decentralization/devolution which may require a shift in policy approach.

High-level conclusion 3: The Global Fund business model does not always work to create strong and clear incentives for partners and other stakeholders to improve program results. Opportunities to do so through the structuring of contracts, arrangements, and processes are often missed.

Several aspects of the business model create incentives that do not fully align with the objective of improving program and/or grant performance. This primarily relates to the design of the MEL system. As noted above, there are some significant gaps in the coverage of the MEL system which, as well as partly explaining why these areas receive less attention, can also help explain why less progress is made in these areas. Most notably, these ‘gaps’ relate to RSSH, HRG, partnership coordination and TA investments, innovation, and achievement of VFM (by which we refer to a rounded assessment of economy, efficiency, effectiveness, equity and sustainability). As such, in line with the conclusions above on prioritization, the review suggests that there is a strong link between observed progress towards the SOs and the design of the MEL system.

Secondly, the Global Fund’s approach to assessing grant performance relies heavily on indicators that measure progress towards national level outcomes and impacts. While Global Fund grants contribute towards national level outcomes and impacts, grants typically have limited influence over whether results at this level are achieved or not. As such, the indicators are a weak proxy for grant performance. Performance against these targets is however used in the determination of grant-ratings which results in an annual funding-decision, a core element of the Fund’s performance-based funding model. In practice, this process creates little incentive to increase grant performance and weak ‘penalties’ for poor performance.

Opportunities exist to strengthen the Global Fund’s approach to performance management but are insufficiently used. The review suggests that contracts, arrangements, and processes with partners are often not structured to incentivize desired behavior and performance in line with the Secretariat’s expectations. This applies to incentivizing grant performance and ensuring that grant investments achieve better value—for instance, despite being highlighted in previous reviews and reports, there is currently no critical analysis by the Secretariat of the amount of funds invested to support recurrent costs programmed as RSSH investments; lines of accountability between SRs, PRs, CCMs are often unclear or not applied; and there is very little independent evaluation to understand grant performance at the country level and make the link to what works and why.

There are also issues with the structuring of contracts with partners—for instance, there is little competition for contracts awarded to implement Strategic Initiatives, and inefficiencies have been highlighted concerning the management of relationships with Strategic Initiative implementers; and there are few processes that enable monitoring and evaluation of grant-funded short and long-term TA investments to determine if these investments are achieving what the set out to do.

8 Main objective 3: Recommendations on future directions

Building on the review findings and conclusions, in particular a forward-looking enquiry into how the Global Fund should position itself in the next strategic cycle (see Annex 4.xv), and discussion with the Secretariat and TERG, this section presents the review’s recommendations.

There are five strategic recommendations. Strategic recommendations 1 and 2 focus on actions that should be implemented now. Strategic recommendations 3, 4 and 5 focus on what should be reflected in the next strategy. Related to each are a series of operational recommendations to guide the Global Fund to meet the strategic recommendations. For each operational recommendation, we provide detail on the target audience, the suggested timeframe for implementation and consideration of the potential impact and feasibility of implementation.

Strategic recommendations to be implemented now

Strategic Recommendation 1: Start now to strengthen the processes by which geographies, populations and intervention mixes are prioritized in NSPs and Funding Requests to ensure that Global Fund investments are evidence based and reflect an appropriate balance across the SOs, VFM criteria and organizational ToC.

The review shows that opportunities are missed to increase impact within disease programs and grants through a lack of prioritization and targeting of high-impact interventions which would guide making smarter investments, including for RSSH and HRG, that build toward sustainability. As a result, the Global Fund's overall effective contribution is not maximized. This is because the systems, processes, and tools that drive the design of national programs and Funding Requests still do not deliver the evidence-based prioritization needed for fully efficient, effective, equitable and sustainable outcomes.

While acknowledging the importance of country ownership, finding this balance in evidence-based prioritization will require:¹⁹²

1. Across the wider portfolio, having a clear and differentiated approach to tackling this issue.
2. Stronger and more specific guidance from the Secretariat and technical partners to encourage prioritized decision-making in resource-constrained settings and the tools to allow quantitative and qualitative VFM assessment of options
3. Processes that support countries to adopt and scale innovations in technology, service delivery and targeted interventions to help ensure that access to KVPs, to encourage more adopting of innovative solutions and their spread between countries
4. Mechanisms that are appropriate, capacitated and financed to develop NSPs and Funding Requests at country level
5. Greater attention to and prioritization of particular service delivery modalities (e.g. CSO, community systems, private sector) that can sustain services, build capacity and create an enabling environment and leading to impact
6. Processes at country level that draw upon the expertise of communities closest to the epidemics to identify innovative, yet context-appropriate and sustainable solutions that target the underserved.

For each country in the Global Fund portfolio, the result should be a Funding Request that contains a strong rationale for the prioritized interventions/populations/geographies and use of Global Fund resources to meet grant and SO targets, in the context of what is being supported by others.

Short-term operational recommendations to facilitate the implementation of Strategic Recommendation 1 within the current strategic period

- 1.1. **Establish a mechanism to: (a) track whether and how TRP recommendations are acted upon; and (b) systematically action TRP recommendations**, with clear justification provided where this has not been possible. We note that point (a) is already underway by the Secretariat. Also ensure the TRP has sufficient time and resources to conduct its business thoroughly.
- 1.2. **Assess, at the country level, the extent to which technical partners can be engaged and may bring sufficient resources to provide capacity support (e.g. financial, human, technical) for national program design, as well as implementation and impact.** This could be done initially by using a simple set of criteria based on the existing knowledge of Country Teams. This could be shared with technical partners at the global level to get agreement on needs for strengthened capacity. **Where existing partners do not have and are unable to meet Global Fund expectations in terms of skills/mandate/capacity, the Secretariat should identify and engage other partners and/or employ Secretariat capacity to meet these needs.**

Op. reco.	Responsible entity	Time frame	Impact/feasibility
1.1. TRP	Secretariat led by Access to Funding Department and Grant Management Division.	Now	High impact; moderate feasibility given there may be reluctance to act on recommendations
1.2. Technical partners	Secretariat. In the event that upskilling within the Secretariat is required, this will have resourcing and budget implications	Now	High impact; moderate feasibility given resource constraints to employ additional capacity

Operational recommendations for the next strategy to facilitate the implementation of Strategic Recommendation 1

- 1.3. Work with technical partners to strengthen support for the development of NSPs to ensure that they are evidence-based, highly targeted and prioritized within an anticipated resource envelope (and/or with scenarios).** This would represent a significant shift in approach for many countries which have previously designed NSPs to meet ambitious global plan targets. Global Fund support should ensure that NSPs better reflect and include consideration of and activities to address factors that influence the achievement of NSP goals—notably RSSH, equity, and HRG considerations (clearly linked to wider sector plans)—as well as plotting a course toward sustainability.
- 1.4. Building on operational recommendation 2.2, refine the funding model to ensure that prioritization decisions are based on solid evidence and analysis and reflect the Global Fund’s strategic priorities and a balance across VFM criteria.**
- Ensure that expanded work on VFM has been utilized alongside the inputs of technical partners, disease experts, CSOs and KVPs to provide a strong evidence base for the prioritization of interventions, population groups, geographies and service delivery modalities within the available resource envelope and appropriate to the country context. Ensure that the results of a rigorous prioritization process are reflected in Global Fund grant design, in the context of what is being supported by others.
 - Where particular issues are known to exist but countries fail to address them, the Secretariat should continue to reiterate its position (e.g. through allocation letters and technical/thematic guidance) and take a firmer approach—this could include making grant approval and/or the release of the full grant allocation contingent on these issues being addressed.
 - Study and design new approaches to understand and influence the political, institutional and financial incentives that drive current practice in the development and negotiation of NSPs and Funding Requests—this should draw on the Secretariat’s understanding and critical thinking on what can practically be done to generate political commitment, and evaluative/political economy analysis. This may involve greater staff time in country and/or senior-level Secretariat engagement at the country level.
- 1.5. Use catalytic investments selectively in areas where there is clear added value, as determined on a thematic (e.g. prevention, AGYW, HRG), country, or regional basis.** These should continue to focus on areas where uptake or performance has been weak, and/or where there is potential for innovation to improve results. They could also be restructured to reward achievement of results rather than to incentivize investment/inputs in some cases.

Op. reco.	Responsible entity	Time frame	Impact/feasibility
1.3. NSPs	Secretariat to engage with countries to ensure there is common understanding and demand for evidence based, highly targeted and prioritized NSPs, and ensure technical partners are able to provide required support.	To be conducted in this strategic period to ensure NSPs are strengthened for next strategic period	High impact; moderate feasibility. Will require significant shift in approach and buy-in from country stakeholders and technical partners (which may be reluctant to depart from approach aligned to global plans)
1.4. Funding model	a) Secretariat, led by Access to Funding Department, to ensure that guidance on prioritization is further strengthened. Technical and other partners are required to engage and support these processes. The TRP and Grant Management Division should ensure that this is translated into grant design	To be prepared for implementation in next strategic period	High impact; moderate feasibility. There may be challenges in building the evidence base in some settings and reluctance at the country level to fully utilize it
	b) Secretariat, led by Grant Management Division	To be prepared for implementation in next strategic period	High impact; moderate feasibility. May pose risks or unintended consequences where countries do not comply
	c) TERG to conduct studies	Study to be conducted within current strategic period to inform any changes in approach for next strategic period	Moderate impact; high feasibility
1.5. Catalytic investments	Secretariat, led by Strategic Information, TAP and Grant Management Division	To be prepared for implementation in next strategic period	High impact; high feasibility

Strategic Recommendation 2: Strengthen the partnership's focus on achieving results as a priority during the remainder of this strategy period as the basis for enhancing impact from the start of implementation during the next strategic period. This should include establishing strong incentives to enhance performance across the business model.

The review highlights that the Global Fund business model does not create strong and clear incentives for partners and other stakeholders to improve program results. Opportunities to do so through the structuring of contracts, arrangements, and processes are often missed. Instituting a strong focus on results should extend beyond the Secretariat (which the Performance and Accountability Framework is helping to achieve) to all direct service providers, most importantly technical partners, PRs and SRs/implementers working at country level. This will involve strengthening the mechanisms for partner and stakeholder engagement, monitoring, evaluation and learning, as well as grant oversight, and in some cases Secretariat capacity.

Short-term operational recommendations to facilitate the implementation of Strategic Recommendation 2 within the current strategic period

2.1. Develop an overarching MEL framework. While we note that this is already underway, the review suggests that this should be holistic of the defined ToC (see operational recommendation 4.1) and start from first principles;¹⁹³ ensure appropriate linkages between the information generated at different levels; fill gaps in the current system (e.g. in relation to equity, HRG, RSSH, partnerships); and prioritize lesson-learning. This should be based on a clear understanding of how achievement of the Global Fund's ambitious aims depend on timely access to actionable information about what works and what does not – and will likely

require an expanded role for grant-level and thematic evaluation. The framework should also accommodate the need for a differentiated approach across the portfolio. This should include consideration of the need for sub-national data, particularly in concentrated epidemics and be developed now to ensure alignment with other short-term actions, with a view to ensuring full roll-out for the next strategic period.

2.2. Strengthen processes to monitor and manage for VFM. This will involve:

- a) Strengthening and expanding analysis of VFM—notably through: (i) expanded unit costing work to facilitate improved and expanded analysis/modelling of allocative and technical efficiency; (ii) greater tracking and support for health technology utilization; and (iii) measuring progress on equity and sustainability.¹⁹⁴ These will mostly focus on program-wide VFM, but efforts should also be made to monitor and evaluate the VFM of grant investments and implementation arrangements. These analyses should be made widely available for incorporation into prioritization decision-making, program reviews (which may require greater Secretariat staff time in country), Global Fund performance frameworks and evaluation exercises—see operational recommendation 2.2.
- b) Developing a comprehensive approach to address risks associated with domestic procurement. This should aim to reduce heterogeneity in the current approach adopted, both across countries and stages of the grant lifecycle, and include tracking experiences with first line drug transition and more active Secretariat engagement in dealing with challenges. Consider requiring PPM, or another reliable procurement agent, until national processes can outperform global market prices and achieve comparable quality and on time, in full delivery.¹⁹⁵
- c) Ensure coordination between Secretariat teams responsible for different VFM components (e.g. as attempted through CRG Accelerate). In particular, in order to optimize investments in health technologies, address domestic procurement challenges and supply chain issues, and ensure VFM analyses are fully utilized in grant design and performance management processes, it is necessary to revisit Secretariat roles, information flows, and lines of accountability.

2.3. Strengthen tools to manage direct service providers. For technical partners:

- Refine and expand transaction-based relationships with defined timelines and outputs (and as part of this consider greater competition and choice of provider and introducing incentives to maximize grant performance through contractual agreements/Indefinite Quantity Contracts).
- Retain the global SCFs but strengthen the Action and Results Matrix to become a robust performance and mutual accountability tool.
- Introduce centralized budgets held by the Secretariat to disburse directly to partners. Develop performance and accountability measures for TA in grant performance frameworks monitored by the PR, LFA and Country Team.
- Strengthen mechanisms to improve TA coordination:
 - Retain principal focus on regional cooperation frameworks and fund the frameworks for specific actions in regions/settings with significant capacity constraints.
 - Consider the potential of and pilot a One TA plan for improved coordination (e.g. with GAVI for RSSH investments), which could be jointly monitored through country performance frameworks.
 - Consider mechanism for Country Team engagement with partners investing in RSSH (e.g. Gavi, Global Financing Facility) to ensure harmonization.

For PRs and SRs/implementers:

- Reform the performance framework to provide a more meaningful sense of grant implementation and improve accountability for implementation progress. This could include indicators on grant-specific outputs, perhaps limited to cover the priority areas

which would improve the ability of the Secretariat/CCM/partners/evaluators to engage in course correction discussions.

- Consider the merits of introducing measures of VFM into Global Fund performance frameworks. This could be through a series of simple quantitative indicators which are combined with a qualitative assessment and summarized through a scorecard approach. Such an approach should be used to monitor economy and efficiency, promote the importance of high quality implementation (which would be considered through assessment of effectiveness), progress in expanding service coverage among KVPs and in addressing human rights and gender-related barriers (which would be considered through assessment of equity), and progress in building RSSH (which would be considered through assessment of sustainability).

- 2.4. Reform the grant-rating and funding-decision processes to strengthen incentives to improve the programmatic performance of grants in line with the new Strategic Objectives.** The strengthening of incentives should involve financial rewards for performance that exceeds expectations (which could be programmed to expand on priority areas) and financial penalties for poor performance (which could be reprogrammed to other implementers in the same country or others via portfolio optimization). Structuring these arrangements should draw on lessons learned from the various Payment for Results trials (which could be expanded more widely across the portfolio and/or for specific grant components/catalytic investments) and the wider evidence base in this area. As above, ideally this would be based on a rounded view of grant performance (e.g. using a VFM scorecard approach) rather than only disease specific indicators. We note that the Secretariat is considering options on this at the time of writing.
- 2.5. Continue to address organizational disincentives to proportionate risk-taking.** The recommendations as a whole are intended to create the incentives for stakeholders to prioritize difficult and innovative activities that offer potential to improve programmatic results. Further efforts should be made to identify the critical barriers to achieving results and share evidence and lessons on what works in other settings—this should involve use of Country Teams, CCMs and partners actively lobbying for new approaches rather than acting passively under the umbrella of country ownership—as well as to ensure that overly burdensome grant processes and risk management measures do not deter investment in these areas or impede implementation. The Secretariat and partners should also take care not to disincentivize innovation by penalizing failure when trying something new.
- 2.6. Continue to strengthen CCMs as a mechanism for coordination and oversight where they show promise, but design and adopt alternative mechanisms where CCMs do not work well.** This will involve a more differentiated CCM approach where alternative arrangements are not treated as a last resort but simply where they can offer a more efficient and effective coordination and oversight mechanism. Alternatives should be context appropriate and could take the form of a small advisory/executive committee and/or expanded technical working group. Through the CCM or alternative mechanism, strengthen engagement with partners working in complementary areas (e.g. private sector, prevention programs, health systems financing and systems strengthening, etc.).
- 2.7. Study the implications to the business model of working across different contexts and in meeting different needs.** This should include analysis of the implications of decentralized/devolved national budgets; policy, governance, and accountability mechanisms; and implementation structures and PHC systems. It should also include analysis of how the business model can work to facilitate sustainable private sector engagement in health service provision, linkage, and reporting. Adaptations to the business model should be made to address identified issues.

Op. reco.	Responsible entity	Time frame	Impact/feasibility
2.1. MEL	Secretariat	Now, with changes piloted to ensure readiness for next strategic period	High impact; high feasibility
2.2. VFM	a) Secretariat, led by Strategic Information, with technical agencies contracted as needed to conduct analysis. Country and partner engagement are required to ensure that outputs are acted upon	Expansion of VFM analysis will require additional budget and may not be possible until next strategic period	High impact; moderate feasibility. Some analyses may continue to be hampered by poor quality data (e.g. unit costing work for technical efficiency analysis). There may be some reluctance to act on recommendations
	b) Secretariat led by Grant Management Division and Supply Operations Department. Implementation of the policy will require country stakeholder buy-in and partner support	Now	Moderate impact; moderate feasibility, although potential impact will grow over time as domestic procurement increases. Will require buy-in and engagement from country stakeholders
	c) Secretariat	Now	Moderate impact; high feasibility
2.3. Manage service providers	Secretariat	Now. Some aspects may require piloting with a view to wider roll-out in the next strategic period	High impact; moderate feasibility. There may be some push back from stakeholders on increased reporting requirements. Data may not be available to set meaningful baselines and targets for some VFM measures
2.4. Incentives	TERG to conduct study and draw out lessons on Payment for Results trials.	Now	High impact; high feasibility
2.5. Risk	Secretariat led by the Risk Department and Grant Management Division. Will require partner engagement to identify barriers and encourage more ambitious programming	Now, also feeding into the next strategic period	High impact; moderate feasibility. Shifting a culture away from one that has been risk averse will likely take time to embed at the country level
2.6. CCMs	Technical partners with support from the Secretariat	The CCM Evolution SI should resume when feasible. Where alternative arrangements are required, these should be adopted within the current strategic period	High impact; moderate feasibility. CCMs struggle to fully function in many countries due to a variety of factors. Technical partner leadership in this area is critical but could be a barrier to making progress
2.7. Business model	TERG	Conducted within current strategic period to inform a differentiated approach for next strategic period	High impact; high feasibility

Operational recommendations for the next strategy to facilitate the implementation of Strategic Recommendation 2

- 2.8. Consider new grant modalities with longer-time horizons on grant agreements.** The three-year funding cycle and focus on results may work well for replenishment, but efforts should be made to work around and mitigate its detrimental effects on long-term planning,

investments, and sustainable results in HRG and RSSH in particular. This does not necessarily mean extending the grant duration; a range of options are possible. The concept of a development continuum could be helpful in this regard to ensure that grant designs are aligned to longer-term vision that builds toward sustainability. Efforts to plan investments in specific areas over multiple grant periods (e.g. through the Breaking Down Barriers initiative) should be expanded. This may require more nuanced budgeting processes, for instance with tentative/indicative planning beyond what the Global Fund can immediately commit to (e.g. in line with Medium-Term Expenditure Framework (MTEF) mechanisms).

2.9. For the new strategic MEL framework at the corporate level, the Secretariat should:

- Build on reforms to the performance framework, provide more meaningful measures of how the Global Fund's investments are performing, and address current gaps in strategic enablers (e.g. partnerships, innovation) and particular areas of investment (e.g. RSSH, HRG). This should be informed by key pathways in the ToC (see operational recommendation 4.1).
- Reflect progress toward Global Fund strategic targets at the outcome and impact levels for each disease separately (i.e. to avoid indicators that aggregates across the three diseases) and in the context of progress toward global plans – this may involve replacing the Lives Saved Model with an easier to interpret indicator on mortality reduction; and
- Continue to report on progress towards service coverage targets using high and low (or optimistic and conservative) projections. This should however be refined for the high projection to reflect historic progress towards targets; and for low projection such that a reasonable degree of progress is assumed throughout the entire strategic period.¹⁹⁶ This should also be expanded to all service coverage indicators where possible.

2.10. Ensure that the Secretariat is adequately resourced and working arrangements are in place to meet evolving demand. This will include the need for greater internal technical capacity to engage more fully in grant design where technical partners are not fully able to meet needs, and to ensure that Country Team skill sets are appropriate as the Global Fund shifts to ensuring sustainable responses to the three diseases (e.g. which may require more senior-level experts who are fluent in both public health and domestic financing). There is considerable scope for the Secretariat and Country Teams to become a more continuously engaged partner at the country level through the use of virtual platforms (which have been normalized through COVID-19). This could have significant benefits and help to address a number of our recommendations but has implications for resourcing.

Op. reco.	Responsible entity	Time frame	Impact/feasibility
2.8. Grant horizons	Secretariat and partners	For next strategy	High impact; moderate feasibility. Will require long-term commitments from countries and partners
2.9. MEL	Secretariat. Consider partners taking greater responsibility for reporting on Global Fund strategic progress in the context of progress to global plans	For next strategy	Moderate impact; high feasibility
2.10. Sec resourcing	Secretariat to communicate needs and budgetary implications to Board for approval	For next strategy	High impact; moderate feasibility. Any revisions will require Board approval

Strategic recommendations for the next strategy

Strategic Recommendation 3: An important new emphasis in the next strategy should be on strengthening the Global Fund's ability to adapt to the range of possible contexts that it might operate post COVID-19.

The rapid emergence of COVID-19 has shown how a global pandemic can affect virtually every aspect of implementing the Global Fund Strategy; and how the Global Fund partnership is able to respond to such a threat. Our limited evidence on the Global Fund's initial response is that it has been smart, swift and focused. Nevertheless, a practical consequence will be the difficulty in differentiating the causes of any under-performance against the strategic targets due to shortcomings in the current Strategy and operationalization of the business model from those associated with COVID-19. This will also make setting of new targets, which rely on stability and predictability in the broader context difficult. This needs to be recognized in reviewing the Global Fund's future performance.

More significant, the consensus view is that the immediate health and medium- and long-term economic, financial and health systems impacts of COVID-19 will be large. How significant these impacts will be cannot easily be predicted as they will be contingent on responses by multiple stakeholders. Development of the next strategy should therefore include a significant focus on testing the resilience of the Global Fund strategy and business model under multiple scenarios. Scenario planning, a strategy development tool that has been used and refined over several decades, should therefore be incorporated into the process of developing the next strategy.

This Strategic Recommendation does not have any operational recommendations.

Strategic Recommendation 4: For the next strategy, the current SOs 1, 2 and 3 should remain at the forefront of the next strategy. However, the next strategy should make it clear that the SOs are mutually dependent with each critical to achieving the other. The business model should adapt to shift the priorities within each SO and enhance coherent management across the three.

Our conclusions show that the current SOs 1, 2, and 3 remain critical for delivering effectively against the Global Fund's mission. Key areas where the new strategy needs to ensure greater prioritization in line with the three SOs are:

- a) **Maximize impact against HIV, TB, and malaria (SO1):** Enhanced delivery requires greater prioritization of prevention programming to reduce new infections/cases and more focus on ensuring equitable outcomes through prioritization of progress in low performing geographies and programmatic areas, and among specific population groups.
- b) **Build RSSH (SO2):** The next strategy should clearly specify what is required from a health system to ensure financial and programmatic sustainability. Based on this, the strategy should then identify what is realistic and within the scope of the Global Fund to achieve and where this might link to the efforts of others operating in this space. This should include consideration of whether all the current operational objectives are relevant and necessary; whether new areas may merit inclusion, for instance in relation to systems for global health security; and where the Global Fund offers comparative advantage and its efforts should be focused.
- c) **Promote and protect HRG (SO3):** The need to effectively address human rights and gender equality as critical components of disease responses is a recognized and long-standing challenge for the Global Fund. The next strategy should nonetheless seek to intensify the focus on these priorities, including by drawing on lessons from the catalytic investments in this area which suggest that dedicated funding and technical assistance can yield gains. Consideration could also be given to focusing the SO more broadly on 'achieving equity' since this might more explicitly emphasize the linkages to other the SOs and secure greater buy-in (and could also be seen as benefiting health beyond the three diseases) but possibly at the

expense of losing traction/focus on human rights and/or gender equality specifically.

Alternatively, equity could be framed as a principle underpinning the entire strategy.

The next strategy should make clear that the new Strategic Objectives are mutually dependent, with each critical to achieving the other.

Notwithstanding that the SOs remain valid, the context within which they will operate will be different. In particular, the next strategy will be drafted amid significant uncertainty about the eventual health, economic and political impact of the COVID-19 pandemic. More collaborative ways of working will be imperative to ensure progress against the SOs, particularly SOs 2 and 3, which require significant multi-sector coordination and joint working. The Global Fund's engagement through the Access to COVID-19 Tools (ACT) Accelerator, may offer lessons and/or set a precedent for future co-working arrangements between governments, scientists, businesses, civil society, philanthropists and global health organizations.

Finally, we recommend that the current SO4—to mobilize increased resources and achieve VFM in their use—should be positioned as a strategic enabler alongside the Global Fund business model and role of partnerships.

Operational recommendations for the next strategy to facilitate the implementation of Strategic Recommendation 4

4.1. Develop a Theory of Change (ToC) to clarify and articulate how the Global Fund partnership will achieve the Strategic Objectives, as well as position the Global Fund to engage in wider global health agendas. The Secretariat should develop this as part of the new strategy which articulates how the different elements of the business model and critical enablers are intended to ensure that investments maximize VFM and lead to the achievement of the Strategic Objectives. The ToC should also situate the Global Fund in the wider global health ecosystem and should draw linkages from the Strategic Objectives to other global health agendas (e.g. climate change, COVID-19, GHS, AMR, One Health, UHC, SDGs). This would make clear how and where the Global Fund will seek to engage partners beyond the three disease programs, where there is common interest. We point to the ToC paper that underpins the 2018–2021 UNICEF Strategic Plan, and the process by which both documents were developed, as a relevant example of good practice.

Any decisions on how far the Global Fund should go in pursuit of wider health agendas, implying an expansion of organizational mandate, is necessarily a political one. Evidence from this review suggests that any expansion should be carefully managed so as not to detract from or adversely affect progress towards other SOs. Prioritizing health system strengthening and sustainability, as well as better demonstrating the Global Fund's contribution to these objectives (see later recommendations on MEL), would enable linkages to wider health agendas to be drawn and strengthened without any expansion of the mandate.

Op. reco.	Responsible entity	Time frame	Impact/feasibility
4.1. ToC	Secretariat led by Strategy and Policy Hub, but will ideally involve partner engagement and Board agreement	To be prepared for implementation in next strategic period	Moderate impact; high feasibility. Will require significant effort to get agreement on ToC structure and assumptions

Strategic Recommendation 5: For the next strategy, position programmatic and financial sustainability for the three disease responses as a high-level strategic priority and ensure mechanisms are in place to operationalize this priority.

This could include making sustainability a strategic objective and/or the overarching goal to which other SOs contribute. This would be effective at signaling its importance to the Secretariat, partners and country stakeholders, and communicate that it should not be treated as a siloed issue, but requires a meaningful and coherent approach across the full scope of the Global Fund's work.

Consideration should be given to broadening the definition of sustainability used by the Global Fund beyond just the three diseases to incorporate the expected benefits of investments to other health agendas/sectors.¹⁹⁷ This would be helpful in clarifying and ensuring that the Secretariat and partners project a common position on the need for the Global Fund to invest in health systems strengthening; and its response to strategic recommendation 4 above. Such an approach would also allow the Global Fund to demonstrate a stronger commitment to supporting wider global health agendas.

The Board will need to consider how and whether framing sustainability in the manner suggested and as a high-level strategic priority can be complimentary to the objective of disease elimination. Slow progress towards disease elimination, as noted extensively throughout this report, combined with the anticipated deleterious effects of COVID-19, suggest that disease elimination, especially for TB and HIV, will be highly improbable in the short-, medium- and even longer-term. While disease elimination is an ambitious goal and has been highly useful as an advocacy strategy, it may ultimately prove detrimental if pursued programmatically and not achieved. As such, there may be merit in framing these goals in a nuanced manner by disease.

At a minimum, we would expect meaningful progress against this priority to require a number of changes to how the business model supports prioritization in NSPs and Funding Requests. Areas of focus should include how the present model supports prioritization of strengthened CSO and community-led systems, investments for KVP and prevention programming, addressing HRG and equity barriers, and strengthening health systems. This will be challenging in what is another well recognized difficult area for all funding agencies and would require partners and countries to support and agree to make hard decisions. Furthermore, its delivery might require accepting a reduction in short-term results delivered when the consequences of COVID-19 would already be depressing progress against the Global Fund's strategic targets.

Short-term operational recommendations to facilitate the implementation of Strategic Recommendation 1 within the current strategic period

5.1. Strengthen and expand the key 'pillars' of work on sustainability across the portfolio, differentiated by country positioning along the development continuum (see operational recommendation 5.2), with a clear path to addressing inequities, structural and HRG barriers, strengthening the health system and sustaining service delivery.¹⁹⁸

Op. reco.	Responsible entity	Time frame	Impact/feasibility
5.1. Sustainability	Secretariat with support from technical partners and buy-in and engagement by country stakeholders	Most steps can be taken now and integrated within the grant designs for NFM3	High impact; moderate feasibility. Required country and partner buy-in. Could also have Secretariat resource implications that will require Board approval

Operational recommendations for the next strategy to facilitate the implementation of Strategic Recommendation 5

5.2. Further embed differentiation throughout the business model to ensure that context sensitive approaches are utilized to achieve all four SOs. A number of aspects of the business model already implement a differentiated approach – e.g. eligibility, allocation, co-financing, transition preparation – but this mostly misses what is actually funded and grant implementation arrangements, and how these should evolve as countries progress along the development continuum. As such, there is scope for the Global Fund to further operationalize the concept of differentiation as part of an approach that more actively considers the longer-term goal of financial and programmatic sustainability. While it is for the Secretariat to consider the most appropriate modality to take forward this recommendation, and there may be a number of ways to do it, in our view, there is considerable merit in utilizing the concept of a development continuum as a framework for guiding the application of all differentiated policies, processes

and approaches. Clearly there is no perfect way to measure where a country sits on or makes progress along the development continuum. Nonetheless, the concept and how it is operationalized will likely gain traction if country progress can be specifically measured along the continuum. While we would expect this to be based on the general criteria posed by the 2015 Development Continuum Working Group,¹⁹⁹ it need not be a purely mathematically derived formula and progress could be adjusted qualitatively, for instance to take account of specific contextual factors. It could be operationalized through a framework setting out ‘guiding principles’ for what the Global Fund is willing to fund (and not fund) as countries progress along the continuum and build toward a point of sustainability—this might involve, for instance, phased approaches to balancing treatment and prevention budgets, progressive investments in RSSH along the ‘4S model’ and working to address human rights and gender-related barriers in a manner builds on previous gains made to create a supportive/enabling environment to achieve and sustain impact over time.²⁰⁰ This would also involve setting clearer expectations on what should be funded by others (donors and domestically); how the Global Fund and partners work together to achieve shared objectives; and further differentiating aspects of the business model based on country positioning along the continuum—e.g. funding model, MEL requirements, CCM model, TA delivery, oversight and risk management measures, technical guidance and guidance on VFM.

While the ToC (as per operational recommendation 4.1) and development continuum need to be linked, there is a clear distinction between them. The ToC explains and presents the process by which the different aspects of the business model work to achieve each of the SOs. The development continuum describes how the various policies, processes and what is actually funded are differentiated (both across the portfolio at a given point in time, and throughout the duration of the Global Fund’s support to any given country) to ensure context appropriate investments and ways of working that enable achievement of the SOs. In combination, the ToC and development continuum would allow the Secretariat to continually test its own assumptions of how the business model works to achieve SOs and build towards a long-term objective of sustainability. It also offers an opportunity for a more holistic and nuanced approach to country engagement that can be flexible to context yet present a firmer position on what is and is not appropriate to fund at different stages of a country’s development in order to maximize disease impact and ultimately sustainability.

Op. reco.	Responsible entity	Time frame	Impact/feasibility
5.2. Differentiation	Secretariat led by Grant Management Division. Aspects of approach would benefit from agreement by countries and partners	To be prepared for implementation in next strategic period	High impact; moderate feasibility. Will require significant effort to operationalize, requiring revisions to technical and operational guidance, and gain country and partner buy-in

Endnotes

- ¹ Some hold viewpoints that disease elimination is the best way to achieve sustainability and the Global Fund should be working to achieve this as quickly as possible, without the need for longer-term systems strengthening; versus the view that elimination is unlikely to be achieved in the medium-term, and longer-term sustainable solutions for most diseases in most countries and regions are still required.
- ² <https://www.cgdev.org/publication/understanding-opportunity-cost-seizing-opportunity-report-working-group>.
- ³ Some of these questions (denoted by '(R)') have been revised from what was set out in the Request for Proposals. These revisions are discussed in the module sections below, with the original and revised questions set out in Annex 2.
- ⁴ Global Fund Strategy targets are lower than global plan targets as they are adjusted based on the expected availability of funding, whereas global plan targets are based on needs to end epidemics. This benchmark is nonetheless helpful for considering KPI progress in the context of global performance.
- ⁵ This is due to the assumption that service coverage targets (which align to Global Fund Strategy targets) will be met for all grants in all countries. Based on historic achievement of Global Fund service coverage targets and most recent progress against current targets, our analysis suggests that this is unlikely.
- ⁶ This is primarily as it assumes that no further progress will be made beyond the last year where each country specific target is agreed in the performance framework (usually 2020) to the end of the Strategic period (i.e. 2022).
- ⁷ We consider that this is the case even when acknowledging that the targets for these indicators are ambitious, more so than for other KPI targets.
- ⁸ This is the case even despite the successful 2019 Global Fund replenishment and assuming countries fulfil the ambitious domestic resource mobilization requests being made of them through the replenishment investment case.
- ⁹ 43rd Board meeting. Strategic Performance Report end 2019; Annex 2: Detailed KPI results
- ¹⁰ These analyses include most up-to-date data provided by the Global Fund.
- ¹¹ Seven additional countries have reported no indigenous cases of malaria since 2015. This is 'on track' to meet the Global Technical Strategy target of ten additional countries with no indigenous case of malaria by 2020.
- ¹² Strategic Performance Report mid-2019, 42nd Board Meeting, GF/B42/19, 14-15 November, Geneva, Switzerland
- ¹³ Our analysis compares progress against Global Fund Strategy indicators using both the cohort of countries used to calculate KPI2 progress and UNAIDS cohort country data. Global Fund Board Strategy Committee report 2017-2022 Strategic KPI Framework: Proposed performance targets for KPIs 1, 2 & 8, Annex 1: Overview of models and methods for KPIs 1,2 and 8. https://www.theglobalfund.org/media/8057/sc02_er02_annexes_en.pdf, accessed 25 May 2020.
- ¹⁴ Trends in this region are influenced by increases in one country that has historically not been supported by the Global Fund, but now is.
- ¹⁵ Alonso P. Recent changes in malaria epidemiology at the World Health Organization Malaria Vaccine Research and Development Consultation. Presentation at MALVAC, 15 – 16 July 2019. 20 Pryce J et al.
- ¹⁶ Placement along the y axis of the map (enabling vs. hindering) is based on the SR2020 team's judgment—informed by expert interviews, literature review and case studies—with enabling factors toward the top and hindering factors toward the bottom. The factors in the middle include those which show mixed progress across countries or where progress has improved but is still not good enough to be placed in the top—highly enabling—part of the figure. Placement along the x axis is based on the degree to which the Global Fund business model is able to shift the factors.
- ¹⁷ For example, in Eswatini, government revenues continue to decline while government expenditures increase. Similarly, in Ukraine the analysis of fiscal indicators indicates that without any monetary policy action there is no potential to increase total government expenditure in the short-term, and that any increases are likely to be realized only through increased tax generation and/or continued growth in gross domestic product (GDP), which is highly uncertain. In these scenarios, any increased allocation to health would most likely require a reduction to other sectors. What this has implied for countries such as Malawi, where the fiscal space for health is severely constrained, is to look at potential efficiency gains.
- ¹⁸ Wagstaff A., Neelsen S, (2019) A comprehensive assessment of universal health coverage in 111 countries: a retrospective observational study. *Lancet Global Health*, [https://doi.org/10.1016/S2214-109X\(19\)30463-2](https://doi.org/10.1016/S2214-109X(19)30463-2).
- ¹⁹ See, for example, Deep Dive on Sustainability, Transition, and Co-financing (STC) Policy, 2019.
- ²⁰ Technical Evaluation Reference Group: Thematic Review on Sustainability, Transition and Co-financing (STC) Policy Position Paper, Management Response and Report, January 2020.
- ²¹ Peter Sands, update to the 40th Board meeting
- ²² Email confirmation from Dianne Stewart, Head of Donor Relations at the Global Fund, 30 July 2020.
- ²³ <https://www.uhc2030.org>
- ²⁴ There is also significant additional 'funding' for RSSH in the PAAR, usually for pilot expansions undertaken with grant funding.
- ²⁵ These are: health management information systems (HMIS); procurement and supply chain management (PSM); human resources for health (HRH); ISD; community systems and responses; governance, leadership, and accountability (GOV); health sector financing and financial management (PFM). Private sector engagement and public-private mix and program implementation and management (PIM) are not RSSH modules, but are often considered as part of RSSH.
- ²⁶ This is based on analysis of two datasets with Funding Request information for the 2017–2019 allocation period. One on the 12 Country Case Studies for SR2020; the other the combination of country case studies form the TRP/RSSH, TERG/RSSH, TERG/STC, and TERG/SR2020 reviews, a total of 77 Funding Requests, including allocation, PAAR and Matching Fund modalities.
- ²⁷ TRP (2018) TRP Report on RSSH Investments in the 2017–2019 Funding Cycle. GF/SC08/04—Annex 2; 8th Strategy Committee Meeting; October 4–5, 2018, Geneva, Switzerland.
- ²⁸ https://www.who.int/healthsystems/strategy/everybodys_business.pdf?ua=1
- ²⁹ Program services integration seeks to find efficiencies, effectiveness and equity at the point of service delivery where differentiated client needs may coalesce and be found at a one-stop point of care.
- ³⁰ Emerging evidence (including observations from case studies) suggests that the work commissioned under the related SI has been of very high quality, however, the TA has been delayed in many countries and there have been challenges to operationalizing its recommendations (in part due to poor coordination between Secretariat teams). Data also indicates that countries in of TA continue to

- face significant PSM challenges (e.g. Nigeria, Uganda, Malawi, Pakistan). These challenges are not usefully highlighted through KPI6b, as intended, with stakeholders noting that reporting on this indicator is expensive and does not reflect useful information on TA performance nor on the country's supply chain integrity. SIs: Additional Supporting Materials for Update, Management Executive Committee Presentation April 6 2020. The Global Fund's In-country Supply Chain Processes April 28, 2017.
- ³¹ This is defined as 80% of facilities reporting for combined set of sub-indicators and good data quality per last assessment.
- ³² For information, equity was defined differently in the VfM Review of Funding Requests, Presentation to the TRP April 2020: Equity: 'ensuring that programs are reaching key populations as driven by epidemiology and programmatic necessity, addressing barriers to access for persons of lower socio-economic status, those who face discrimination or who face other structural barriers.'
- ³³ A range of evidence suggests that there has been weak ownership of HRG issues across the Secretariat (which is partly a function of varying degrees of awareness and understanding). To address these gaps, in July 2019, the CRG Department implemented *CRG Accelerate*, a 6-month reorganization effort designed to provide more effective and focused CRG support to the Secretariat. This involved CRG staff shifting to serve as generalists for a percentage of their time, organized around Global Fund regions, and with some anecdotal evidence of strengthened integration of HRG issues into TB programming. Dedicated TB focal points have also been assigned to provide CRG-focused support to GMD and Country Teams through Funding Request reviews and Grant-Making.
- ³⁴ https://www.who.int/gho/health_equity/en/.
- ³⁵ WHO, TB in prisons, <https://www.who.int/tb/areas-of-work/population-groups/prisons-facts/en/>
- ³⁶ RB Malaria Partnership to End Malaria (2019) Gender-responsive strategies to End Malaria, Thematic Brief, p.1-2
- ³⁷ EHG, Itad, UCSF, IHME, PATH. (2020) Prospective Country Evaluation 2019/20 Synthesis Report; EHG, Itad, UCSF, IHME, PATH. 2019. Prospective Country Evaluation 2018/19 Synthesis Report.
- ³⁸ The Technical Brief Malaria, Gender and Human Rights, November 2019.
- ³⁹ UNAIDS Laws and Policies Database.
- ⁴⁰ L F Johnson, P Mulongeni, A Marr, T Lane (2018) Age bias in survey sampling and implications for estimating HIV prevalence in men who have sex with men: insights from mathematical modelling. *Epidemiol. Infect.* 146(8):1036–1042. doi: 10.1017/S0950268818000961.
- ⁴¹ EHG, Itad, UCSF, IHME, PATH. 2020. Prospective Country Evaluation 2019/20 Synthesis Report; EHG, Itad, UCSF, IHME, PATH. 2019. Prospective Country Evaluation 2018/19 Synthesis Report.
- ⁴² In 2017, Global Fund investments meant that 696,000 women received PMTCT services (The Global Fund (2019) Investing in the Future: Women and Girls in All their Diversity, May 24, 2019, p.21) However, there is still low coverage of women on ART across regions. For example, though treatment rates in ANC clinics are high, only 56% of HIV-positive pregnant women in Asia are on ART, suggesting continuing and significant barriers to accessing and receiving care. Additionally, less than half of infants exposed to HIV are tested within two months of being born and AIDS-related illnesses still represent the highest cause for mortality in HIV+ infants.
- ⁴³ Gender-Focused Grant Review, Global Fund 2019.
- ⁴⁴ The Global Fund (2019) Step Up the Fight; Investment Case Sixth Replenishment 2019, p.43. Our analysis shows that global new cases of HIV among female youths (15–24) have been decreasing 2010–2017 which is correlated with a decreasing number of out of school females, especially in South and Eastern Africa. West-Central Africa has allocated a lesser proportion of total grant awards to prevention in adolescents and youth. The region also displays a much slower decline in out of school youth as well as very little change in the number of new cases of HIV. This suggests that the investment in adolescent girls through prevention and education can be a powerful tool for mitigation of HIV infection.
- ⁴⁵ Gender-Focused Grant Review, Global Fund 2019.
- ⁴⁶ The Global Fund (2020) Report on Community, Rights and Gender, 43rd Board Meeting, GF/B43/04, May 14–15, 2020, Virtual, p.21
- ⁴⁷ There are difficulties in estimating investment in human rights, and HRG more generally, as the data categorisation does not lend itself well to this disaggregation and it is not mandatory to provide human rights domestic investment details in the funding landscape table or allocation letters. As such, the estimates presented below should be interpreted with caution as an 'informed estimate' but not as comprehensive.
- ⁴⁸ UNAIDS (2019) Communities at the centre; Defending rights, breaking barriers, reaching people with HIV services, Global AIDS Update 2019, p.115
- ⁴⁹ The Global Fund (2019) Investing in the Future: Women and Girls in All their Diversity, 24 May 2019, p.25.
- ⁵⁰ Data sources and assumptions: (i) % of Human rights module investments (A) is calculated from detailed budgets under 'Programs to reduce human rights related barriers'; (ii) % of Human rights investments falling outside the module (B) is calculated through the KPI 9b methodology and reporting for 56 countries for HIV and 11 for TB (31 Jan 2019); (iii) Countries with human rights module investments (A) which are not included in the KPI9b methodology are assumed to spend the same percentage on (B). Advisory Review Removing human rights-related barriers: Operationalizing the human rights aspects of Global Fund Strategic Objective 3, November 2019.
- ⁵¹ Advisory Review Removing human rights-related barriers: Operationalizing the human rights aspects of Global Fund Strategic Objective 3, November 2019.
- ⁵² The Global Fund (2019) Focus on Human Rights, May 2019, p.3.
- ⁵³ Advisory Review Removing human rights-related barriers: Operationalizing the human rights aspects of Global Fund Strategic Objective 3, November 2019. UNAIDS laws and policies database.
- ⁵⁴ These might include, for example, shifts in HIV related policies and laws <http://lawsandpolicies.unaids.org/>. At the time of this review, mid-term assessments were underway in the 20 countries included the BDB initiative, and these may provide data on impact.
- ⁵⁵ As of April 2020, 10 of the 21 technical briefs posted on the Global Fund website were CRG-related, including a brief on Gender and Human Rights for each of the three diseases.
- ⁵⁶ For instance, for RSSH while there is clearer guidance on the need for a differentiated approach to shift investments from supporting to strengthening health systems, there are a number of gray areas, for instance, relating to how the costs of procuring and distributing commodities should be allocated across modules; in what settings countries should invest in capital investments for ISD, and health worker salaries and incentives; whether disease specific investments in HMIS (e.g. for a prevalence survey) should be considered as RSSH; and how/whether program management costs can be allocated to the module on financial management systems.

- ⁵⁷ E.g. through SIs; bilateral set asides; BMGF work with WHO on TB NSP strengthening and unit costs; Avenir Health on impact modelling (see also Partnerships), and PMI/PEPFAR involvement.
- ⁵⁸ Strategic Recommendations 2015 and PCE Synthesis Report 2017/18.
- ⁵⁹ Less evident at this point are developments to align Global Fund funding cycles of three years with national strategy planning cycles of five years—a recommendation emerging from the 2018 Access to Funding Recommendations Report for the 2020–2022 cycle and supported by evidence from other sources such as the PCE.
- ⁶⁰ EHG, Itad, UCSF, IHME, PATH. 2019. Prospective Country Evaluation 2018/19 Synthesis Report.
- ⁶¹ The Strategic KPI focuses on alignment of Funding Requests with NSP but the KPI does not track the quality of the NSP, which is important given the level of partner engagement and TA investments in this area every funding cycle. Partner investment includes that provided through SIs; bilateral set asides such as France 5%, German international development organization, GIZ, UNAIDS Technical Support Mechanisms; Bill and Melinda Gates Foundation (BMGF) work with WHO on TB NSP strengthening and unit costs; Avenir Health on impact modeling; and the President's Malaria Initiative (PMI)/PEPFAR involvement.
- ⁶² TRP Observations Report 2017–2019.
- ⁶³ WHO 2018 Focus on Key Populations in HIV NSPs in the African Region.
- ⁶⁴ This dilemma is most evident in malaria, for example in the following representative examples of TRP issues raised during NFM2:
'... in the context of a lack of funding for other key interventions, the TRP recommends a careful review of the relative anticipated impact of IRS in comparison to IPTp and SMC, and other programmatic aspects, which are under-funded in the allocation request, to ensure that the funding mix is structured to achieve the greatest impact.'
'Considering the extent of the burden of malaria and the less than optimal prevention/vector control strategies, the incidence of severe malaria will be significant in the country, the TRP is concerned that injectable artesunate is only provided for through funding under the PAAR.'
- ⁶⁵ See Box 1 of the TB Information Note July 2019 and Box 3 of the HIV Information Note September 2019.
- ⁶⁶ *Allocative efficiency models*, based on disease transmission and costing, are being applied in 60 countries, including all high-impact countries, by June 2020 in addition to some non-high-impact countries identified by the PRI team. Also, *geospatial modeling* (mapping the physical distribution of health services and epidemiological impact variations to inform more rational planning) is ongoing in five countries.
- ⁶⁷ May 2020 KPI4 report to Board states 'a very limited number of countries have applied malaria epidemiological impact models to inform the development of NSPs and Funding Requests.'
- ⁶⁸ Modeling work is heterogeneous, determined by the research question and the Terms of Reference (ToR) agreed by the country. It also does not factor in all criteria which may be relevant to resource allocation decision-making in a country. Some models determine the optimal prioritization of geographies and populations to target but assume within the parameters a standard intervention mix, which may not include all of the possible interventions. This does not help if resources are scarce and countries need to decide whether to introduce PrEP in one population group at the expense of increasing service coverage in another group, for example. Work to build equity parameters into allocative modeling is embryonic. Across diseases, a key challenge is that modeling work is agnostic of social and political considerations, which may pull in different directions from the modeling results. For example, politics may incentivize coverage of large geographies and population groups in the context where a more targeted approach is warranted. Similarly, even though prevention may be more cost-effective, social values may dictate a prioritization of case management to prevent deaths.
- ⁶⁹ Within the Secretariat, the Country Teams are the data owners of these studies, so it becomes necessary to get approval from each Country Team to obtain access to studies conducted in/for that country (the same issue was noted when country data is needed to support market shaping objectives).
- ⁷⁰ Such as the TRP Observations Reports; other specific technical inputs such as the RSSH roadmap workstream.
- ⁷¹ Global Fund (2019) Portfolio Optimisation: An overview.
- ⁷² Indeed, although we have not been able to obtain data to confirm this and are not implying that this has an impact on results, given that RSSH and HRG activities are often among the lowest absorbing areas, it is likely that portfolio optimization has taken money away from these areas.
- ⁷³ Despite efforts to streamline grant revision processes, evidence from the PCE and our case studies indicates that revisions are still lengthy and burdensome.
- ⁷⁴ As part of the 2017–19 allocation methodology, USUSD 800m was reserved for catalytic investments to 'ensure delivery against the 2017–2022 Global Fund Strategy'. They aim to do so by investing in priorities that are unable to be addressed through country allocations alone, yet deemed crucial to ensure Global Fund investments are positioned to deliver against its strategic aims. Where possible, catalytic investments are intended to build on country allocations to underpin direct investments in recipient countries and to strengthen countries' responses to fight the three epidemics'. GF/B35/DP04.
- ⁷⁵ An alternative would also have been to initiate Payment for Results in these areas—e.g. by paying a performance related bonus for every additional TB case found. This would incentivize countries to select and pay for TA providers where they felt this would help and would have avoided the significant transactions costs incurred through the separate catalytic funding streams.
- ⁷⁶ Given that SR2020 began only a few months after the Market Shaping Strategy (MSS) Mid-Term Review (MTR) was concluded, it was agreed that SR2020 would focus on those areas suggested by the MSS MTR as important for the Global Fund's overall Strategy. As such, following a short summary of the main MSS MTR findings, we focus on the risks associated with increased domestic financing; market-shaping objectives beyond availability and affordability, to cover spend channels beyond PPM; and institution-wide efforts shape markets through supporting introduction and scale of new or underused health products.
- ⁷⁷ TERG Market-Shaping Strategy Mid-Term Review Final Report, July 31, 2019, Boston Consulting Group.
- ⁷⁸ This came about in tandem with the change in the business model in 2013–2014; and the shift to an allocation-based funding model that led to more active engagement from the Secretariat.
- ⁷⁹ TERG Market-Shaping Strategy Mid-Term Review Final Report, July 31 2019, Boston Consulting Group .
- ⁸⁰ For 2019, 83% of the USD 59 million savings surplus is driven by ARV and LLIN product categories. 1st line ARV regimen volume increased by 18% vs. projection from late 2018. 1st Line regimen is the key driver of ARV savings. Further price decrease of ARV 1st Line regimen by 8% and lower prices for other ARV products achieved as a result of regular supplier negotiations. There has been an

increase in PBO LLIN volume 15% vs. 5% of overall volumes projected. Increased PBO net uptake and PBO net price decreases due to supplier negotiations resulted in larger LLIN savings. Further 11% decrease in prices of ANTM medicines (AL) has been achieved as a result of upstream strategy of securing artemisinin supply and stabilizing artemisinin prices.

⁸¹ TERG Market-Shaping Strategy Mid-Term Review Final Report, July 31 2019, Boston Consulting Group.

⁸² Country teams, sourcing team and disease leads—all required for product introduction and scale up—separated into GMD, SSC, and TAP divisions, with no structured mechanism to coordinate and share information. Because the Secretariat divisions, and information holding, is so piecemeal, it becomes necessary to talk to each FPM to find out for, e.g. when net campaigns are scheduled, which size nets, type, quantities each country will buy. Under the new nets project, the TAP focal point will be responsible for doing that ‘but it would be so much better if it were possible to just click a button and have the information.’ (KII)

⁸³ e.g. RDT interchangeability, PBO vs. standard LLINs.

⁸⁴ Examples of countries fully funding ART with domestic funds: Bangladesh, Philippines, DPRK, Egypt, Columbia, Botswana, India, Honduras, Georgia, Sri Lanka. Countries relying fully on Global Fund or other partners are primarily lower-income or LMIs, COE and small island economies, and almost universally have high or less than high disease burden (as opposed to severe or extreme, 42/48)—i.e. Ethiopia, Mozambique, Central African Republic, Gambia, Rwanda, Kiribati, Samoa, Tonga, Guinea Bissau.

⁸⁵ Jan 2020 wambo.org consultations: Health financing trends and Global Fund efforts to strengthen the sustainability of national procurement programs.

⁸⁶ Based on (i) the TRP database 2017–2019 and W1 March 2020; (ii) sustainability issues identified by the GAC; (iii) four health plan manager focus groups; and (iv) interviews with members of Secretariat.

⁸⁷ Methodology notes: TRP issues coded as PSM and STC were searched using key words (e.g. stock-outs, procurement) and reviewed for relevance specifically to challenges related to domestic finance or procurement of health products. Issues related to supply chain and distribution were excluded. Relevant issues which were coded as a disease issues will not have been captured under this methodology, so 38 is a conservative figure. The scan of the TRP database was supplemented with three additional information sources (four health plan manager focus groups allowing for further data capture from 13 of 21 health plan managers in post, Secretariat interviews and review of the GAC sustainability concerns database).

⁸⁸ Although other Global Fund reviews have documented selected country experiences with domestic procurement (e.g. TRP lessons learned, the STC Thematic Review and the MSS MTR) and Global Drug Facility has published data on challenges with domestic procurement for TB drugs specifically (Waning, B. Risks of decentralized procurement in fragile TB markets: Observations, implications, and recommendations at national and global levels. 2018 as quoted in Médecins Sans Frontières (MSF) Access Campaign Policy Brief July 2019, BEWARE THE GLOBAL FUND PROCUREMENT CLIFF Safeguarding supply of affordable quality medicines and diagnostics in context of risky transitions and co-financing), this is the first effort to more systematically review the challenges experienced by Global Fund supported countries in domestic financing and procurement for both TB and HIV drugs during the current Strategy.

⁸⁹ This is consistent with OIG’s conclusions in the May 2020 Annual Report ‘there is still limited follow-up and weak accountability in the implementation of key mitigating actions by front-line grant management units’; and ‘controls are not yet in place to ensure follow-up on these (TRP) recommendations as part of key decision-making processes during the grant lifecycle, such as the Annual Funding Decisions and/or Disbursement requests. Instead, the follow-up practices are ad hoc and inconsistent across different Country Teams. As a result, a risk remains that key programmatic recommendations from TRP may remain unresolved during the grant implementation cycle.’

⁹⁰ To build capacity, the Global Fund Secretariat provides guidance (e.g. updated STC Guidance Note, with an annex on Health Product Management); supports benchmark pricing; engages via Country Teams and HPM specialists to encourage quality domestic procurement, support national capacity, foster early planning, and advocates for use of international pooled procurement platforms, including wambo.org, where appropriate. The SO Department also provides selected TA (e.g. Ethiopia) and capacity is built through grants and SIs as well. See Annex 4.iii for further details. See also p. 73 of the Market Shaping Strategy Mid-Term review.

⁹¹ KPI 4 is the indicator the Global Fund uses to evaluate across-portfolio efficiency improvement. Nearly 70% of the disease programs in the cohort have been assessed to date, and of these, 88% of the disease programs assessed have shown efficiency gains. HIV programs have shown the most solid gains, while only a few TB programs have been flagged for inefficiency concerns. Far fewer malaria programs have been assessed to date. KPI4 contrasts a country’s former spending pattern per case with its current spending, observing the difference in aggregate as well as at a unit cost/intervention level in comparison to the region. To date, 75 components in 25 high-impact countries (out of approx. 120 countries funded by Global Fund) have been included in a KPI4 assessment, 49 disease components have been assessed to date, and 88% of those assessed showed efficiency gains, that is a decrease in cost of life saved or infection averted over the 2017–2019 allocation period. The KPI4 methodology has been endorsed by the Global Fund Modelling guidance group, which includes e.g. UNAIDS, StopTB, RB Malaria, World Bank, however KPI 4 results cannot be extrapolated to all of Global Fund investment and there are a lot of caveats; it is solely one of the many internal measures that offer a partial gauge of performance. KPI4 does not capture the private sector—only public—so it can undercount impact for example in Asian countries where PPM models contribute substantially to TB caseload.

⁹² This indicator includes all donor and domestic funding to the sector; thus it is a global measure which does not specifically reflect on Global Fund effort or on how Global Fund grants are utilized. Also see the previous footnote.

⁹³ EHG, Itad, UCSF, IHME, PATH. 2020. Prospective Country Evaluation 2019/20 Synthesis Report; EHG, Itad, UCSF, IHME, PATH. 2019. Prospective Country Evaluation 2018/19 Synthesis Report.

⁹⁴ Allocative efficiency.

⁹⁵ Technical efficiency.

⁹⁶ Nicely illustrated in TB on page 138 of the World TB report, WHO 2019.

<https://apps.who.int/iris/bitstream/handle/10665/329368/9789241565714-eng.pdf>

⁹⁷ <http://www.morehealthformoney.org/04-cost-spending>

⁹⁸ Other work to improve technical efficiency relates to an SI on ‘differentiated service delivery,’ which is rolling out differentiated models of care in HIV testing care and treatment in four countries (Kenya, Uganda, Tanzania and Ghana) and different TB screening is being promoted in Tanzania and a few other countries which results in higher TB notification with minimal additional resource inputs. Other work led by disease focal points is ‘costing, cost-effectiveness and efficiency analysis’ funded through the STE-SI to identify

sources of cost differentials, cost-drivers and sources of inefficiencies associated in service delivery. This has been implemented in two countries with expansion by December 2020.

⁹⁹ In fact, for some product sectors (where the market is small and fragmented e.g. pediatric or second line products) it will make sense for most countries, no matter how developed, to opt into pooled procurement platforms. This should not be seen as a lack of procurement capacity but as an economically rationale thing to do.

¹⁰⁰ OIG Audit Pakistan April 2020.

¹⁰¹ More information is provided in Annex 4.iii.

¹⁰² Forthcoming OIG report on GeneXpert.

¹⁰³ KII WHO TB program.

¹⁰⁴ TRP Report (2018) RSSH Investments in the 2017–2019 Funding Cycle.

¹⁰⁵ Absorption is defined as the percentage of the budget that was spent within a given time period.

¹⁰⁶ Although 2019 data is included in Annex 4.vii, we do not present it here as it is incomplete and known not to include data on commitments and obligations (i.e. where there is agreement to pay for a good/service but it has not yet been paid for). Detailed analysis through the PCE found that absorption rates after 18 months of implementation (i.e. to mid-2019) were comparable to absorption levels at the same point in previous grants in PCE countries (although absorption was lower for RSSH investments).

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

¹⁰⁷ The Global Fund. 2019. Strategic Performance Reporting—end 2018. For Board Information (GF/B41/14).

¹⁰⁸ (a) Thirtieth Board Meeting Geneva, Switzerland, November 7–8, 2013; (b) Introduction to the 2017–19 funding cycle and the differentiated funding application process: Access to Funding Training; (c) Thematic Review of the Allocation Methodology.

¹⁰⁹ Although as noted in SR2017, stakeholders have raised concerns that this does not necessarily incentivize high quality implementation and VfM, which is likely to be a particular problem in countries where human resource capacity is low. Our analysis shows that a majority (~60%) of this ‘additional’ expenditure in 2017 was for health commodities and technology, with around 15% for HIV prevention and 15% for program management.

¹¹⁰ At the portfolio level, this resulted in: USD 196 million moved toward the top 15% of country components with greatest potential for impact and absorption; USD 214 million moved toward 70% of country components with average potential for impact and absorption; and USD 404 million moved out of the lowest 15% of country components with the lowest potential for impact and absorption. *Global Fund Strategy Committee (2016): Allocation 2017–2019: ¹¹¹Report on Qualitative Adjustments.*

¹¹¹ For example, the fact that the Fund is a financing and not implementing body, it is based on country ownership and a country-led delivery model, and funding is performance-based.

¹¹² These reviews follow previous activity in this regard by the Global Fund Secretariat, including production of a draft M&E Strategy for the period 2017–22, developed in 2016 with assistance from the TERG. The Strategy was not, however, taken forward.

¹¹³ Global Fund Oversight, Accountability and Learning: Focus on Global Fund M&E, 12th Strategy Committee Meeting, GF/SC12/REF No 10, March 19–20, 2020, Geneva, Switzerland

¹¹⁴ For example, interviewees pointed to inconsistencies in interpretation and presentation of Strategic KPI results by different parts of the Secretariat, as well as organizational and funding inconsistencies limiting MECA’s ability to quality assure the work PHMEs and grant performance frameworks; findings from country case studies suggest inconsistent use/and or follow up by Country Teams of tools and processes intended to reinforce mutual accountability for performance, a finding corroborated by previous OIG and TERG-commissioned reviews.

¹¹⁵ SR2020 sample analysis found performance frameworks in Focused Countries had on average twice as many as the amount proposed in the Global Fund’s policy; and found that performance frameworks in Challenging Operating Environments (COEs) contained as many (if not more) than in non-COE countries.

¹¹⁶ For example, SR2020 analysis of the links between Strategic KPIs and the PAF found more than half of the Strategic KPIs had weak or no linkages to critical Global Fund business processes.

¹¹⁷ Global Fund (2019) Managing SIs, September 2019, Geneva, Switzerland.

¹¹⁸ Global Fund (2019) Advisory Report: Grant implementation in Western and Central Africa, GF-OIG-19-013 May 2019 Geneva, Switzerland.

¹¹⁹ Global Fund Strategic MLE Framework: Synthesis of insights gathered to date on delivery of MLE, March 2020; Global Fund Oversight, Accountability and Learning: Focus on Global Fund M&E, 12th Strategy Committee Meeting, GF/SC12/REF No 10, March 19–20, 2020, Geneva, Switzerland.

¹²⁰ Global Fund Oversight, Accountability and Learning: Focus on Global Fund M&E, 12th Strategy Committee Meeting, GF/SC12/REF No 10, March 19–20, 2020, Geneva, Switzerland.

¹²¹ Global Fund (2019) Audit Report, Managing investments in Resilient and Sustainable Systems for Health, GF-OIG-16-011, 03 May 2019, Geneva, Switzerland; TRP Observations on the 2017–19 allocation cycle, GF/B42/08, November 14–15, 2019, Geneva, Switzerland; CEPA (2019) TERG Thematic Review to assess the current approach to investments in resilient and sustainable systems for health (RSSH), Final Report, February 13, 2019; Global Fund (2019) Advisory Report, Removing human rights-related barriers: Operationalizing the human rights aspects of Global Fund Strategic Objective 3, GF-OIG-19-023, November 27, 2019, Geneva, Switzerland; Report of the 42 Board Meeting, GF/B42/22, November 14–15, 2019, Geneva, Switzerland.

¹²² For example, KPI9a refers to the number of priority countries with comprehensive programs aimed at reducing human rights barriers to existing HIV and TB services, but examines progress in only 20 countries, with the target by 2022 for four countries in HIV and four countries in TB to have comprehensive programs in place, from a baseline of 0 in 2016.

¹²³ Global Fund (2019) Audit Report, Managing investments in Resilient and Sustainable Systems for Health, GF-OIG-16-011, May 3, 2019, Geneva, Switzerland; CEPA (2019) TERG Thematic Review to assess the current approach to investments in resilient and sustainable systems for health (RSSH), Final Report, February 13, 2019.

¹²⁴ Reflecting the Partner-developed Indicator Frameworks used by the Global Fund.

¹²⁵ SR2020 analysis.

¹²⁶ Global Fund (2017) Audit Report, Monitoring Processes for Grant Implementation at the Global Fund, GF-OIG-17-022, November 3, 2017, Geneva, Switzerland.

- ¹²⁷ Global Fund (2017) Audit Report, Monitoring Processes for Grant Implementation at the Global Fund, GF-OIG-17-022, November 3 2017.
- ¹²⁸ Global Fund (2019) OIG Advisory Report Managing SIs, September 2019, Geneva, Switzerland.
- ¹²⁹ EHG, Itad, UCSF, IHME, PATH. 2020. TERG Prospective Country Evaluation 2019/20 Synthesis Report.
- ¹³⁰ EHG, Itad, UCSF, IHME, PATH. 2020. TERG Prospective Country Evaluation 2019/20 Synthesis Report.
- ¹³¹ Analysis by the Secretariat for SR2020 indicates that in 2018, 76% of grants were unadjusted (339 grants); preliminary figures for 2019 indicate 79% of grants were unadjusted (225 grants). These figures are in line with previous analysis by the Secretariat.
- ¹³² 89% rated B1 or higher (2018) and 91% rated B1 or higher (2019)—analysis by the Secretariat for SR2020.
- ¹³³ Rwanda HIV; Ukraine HIV; El Salvador TB; Solomon Islands Malaria; Uzbekistan Malaria.
- ¹³⁴ Global Fund (2017) Audit Report: Global Fund Grant Management in High Risk Environments, GF-OIG-17-002, January 23, 2017, Geneva, Switzerland.
- ¹³⁵ Global Fund (2017) Audit Report: Global Fund Risk Management Processes, GF-OIG-17-010, May 16, 2017, Geneva, Switzerland.
- ¹³⁶ ITAD with EHG (2018) TERG Thematic Review of in-country programmatic assurance, April 2018.
- ¹³⁷ EHG, Itad, UCSF, IHME, PATH. 2019. TERG Prospective Country Evaluation 2018/19 Synthesis Report.
- ¹³⁸ Global Fund (2019) OIG Annual Report 2018, 41st Board Meeting, GF/B41/08, May 15–16, 2019, Geneva, Switzerland.
- ¹³⁹ Global Fund (2019) Risk Management Report, 42nd Board Meeting, GF/B42/20, November 14–15, 2019, Geneva, Switzerland.
- ¹⁴⁰ Global Fund (2020) Risk Management Report and the Chief Risk Officer’s Annual Opinion, 43rd Board Meeting, GF/B43/011, May 14–15, 2020, *Virtual*
- ¹⁴¹ Global Fund (2019) Advisory Report: Grant Implementation in Western and Central Africa, GF-OIG-19-013, May 31, 2019, Geneva, Switzerland
- ¹⁴² Global Fund (2019) Audit Report: Global Fund Grants in the Republic of South Sudan, GF-OIG-19-021, November 4, 2019, Geneva, Switzerland.
- ¹⁴³ We define Partnership as a voluntary, collaborative relationship between two or more actors to achieve a shared goal based on mutual agreement (ITAD, 2019).
- ¹⁴⁴ For the purposes of SR2020, partnership ‘in scope’ include UN Technical Partners; bilateral partners with 5% Set Asides; and USG/PEPFAR/PMI. Private sector partnerships were not in SR2020’s scope although the review does include some findings from case studies.
- ¹⁴⁵ Spark Street Consulting Report 2018, TERG Review of Partnerships, 2019, OIG Advisory Report on SIs, 2019, OIG Advisory Report on West and Central Africa, 2019, OIG Audit of Technical Support, April 2020.
- ¹⁴⁶ The focus of our review has been on most recent/current efforts identified by the Secretariat as most relevant to SR2020 evaluation questions. ITP2, which started in 2017, was reviewed in the 2019 TERG Thematic Review of Partnerships and was not identified by the Secretariat and Strategic Review team as a priority intervention to review.
- ¹⁴⁷ Partners in scope for the PEI were: bilateral partners (e.g. PEPFAR/PMI, GIZ, Expertise France, DIFD, JICA), multilaterals (e.g. WHO, UN Agencies, Stop TB, RB Malaria, GAVI, UNICEF), community and civil society organizations, Foundations (e.g. BMGF) and private sector partners (i.e., those providing in kind support).
- ¹⁴⁸ Audit of Global Fund capacity building and TA, OIG, April 2020. Follow up to this report has focused on intensifying efforts in the Secretariat with additional resources.
- ¹⁴⁹ Performance Improvement of Global Fund Partnership Engagement Initiative SteerCo #1: Focusing the Effort, April 2019.
- ¹⁵⁰ From data received from the Secretariat regarding calculations of TA investments through grants, there seemed to be an acceptance that the cost input category 2.2. TA-related per diems/transport/other costs, was being taken as a representative total for TA provided through current grants. This presented an inaccurate estimate that Kenya’s HIV/TB grant was using over USD 40 million for TA over the three-year period. This figure was discounted by PRs and LFA.
- ¹⁵¹ For instance, monthly bilateral calls are high level and reportedly do not include the sharing of relevant information on TA funded through set asides; the Situation Rooms have mixed performance, with some reportedly less effective than others (TB was cited as one of the weaker Situation Rooms; HIV was weak but is reported to be improved).
- ¹⁵² For instance, KIs pointed to the Global Fund’s partnering with UNAIDS around KVP programming, including involving UNAIDS’ senior leadership in discussions with host-country governments, as a success. One example of the Global Fund’s willingness to take a stand resulted in Djibouti implementing an MSM program.
- ¹⁵³ For instance, United States Government (USG) partners have engaged in the evolution of the CCM in Ethiopia, building on GIZ support; in PNG, Australia’s Department of Foreign Affairs and Trade (DFAT) is very actively involved in the current preparation of Funding Requests and the development of NSPs for malaria and TB. DFAT also sits on and is highly active in the CCM and its technical working groups.
- ¹⁵⁴ Of the eleven case studies conducted for SR2020, six reported any findings on private sector engagement.
- ¹⁵⁵ National Strategic Plan commitments by Eswatini and Viet Nam’s involve health insurance coverage for all. Ethiopia’s investments in PHC and the expansion of community health workers demonstrate progress toward more equitable distributions of health services to the poorest of the poor, i.e. vulnerable populations, while Kenya has a long-term goal of integrating the three diseases into PHC settings.
- ¹⁵⁶ The Global Fund. Mitigating the impact of COVID-19 on countries affected by HIV, tuberculosis and malaria. June, 2020. https://www.theglobalfund.org/media/9819/covid19_mitigating_impact_report_en.pdf (accessed July 2, 2020).
- ¹⁵⁷ Hogan AB, Jewell BL, Sherrard-Smith E, et al. Potential impact of the COVID-19 pandemic on HIV, tuberculosis, and malaria in low-income and middle-income countries: a modelling study. *Lancet Glob Health* 2020; published online July 13. [https://doi.org/10.1016/S2214-109X\(20\)30288-6](https://doi.org/10.1016/S2214-109X(20)30288-6).
- ¹⁵⁸ AIDS, malaria and tuberculosis are surging. *The international journal of science. Nature* | Vol 584 | 13 August 2020.
- ¹⁵⁹ Examples of collaborations include the development of a new co-financing Framework Agreement with the World Bank for innovative financing; a framework agreement with the French Development Agency for bilateral RSSH support to West and Central Africa; increased cooperation between the Global Fund, GAVI, World Bank and GFF for more shared activities from program design to monitoring of activities; and joint in-country GAVI-Global Fund missions since early 2018.
- ¹⁶⁰ Itad 2019 Thematic Review of the Global Fund country level technical support partnership model.

- ¹⁶¹ For example, Thomson Reuters Foundation: legal research, support and advice; Société Générale: financial and entrepreneurship skills strengthening for women in West/Central Africa, and others.
- ¹⁶² Sustainability, Transition, and Co-Financing Policy, 2016. Guidance Note: Sustainability, Transition, and Co-financing, 2019.
- ¹⁶³ Deep Dive on Sustainability, Transition and Co-financing (STC) Policy, 2019.
- ¹⁶⁴ Technical Evaluation Reference Group: Thematic Review on Sustainability, Transition and Co-financing (STC) Policy Position Paper, Management Response and Report, January 2020.
- ¹⁶⁵ See, for example, Deep Dive on Sustainability, Transition, and Co-financing (STC) Policy, 2019.
- ¹⁶⁶ Technical Evaluation Reference Group: Thematic Review on Sustainability, Transition and Co-financing (STC) Policy Position Paper, Management Response and Report, January 2020.
- ¹⁶⁷ Sustainability, Transition, and Co-Financing Policy, 2016.
- ¹⁶⁸ These include: national planning, mobilizing domestic resources, encouraging VfM, addressing human rights and barriers to access, strengthening national governance, implementing programs through country systems (including both state and non-state actors), and building RSSH.
- ¹⁷⁰ Technical Evaluation Reference Group: Thematic Review on Sustainability, Transition and Co-financing (STC) Policy Position Paper, Management Response and Report, January 2020.
- ¹⁷¹ KPI9c indicates that there are still substantial gaps in the ability to obtain, verify, and aggregate data on domestic investments in KVPs and human rights programs for the 2017–2019 period. 2019 end of year results for KPI 11 (Domestic investments).
- ¹⁷² In Lao PDR (an earlier non-complier), and for Kenya there is a strategic change from the previous co-financing requirement in that the government has to commit to specific budget lines making it more obvious in what their commitments are.
- ¹⁷³ Co-financing can include pooled domestic public resources and private contributions that finance the health sector and NSPs and should demonstrate progressive government expenditure on health to meet national UHC goals and increasing co-financing of Global Fund supported programs, focused on progressively taking up key costs of national disease plans.
- ¹⁷⁴ In Ethiopia, even though the devolved system of governance makes tracking budgets challenging, KIs confirmed that the co-financing commitment is being compiled from national health accounts and that there is a strong desire to ascribe co-financing to specific and tangible interventions such as ARV procurement and/or recurrent costs in the next co-financing agreement. Even in countries such as Mauritius, where the current Global Fund investment is relatively minor and, thus, the potential for leveraging the grant is reduced, the co-financing requirement, though easily met, has been used to focus in-country stakeholders on issues such as quality programming and VFM.
- ¹⁷⁵ Sustainability, Transition, and Co-Financing Policy, 2016. Guidance Note: Sustainability, Transition, and Co-financing, 2019.
- ¹⁷⁶ In Kenya, KIs cited the visit of the Global Fund's previous Executive Director as helping to change top government officials' attitudes to KVPs and health financing. In Georgia, the engagement of the Country Team in high-level advocacy and policy dialogues led to increased and sustainable domestic allocations for HIV and TB. In Tanzania, the Global Fund Country Team supported the organization of a strategic workshop with partners and the private sector to discuss domestic funding and resources allocation in-country. In other countries, such as Kazakhstan, which funds 95% of its national response, the Global Fund has provided support to ensure that the domestic share of resources is catalytic and for the optimization of interventions and services.
- ¹⁷⁷ Evaluation of the GAVI Co-financing Policy, 2014.
- ¹⁷⁸ Technical Evaluation Reference Group: Thematic Review on Sustainability, Transition and Co-financing (STC) Policy Position Paper, Management Response and Report, January 2020.
- ¹⁷⁹ Global Fund Prospective Country Evaluation: 2020 SYNTHESIS REPORT, February 2020.
- ¹⁸⁰ Interregional workshop in preparation for transitioning towards domestic financing in TB, HIV and Malaria response, 2019.
- ¹⁸¹ Transition and Sustainability of Global Fund Programs: Synthesis Report of Selected Country Case Studies and Reviews, 2015.
- ¹⁸² Sustainability of Global Fund Programs Report of the Review of sustainability planning Issues, Lessons Learnt and Recommendations, April 2013.
- ¹⁸³ Evaluation of Gavi's Support to Civil Society Organizations, November 2018.
- ¹⁸⁴ Building a Sustainable Future: Report on the 2016 PEPFAR Sustainability Indices and Dashboards (SIDs), 2016.
- ¹⁸⁵ Many of the country case studies, particularly those for high-impact Africa, point to structural barriers (cultural, legal, political will) for addressing KVP programming. Indeed, some country cases studies demonstrated that there is no acknowledgement that some of these groups exist. The role that legality or illegality of these groups seems to vary with some countries turning a 'blind eye' and allowing programming from external sources while dedicating minimal domestic resources and other countries not allowing KVP data to be collected and/or released.
- ¹⁸⁶ Technical Evaluation Reference Group: Position Paper—Thematic Review on Resilient and Sustainable Systems for Health (RSSH), 2019.
- ¹⁸⁷ Sustainability, Transition, and Co-Financing Policy, 2016. Guidance Note: Sustainability, Transition, and Co-financing, 2019.
- ¹⁸⁸ Most notably these related to related to human resource capacity constraints, insufficient community and private sector engagement in service delivery, weak procurement and supply chain management, limited data and use of data to inform targeting and tailored responses, inadequate service delivery models to address KVPs needs and long-term insufficient funding of health systems.
- ¹⁸⁹ Some hold viewpoints that disease elimination is the best way to achieve sustainability and the Global Fund should be working to achieve this as quickly as possible, without the need for longer-term systems strengthening; versus the view that elimination is unlikely to be achieved in the medium-term, and longer-term sustainable solutions for most diseases in most countries and regions are still required.
- ¹⁹⁰ Our analysis suggests that many processes lack engagement of CSOs, KVPs, health sector and human rights and gender specialists.
- ¹⁹¹ Some hold viewpoints that disease elimination is the best way to achieve sustainability and the Global Fund should be working to achieve this as quickly as possible, without the need for longer-term systems strengthening; versus the view that elimination is unlikely to be achieved in the medium-term, and longer-term sustainable solutions for most diseases in most countries and regions are still required.
- ¹⁹² <https://www.cgdev.org/publication/understanding-opportunity-cost-seizing-opportunity-report-working-group>.

¹⁹³ I.e. identifies clearly the purposes and objectives for performance information in the Global Fund; selects the appropriate mix of monitoring, internal and independent evaluation and learning activities to achieve those objectives; and then determines the most efficient and effective division of roles and responsibilities to deliver the mix of MEL activities.

¹⁹⁴ The latter might include tracking trends and evaluating shifts from non-government to government KVP service delivery transitions.

¹⁹⁵ For some countries and some products, this may imply a long-term reliance on third party procurement; this should not be interpreted as lack of national sovereignty or poor planning for sustainability but as a natural market imperative.

¹⁹⁶ We note that this requires an assumption on resource availability for the portion of the strategic period beyond the immediate funding cycle.

¹⁹⁷ Our understanding is that the current definition of sustainability (as per Section 6.2.6) considers both financial and programmatic sustainability in light of the epidemiological context but is focused specifically on the three diseases. A heightened focus on sustainability in manner suggested here may require a broader definition that considers the benefits of investments to other health agendas/sectors.

¹⁹⁸ The pillars of work are referenced here: <https://www.theglobalfund.org/en/sustainability-transition-and-co-financing/>.

¹⁹⁹ I.e. health status (disease burden, disease trajectory/trends) at national and sub-national levels and among most affected populations; presence of relevant policies (health, financial, systems and human rights); governance, leadership and management capacity; financial resources; institutional capacity, national systems and human resources; and systems for accountability and managing risks.

²⁰⁰ These principles are already contained within the STC Policy but could be elaborated on for all stages of development and made more specific to each of the strategic objectives, with a view to achieving greater financial and programmatic sustainability of services.