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Global Fund Prospective Country Evaluation

2021 SYNTHESIS REPORT

REPORT PREPARED BY

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

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Acronyms

ACT	Artemisinin-based combination therapy
APE	Agente Polivalente Elementars
AGYW	Adolescent girls and young women
ART	Antiretroviral therapy
C19RM	COVID-19 Response Mechanism
CCM	Country Coordinating Mechanism
CCS	Collaborating Centre for Health [Mozambique]
CEP	Country Evaluation Partner
CRG	Global Fund Communities, Rights, and Gender Team
COE	Challenging Operating Environment
CSO	Civil society organization
CSS	Community Systems strengthening
CT	Country Team
DGS/DAGE	Direction Générale de la Santé/Direction de l'Administration Générale et de l'Equipement [Sénégal]
DHIS2	District Health Information System 2
DRC	Democratic Republic of the Congo
EDT	Essential Data Tables
EHG	Euro Health Group
FEW	Female Entertainment Worker
FSW	Female sex worker
GAC	Grant Approvals Committee
GEP	Global Evaluation Partner
HMIS	Health Management Information System
HRG-Equity	Human rights, gender, equity
IHME	Institute for Health Metrics and Evaluation
ISD	Integrated service delivery
KII	Key informant interview
KVP	Key and vulnerable population
LFA	Local Fund Agent
LIC	Low-income country
LLIN	Long-lasting insecticide-treated net
LMIC	Lower-middle income country
M&E	Monitoring and evaluation
MDR-TB	Multidrug-resistant tuberculosis
MMT	Methadone maintenance treatment
MoH	Ministry of Health
MoHA	Ministry of Home Affairs [Myanmar]
MoU	Memorandum of Understanding
MSAS	Ministère de la Santé et des Affaires Sociales [Sénégal]
MSM	Men who have sex with men
NFM2	New Funding Model 2 (2017-2019 funding cycle)
NFM3	New Funding Model 3 (2020-2022 funding cycle)
NSP	National Strategic Plan
OBR	Official Budget Revision
OIG	Office of the Inspector General

OPN	Operational Policy Note
PAAR	Prioritized Above Allocation Request
PCE	Prospective Country Evaluation
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PR	Principal Recipient
PSM	Procurement and supply chain management
PU/DR	Progress update and disbursement request
PWID	People who inject drugs
QA	Quality Assurance
RAI3E	Regional Artemisinin-resistance Initiative 2 Elimination Program
RCA	Root cause analysis
RSSH	Resilient and sustainable systems for health
SO	Strategic Objective
SR	Sub-recipient
STC	Sustainability, transition, and co-financing policy
TERG	Technical Evaluation Reference Group
TRP	Technical Review Panel
UCSF	University of California, San Francisco
UHC	Universal health coverage
UMIC	Upper middle income country
UNOPS	United Nations Office for Project Services
UQD	Register of Unfunded Quality Demand
VfM	Value for Money
WPTM	Work Plan Tracking Measures

Executive Summary

Introduction

In 2020, the Prospective Country Evaluation (PCE) took a comprehensive look at the Global Fund grant cycle, assessing how business model factors have facilitated or hindered the achievement of objectives during implementation of grants approved through New Funding Model 2 (NFM2; 2017-2019 funding cycle), including around Resilient and Sustainable Systems for Health (RSSH), sustainability and equity, and whether lessons learned during the current grant have informed the next funding cycle. In this report, we present our synthesis of findings from eight PCE countries: Cambodia, DRC, Guatemala, Mozambique, Myanmar, Senegal, Sudan and Uganda. The objective of the grant cycle analysis was to understand what, when, why and how grant investments change over time, including significant factors that influenced the implementation of and changes to the original grant. In each country, this was assessed using focus topics as lenses to evaluate the grant cycle and to better understand drivers of change. This report follows the grant cycle, first presenting synthesis findings from NFM2, including the funding request and grant making process and implementation, followed by how the NFM3 (2020-2022 funding cycle) grant design process was informed by lessons from NFM2. Conclusions related to grant design and implementation are discussed in Chapter 4, focusing primarily on RSSH and human rights, gender and other equity-related investments (HRG-Equity), paralleling Global Fund Strategic Objectives 2 and 3.[1]

NFM2 funding request to grant making

The PCE found that grant design and budgets did not change significantly during the NFM2 grant making process from the Global Fund's Technical Review Panel (TRP)-approved funding requests, although proportionally more changes were made to investments in HRG-Equity and RSSH areas. In the majority of PCE countries, investments in reducing HRG-Equity barriers declined during grant making, whereas RSSH budgets show large increases in some countries and declines in others. Factors that influenced prioritization and changes during grant making included Country Team support and input, catalytic matching funds investments and TRP review and comments, among others.

NFM2 grant implementation

NFM2 grant implementation has been uneven, including start-up delays during Year 1, primarily as a result of the lengthy selection and contracting processes for sub-recipient implementers. After grant start-up, absorption performance increased in Year 2, although weak grant coordination and issues with performance monitoring constrained ongoing implementation progress. The PCE found that early implementation delays disproportionately affected RSSH and HRG-Equity activities and absorption remained particularly low in some RSSH and HRG-Equity-related investment areas. However, regular progress reviews and grant coordination meetings among key stakeholders helped accelerate implementation of the grants. During Year 3, the onset of the COVID-19 pandemic caused significant disruption, particularly for HRG-Equity investments, which required agile adaptations. Grant revision processes introduced to support

[1] Building from this 2021 PCE Synthesis Report, the TERG commissioned a three-month extension phase (April-June 2021) to focus on deeper analysis. Key areas explored included: NFM2 grant revision issues and lessons learnt from the Global Fund's response to COVID-19; Health systems support and strengthening; Reasons for the limited uptake of RSSH coverage indicators; and NFM3 grant making, including drivers of budgetary shifts and transparency, country ownership and inclusion. Additional findings and recommendations are being produced.

the COVID-19 response were flexible and a reasonably 'light lift' for country stakeholders, enabling rapid implementation adjustments in 2020.

In contrast, grant revisions are usually perceived as burdensome and administratively complex. *Additional funding revisions* tended to occur earlier in the grant lifecycle, initiated by the Secretariat and negotiated between the Country Teams (CTs), Country Coordination Mechanisms (CCMs) and grant recipients, and were based on reviews of high-priority activities from the register of unfunded quality demand (UQD). *Program revisions* ('reprogramming') to the scale or scope of grants were uncommon, occurring in only four PCE countries. Evidence from some PCE countries suggests that some potential program revisions (e.g., where new evidence became available) were not undertaken during NFM2 and were instead shifted for inclusion in NFM3 funding requests—in part due to the burdensome program revision process and the short three-year implementation cycle. PCE countries most frequently made *budget revisions* ('reallocation') as a financial management tool to influence absorption. In most PCE countries, this resulted in a cumulative shifting of unused resources to later in the grant cycle, rather than undertaking a more substantial *program revision*, particularly for low absorbing RSSH and HRG-Equity interventions. Using budget revisions systematically to shift unutilized resources from Year 1 to Years 2 and 3, and subsequently from Year 2 to Year 3, has significant potential to reduce allocative efficiency. The lack of sufficient programmatic performance data upon which to guide revision decisions likely contributes to the emphasis on using budget revisions to influence absorption.

The annual funding decision does not appear to be working as intended to operationalize the principle of performance-based funding. Specifically, disbursements often varied dramatically from the total agreed budget for each reporting period and, even when performance against grant targets and indicators was weak, disbursements were often above or a relatively high proportion of the total grant budget. As such, it is unclear if or how disbursements are being used to incentivize performance.

Lessons learned NFM2 to NFM3

Ensuring grants are well designed at the time of the grant award is critical. In most PCE countries, the NFM3 funding request process was an improvement over NFM2. With some variation, it was more streamlined, efficient and flexible, characterized by improved country ownership, participation by a wider group of stakeholders and with a range of business model factors used effectively to influence grant priorities. However, despite greater inclusivity, transparency and country ownership during funding request development, this tended to decline during the grant making stage, where key decisions were often taken. Nonetheless, KVP representatives reported feeling more included in NFM3 funding request processes than in NFM2, in some cases helped by having gained experience from previous processes and having received support to build their capacity. The efficiency of the Matching Funds application process also improved for NFM3 compared to NFM2. TRP recommendations (made both on NFM2 and NFM3 funding requests) informed NFM3 grant designs, often with implications for HRG-Equity and RSSH related investments. However, across all application approaches, COVID-19 changed the way the funding request and grant making processes were managed, with both positive and negative implications.

The Global Fund's successful Sixth Replenishment, alongside a commitment to 'do things differently' offered an important opportunity to 'change the trajectory' in NFM3. NFM3 funding requests included significantly larger budgets and focus on some—but not all—of the areas where a change in trajectory is needed to meet the Global Fund Strategic Objectives.

HRG-Equity: PCE countries show evidence of NFM3 funding requests being designed with explicitly more focus than in NFM2 on improving equitable access to health services and allocating resources to intervention approaches that are known to contribute to greater programmatic sustainability. However, in some cases, efficiency and/or effectiveness considerations appear to have taken precedence over equity considerations in NFM3 grant design. For instance, in response to concerns with efficiency, some countries adjusted NFM3 PR and SR implementation arrangements with potentially negative consequences for equity. On the other hand, several PCE countries used better-quality and/or more recent data on KVPs during NFM3 compared to NFM2, which enabled grants to set up new interventions to target KVPs more precisely or widen the geographical distribution of places that KVPs would receive services. However, the quality of data (particularly the accuracy of KVP population size estimates) continues to constrain these decisions and overall allocative efficiency.

RSSH: Most PCE countries increased their allocation to RSSH in NFM3, although, compared to NFM2, a greater proportion of these investments are designed to support rather than strengthen health systems. As such, it is unclear how the NFM3 grants are intended to 'change the trajectory' for the achievement of SO2. Evidence suggests that the Global Fund's RSSH guidance "*to shift from a focus on short-term, input-focused support...towards more strategic investments...that build capacity and lead to sustainable results*"(1) is not being systematically operationalized. In some countries, NFM3 RSSH investment design builds upon progress made during NFM2, especially in HMIS/M&E, but most PCE grants did not appear to use the NFM3 funding request process to link RSSH investments more strategically with sustainability plans. In some countries, NFM3 grants are shifting RSSH intervention approaches, with greater emphasis on community systems strengthening for improving access to and quality of service delivery. Several countries show governance adaptations to improve coordination and implementation of crosscutting RSSH investments. Despite extensive new guidance, most NFM3 grant performance frameworks do not appear to include many of the new RSSH coverage indicators, suggesting that monitoring RSSH performance and progress toward meeting SO2 will remain a challenge. Coverage indicators rarely capture aspects of system strengthening (such as data use for decision-making) and some RSSH investment areas do not map well to available indicators.

Conclusions

Grant design

1. Improvements to the business model between NFM2 and NFM3 contributed to more efficient and inclusive funding request processes. However, NFM3 saw limited adoption of changes in the design of performance monitoring, particularly for HRG-equity and RSSH.
2. In NFM3, both RSSH and HRG-Equity investments rose, in many cases as a result of overall allocation increases. An increased proportion of RSSH investment is directed toward activities that support rather than strengthen the health system.

Grant implementation

3. Implementation of NFM2 grants faced significant start-up delays and COVID-19 interruptions. Absorption was overall weaker for RSSH and HRG-Equity interventions.
4. Multiple barriers and challenges exist for undertaking revisions to the scope and/or scale of grants mid-cycle, such as in response to new evidence or emerging performance issues.

Recommendations

Recommendation 1: Improve grant-specific performance monitoring to inform implementation decisions.

- Establish routine grant review processes at the country level with a quality improvement lens, emphasizing grant-specific performance data and drawing on emerging evidence and data to better inform revisions that maximize impact. (PRs, Grant Management Division including Country Teams)
- Implement proposed reforms of the grant rating system to reflect both grant-specific performance and contribution of Global Fund grants to national program performance. Additionally, this should draw upon qualitative inputs, including expertise of the CCM, LFA, Country Team and wider Secretariat. (Grant Management Division, Strategy Committee, Board)
- Based on the revised grant rating system, the Secretariat should also develop a set of indicative options to demonstrate how good and poor performance could be responded to, and a framework for deciding when and how to introduce these measures in different contexts and circumstances (Grant Management Division, Strategy Committee, Board).
- Strengthen the use of revised RSSH indicators to address delayed implementation and potential deprioritization throughout grant implementation. (PRs, Grant Management Division including Country Teams)

Recommendation 2: Build in more flexibility and responsiveness in implementation by simplifying grant revision processes to encourage their use throughout the grant cycle.

- Consider flexibilities and streamlining of material program revision process to encourage/reward earlier introduction of innovative programming that maximizes impact and limits non-strategic budgetary shifts to later in the 3-year grant cycle. (Secretariat)
- Introduce flexibilities to PR and SR contractual arrangements and performance frameworks that can be used to introduce mid-term changes as required. (PRs, Grant Management Division)
- Through the Secretariat's planned grant revision review (mid-2021), examine how countries could strengthen data-driven revision decisions (thereby avoiding the over-reliance on financial data to guide revision decisions), in line with establishing a more streamlined, flexible process for program revision. (Secretariat)

Recommendation 3: In order to reduce gaps between policy guidance and grant design, improve communication around how to invest more strategically in RSSH, including CSS.

- In the next Strategy, the Global Fund board in collaboration with the Secretariat should clarify their position on whether the primary objective of RSSH is to support the three disease programs or to invest more holistically in health systems strengthening. (Board, Secretariat RSSH team)
- Clarify specific Global Fund RSSH priority areas and what strengthening as opposed to supportive investment would look like for these, including specific purpose, indicators and targets in performance frameworks. (Secretariat RSSH team, Country Teams)
- To facilitate integration and strengthening RSSH, ensure proper engagement and ownership from health system planning experts and leaders to support health sector-wide programming decisions, including alignment of grant design and sustainable financing within wider national health, health system and UHC policy context, and the timelines associated with broader strengthening efforts. (PRs, Country Teams)

Recommendation 4: In order to improve grant contribution to equity and SO3, explicitly promote grant investments in these areas, including through more direct measurement of the drivers of inequity and of outcomes of human rights and gender investments.

- Invest more in data and data use, including up-to-date KVP surveys as well as other data sources that shed light on socio-economic, gender, geographical and ethnic differences in disease burden and access to services that grants are aiming to contribute to. (Country Teams, national stakeholders)
- Ensure performance frameworks incorporate existing data including on human rights and political commitment as well as disease burden and service access amongst different population groups and use this data effectively to monitor grant contribution to both SO3 and SO1 or disease impact. (Country Teams, national stakeholders)
- Recognizing the success of strategic initiatives and/or matching funds in incentivizing grant investments in reducing equity, human rights and gender related barriers to accessing services, prioritize scaling up across the portfolio and incentivizing such investments through mainstream grant management operations. This should include explicit efforts to improve implementation and where necessary, timely revisions to maximize grant contribution to reducing barriers to care and disease impact. (Grant Management Division, Strategic Initiatives team)

Chapter 1

1.1 Introduction

The Prospective Country Evaluation (PCE) is an independent, multi-year prospective evaluation of the Global Fund, commissioned by the Global Fund's Technical Evaluation Reference Group (TERG). The goal of the PCE is to evaluate how the Global Fund business model operates in eight countries in order to generate evidence that will accelerate progress towards meeting the Global Fund Strategic Objectives (SOs). The PCE is led by two Global Evaluation Partners (GEPs), in collaboration with eight Country Evaluation Partners (CEPs). The Euro Health Group/University of California San Francisco (EHG/UCSF) consortium supports Cambodia, Mozambique, Myanmar and Sudan; the Institute for Health Metrics and Evaluation (IHME)/PATH consortium supports the Democratic Republic of the Congo (DRC), Guatemala, Senegal and Uganda. These eight countries, although not selected to be formally representative of the Global Fund portfolio overall, comprise approximately 20% of the investment during the 2017-2019 allocation period (US$2.2 billion) and 2020-2022 allocation period (US$2.5 billion), and present an array of disease epidemics, geographies, development statuses and Global Fund support (Table 1, with additional details available in Annex 1). Among the countries, only Guatemala is transition-eligible for malaria and TB in the next funding cycle.

Table 1. PCE Portfolio Characteristics (US$)

Characteristic	CAM	DRC	GTM	MOZ	MYN	SEN	SDN	UGA	Total
World Bank Income Group	LMIC	LIC	UMIC	LIC	LMIC	LIC	LIC	LIC	
High Impact Portfolio	X	X		X	X			X	5
Core Portfolio			X			X	X		3
Challenging Operating Environment (COE)		X					X		2
AGYW Priority Country				X				X	2
Matching funds eligible (NFM2, millions)	NA	$16.0	NA	$19.7	$19.3	$2.5	NA	$9.4	$66.9
Matching funds eligible (NFM3, millions)(2)	$6.0	$12.6	NA	$22.4	$12.3	$1.3	NA	$23.5	$77.9

Table Notes: LIC = low income country; LMIC = lower-middle income country, UMIC = upper middle income country

1.2 Grant cycle approach

Each year, the PCE synthesizes country findings to present a more comprehensive assessment of the Global Fund business model. During the 2020 evaluation phase, the approach was informed by the TERG's interest in understanding how the Global Fund grant cycle has facilitated or hindered the achievement of grant objectives during implementation within the New Funding Model 2 (NFM2) grant cycle (2017-2019 funding cycle), including around Resilient and sustainable systems for health (RSSH), sustainability and equity, and whether lessons learned during the current grants have informed the New Funding Model 3 (NFM3) (2020-2022 funding cycle). Applying a mixed-methods approach, information was collected from a variety of quantitative and qualitative data sources; through analysis and data triangulation, the PCE generated results that elucidate how the Global Fund business model plays out in-country.

The objective of the grant cycle analysis was to understand what, when, why and how grant investments change over time, including significant factors that influenced the implementation of and changes to the original grant. We examined aspects of grant design and implementation, and specifically aimed to evaluate:

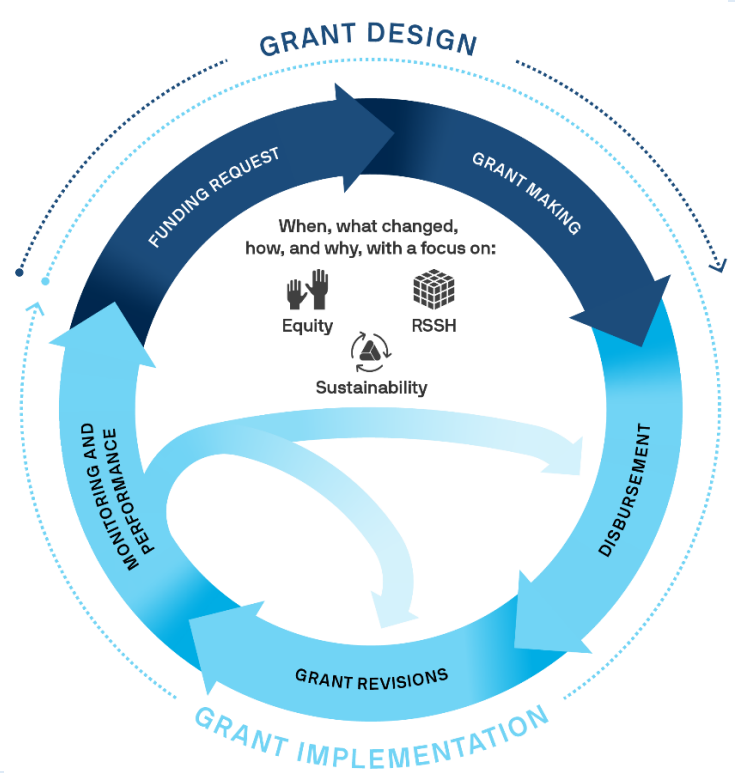
- how and why the NFM2 grants were modified along the grant cycle (during grant making, implementation, and grant revision);
- how the Global Fund business model facilitated or hindered modifications along the grant cycle; and

- whether and how grants contributed to achieving progress towards (or away from) equity, sustainability and/or health systems strengthening objectives.

In addition, the PCE assessed the 2020 funding request and grant making process for NFM3 on five themes, relative to the NFM2 process where relevant: (1) Differentiated applications: tailored review, program continuation, and full review; (2) Transparency, inclusion, and country ownership; (3) Moving beyond 'business as usual' to change in trajectory for achieving impact; (4) Data use and target setting; and (5) Value for money.

The PCE used a Grant Cycle framework (Figure 1) as the primary evaluation framework for organizing 2020 data collection and analysis. The Global Fund grant cycle begins with the funding request development leading to grant making, grant award, and grant signing. This process takes eight to nine months and is followed by a three-year implementation period during which funds are disbursed, activities are implemented, grants are modified through revision processes, and progress is monitored. During the third and final year of implementation, the next funding request development and grant making process begins for the upcoming grants and aims to be informed by lessons learned from the current grants.

Figure 1. Grant cycle framework



NFM2 grant design: Little is known about shifts between the Technical Review Panel (TRP)-reviewed funding request and grant making. We examine shifts during the grant making process as they relate to Global Fund strategic objectives, including prioritization of equity and RSSH in funding requests and shifts in equity and RSSH-related investments during grant making.

NFM2 implementation: We examine performance against grant and national program indicators and targets, Global Fund strategic objectives, and implementation progress, including the barriers and facilitators to implementing RSSH and equity-related investments. We further examine budgetary shifts and the role of grant revisions in enhancing or detracting from RSSH and equity investments.

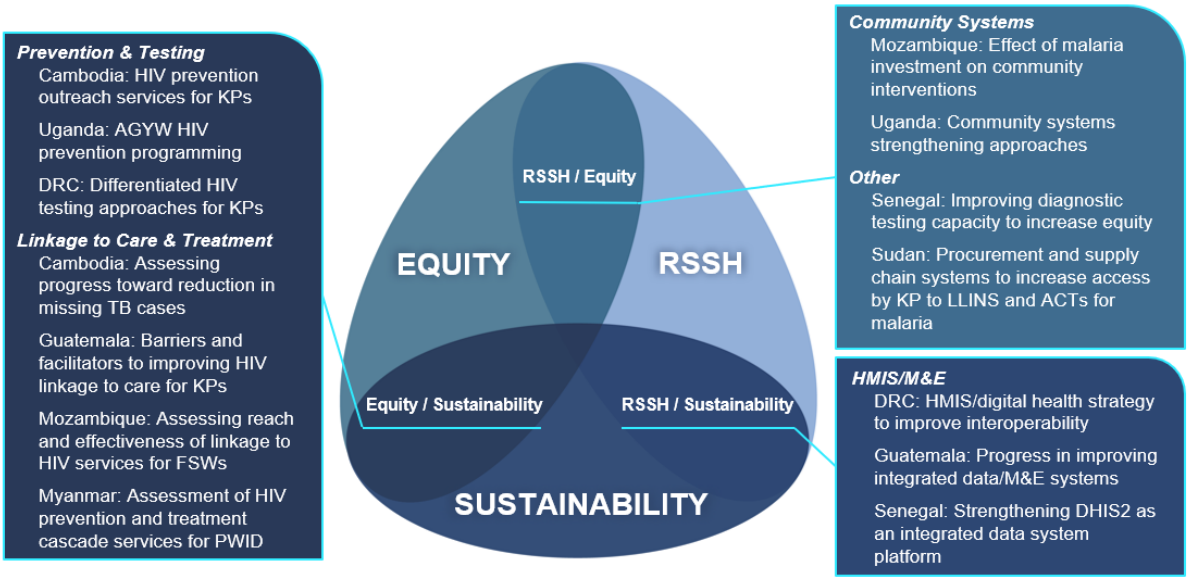
NFM2 vs. NFM3: Global Fund's 2019 replenishment set commitments to change the trajectory to meet 2030 disease goals. We compare NFM2 and NFM3 investments and interventions, exploring whether lessons learned in NFM2 are informing the NFM3 funding request processes and grant design, with a particular focus on equity, RSSH, and sustainability.

1.3 Focus topics

The PCE used a series of focus topics as lenses through which to evaluate the grant cycle and to better understand drivers of change and results at the country level (figure 2). Focus topics were selected with relevance to equity, RSSH and, in limited instances, sustainability considerations. Through these focus areas, we examined how and why grants were modified along the grant cycle,

successes and bottlenecks to implementation, and results achievement against grant performance targets.

Figure 2. Focus topics by country and theme



1.4 Methods

The PCE employed a mixed methods approach to assess how Global Fund business model factors influence performance of grants throughout the stages of the grant cycle. Relying upon analyses using both quantitative and qualitative data, the PCE examined and sought to explain changes in planned resources and activities throughout the grant making process, revisions and performance during grant implementation, as well as changes to the next grant window. Triangulation of data across multiple sources and analytic approaches was used to ensure robustness of findings, and interpretation of findings was commonly based on more than one analysis. The EHG/UCSF consortium used contribution analysis to structure the interpretation of findings against evaluation questions focused around the contribution of grant inputs (resources and other inputs) to national disease program outcomes, as well as to assess the degree to which this also enabled the achievement of Global Fund Strategic Objectives.

Data

Primary data were collected through meeting observations and key informant interviews (KIIs) to explore issues in-depth; in addition, fact-checking interviews were conducted to fill information gaps (Annex 2). KIIs elicited stakeholder perspectives on global and country-specific evaluation questions and allowed the PCE to better understand grant cycle processes, including barriers and facilitators. Interviews were also used to triangulate, interpret and validate results generated through quantitative analyses and document review. Interview transcripts and meeting notes were coded according to key themes.

The PCE obtained detailed budgets for all available active and planned grants from the Global Fund Secretariat for funding requests, approved grants, awarded for grant making, and official revisions (with corresponding Implementation Letters). In addition to detailed budgets, local fund agent (LFA)-verified progress update/disbursement requests (PU/DRs) were obtained.

Budget variance

The PCE conducted detailed financial analyses of Global Fund budgets throughout the grant cycle for NFM2 grants as well as available budgets from funding requests to grant making during NFM3.

Budgets were analyzed by recipient, disease, module, intervention, and focus topic.[2] Observed changes in financial resources and prioritization between activities were triangulated using qualitative data collected during KIIs, document review, and additional interviews. Using the Global Fund's modular framework, the PCE tracked resources for RSSH and human rights, gender, and other equity (HRG-Equity) related interventions. HRG-Equity modules and interventions were identified using Global Fund's disease-specific technical briefs on gender, human rights, and key populations; gender technical briefs; and validated through conversations with the Global Fund Secretariat's Community, Rights and Gender (CRG) team. Additional details can be found in Annex 3, including a complete table of modules and interventions included in the PCE analysis of HRG-Equity.

An analysis of financial absorption (expenditure as a percentage of budget) within and across grants was conducted using PU/DRs, examining trends in absorption by semester, module, and intervention. Similarly, absorption for RSSH- and HRG-Equity-related modules and interventions were tracked throughout the grant cycle.

Indicator performance tracking

Indicator achievement against targets are reported within the LFA-verified PU/DRs during grant implementation. These data were also compiled and tracked over the grant cycle to understand changes in performance across grants, focus topics, and RSSH and HRG-Equity. Insights from indicator trends over time were used to guide KIIs and fact checking interviews to triangulate how the Global Fund business model facilitated or hindered performance.

Root cause analyses

The PCE used root cause analyses (RCA) to further explore, analyze and understand the root causes underlying observed challenges or successes identified through a variety of triangulated data sources (KIIs, secondary data analysis, document review).

RSSH Support vs. Strengthening "2S" analysis

The PCE analyzed RSSH activities in NFM2 and NFM3 according to whether they contributed to "systems support" or "system strengthening," drawing on definitions from Chee et al. (2013). (3) We developed a coding methodology, aligned to Global Fund's RSSH modules in the modular framework, to designate each RSSH activity in the budget as either predominantly support or strengthening. Three parameters—scope, longevity, and approach—were examined for each RSSH intervention/activity pair, adapted from the methodology previously used by the TRP's examination of RSSH in the 2017-2019 funding cycle.(4) Two coders independently applied a determination of support or strengthening after reviewing each intervention and activity description, and any relevant text in the funding request narrative, and cost category. Details on the methodology used are available in Annex 3.

Analytical approach to synthesis

Drawing from country analyses and annual reports, the GEPs compiled quantitative and qualitative evidence into matrices organized by grant cycle stage and RSSH, equity, and sustainability thematic areas. Evidence was drawn from focus topics as well as grant- and country-level analyses. The evidence matrices helped identify patterns in the data across countries and informed further discussion and analytical triangulation with cross-country budget variance data. Due to the variation of focus topics, not all findings were able to be substantiated across the eight countries; wherever possible, findings were supported by additional country focus topics and portfolio-level analyses. Early synthesis findings were validated with CEP teams for feedback and additional data interpretation.

[2] Some budgets were not included in the synthesis as these grants were not subject to analysis at the country level during the course of 2019-20, namely: Sudan HIV/TB, Cambodia malaria, and Myanmar malaria.

Chapter 2: NFM2 grant cycle

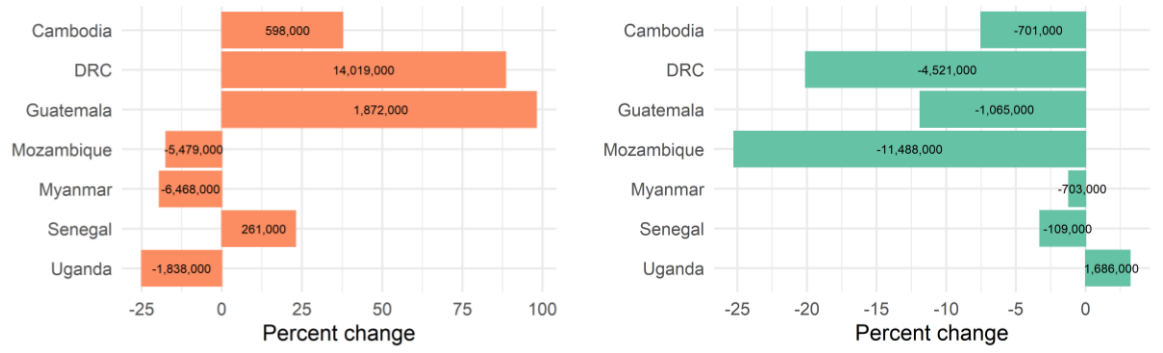
2.1: NFM2 funding request to grant making

This section presents findings on the changes that were made during 2017/2018 to NFM2 grant designs between the country funding request submissions and the final approved grant award—i.e., through the grant making process. This includes analysis of how and why changes were made, who suggested that they be made, and whether these changes were in line with the Global Fund guiding policies and priorities.

Key message 1: Overall grant designs and budgets did not change significantly during the 2017 grant making process (NFM2). More substantial changes were made to investments supporting the achievement of SO2 (RSSH) and SO3 (HRG), although not necessarily to prioritize these areas (despite being consistently highlighted through the PCE and other analyses as requiring more attention).

In general, during NFM2, relatively few major changes in overall grant design and budgets occurred between funding requests and final approved grant awards for PCE countries (as seen in Annex 5 figures 5.1, 5.2 and 5.3). Proportionally (given investments in these areas are relatively small compared to the overall grants), more significant changes were made to investments in HRG-Equity and RSSH for most PCE countries during the NFM2 grant making process (Figure 3).

Figure 3. Percent change in RSSH (left) and HRG-Equity (right) investments from NFM2 funding request to grant award[3]



Source: Global Fund detailed budgets

HRG-Equity Investments

Analysis of all investments that seek to address HRG-Equity-related barriers to access and/or health outcomes show that the budget for these areas declined in six of the eight PCE countries during the grant making process. While no clear patterns emerged for TB and malaria (for which these types of investments are small and difficult to track), HIV grant budgets mostly declined, particularly for prevention among key and vulnerable populations (KVPs). Specifically, in all countries that included some budget allocation for the following modules, the budget decreased between the funding request and grant award:

- **Prevention for Men who have sex with men (MSM):** Substantial declines in Mozambique, DRC and Guatemala.
- **Prevention for People who inject drugs (PWID):** Almost complete removal in Mozambique and heavy cuts in DRC.

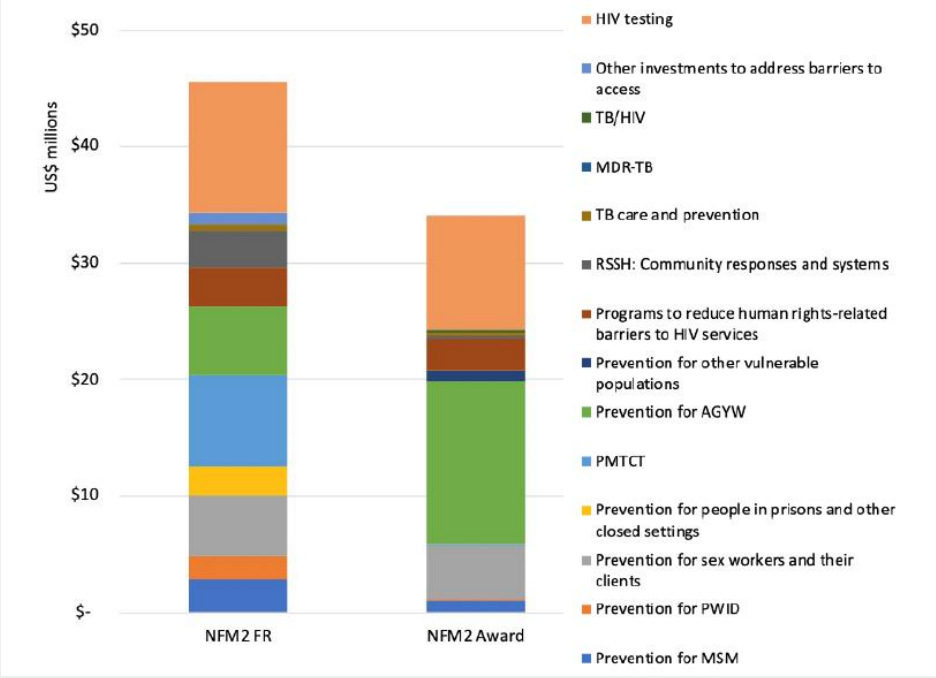
[3] To ensure comparability, we restricted the grants to only those with full and tailored review (excludes continuation grants for malaria in DRC, Mozambique, Senegal and Sudan, as well as HIV in Senegal and Sudan, and TB in Sudan).

- **Prevention among prisoners:** Complete removal in Mozambique and heavy cuts in Cambodia and Guatemala.

The budget for prevention for female sex workers (FSW) also reduced or stayed the same in three out of five countries, only increasing in Cambodia, where there was focused effort to increase targeted programming to this group (and other KVPs) via improved management and support for outreach workers.

Box 2.1: Mozambique HIV/TB investments to address equity-related barriers.
The NFM2 grant making process reduced investments to address HRG-Equity-related barriers in Mozambique by 25% (from US$46m to US$34m), mainly driven by a US$6m (68%) reduction in HR-related investments and a US$3m (30%) reduction in wider KVP investments.[4] These reductions were partly offset by a substantial increase in funding for prevention among adolescent girls and young women (AGYW), from US$6m to US$14m, in response to emergent evidence of increasing incidence among this group. Of note, anticipated matching funds for human rights (US$4.7m) were added after the grant award, so appear in the first implementation letter. For human rights, it was felt the strategy was not complete and the implementation therefore was also not ready, so the Grant Approvals Committee (GAC) agreed to delay the start and reduce the budget from the core allocation without jeopardizing eligibility for matching funds. For AGYW, the budget from the core allocation was increased to support more activities for this group.

Figure 4. *NFM2 HIV/TB funding request and grant award budget variance analysis of investments designed to address HRG-Equity or other barriers to accessing health services and/or achieving health outcomes:*



Source: Global Fund detailed budgets

[4] There was also a US$8m (98%) reduction in funding for Prevention of mother-to-child transmission (PMTCT) — reflecting the shift from Option B+ to test and start. The related increases in testing and treatment costs were included in other budget lines, notably treatment care and support, which is not included in our estimates of equity-related investments at grant award.

RSSH Investments

Analysis of RSSH budget changes during grant making shows large increases in some countries and significant declines in others, as well as substantial shifts between modules/program areas in many countries. Three PCE countries increased the overall RSSH allocation from funding request to grant award (Cambodia, DRC, Guatemala) and three countries decreased the overall RSSH allocation (Mozambique, Myanmar, Uganda). In all countries, the final agreed level of RSSH investment was below what was recommended by the Secretariat (which varied from 5% to 11% of total grant value across countries) and the vast majority of the agreed NFM2 RSSH investments were designed to support rather than strengthen the health system.(4)

RSSH module budgets shifted in different ways during grant making. Four out of seven PCE countries with available data (excluding Sudan) increased resources for the Health Management Information System and Monitoring and evaluation (HMIS/M&E) module and three countries increased resources for Procurement and supply chain management (PSM)—two areas critical to supporting core disease grant implementation. Guatemala introduced a substantial increase in HMIS and M&E in response to TRP comments (discussed further below). In Mozambique, investments for integrated service delivery (ISD) and quality improvement, which were relatively limited in most PCE countries, declined significantly during grant making. Three countries reduced resources allocated to community responses and systems between the funding request and grant award, with negative implications for equity, given the role of these systems in reaching the most vulnerable, and for achieving sustainability objectives. Value for Money (VfM) considerations sometimes drove reductions. In Uganda, for example, per diem allocations for community systems strengthening (CSS) outreach were reduced in alignment with the government's policy on rates.

Key message 2: Several business model factors, including the role of the Secretariat Country Teams (CT), matching funds and the TRP review process, influenced prioritization during grant making.

A range of country-specific and Global Fund business model factors affected prioritization decision making during the grant making process. As compared to the relatively open and transparent funding request development process, grant making was difficult to observe from an evaluation perspective, with many discussions taking place in private between senior Secretariat staff and country stakeholders. Nonetheless, evidence suggests that the most significant business model factors influencing the design of grants were:

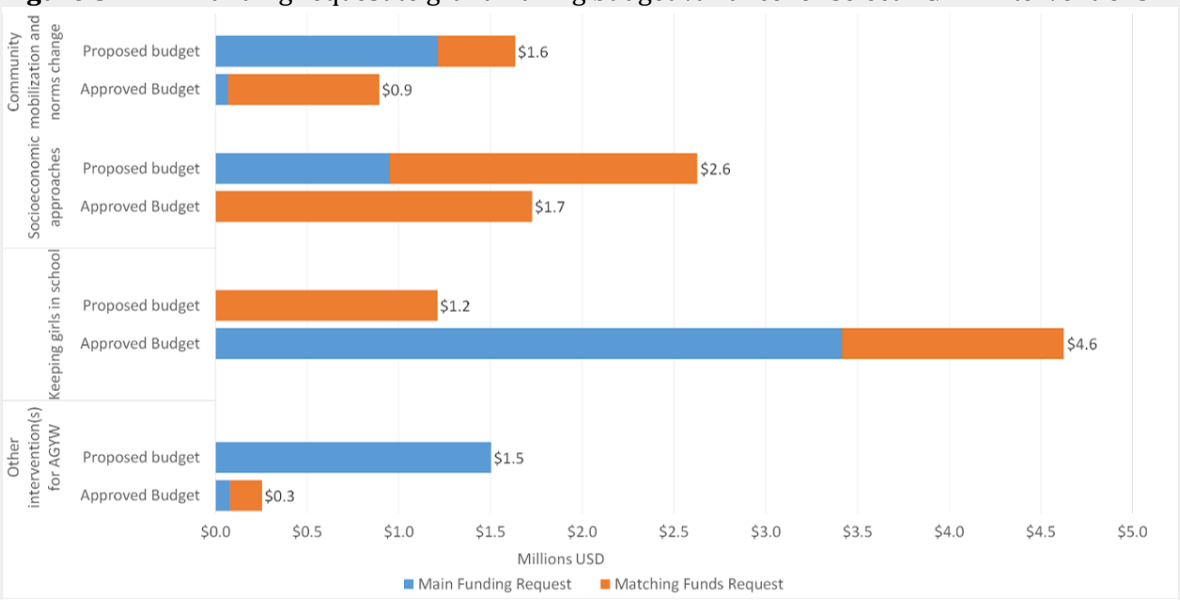
Role of the Secretariat: Across all PCE countries, qualitative evidence suggests that the Secretariat played an important role in working alongside country stakeholders to guide prioritization decision making. This included working with country stakeholders to revise initial funding request submissions prior to TRP review, and in interpreting the recommendations made by the TRP and GAC to finalize grant designs and budgets. In some countries, the Secretariat has a 'hands on' role, such as in the DRC, where the budget for HIV testing among KVPs was reduced during grant making to accommodate a Secretariat request to partake in the Supply Chain Transformation Project, and the CT asked Principal Recipients (PRs) to identify budget cuts across various modules to make US$10m available.

Matching funds: Five out of eight PCE countries received catalytic matching funds that served to increase total investment in HRG-Equity-related areas. However, evidence is mixed on whether these funds had the desired effect of increasing the level of investment to these areas made from the core country allocations. Although in Mozambique, the human rights budget reduced (Box 1.1), for most countries receiving human rights matching funds (DRC, Senegal, Uganda), the total budget from the core allocation increased for this priority area during grant making. By contrast, of the three PCE countries that received matching funds for RSSH/data systems, the related

budget from the core allocation decreased in Mozambique, while in DRC it increased. In Myanmar, although the allocation to RSSH from the HIV budget increased, the overall allocation to RSSH declined due to TB grant reductions.

Box 2.2: Drivers of AGYW intervention shifts during grant making in Uganda.
The total investment in interventions within the AGYW module remained relatively unchanged after grant making, decreasing 1% from US$5.0m to US$4.96m. However, there were substantial shifts across four of the seven AGYW intervention areas budgeted, mainly in response to TRP comments on the matching funds application requiring iteration. Per the TRP comments, the proposed matching funds were spread across too many interventions and geographies, and some interventions were unrelated to the proposed outcomes. During grant making, the PRs and CCM adjusted the AGYW interventions in the HIV grant's main allocation and revised the matching funds submission to remove activities that did not contribute directly to accelerating progress and enhancing outcomes among vulnerable AGYW. The reductions in the socioeconomic approaches, community mobilization, and other AGYW interventions created room for an increase of US$3.4m in the main HIV grant activities focusing on keeping girls in school interventions, which had no allocation in the original funding request.

Figure 5. NFM2 funding request to grant making budget variance for select AGYW interventions:



Source: Global Fund detailed budgets in Uganda

TRP review process: TRP comments and recommendations influenced the grant design and budget in several countries. For instance, following the TRP comments in Mozambique, during grant making the PR placed significant emphasis on prevention among AGYW and reduced budgets for prevention among other KVPs. TRP comments in Uganda contributed to narrowing the focus of AGYW intervention areas during grant making with the aim of maximizing investment into interventions with a strong evidence base, that would significantly reduce the HIV risk among AGYW. Another example from Myanmar is provided in Box 2.3.

Box 2.3: Effect of TRP comments on equity investments during grant making in Myanmar.
One of the TRP comments on the NFM2 funding request was a request to expand service coverage for HIV testing and methadone maintenance treatment (MMT) for PWID. Following grant negotiations with the Secretariat, the two PRs increased targets for reaching PWID with

HIV prevention, testing and MMT for the NFM2 grant period through cost efficiencies in prevention activities: PWID HIV prevention targets increased by 16%; the PWID tested target increased by 32%; and the PWID on MMT target increased by 38%. The revised targets were confirmed by the GAC for the grant award.

Box 2.4: Effect of TRP comments on RSSH design during grant making in Guatemala. During grant making, the HMIS budget more than doubled in direct response to comments from the TRP. Noting persistent weaknesses in the ability of the national HMIS to track program indicators and monitor progress, the TRP requested a detailed plan to strengthen HMIS and better monitor progress toward epidemic control and recommended consideration of DHIS2 as a platform. As a result, the PR INCAP added US$500,000 to the program and data quality intervention, to support the strengthening of the national HMIS and develop a system to enable to PR to track relevant community level indicators. This targeted investment for the PR was aligned with a national HMIS strengthening plan that had identified DHIS2 as an option for wider HMIS strengthening endeavors and was presented by the CCM and PR as the response to the TRP comments. Despite the increased investment in HMIS, no additional relevant indicators were added to the performance framework.

2.2: NFM2 grant implementation

Implementation Progress

Key message 3: A number of Global Fund business model factors influenced grant start-up and early implementation, especially: lengthy selection and contracting processes for implementers and CT support. Early implementation delays disproportionately affected RSSH and HRG-Equity activities.

NFM2 grant implementation was significantly disrupted, both by delays to start-up in Year 1 and by the onset of the COVID-19 pandemic in Year 3. Across PCE countries, a number of Global Fund business model factors resulted in initial start-up delays in Year 1 of NFM2 grant implementation, discussed further below. Overall Year 1 absorption for all modules across all grants ranged from a low of 54% in Cambodia to a high of 74% in Myanmar, with an average of 68% (Figure 6). Implementation progress accelerated in Year 2 in nearly all PCE countries as implementers overcame start-up delays and in some cases put in place accelerated or 'catch-up' implementation plans. Average absorption across PCE countries was 81% (see Figure 6 and Annex 6). Based on available data for the first half of Year 3 (2020) in a subset of countries (DRC, Senegal, Uganda), we observed lower absorption compared to Year 2. Evidence suggests that this is partly due to challenges in implementation resulting from the COVID-19 pandemic. However, the cumulative effect of budget revisions resulting in unutilized budgets from earlier years being shifted to the final year of grant implementation also contributed to low absorption in Year 3.

Compared to the grants' overall average progress, implementation remained particularly slow in some RSSH and HRG-Equity-related investment areas. At the most recent time point where data are available (2019 S2 or 2020 S1, depending on the country), seven of eight PCE countries had lower cumulative absorption for HRG-Equity investment areas compared to the overall grants, and all eight PCE countries had significantly lower cumulative absorption for RSSH investments compared to the overall grants (see Figure 6).[5] Financial absorption is defined as the percentage of the budget that was spent within a given time period. However, as noted in previous PCE reports, absorption is an imperfect measure of implementation progress as it does not

[5] RSSH absorption was 15 or more percentage points below total absorption in all countries, and in half of the PCE countries (Mozambique, Senegal, Sudan, Uganda) it was 30 or more percentage points lower.

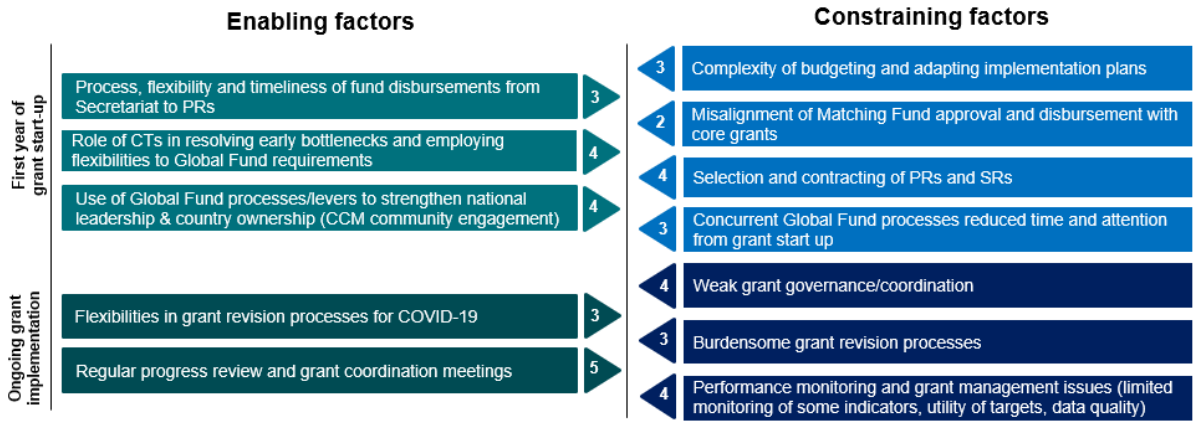
capture the quality of implementation and may incentivize implementers to focus on activities that are more quickly absorbed.

Figure 6. NFM2 cumulative absorption over time for all modules, HRG-Equity-related investments, and RSSH investments

Figure note: 2020 absorption only includes S1; Guatemala grants began NFM2 implementation later.
Source: PU/DRs

As summarized in Figure 7, and explored in more detail below, a number of Global Fund business model factors influenced implementation progress during NFM2, with some particularly affecting the grant start-up phase in Year 1.

Figure 7. Global Fund business model factors influencing implementation progress[6]



Lengthy selection and contracting of implementers, particularly SRs by PRs, delayed implementation of activities in the majority of PCE countries. In Sudan, the new PR undertook capacity assessments with 14 new SRs and Implementing Units but not sufficiently in advance of grant implementation, causing significant delays. In Cambodia, DRC, Mozambique, Senegal and Uganda, disbursements to SRs did not occur until the second or in some cases third quarter of 2018 as a result of SR contracting delays due to weak capacity. SR contracting delays during grant

[6] Each of the factors have been weighted in the form of a score based on their relative level of influence over grant implementation, where five (5) is the most important and one (1) the least (noting that the least important factors are not included to aid readability).

start-up particularly affected the implementation of HRG-Equity activities as PRs often rely on SRs with community experience to deliver KVP, HR and gender interventions and these organizations have less experience with Global Fund management systems. In other cases, new government PRs, appointed to enhance sustainability, had relatively little experience with Global Fund processes, resulting in early implementation delays. For example, Cambodia appointed the Ministry of Finance as PR for NFM2 to promote national ownership and sustainability, which led to a slow grant start-up in year 1 due to disbursement delays, but subsequently implementation picked up pace (see also Senegal example in Box 2.5).

Box 2.5: Senegal new government PR lack of familiarity with Global Fund processes.
For NFM2, Senegal moved to consolidate and centralize responsibility for grant management within the Ministry of Health to create efficiencies and streamline ownership. As recommended by the CCM, the Secretariat awarded PR-ship of the TB/RSSH grant to the Direction Générale de la Santé/Direction de l'Administration Générale et de l'Equipement (DGS/DAGE), while the national TB program, the former PR, became a sub-recipient. These implementation arrangement changes affected roles and responsibilities across different Ministry of Health actors, and, along with the DAGE's relative inexperience with Global Fund procedures as a new government PR, caused implementation delays, which stakeholders attributed to the absence of a transition phase between allocation cycles and inadequate consideration of onboarding needs to support new PRs.

Box 2.6: Sudan new PR lack of familiarity with Global Fund processes inhibited malaria grant implementation.
Under NFM2, the PR for the malaria grant transitioned to the Ministry of Health (MoH), although government financial and management systems did not fully meet standard Global Fund requirements. Throughout NFM2, extreme political and economic upheaval severely impacted on the delivery of the malaria program, partly due to PR lack of familiarity with the Global Fund business model. Together, these factors limited disbursement and delayed implementation and absorption, particularly for routine LLIN distribution. Despite these problems, in 2019 the GAC approved a budget of $25 million for LLIN mass distribution.

Concurrent Global Fund processes were a barrier to implementation progress. Most PCE countries spent the first six months of NFM2 grant start-up simultaneously closing NFM1 grants. These concurrent processes were reported as time-consuming in several PCE countries (Sudan, Myanmar, Uganda) and reduced time and attention from grant start-up activities, even in the case of program continuation grants.

Aligning budgets and implementation plans for Global Fund grants was a highly complex process. As observed across all PCE countries, the advantages of input-based budgeting in terms of risk management did not outweigh the complexity of subsequent changes to implementation plans. In Myanmar, budgetary management tools inhibited implementation in a number of ways. For instance, the managed cash flow system, introduced as a financial risk mitigation measure, contributed to low budget absorption, alongside high program management costs. Intensive reporting and data verification processes also took significant time for PRs to deal with, detracting their focus from implementation.

Finally, some countries did not approve **Matching Funds and related disbursements** until well into the NFM2 grant implementation period. This misalignment with the main grant approvals negatively affected the implementation of those activities and had a significant effect on RSSH and HRG-Equity activities, as they rely more on matching funds and take significant time to plan. In DRC for example, the Secretariat processed matching funds for RSSH/data systems separately from the main grant and they did not go through GAC approval until eight months into NFM2

implementation. Similarly, in Uganda, misalignment of timing of matching funds for AGYW and Human Rights, due to the matching funds request sent back from TRP for iteration, delayed signing of MoUs with public sector SRs, causing further implementation delays. Senegal also experienced significant delays in the incorporation of matching funds.

Influential enablers of early implementation progress during NFM2 included the **role of CTs** in resolving early bottlenecks and employing flexibilities to Global Fund requirements and the **process, flexibility and timeliness of fund disbursements** from the Global Fund Secretariat to PRs—most PCE countries received initial disbursements on time. In Uganda, DRC, Cambodia and Senegal, the CTs played an important role in allowing for flexibility in the disbursement of funds to avoid disruption to grant implementation. In Myanmar, stakeholders reported that alignment with the National Strategic Plan (NSP) and the CCM coordinating partners also supported implementation.

Key message 4: After grant start-up, weak grant coordination as well as issues with performance monitoring constrained ongoing implementation progress. Again, these factors particularly affected RSSH and HRG-Equity-related activities. Conversely, stakeholders' engagement in regular progress reviews and grant coordination meetings facilitated implementation.

As summarized in Figure 7 above, a number of Global Fund business model factors influenced implementation progress in Years 2 and 3. Most notably:

Weak coordination within and between grants, with other program teams and between donors, constrained implementation in multiple PCE countries (Cambodia, DRC, Guatemala, Senegal and Sudan). Coordination challenges particularly affected RSSH investments, in part due to resources for RSSH activities being spread across grants, and because responsibility for the aspects of health systems being targeted often lies outside of the disease programs. As a result, a diverse set of stakeholders needed to be involved in grant design and implementation, which evidence suggests was lacking in many countries. Where RSSH funds and activities were provided through the disease-specific grants, stakeholders found it challenging to implement activities that were intended to be integrated across diseases (see Box 2.7). In DRC, governance and coordination challenges stymied implementation of digital health interventions following the government's creation of a new digital health agency with responsibilities overlapping those of the national health information systems agency. In Senegal (Box 2.7), the Secretariat lacked an accountability mechanism for ensuring follow-through and/or intervention, although between NFM2 and NFM3, a strategic shift centralized management of TB and Malaria grants under a single unit within the MoH, which may help address both coordination and leadership issues in the future. These examples highlight that coordination and leadership are needed to implement activities with objectives beyond the disease grants.

Box 2.7: Senegal RSSH coordination challenges. In Senegal, each disease program grant was expected to contribute 10% of its RSSH budget to support the multi-sectoral RSSH platform, created to improve coordination and harmonization of crosscutting RSSH activities under the Ministère de la Santé et des Affaires Sociales (MSAS) Direction Générale de la Santé (DGS), which was selected as the PR of the TB/RSSH grant. However, only the TB program allocated a portion of their funds, while the HIV and Malaria programs did not because they were unclear how the funds would be used. This contributed to the platform's already weak financial and logistical management capacity, and undermined efforts to integrate RSSH investments across all three disease programs.

Some PCE countries have examples of successful approaches to overcoming coordination challenges. In Mozambique, initial delays in recruitment of an RSSH lead delayed implementation of critical RSSH investments. However, once that position was filled, their leadership facilitated

RSSH implementation progress. In other countries (DRC, Guatemala), support and/or persistent follow-up from the CT supported RSSH implementation progress.

While weak grant coordination was identified as a common implementation constraint, a number of other mechanisms strengthened these functions and leveraged national leadership and country ownership over grant implementation. In some cases, the CCM ensured broad and diverse engagement of stakeholders in a number of countries, particularly in Myanmar.

Regular progress reviews and grant coordination meetings, supported by CTs, also enabled progress. In DRC, Uganda and Senegal, these reviews and meetings at national and/or subnational levels facilitated coordinated implementation progress. In Mozambique, coordination of the grant with the wider MoH program similarly facilitated implementation. Conversely, where there are examples of lack of political support and the above levers were not suitable and/or used to good effect, this negatively affected implementation—for instance, with a lack of progress made in implementing activities to strengthen DHIS2 in Senegal.

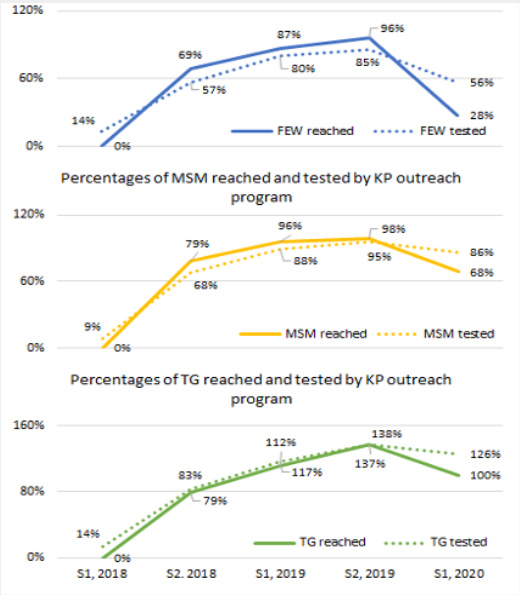
Issues with performance monitoring and grant management inhibited implementation across PCE countries. The Global Fund has designed performance frameworks to include indicators that are helpful for tracking overall country progress but less useful as indicators to measure grant implementation progress or results. Moreover, NFM2 performance frameworks lacked specificity on key RSSH and HRG-Equity investments. Where indicators were proposed, poor data quality often hampered their use (see Box 2.10 and 2.11).

The **grant revision process**, discussed in more detail in the section below, was also a barrier to implementation progress. While the Global Fund intended grant revisions processes to enable implementation adjustments to maximize impact, in practice, stakeholders found the process burdensome and have sought to avoid undergoing significant changes that would trigger a TRP review. In contrast, the grant revision processes for COVID-19 revisions were perceived as more flexible and a lighter lift for country stakeholders, which has enabled rapid implementation adjustments in 2020 (see Box 2.8), and may be a source for lessons learned in addressing some limitations of the standard revision processes.

Box 2.8: Grant implementation and COVID-19 disruptions. Evidence from the PCE countries underscores how COVID-19 particularly affected HRG-Equity investments in NFM2. For example, the social distancing measures in Uganda as part of the COVID-19 response included a ban on social gatherings and movement, as well as school closures, which affected activities like dialogues, sports campaigns, outreach, and in-school activities that targeted AGYW to reduce gender barriers to HIV prevention, care, and treatment. COVID-19 also affected HIV services for KVPs in Cambodia, as described further below.

Equity implications of COVID-19 on delivery of HIV services for key populations in Cambodia. By the end of 2019, KVP outreach targets had largely been met and/or exceeded, with the exception of PWID (not shown). As a result, in 2019, the grant increased resources for these services through portfolio optimization and revisions, shifting funds to the stronger performing interventions targeting Female Entertainment Workers (FEW), MSM and transgender people. However, during 2020, COVID-19 restricted achievement of targets for all key populations, especially FEW and PWID (not shown). Entertainment venue closures triggered FEW to migrate, which disrupted outreach contact. Some stakeholders expressed concern around the capacity of implementers to deliver on additional services under COVID-19 and its effect on absorption.

Figure 8. Percentages of FEW reached and tested by KVP outreach program



Global Fund business model flexibilities were critical in channeling additional resources to the COVID-19 national response through grant savings and the COVID-19 Response Mechanism (C19RM). Countries used flexibilities within the NFM2 grants through a mix of 'true' savings (e.g., delayed implementation over Year 1-2, lower unit costs, over-budgeting, etc.) and savings from activities that could not be implemented during lockdowns (e.g., outreach, training, meetings, supervision, school-based activities), revising US$26m from current grants. An additional US$209m was approved through C19RM. PRs and SRs undertook various implementation adaptations in responding to COVID-19 disruptions. For example:

- Cambodia: COVID-19 was predicted to affect antiretroviral therapy (ART) attendance, so implementation shifted to providing multi-month scripting for all stable ART patients to ensure maintenance.
- Guatemala: To limit face-to-face outreach interactions, a SR switched to online outreach for KVPs, with early evidence of improved performance.
- Myanmar: Additional procurement for ARV buffer stock through October 2021, treatment for opportunistic infections and methadone maintenance, rapid test kits.
- Senegal: Strengthen procurement and supply of laboratory equipment and reagents in reference labs and potentially increasing use of GeneXpert for COVID-19 testing.
- Uganda: Innovations that leverage Global Fund investments, such as using the bed net campaign database to guide distribution of facemasks to households, or utilizing community health volunteers to support medication refill and distribution.

***Table 2**. Approved grant flexibilities and C19RM ($US millions).(5)*

Mechanism	CAM	DRC	GTM	MOZ	MYN	SEN	SDN	UGA	**Total**
Flexibilities	$0.52	$0	$2.3	$2.6	$6.3	$2.2	$1.6	$10.5	**$26.1**
C19RM	$0	$55.1	$1.1	$60.5	$27.3	$4.9	$8.7	$51.9	**$209.5**

The role of revisions during implementation

As per the Operational Policy Manual: "*The goal of a grant revision is to allow Global Fund investments to adjust to programmatic requirements during grant implementation, in order to ensure the continued effective and efficient use of Global Fund resources invested to achieve*

maximum impact in line with the Global Fund's 2017-2022 Strategy. A grant revision may also occur due to other changed circumstances and arrangements."(6) Grant revisions include:[7]

- **Additional funding revisions:** When the total approved funding is adjusted, including through 'portfolio optimization' and additional donor pledges.
- **Program revisions:** When programmatic changes in the scope (changing goals, objectives, or key interventions) and/or scale (increasing or decreasing targets) are applied to the grant (formerly referred to as "reprogramming").
- **Budget revisions:** When the budget is adjusted but the total approved funding does not change, nor is there any effect on the performance framework.

In addition, subject to its review of grant performance, the Secretariat makes an annual funding decision that determines the proportion of the grant budget that will be disbursed in the following period. This is in effect how the Global Fund's performance-based funding model is operationalized—i.e., the full budget is disbursed where grant performance is strong, but a proportion of the budget is withheld where grant performance is weak (see Annex 7). As such, in theory these decisions also influence whether and how grant revisions are made. The cumulative effect of these various processes is a grant budget that is frequently subject to change and highly complex. We explore the implications of these processes for grant management and implementation in the findings below.

Key message 5. The burdensome revisions process, alongside management incentives on PRs and CTs to maximize absorption, resulted in revisions being used predominantly as a financial management tool, rather than necessarily to maximize impact. The cumulative effect was that grants shifted resources to later in the cycle rather than undergoing significant restructuring to the scope and/or scale of grants, having the potential to reduce allocative efficiency.

PCE countries made frequent budget revisions (N=38) and additional funding revisions (N=37), but program revisions (N=17) to scale or scope were uncommon (Table 3).

Table 3. Number and type of grant revisions during NFM2

`	CAM	DRC	GTM	MOZ	MYN	SEN	SDN	UGA	Total
Additional Funding Revision	1	11	2	11	0	3	4	5	37
Budget Revision	3	0	5	8	4	5	3	10	38
Program Revision	0	8	0	1	6	2	0	0	17
Total	**4**	**19**	**7**	**20**	**10**	**10**	**7**	**15**	**92**

Table 4. Number of grant revisions and length of approval process by revision type during NFM2

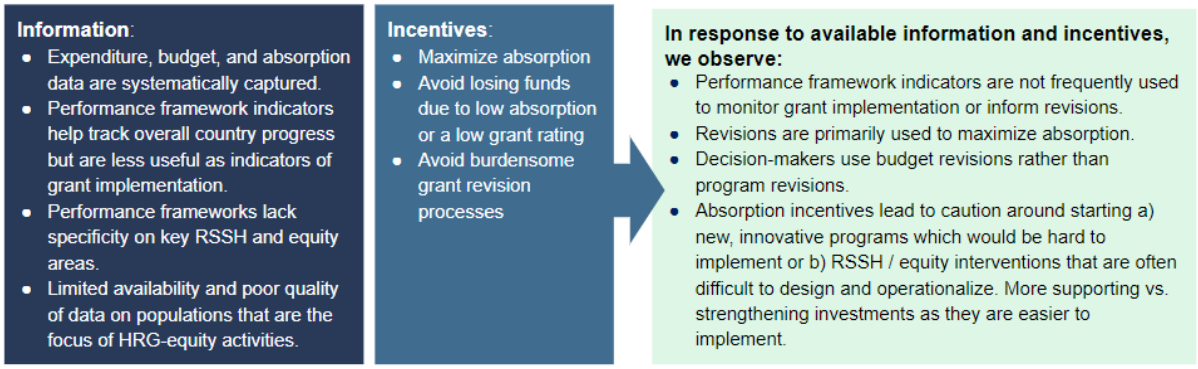
Type of revision	Number of revisions	Average revision approval duration (days)	Average revision approval date
Additional Funding Revision	37	132	11/7/2019
Budget Revision	38	57	4/22/2020
Program Revision	17	52	12/5/2019
Grand Total	**92**	**87**	**1/15/2020**

[7] The PCE did not examine the other two types of revisions defined in the Operational Policy Manual: Extensions (End Date Revisions) and Administrative Revisions.

As shown in Figure 9, a range of incentives drove grant revision decision making. ***Additional funding revisions*** **tended to occur earlier in the grant lifecycle, be initiated by the Secretariat and negotiated between the CTs, CCMs and grant recipients, and were based on reviews of high-priority activities approved in the register of unfunded quality demand (UQD)**. Decision makers used funds to fill gaps and reinforce approved grant strategies, including: increasing the investment in community TB care delivery in Cambodia; maintaining vector control coverage and covering the 2020 ART gaps in Mozambique; providing emergency funding for refugee LLINs and filling case management gaps in ACTs, in Sudan, alongside filling gaps in IRS and LLIN mass campaigns in year 3; expanding geographic coverage of the LLIN campaign and HIV testing and treatment in DRC; and incorporating funds from Comic Relief to ramp up efforts to eliminate mother-to-child transmission of HIV in Guatemala.

Evidence from Cambodia suggests that the process for selecting what activities/interventions are supported with the additional funding can be problematic. Specifically, despite national stakeholders being encouraged by the Secretariat to put forward innovative programming proposals, the Country Team aligned with TRP approved proposals, although the process through which these decisions were made became a source of frustration and disillusionment among national stakeholders

Figure 9. Available information and incentives drive decisions and influence grant revision processes.



Most PCE countries undertook frequent *budget revisions* (reallocation), in order to improve financial performance and maximize absorption. In Cambodia, for instance, where the PR shifted funds away from poorly absorbing (and performing) PWID activities and into better absorbing (and performing) FEW/MSM/transgender interventions. DRC was a notable exception because it did not undergo any budget revisions, but, compared to other PCE countries, had the most program and additional funding revisions. Tracking budget revisions is time-consuming and lacks a systematic process of documentation, which has implications for transparency beyond the PRs and LFA. Implementation letters (when official budgets are updated) did not generally document budget revisions, which meant PCE teams examined budget revisions through detailed comparison of official budgets over time.

Only four PCE countries executed *program revisions*. Revisions resulted from various triggers (e.g., changes in implementation arrangements, in response to absorption issues, and/or administrative issues—such as shifting funding between PRs in DRC due to changes in commodity and freight unit costs). DRC had the most program revisions compared to other PCE countries, which is likely a reflection of the portfolio size and complexity. However, the broader trend across PCE countries suggests that program revisions were an underutilized mechanism for executing changes in programmatic scope and scale. At the midpoint of the grant lifecycle, PRs did not want funds to be withdrawn from their grant budgets, nor did they want to introduce new programmatic activities (particularly for RSSH) that would be difficult to implement and may not align with grant performance framework targets. Furthermore, the burdensome grant revision

process, particularly for program revisions, acted as a disincentive to undertaking substantial grant revision. As shown in Table 4, program revisions took on average 52 days for approval. However, this average duration does not include any 'material' program revisions requiring TRP or GAC reviews, as none occurred in PCE countries in part due to the perceived burdensomeness of the process; material program revisions would likely have taken longer on average. Limitations to programmatic evidence available to inform grant revisions also restricted the ability of PRs, CCMs and CTs to revise grants based on data/evidence about programmatic results or impact (in line with the objective to 'maximize impact').[8]

Box 2.9: AGYW investments in Uganda underwent frequent budget revisions by the civil society PR, whereas the government PR appeared to miss opportunities for revision. The civil society PR made budget revisions within the AGYW module, in some instances resulting in a 60% increase/decrease to intervention totals, but did not introduce changes to targets. They viewed budget revisions as necessary to improve absorption and responding to AGYW beneficiaries' preferences for vocational training offerings (with sustainability implications of improving AGYW livelihood opportunities). Despite several budget shifts, the overall total investment remained roughly stable at US$10m. Stakeholder interviews indicated that they viewed matching funds as 'protected' or 'sacred'—and that this drove efforts to ensure any budget reallocation retained the funds within the AGYW module. The government PR did not undertake similar budget revisions for AGYW interventions, despite ongoing delays in implementation through 30 months of the grant, and only three of six interventions registering any expenditure as of S1 2020 (cumulative 1.49% absorption). However, in September 2020, the Ministry of Education, an SR, in consultation with the government PR, proposed 38% of its AGYW module allocation be reallocated toward the prevention of gender-based violence, which was approved by the CT. This example highlights evidence of COVID-19-related revisions aiming to incorporate equity considerations, including programming to address the indirect impacts on young people resulting from COVID-19, including increased gender-based violence, teenage pregnancies and HIV infections among AGYW.

Box 2.10: Mozambique did not use grant revisions to rectify a known issue with the budget versus target linking HIV+ FSWs to care. The recently established FSW program had funding doubled during NFM2 grant making, but with targets set low based on relatively out-of-date KVP data estimates (in spite of the TRP's recommendation to scale up targets). The SR, FDC, initially overachieved targets for outreach and testing, so grant performance was rated high. However, partly because of the way targets are calculated in the prevention cascade, in reality the program missed many HIV-positive FSW for linkage to care. In addition, FDC responsibility for linkage ended with one visit to the closest health center, and they made no effort to follow up or ensure clients fully entered into treatment. During implementation, the CT did not revise linkage targets upwards as the budget did not increase and no grant revision took place. The CT did draw attention to the women missed for linkage to ART, so FDC are altering their model of service delivery for NFM3.

Box 2.11: DRC did not use grant revisions to adjust differentiated HIV testing targets following new data on HIV incidence. DRC submitted a tailored review NFM2 funding request for HIV/TB because the HIV component remained largely unchanged due to NFM1 grant delays

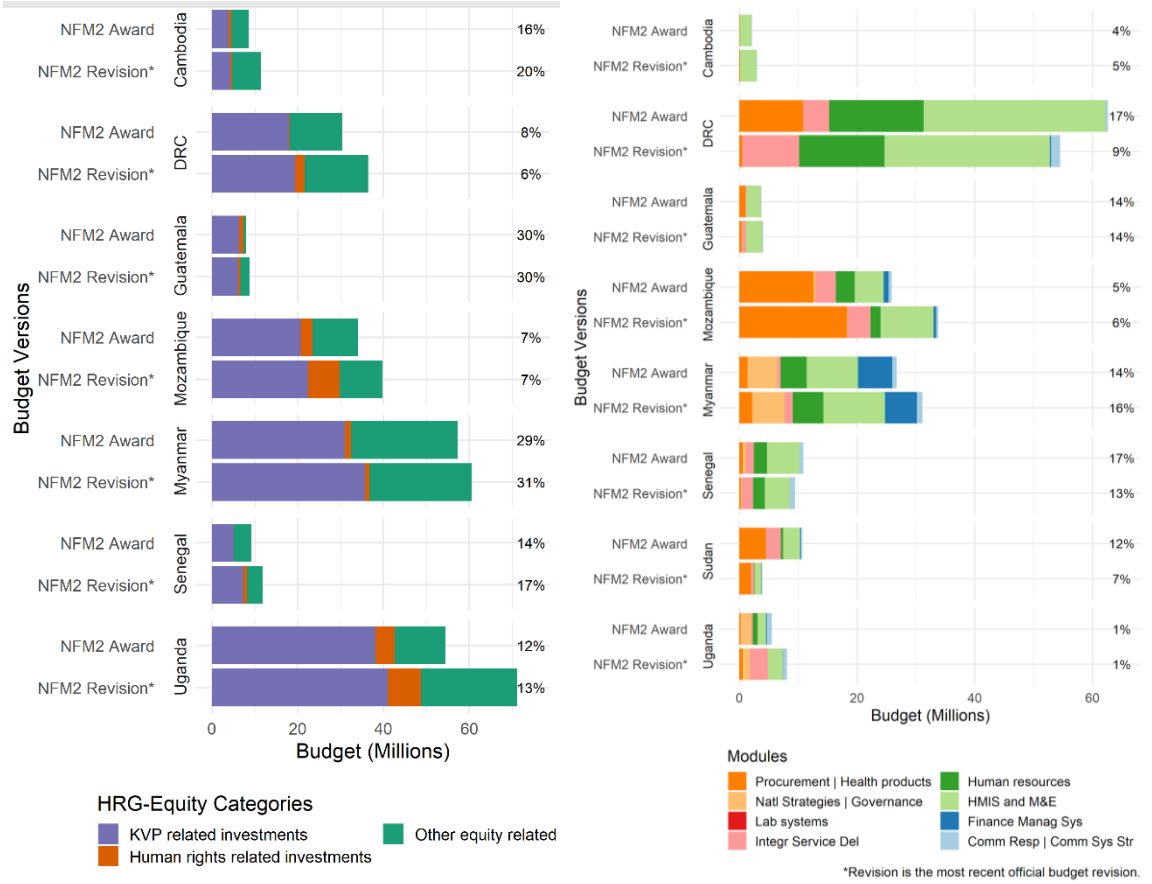
[8] In particular, this refers to data on absorption being a weak proxy for implementation progress, limited quantitative and standardized evidence available on grant implementation progress, grant performance framework indicators not reflecting grant-specific results and not having any indicators in some important areas of the grants (often for RSSH), and limited utilization of Work Plan Tracking Measures (WPTMs).

and lack of new epidemiological data. HIV grants were thus approved by the GAC with the understanding that KVP testing targets would be updated during grant implementation following the results of the 2017 HIV incidence study. However, by the time the new data on HIV incidence were released in Q1 of 2020, development of the NFM3 funding request was already underway and both the CT and PR considered it too late in the NFM2 grant cycle to undergo a grant revision. This example highlights challenges with the business model of responding quickly to new data and changes in programmatic and epidemiological context, but also raises limitations in monitoring grant performance. For example, by semesters 3 and 4, HIV tests administered to KVPs largely exceeded grant targets although it was acknowledged that the under-estimated targets were driving the indicator performance.

In most PCE countries, PRs and CTs responded to low absorption of RSSH and HRG-Equity budgets by shifting unused resources to later in the grant cycle rather than to higher-absorbing program areas. For HRG-Equity-related areas, grant revisions mostly had the net effect of increasing the budget. As depicted in Figure 10 (left), at the beginning of implementation, investments related to HRG-Equity made up between 7% and 30% of PCE country budgets, with an average of 16%. Of these investments, across countries the majority consisted of KVP-related investments, followed by other equity-related investments and lastly, human rights. At the most recent official revision observed by the PCE, funds for HRG-Equity had increased in all countries.

Grant revisions had a mixed effect across countries on the budget for RSSH. RSSH-related investments during implementation decreased or remained fairly constant in half the PCE countries while the other half observed increases (Figure 10, right). However, as a share of total budgets, RSSH investments on average decreased from 11% to 9% across all countries.

Figure 10. HRG-Equity (left) and RSSH (right) related investments during implementation

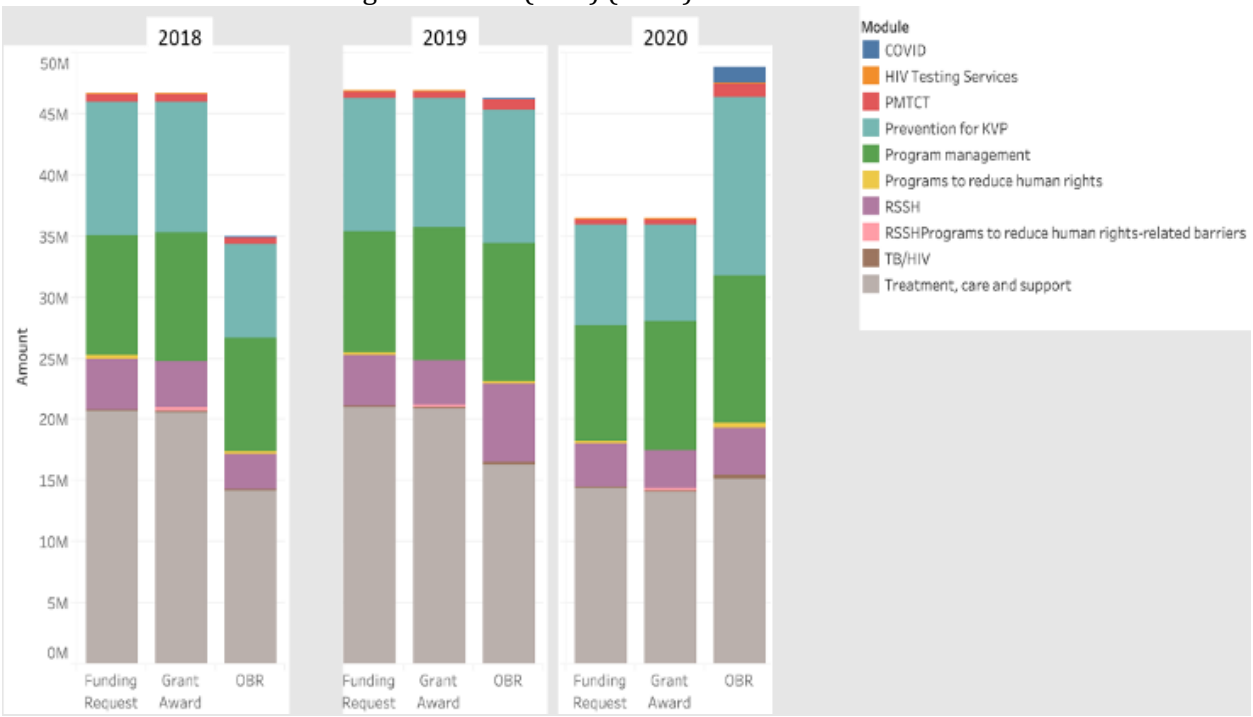


Source: Global Fund detailed budgets

Using budget revisions systematically to shift unutilized resources from Year 1 to Years 2 and 3, and subsequently from Year 2 to Year 3, has potential to reduce allocative efficiency. For example, in Myanmar (Figure 11), the HIV/TB grant budget reduction in Year 1 raised absorption against the originally approved grant budget, with implications for grant management. While it makes sense to shift resources to later in the grant cycle if this ensures that they are well used, substantial sums were involved (around US$15m in the Myanmar example) and the processes in place to make budget revisions were informal and did not require any form of approval outside of the CT. When resources are moved around mid-cycle, the significant benefits of the NFM model in terms of the predictability of funds are also eroded. Furthermore, the accumulation of budget in the last year of the grant cycle places additional pressure on PRs and SRs to avoid the Secretariat reallocating the resources through portfolio optimization. Although the PCE has not yet been able to collect evidence on this as 2020 budgets had not been published at the time of writing, other reviews, including SR2020, linked this situation to a dramatic increase in spending on commodities in the final year of NFM1 grants and questioned whether this was a good use of funding.

Analysis shows that the effects noted above were more pronounced for modules and/or intervention areas where absorption is low in the early years of implementation. As shown above, this affects both RSSH and HRG-Equity-related investments, which also often require more time to plan for and implement than other investment areas. Box 2.12 provides an example from Mozambique.

Figure 11: Comparison of the Myanmar HIV/TB grant budgets between Funding Request, grant award and latest Official Budget Revision (OBR) (2019).

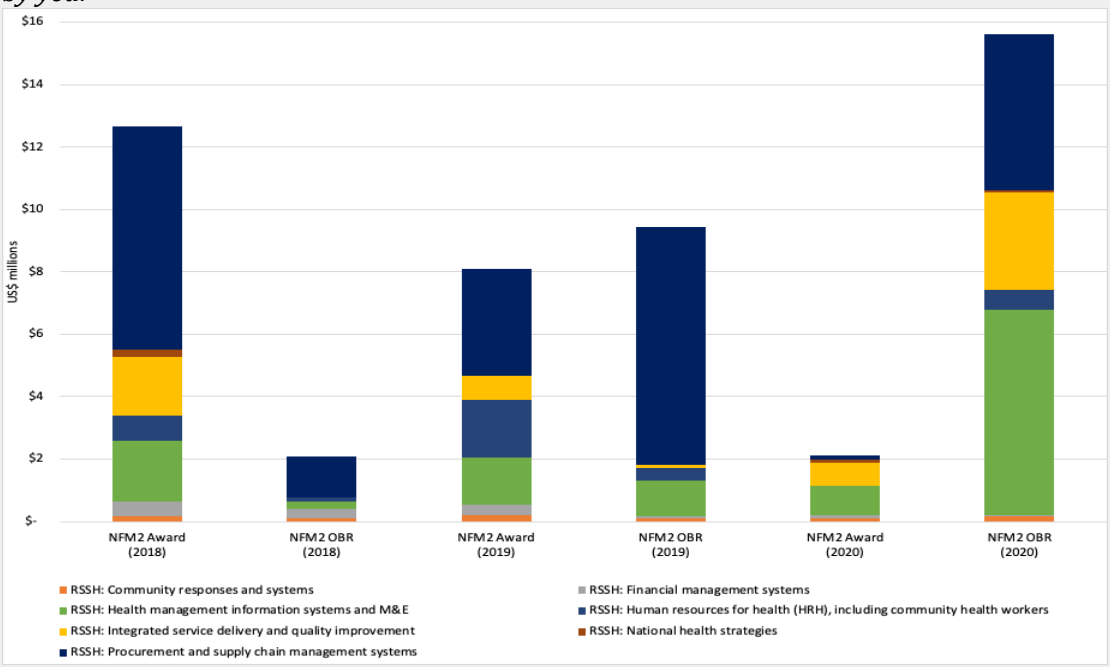


Source: Global Fund detailed budgets

Box 2.12: Delayed implementation of RSSH interventions in Mozambique. The budget for RSSH within the HIV grants for 2018-20 was US$23m at grant award and US$27m as per the latest grant revision, including an additional US$3m from matching funds. Based on cumulative

rate of absorption at mid-year in final year of grant, which was approximately 50%[9], a large amount of the funds would be unspent by the end 2020. At mid-2020, expenditure for the largest investments—activities primarily designed to *support* health systems—was below budget, but investment areas designed to strengthen the health system were even worse. The exception is community responses and systems, for which the budget was reduced during grant making. Low absorption partially stems from the delay of appointing a coordinator/lead for RSSH until May 2020. Despite low absorption, the grant did not use revisions to shift funds away from RSSH to other programmatic areas, as funds were already committed in RSSH procurement processes. Rather, as shown in Figure 12 below, the PR and CT shifted unused resources to later in the grant. Despite this, a significant increase in resources for RSSH is planned during NFM3. Stakeholders report that, although the NFM business model has increased predictability for RSSH funding, the three-year cycle does not lend well to strengthening and sustaining improvements in the health system.

Figure 12: *Budget variance for Mozambique NFM2 HIV grants, RSSH modules only, 2018-2020, by year*



Source: Global Fund detailed budgets

Key message 6: Global Fund disbursements to countries often varied from the total budget for each period but were not linked to indicator or grant performance ratings. As such, this element of the business model does not appear to be working as intended to incentivize performance.

The Global Fund seeks to incentivize performance, in part, by linking disbursement amounts to the achievement of grant targets (summarized through an indicator rating, which informs an overall grant rating).

As shown in Annex 7, disbursements often varied dramatically from the total agreed budget for each reporting period.[10] Even where performance against the indicators within each grant

[9] Information provided following the end of data collection for this report suggests absorption was over 90% by end of December 2020, reportedly due to a significant increase in expenditure at the end of the grant cycle related to procurement of commodities.

[10] For instance, as shown in Annex Table 6.3, disbursements for 2018/19 exceeded the total original budget for this period in 15 out 30 grants.

performance framework was weak (e.g., for some grants in Mozambique, Uganda and Senegal), Secretariat disbursements were often above or a relatively high proportion of the total grant budget.[11] Although indicator performance provides only a 'starting point' for determining disbursements, the lack of any relationship across all grants in PCE countries suggests that the annual funding decision is not working as intended to operationalize the principle of performance-based funding.

As noted in the sections above, analysis conducted through the PCE and elsewhere (e.g., SR2020) suggests that this may be a function of:

a) The grant monitoring system being focused mostly on reporting progress against national program-wide indicators rather than reporting the results of the Global Fund grant specifically, and therefore not being a good proxy for grant implementation and performance;
b) Limitations of grant performance frameworks, for instance where they include weak/unrelated indicators with unrealistic targets, and/or where important investment areas are omitted from the performance framework (e.g., human rights, RSSH), reflecting wider measurement challenges.[12](7,8) This is particularly true when considering how few indicators are reported for some semesters.

The quantitative evidence on which to base disbursement decisions (and decisions on grant revisions) to ensure they incentivize appropriate and optimal behavior is therefore limited. The Mozambique example in Box 2.10 highlights a specific example of the difficulties faced in measuring grant-specific progress. A number of PCE CEPs also reported that disbursement decisions are made primarily based on financial needs, and possibly also qualitative information on performance. The Secretariat may also consider it inappropriate to reduce funding to poorly performing grants after only a year of implementation.[13] Nonetheless, the lack of clarity over how the system works and how funding decisions are made may undermine the performance-based funding model.

Box 2.13 provides an example of how disbursements decisions were made for a grant in Mozambique.

Box 2.13: Disbursement decisions encouraged the achievement of results for a grant in Mozambique with a troubled start

The Collaborating Centre for Health (CCS) HIV/TB grant achieved an indicator and grant rating at the end of 2018 of B2 (inadequate but potential demonstrated). Correspondingly, the OPN suggests that between 30% and 59% of the cumulative budget for 2018 and 2019 should be disbursed in 2019.(6) While this is indicative and can be adjusted, analysis shows that disbursements were much higher, at 94%. The CT confirmed that disbursement decisions were made to manage financial resources, as well as performance. However, reducing funding to low performing grants may not be the best way to maximize results. The indicator and overall grant rating for this grant increased dramatically to A2 (meeting expectations) by the end of 2019.

[11] As shown in Annex Table 6.3, the level of disbursements made is substantially different to the indicative funding range for 19 out of 30 grants.
[12] Ref previous PCE synthesis report, SR2020. For example, previous OIG analysis of 27 grants found that nearly 30% of the budget was not reflected in the performance framework.
[13] It is also worth noting that doing so may affect grants with a strong focus on activities that take more time to plan and start implementation (e.g. those focused on RSSH, human rights, etc.).

Chapter 3: Lessons learned NFM2 to NFM3

As shown in Chapter 2, the ability of grant managers (both Secretariat teams and country stakeholders) to adjust grants mid-term is fairly constrained, in part due to burdensome formal revision processes and the significant disruption that these revisions potentially pose for implementation. As also shown in Chapter 2, grant managers have few incentives to undertake revisions that include scope/scale adjustments to grants; and instead tend to shift the unutilized budget to later years in the grant cycle and delay major structural decisions until the next funding request application. Ensuring grants are well designed at the time of the grant award is therefore critical.

In this chapter, we therefore explore PCE findings on how the grant design process was informed by lessons from NFM2, NFM3-specific elements of the business model, and new information and policy to determine grant priorities, budget allocation and performance framework elements.

Key message 7: In most PCE countries, the NFM3 funding request process was an improvement on NFM2: more streamlined, efficient and flexible; characterized by improved country ownership and participation by a wider group of stakeholders; and with a range of business model factors used effectively to influence grant priorities.

NFM3 'Tailored for NSP' and 'Full Review' processes were found to be more efficient than NFM2 'Full Review' processes. Just two PCE countries, Myanmar and Uganda, submitted *tailored for NSP* funding requests during NFM3, and stakeholders reported the process to be more efficient than the NFM2 full review. Both countries reported that information generated during NSP development consultations fed directly into funding request processes. In Myanmar, both processes were embedded in the CCM structures that facilitated coordination and synergies. In Uganda, because the NSP priorities were still 'fresh' in the minds of those developing the funding request, they referred to the NSP more frequently, promoting greater alignment and harmonization, and thus improving sustainability. However, the finalization of the disease NSPs occurred concurrently with the funding request development processes, which created some challenges for key actors and in determining how priorities from both processes would be harmonized. **Box 3.1: Process improvements through Tailored for NSP funding request in Myanmar**.

The MoH was keen to ensure that the NSP was well integrated with a wider national health strategic plan and focused on the overall objective of universal health coverage (UHC). They therefore worked hard to make diverse stakeholder participation more meaningful through the *Tailored for NSP* approach: the CCM Secretariat was better embedded in the MoH and shared information widely on timelines for NSP and funding request development, well ahead of the actual process; UN agencies facilitated community networks' engagement, including on matching funds and community system strengthening; and a smaller, more strategic working group led the process, operating on a tighter, more compressed timeline.

However, NFM3 full review processes were not always more efficient, compared to 'lighter touch' processes for NFM2. Three PCE countries—DRC, Mozambique and Sudan— moved from 'lighter touch' approaches (e.g., program continuation and tailored review) in NFM2 to full review applications in NFM3. In DRC, stakeholders regarded the 2017 program continuation and tailored review processes as being restricted because interventions were predetermined and, as such, they preferred the NFM3 Full Review process, which gave them greater latitude to propose new interventions and strategies based on data, context and NFM2 lessons learned. In Mozambique, the NFM3 process allowed for building on a recent NSP mid-term review, to incorporate its findings into the new NSP and funding request. On the other hand, Sudan reported the 2020 process to be significantly more burdensome than their program continuation application in

2017, due to delays in developing the NSP, which further interrupted the funding request submission.

Compared to NFM2, the NFM3 process benefitted from greater inclusivity, transparency and country ownership during funding request development, but not during grant making where key decisions were often made. CCMs were reported to be smaller, more informed and organized, and with better coordinated technical working groups across Sudan, Myanmar, Guatemala and Mozambique, mainly due to better government leadership and wider participation. Sudan and Myanmar reported a reduced role needed by UN agencies as government stakeholders showed greater leadership. For the early stages of the funding request development process, engagement and ownership by national stakeholders extended beyond the usual Ministry of Health program leads, including Ministries of Finance (Mozambique, Uganda), Education and Gender Ministries (Uganda), subnational or provincial stakeholders (Cambodia, DRC, Mozambique, Myanmar), and civil society organizations (CSOs) and KVP representatives (DRC, Senegal, Guatemala, Mozambique), suggesting a shift toward greater integration of the grants across national health budget processes and health systems, compared to NFM2.

However, later on in the process, (i.e., during budget allocation and priority setting) stakeholders in most countries reported lower transparency for crucial decisions. For example, in Guatemala, although participation in early meetings was wide, final prioritization and budget allocation decisions were made by the PR and MoH and did not include KVP representatives. CTs also appeared to exert a strong influence during the latter stages of the funding request process, with countries reporting significant pressure to absorb Global Fund priorities into grants. This was also a finding of the 2017/2018 PCE Synthesis Report.(9)

A number of KVP representatives reported feeling more included in NFM3 funding request processes than in NFM2, in some cases helped by having gained experience from previous processes and support to build their capacity. In DRC, KVP representatives reported that their earlier participation in the National Program Review in 2019 strengthened subsequent contributions to the funding request process. In Uganda, a KVP consortium organized separate meetings and a system of email inputs which assisted a much wider group to participate than previously, as well as technical assistance from CRG SI to civil society actors involved in the writing process to help better articulate their priorities. Other countries where KVP representatives reported better participation included Guatemala, Myanmar and Senegal. Uganda and Myanmar, with Tailored for NSP funding requests, reported increased participation by KVPs across both NSPs and the funding request, with potential implications for the design of more sustainable and effective responses to the diseases.

Irrespective of differentiated application approaches, COVID-19 changed the way the funding request and grant making processes were managed, with both positive and negative implications. In response to COVID-19-related restrictions, many countries conducted funding request and grant making meetings online, which stakeholders in some countries reported as increasing transparency and participation by a wider range of organizations. For example, in Mozambique, an online platform enhanced transparency compared to NFM2, and the CCM used online surveys to achieve greater consensus. Based on lessons learned in the development of the C19RM funding request in virtual engagement of youth across regions, Uganda's CCM is considering the continued use of virtual consultations to increase targeted constituency engagement going forward. However, these approaches depend on stakeholders having good access to internet connections, which was not always the case.

The process of applying for matching funds improved for NFM3 compared to NFM2. As noted in earlier PCE reports, in many PCE countries, the NFM2 separate application processes for matching funds led to their budgets not being aligned to other grant implementation cycles. For NFM3, stakeholders reported significant efficiencies from integrating matching funds processes

within the main grant applications. As explored below, matching funds for NFM3 (as for NFM2) also appear to be helping to ensure that Global Fund strategic priority areas are addressed within country grants, with some countries even exceeding the match requirement (for example, 2:1 matching for Uganda's AGYW investments and marginal increase over requirements for AGYW in Mozambique).

TRP recommendations (made both on NFM2 and NFM3 funding requests) informed NFM3 grant designs, with particular implications for HRG-Equity and RSSH related investments. For example, Sudan in NFM3 is investing in strengthening HMIS data; prioritizing programs to reach Internally displaced people, refugees and nomadic populations in remote states; addressing acute gender barriers in these groups; and expanding investment in Community health workers—all areas the TRP recommended during NFM2. In Mozambique, the NFM2 comments from the TRP recommended increased coverage for services targeting FSWs. This was responded to in NFM3 by increasing the performance framework target for the proportion of FSW reached with prevention services from 13% by 2020 to 46% (67% in total including PEPFAR support) by 2023.[14] However, during NFM3, the TRP has again commented that coverage targets for FSW are insufficient to reach epidemic control. In DRC, similar to comments provided in 2017, the TRP again noted a lack of detail in the NFM3 HIV/TB funding request on differentiated HIV testing strategies for KVPs. Although the applicant proposed numerous strategies such as HIV self-testing at the community level, inadequate detail was included on other potential high-impact strategies (e.g., index testing, online recruitment, and HIV case analysis from Enhanced Peer Outreach Approaches). In response, the applicant provided a robust response with details regarding additional high-impact strategies that will be implemented. In Uganda, there were no recommendations related to CSS in the NFM2 request, but in NFM3 the applicants have been responsive to a TRP recommendation to shift institutional capacity building, planning and leadership development from the PAAR to the main allocation, which increased the RSSH CSS allocation by 15%.

Box 3.2: TRP comments on the Myanmar 2020 funding request call for a stronger evidence base on PWIDs to guide NFM3. During NFM2, overall HIV grant performance was generally on track with the majority of grant coverage targets for KVPs being overachieved, except for PWID. Despite a grant revision that significantly increased resources for PWID during NFM2, absorption of PWID interventions addressing stigma, discrimination and violence, and community empowerment was weak and the program achieved relatively low coverage. TRP comments in both 2017 and 2020 highlighted the need for better evidence in relation to PWID service coverage, access to methadone maintenance treatment and linkage to care. In response, in 2020, the Myanmar CT requested the PCE Myanmar CEP to assess these issues to inform the NFM3 planned expansion of PWID interventions. Findings were presented to a large group of national stakeholders in November 2020, at an all-day meeting dedicated to the topic. As a result, under the NFM3 grant, allocation to human rights and gender interventions has increased from 23% to 32% of the grant, including specific investments in strengthening community systems, and resources for interventions specifically designed to address human rights barriers for PWID have doubled from US$0.8 to US$1.6m under NFM3.

Key message 8: NFM3 funding requests included significantly larger budgets and focus on some but not all of the areas where a change in trajectory is needed to meet the Global Fund Strategic Objectives, largely as a result of the overall increase in country allocations.

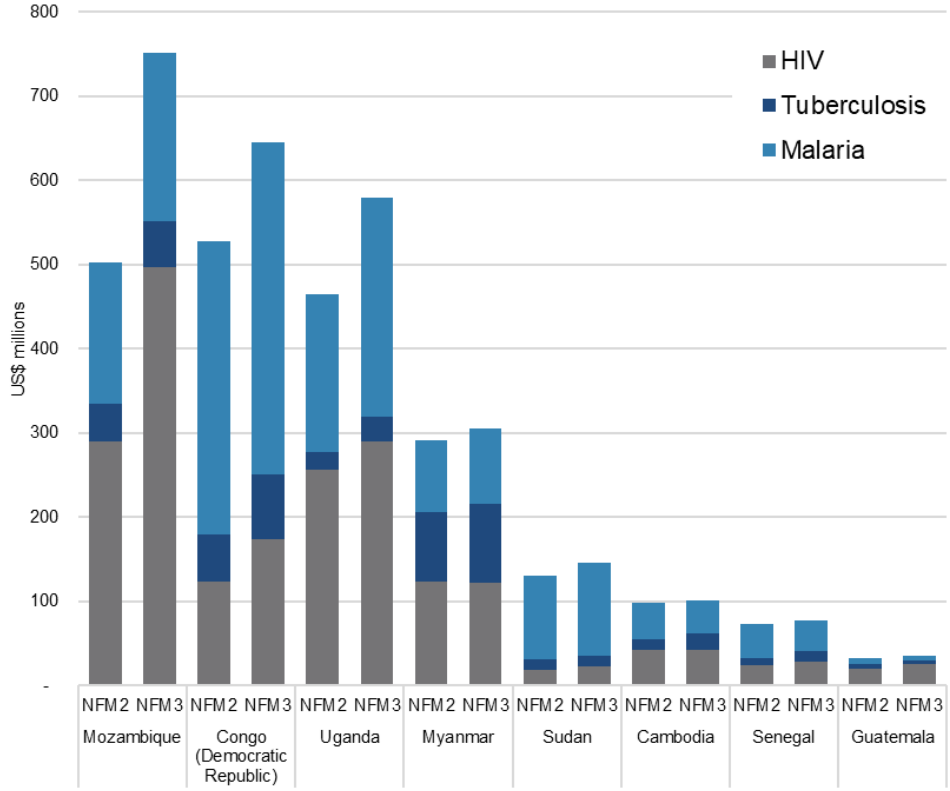
[14] We note a decrease in the denominator (from 97,712 in NFM2 to 86,000 in NFM3), which reflects the FSW size estimates in the districts where the Global Fund grants are operating and is important to interpreting the scale of the increase in the percentage of FSW targeted. The target may be subject to change in the final performance framework.

The successful Sixth Replenishment alongside a commitment to 'do things differently' offered an important opportunity to 'change the trajectory' in NFM3. The Global Fund's 2019 investment case, used as the basis for the Sixth Replenishment to fund NFM3 grants, made a compelling case to 'do things differently' in order to meet its Strategic Objectives.(10,11) Specifically, it called for greater innovation, collaboration and effective execution, with a particular emphasis in HIV on scaling up effective prevention to KVPs and AGYW, and significantly more investment in overcoming HRG-related barriers to accessing health services. For TB, the investment case called for expansion in both case finding and treatment of drug-sensitive and MDR-TB cases, and for malaria, it called for expansion in the distribution of bed nets alongside interventions to ensure they are used, as well as in testing and treatment. Lastly, it called for a scaling up of investments to build RSSH. In addition, a series of applicant resources (12), including information notes on HIV, TB, malaria and RSSH, and technical briefs on key areas of the Strategy (human rights, gender equity, value for money, etc.), were updated to support countries in operationalizing priorities as articulated in the Investment Case.

The 2019 Global Fund replenishment led to increases in total NFM3 allocations for all PCE countries. As per the indicative program splits provided by the Global Fund (Figure 13), more than half (55%) of the increased funding available in NFM3 is intended for HIV, with 35% for malaria, and 10% for TB, with some variation by country. For example:

- Cambodia: 100% of the additional funding available in NFM3 is intended for malaria.
- Uganda: 63% of the additional funding available in NFM3 is intended for malaria.
- Mozambique: 83% of the additional funding available in NFM3 intended for HIV.
- Myanmar: 68% of the additional funding available in NFM3 is intended for TB, with a 1% decline in funding for HIV.

Figure 13: PCE country allocations with indicative program split[15]



Source: Global Fund detailed budgets

[15] Data accessed through the Global Fund Data Service Allocations dataset.(13) Accessed on 25 November 2020. Actual funding request budgets for the RAI3E included for Cambodia and Myanmar.

HRG-Equity

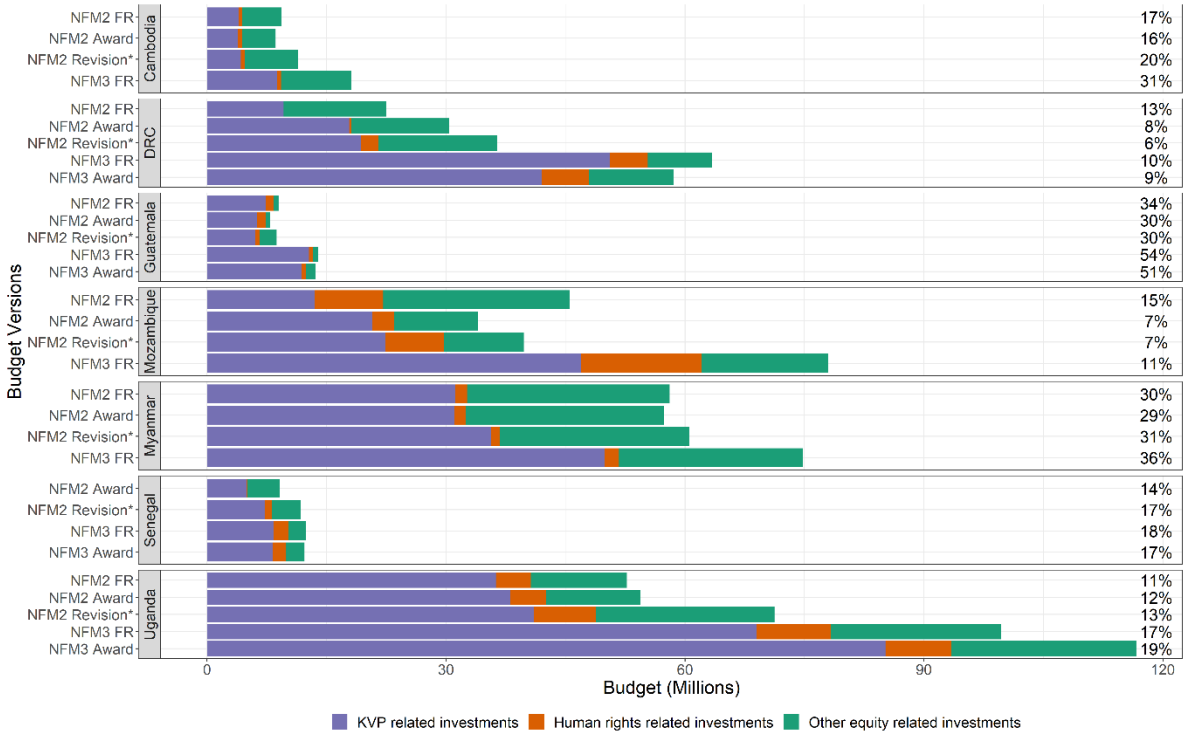
Key Message 9: PCE countries show evidence of NFM3 funding requests being designed with explicitly more focus than in NFM2 on improving equitable access to health services and allocating resources to intervention approaches that are known to contribute to greater programmatic sustainability.

Nearly all PCE countries increased investments (both in absolute terms and as a proportion of their NFM3 budgets) in prevention and KVPs compared to NFM2 budgets (Figure 14). Overall, HIV prevention budgets increased in Cambodia, Guatemala, Mozambique, Myanmar and Uganda (Annex Figure 5.1). In Cambodia and Myanmar, this was made possible by governments taking on increasing responsibility for financing treatment costs, related to the STC Policy, which freed up Global Fund resources for other purposes.[16] In DRC, Guatemala, Mozambique and Uganda, the increase in budget for prevention emerged from the increased NFM3 HIV allocation rather than by sacrificing other aspects of the grant (Annex Figure 5.1). Only Senegal saw relatively small or no increases in KVP or HRG-related investments, as the planned responses for KVPs in the HIV program were not considered sufficiently comprehensive by the TRP or ambitious to achieve proposed 2022 targets, even though KVP targets increased between NFM2 and NFM3. Smaller gains were notable for programming to address human rights barriers in countries eligible for crosscutting human rights matching funds, including DRC, Mozambique, Senegal and Uganda. Global Fund business model drivers of expansion in equity-related investments, including the overall larger allocations, matching funds incentives, and improved data sources to guide target setting, are discussed below. Likewise, for TB, as well as general increases in funding for case finding (supported through matching funds), TB care and prevention and MDR-TB, five PCE countries included TB-specific human rights-related investments in NFM3 (Cambodia, DRC, Mozambique, Myanmar and Senegal).

Box 3.3: Mozambique's substantial increase in equity-related investments in NFM3 as a result of increased overall allocation. The budget for activities to address HRG-Equity-related barriers in the NFM3 HIV/TB funding request (US$78m) is significantly higher than under NFM2 (US$46m at funding request; US$34m at grant award; and US$40m as per the latest official budget revision), reflecting the huge increase in the overall NFM3 allocation. The NFM3 budget includes US$15m for human-rights-related investments, US$23m for wider KVP investments and US$40m for other equity-related investments. Similarly, reflecting concerns around increased HIV incidence in Mozambique, the prevention budget, excluding PMTCT, more than doubled, from US$18m in the NFM2 funding request to US$46m in the NFM3 funding request, most notably for prevention among AGYW: from US$6m in the NFM2 funding request to US$14m through NFM2 grant implementation and to US$20m in the NFM3 funding request.

[16] In Cambodia for example, the government commitment to ARV procurement has increased from US$9m under NFM2 to US$20m under NFM3.

Figure 14: Changing budgets for HRG-Equity-related investments across NFM2 and NFM3.[17]



Source: Global Fund detailed budgets

In some cases, efficiency and/or effectiveness considerations appear to have taken precedence over equity considerations in the design of NFM3 grants. For example, compared to NFM2, NFM3 grants cut subsidies for linkage to care (Guatemala) and patient living support (Cambodia, Myanmar)—both critical to ensuring that the poorest can afford to access services. Cambodia and Myanmar cut resources for PLHIV living support in order to prioritize more efficiently targeted KVP HIV testing and increased budget for prevention. Guatemala reduced the budget for travel subsidies and sub-recipient peer promoters due to concerns about the effectiveness of promoters in identifying new HIV cases during NFM2. Although the Global Fund issued new guidance on VfM to inform grant design, stakeholders in some countries (Cambodia, Sudan) reported that VfM guidance had mainly been used by in-country consultant drafting teams rather than reflecting improved discussion on VfM and/or equity among national stakeholders.

Box 3.4: Concerns about perceived inefficiency of peer promoters in Guatemala during NFM2 seemed to outweigh equity considerations in NFM3. During the NFM3 funding request development, updated KVP prevalence data were unavailable due to delays, which was a barrier to improved intervention targeting. With limited data on KVPs, the PR relied on data from a report, commissioned by the CT, on the productivity of peer promotors in NFM2 which found low productivity in detecting and linking new cases to care. These findings informed a decision by the PR to cut the budget for promotors in NFM3 and it is unclear whether potential consequences on equitable access by key populations were given equal weight to efficiency concerns.

[17] Figure notes: *Revision is the most recent official budget revision. Percentages show the share of total grant budgets that HRG-Equity makes up. Sudan is excluded from the figure, as the malaria grant did not include HRG-Equity investments. Guatemala data include the HIV grant only. NFM2 funding requests (FR) in Senegal and DRC do not include Program Continuation, specifically malaria grants in DRC and HIV and malaria in Senegal. In NFM2, due to the delayed incorporation of catalytic matching funds after grants were approved, catalytic funds are reflected in the most recent revision, except in Myanmar where they are included in the NFM2 funding request.

In response to concerns with efficiency, and given the lessons learned during NFM2 related to SR selection and contracting issues that delayed implementation start-up, several countries are retaining well performing SRs into NFM3 (Cambodia, DRC, Uganda), which will help promote 'implementation readiness' of approved grants—particularly for equity-related investments carried out predominantly by SRs. In line with the Secretariat's new guidance on preparing for implementation ready grants, in early 2021 LFAs are conducting verification of implementation readiness to quickly assess whether grant implementation is on track and the reasons why (recognizing that COVID-19 is likely to have impacted plans around implementation readiness).

NFM3 grants have not substantially changed their orientation toward human rights, gender and other elements of equity that would promote more sustainable impact on services access and disease outcomes. Importantly, a disconnect remains between grant 'equity' indicators (which focus largely on budgetary contributions to human rights and KVP interventions in addition to being heavily weighted toward HIV-relevant indicators) and wider understanding of inequality in access to health services or health outcomes, which could better inform an understanding of the equitable distribution of grant investments. A stronger consideration for geographic accessibility was, however, evident in several countries. For example, Senegal will expand diagnostic tools during NFM3 (GeneXpert, PCR, microscopy) to address a lack of access in some high-burden areas. In Mozambique, malaria modeling and surveillance results are being used to target higher-burden areas (see Box 3.5). In Sudan, the malaria program has expanded to reach a wider number of provinces, many of which have large internally displaced populations and refugees that were previously not reached.

Box 3.5: Mozambique's VfM considerations in prioritizing malaria investments. During NFM2, where the Agente Polivalente Elementars (APE) community health worker malaria program operated, it performed well against mortality performance metrics. However, APE distribution was not determined by malaria burden of disease, with some geographic areas being under-resourced, thus limiting its overall impact. Under NFM3, the grant is expanding community diagnosis and treatment for malaria, and community awareness through conducting social and behavioral change communication activities designed to encourage greater impact as well as continued provision of supply kits to the APEs for diagnosis and treatment. NFM3 responds to new malaria modeling and surveillance results, which revealed the need to target high-burden areas with more effective interventions, thereby prioritizing equity as well as efficiency.

Several PCE countries used better-quality and/or more recent data on KVPs during NFM3 compared to NFM2, which enabled grants to set up new interventions to target KVPs more precisely or widen the geographical distribution of places that KVPs would receive services. However, ongoing concerns on the quality of data (particularly the accuracy of KVP population size estimates) continue to constrain allocative efficiency. In some PCE countries, the NFM3 funding request development process was more data-driven than that of NFM2, largely because new data, particularly on KVPs, had become available. For example, based on newly available data in Uganda and Mozambique, NFM3 grants are significantly expanding HIV prevention programming for AGYW to include new geographies and increased overall coverage targets. In Uganda, a baseline AGYW assessment completed during NFM2 informed the NFM3 design, including a strategic shift toward scale-up to achieve the 'saturation' required to reduce incidence among AGYW, coupled with stronger integration of sexual and reproductive health and HIV services for adolescents, both of which contributed to incorporation of US$59m for AGYW in the Prioritized Above Allocation Request (PAAR).

In addition, the Essential Data Tables (EDT) (a new tool introduced by the Secretariat to improve the funding request process by providing applicants with pre-populated and up-to-date data

related to demographics, the three diseases and other relevant crosscutting information) informed NFM3 planning. DRC, Senegal and Myanmar reported using the new EDT to inform NFM3 planning. Stakeholders in DRC considered the EDTs to contribute to a more efficient process by reducing the time required to consolidate various data sources. In Senegal, although stakeholders used the EDTs, they continued to question the accuracy of KVP estimates. In Guatemala, implementation delays for HIV prevalence studies in NFM2 meant that those studies were not available to inform NFM3 design. Both Guatemala and Senegal included investments in NFM3 to improve KVP estimates.

Box 3.6: Using data to inform prioritization of human rights and gender investments in DRC. NFM3 grants will prioritize equity through the sizable scale-up of activities targeting KVPs and the expansion of interventions to reduce HRG barriers to services. DRC's indicative HIV allocation increased by 42% in NFM2, from US$123m to US$174m. Drawing upon updated KVP size estimates that revealed a six times larger KVP population than previous estimates, in consultation between the CT, country stakeholders, and technical partners, the PR decided to intensify prevention activities that have historically been under-prioritized. NFM3 HIV testing targets for all KVP categories are significantly higher than NFM2, which will address the current low percentage of people living with HIV that know their status. The TRP review of the 2020 funding request noted strengthened and expanded HRG interventions compared to previous rounds. Key facilitators included the use of data to define strategies for addressing HR barriers; the Global Fund-supported Breaking Down Barriers initiative that produced a baseline assessment and convened stakeholder consultations leading to the development of a five-year costed HRG National Plan with priority activities; and availability of catalytic matching funds.

RSSH

Key Message 10: Most PCE countries increased the overall allocation to RSSH in NFM3, although, compared to NFM2, a greater proportion of these investments are designed to support rather than strengthen health systems. As such, it is unclear how the NFM3 grants are intended to 'change the trajectory' for the achievement of SO2, which is intended to increase strengthening investments and enhance RSSH.

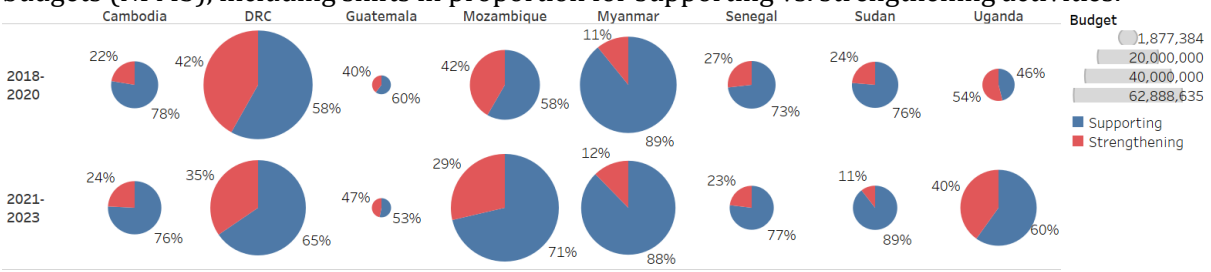
The budget for RSSH modules increased significantly in NFM3 in several PCE countries (Cambodia, Mozambique, Senegal, Uganda), while in other countries the RSSH budget remained relatively stable (Guatemala) or declined slightly compared to NFM2 approved budgets (DRC, Myanmar, Sudan). However, only Cambodia, Guatemala and Myanmar saw increases in strengthening investments from NFM2 to NFM3 (Figure 15), and they were minor.[18] In most PCE countries, the proportion directed to strengthening activities actually decreased from NFM2 to NFM3. While a higher allocation to supportive investments may be appropriate in some countries (e.g., Uganda, Mozambique, DRC) given their place on the development continuum, this is not the case in other countries that are closer to transition (e.g., Cambodia, Guatemala).

As such, evidence suggests that the Global Fund's RSSH guidance "*to shift from a focus on short-term, input-focused support…towards more strategic investments…that build capacity and lead to sustainable results*" is not being systematically operationalized.(1, p. 5) This is partially explained by the shorter (three-year) funding period, lack of domestic and donor funding sources for RSSH (other than the Global Fund), use of funds for commodities, and the persisting vertical nature of the three disease programs. It is worth emphasizing that despite the

[18] Building from the "2S" framework proposed by Chee (2013) (3) and the "4S" work in the TRP's RSSH Review (2018) (4), the PCE developed a simplified coding "2S" application to analyze support and strengthening activities. See Annex 4 for protocol guidance. The 2S analysis compares the final NFM2 approved budgets with the NFM3 funding request budgets (because at the time the analysis was conducted the NFM3 grant making budgets were unavailable).

stated desire by the Global Fund to invest in more strategic strengthening interventions, many PCE countries still require some level of investment in systems support (indeed, inputs-oriented investments may be a precursor to some longer term strengthening efforts). If the Global Fund truly intends its investments to be primarily strengthening RSSH, rather than supporting disease program functions, PRs and country-level program managers require more information for how to distinguish support and strengthening investments and also how to operationalize the guidance to invest more in strengthening activities.

Figure 15. Comparison of RSSH budget between approved grants (NFM2) and funding request budgets (NFM3), including shifts in proportion for supporting vs. strengthening activities.



Source: Global Fund detailed budgets

Note: Circles are sized according to overall RSSH budget size, as indicated by key with grey bars to the right.

In some countries, NFM3 RSSH investments are designed building on progress made during NFM2, especially in HMIS/M&E. In DRC, Mozambique, Myanmar, Senegal and Sudan, work in NFM2 to develop, roll out and expand DHIS2 (e.g., through an eHealth platform in Myanmar) intends to be expanded upon in NFM3, where the focus is more oriented toward expanding routine data collection, assessing data quality and training of technicians to improve its application. In Mozambique, plans include a shift in PSM/HPM investments from support for warehouse infrastructure and commodity storage capacity in NFM2 toward in-country distribution and regulatory/QA support to combat counterfeit or low-quality drugs in NFM3. In Sudan, investments in laboratory systems also appear to have evolved from infrastructure and rehabilitation costs in NFM2 to improving the efficiency and quality of laboratory functions in NFM3.

Box 3.7: Strengthening HMIS and digital health investments in DRC. In NFM3, DRC's investments in digital health, although smaller than in NFM2, received the largest portion of the RSSH budget (the HMIS/M&E module represents 56% of the total RSSH budget). While DRC's 2S analysis showed an overall decrease in strengthening investments from 42% to 35% between the NFM2 approved budget and NFM3 funding request, the HMIS/M&E module was the exception where strengthening investments increased from 50% to 55%. In part, this is explained by NFM3 digital health interventions that build upon lessons learned during NFM2. For example, NFM3 grants increased focus on *improving HMIS data quality and data use.* While NFM2 investments were successful in improving systems integration and reporting by all disease programs in DHIS2 (achieving greater than 90% data completeness), gaps remain in data quality, reporting timeliness and data use for program management that will be addressed during NFM3. In addition, DRC also aims to *enhance coordination between public and private sectors* in NFM3 with integration of private sector data in DHIS2 as a key priority. Related investments include developing official guidelines and standard operating procedures for how private health establishments will be integrated into national policy and information systems, including at the provincial level, which will further promote data system sustainability.

Box 3.8: Sustainability considerations in strengthening HMIS in Guatemala. Despite a large investment in NFM2 to deploy DHIS2 to facilitate monitoring and reporting by the non-governmental PR, and encouragement by the CT, TRP and others to build upon this, the PCE found that certain stakeholders were against adoption of open-source technologies such as DHIS2 and favored the development a new informational system for the national HIV program using an Oracle platform. However, recently, the Minister of Health has stated an interest in scaling up DHIS2 for the whole MoH. Many HIV program stakeholders, including the PR, were unaware of the Minister's interest until the end of 2020. While greater country ownership and political will is indeed positive, these more recent developments could slow the Global Fund HMIS investments as they will need to be aligned to the still nascent strategy of the MoH. Considering that malaria and TB are entering transition during NFM3, delays to HMIS strengthening presents risks.

Most PCE grants did not appear to use the NFM3 funding request process to link RSSH investments more strategically with sustainability plans. In PCE countries, in addition to findings above on the type of RSSH investments, few countries appeared to have prioritized alignment of funding requests and NSPs with wider health plans, and transition plans did not appear to be used systematically to guide domestic RSSH investments. In addition, few PCE countries reported successful grant investments in structural or institutional shifts toward a more sustainable approach to addressing their disease epidemics, as is confirmed in other assessments of policy strength, an exception being Cambodia, where a 2019 proclamation aimed to facilitate government contracting with NGOs.(16) PCE evidence suggests the NFM3 funding request process may therefore have missed an opportunity to move national disease programs toward eventual transition away from dependence on external funds. This finding aligns with sustainability challenges raised by the TRP, many of which overlap with RSSH: 1) limited planning of domestic resources for pooled procurement and integrated service delivery across programs (Cambodia, DRC, and Uganda), for maintaining KVP outreach and programming (Guatemala), and to meet financing gaps for NSP (Cambodia); 2) gaps in capacity of national entities to identify efficiencies and cost savings (DRC, Guatemala, Mozambique, Myanmar); and 3) lack of M&E for sustainability roadmaps (Cambodia, Myanmar), Health Financing Strategies (DRC, Mozambique), and other program-specific sustainability plans (Cambodia, Uganda).

Box 3.9: Mixed progress on sustainability in Myanmar. During NFM2, the national HIV program introduced significant policy reform to increase equitable access to treatment and prevention services for KVPs, including legal reforms to reduce punitive measures for KVPs; shifting the National Drug Control Policy toward a public health approach to improve PWID access to harm-reduction services; launching a Prison SOP in collaboration with Ministry of Home Affairs (MoHA) to improve HIV services in prisons; initiating guidelines for new combination of prevention interventions for KVPs; and revising township classification for HIV programming based on HIV burden to ensure key populations in remote and hard-to-reach areas are not left behind. The Global Fund is the major financier of all these efforts, and the NFM2 grant prioritized treatment and prevention service coverage in high-burden areas. However, despite progress, root causes of the barriers remain unaddressed: armed conflicts and security situations in Kachin, Shan and Rakhine continue to prevent the full implementation of TB and HIV programs; and poverty, external and internal migration, and language barriers in ethnic minority states continue to pose as barriers to accessing services. Advocacy efforts for protection of violence against women have become visible in recent years, but no legal framework exists to prevent and protect from intimate partner violence. TRP comments in both 2017 and 2020 highlighted limited progress in building long-term program sustainability beyond the grant period, particularly human resources for health and community system strengthening and contracting.

In some countries, NFM3 grants are shifting RSSH intervention approaches, with greater emphasis on community systems strengthening for improving access to and quality of service delivery. Several countries substantially expanded CSS investment under NFM3, including DRC, Mozambique, Myanmar, Senegal and Uganda (in line with broader NFM2 TRP observations).(17) Both Senegal and Uganda included investment in community-level data collection and reporting into DHIS2. Some countries are building integration and equity considerations into RSSH investment design. In Senegal, for example, addressing laboratory services gaps will help improve overall diagnostic testing service availability to KVPs. In DRC, the NFM3 funding request includes stronger emphasis on integrating across disease programs, including greater support for community-based organizations involved in comprehensive health prevention and promotion; integrated supervision tools for the three diseases and other maternal and child health interventions; and capacity building for provincial health authorities. In Cambodia, most CSS investments coded as 'strengthening' in NFM2 were outsourced to a CSO partner to coordinate KVP meetings. Stakeholders reported limited added value for this as a primary activity and, although it was retained in NFM3, it was moved from the RSSH CSS module and re-assigned to the 'removing human rights barriers' module.

Box 3.10: Investing in stronger community systems in Uganda. The RSSH allocation for the CSS module increased seven-fold from the NFM2-approved grants (US$830K) to the NFM3 approved grants (US$6.9m), driven by several factors including increased civil society advocacy and active engagement in the funding request process, as well as previous PCE findings highlighting limited Global Fund investment in CSS. During NFM3 grant making, an additional US$908K was added in response to a TRP recommendation to move the "*institutional capacity building, planning and leadership development*" intervention from the PAAR to the main grant. However, given that CSS investments during NFM2 have been extremely delayed in implementation (absorption <30% as of June 2020), PRs will need to ensure more effective grant start-up to avoid delays. The 2S analysis of the CSS RSSH module suggests a marginal improvement toward increased strengthening investments, from 32% in NFM2 to 40% in NFM3. An infusion of US$3.0m through matching funds for community health data science will support strengthening community reporting, including through digitization efforts interoperable with DHIS2 systems, thereby promoting stronger use of data for decision-making and programmatic sustainability.

Several countries show governance adaptations to improve coordination and implementation of crosscutting RSSH investments. In Senegal, for example, grant implementation arrangements are structured so that ownership of RSSH investments is more centralized under a single government PR and a civil society PR implementing community-based activities. Similarly, in Uganda, a stronger coordination structure with the government PR providing oversight and implementation of crosscutting RSSH investments, while the civil society PR manages and coordinates CSS interventions was developed. Both Cambodia and DRC have applied for stand-alone RSSH grants in NFM3. In DRC, this was proposed by the CCM to deliver more integrated RSSH interventions and elevate health systems issues to the Secretary General and MoH, who will be managing the grant. In Cambodia, RSSH resources come from the regional malaria grant (RAI) and, in order to integrate it better with other disease grants, the CCM decided to continue implementation through the MoH Lead Implementing Team, but have the grant managed by the Ministry of Economy and Finance rather than UNOPS, which is anticipated to improve governance and coordination.

Despite extensive new guidance, most PCE NFM3 grant performance frameworks do not appear to include many of the new RSSH coverage indicators,[19] suggesting that monitoring RSSH performance and progress toward meeting SO2 will remain a challenge. The Global Fund updated the modular framework in 2019 with extensive revisions and additions to coverage indicators for each of the RSSH modules: expanding from 13 to 24 RSSH coverage indicators, 22 of which were newly added.[20] However, beyond standard HMIS and M&E module indicators, adoption of other RSSH indicators aligned to major investment areas was infrequent in performance frameworks submitted with funding requests (consistent with the TRP Window 2 review findings regarding an inadequate range of indicators for coverage, outcome and impact of RSSH investments)(15) (Table 5). For instance, in Guatemala, where HMIS comprises the majority of the RSSH investment within the HIV grant, no RSSH coverage indicators were included in the performance framework. There does, however, appear to be more progress for CSS investments—for instance, three countries prioritizing CSS investments (DRC, Senegal and Uganda) included one of the two newly added CSS indicators from the modular framework. Several funding request performance frameworks included Work Plan Tracking Measures (WPTM) for monitoring investments in CSS (Cambodia, Uganda), laboratory strengthening (Cambodia, Mozambique), and HMIS/M&E (Mozambique). Additional WPTMs were also introduced during grant making, for example for monitoring integration of private sector reporting into DHIS2 (DRC), and improvements in the comprehensiveness and quality of routine reporting (Myanmar), among others.

Coverage indicators rarely capture aspects of system strengthening (such as data use for decision-making) and some RSSH investment areas do not map well to the available indicators. Beyond performance framework indicators, some countries may include complementary in-depth RSSH assessments to measure aspects of systems strengthening and performance, which was an approach undertaken in NFM2 for equity-related investments. Some countries included custom RSSH indicators in performance frameworks to better fit the monitoring needs of their RSSH investment areas and stronger opportunities to measure aspects of systems strengthening. For example, according to stakeholders in DRC, there was a concerted effort to develop indicators beyond output measurement (such as facilities that receive supportive supervision), but also capture the *quality* of those supervision visits according to national standards and guidelines. Following funding request submission, the TRP did not provide feedback for amending, including, or strengthening RSSH indicators. Additional investigation is warranted to understand the limited uptake of RSSH indicators in some countries.

[19] The PCE has previously reported challenges in performance monitoring of Global Fund RSSH investments, wherein NFM2 grants reported against only three RSSH coverage indicators: M&E-1: Percentage of HMIS or other routine reporting units submitting timely reports according to national guidelines (Cambodia, Myanmar, Senegal, Sudan, Uganda); M&E-2: Proportion of facility reports received over the reports expected during the reporting period (Cambodia, DRC, Mozambique); and PSM-2: Percentage of health facilities with essential medicines and life-saving commodities in stock (Senegal).

[20] Of the 13 RSSH coverage indicators in the 2017 modular framework, 11 were discontinued and only two were retained in the 2019 modular framework, which contains 22 new RSSH coverage indicators. All RSSH impact indicators were removed and four new RSSH outcome indicators were included. Of the PCE countries, DRC (HSS O-6, HSS O-7, HSS-O8, and a custom HSS outcome indicator) and Sudan (HSS O-5) are the only to incorporate RSSH outcome indicators into NFM3 funding request performance frameworks.

Table 5. Coverage indicators in NFM3 funding request performance frameworks by RSSH module and proportion of RSSH investment in each RSSH module, per country.[21]

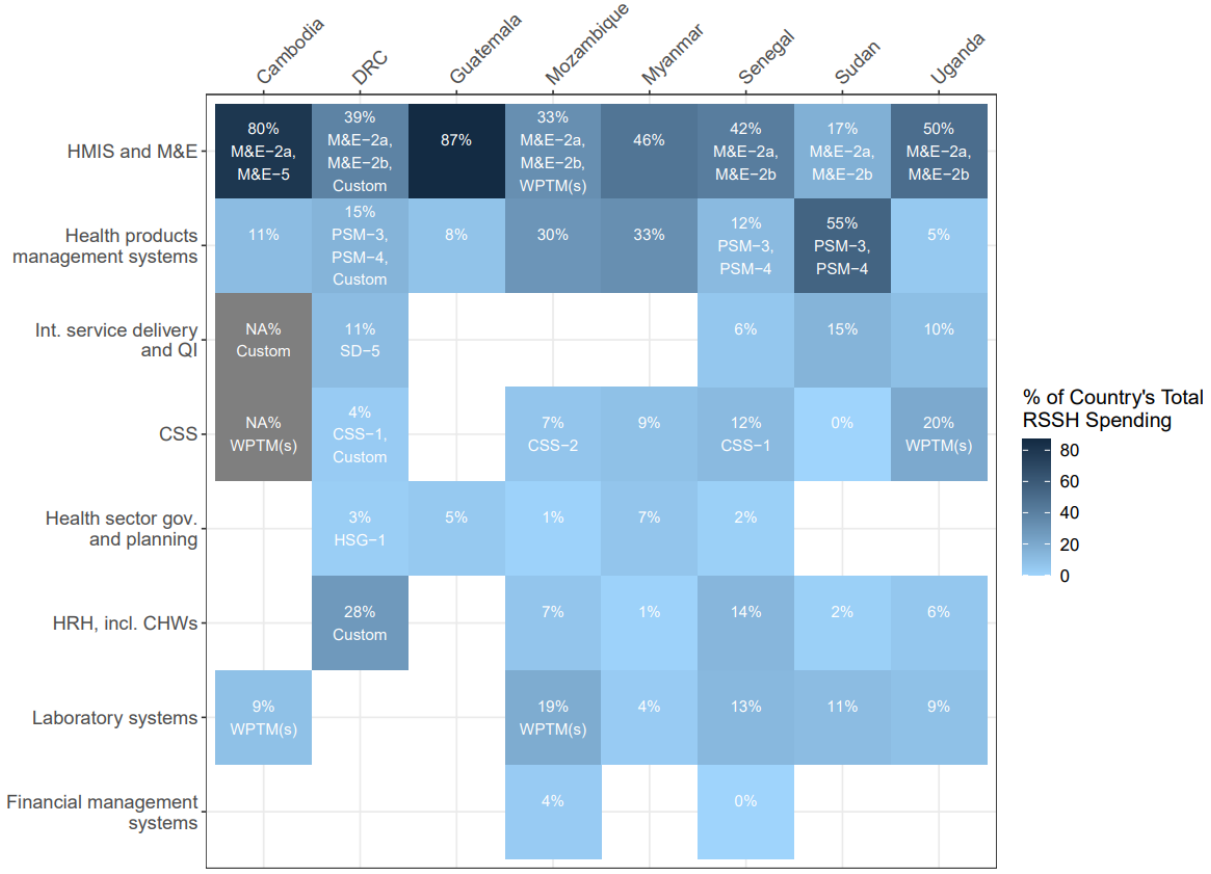


Table Notes: Percentages and color gradient represent the amount of the total country RSSH budgets each module comprises. Indicator definitions: **M&E-2a** Completeness of facility reporting: Percentage of expected facility monthly reports (for reporting period) that are actually received; **M&E-2b**: Timeliness of facility reporting: Percentage of submitted facility monthly reports (for reporting period) that are received on time per the national guidelines, **M&E-4**: Percentage of service delivery reports from community health workers integrated into HMIS; **M&E-5**: Percentage of facilities which record and submit data using the electronic information system; **PSM-3**: Percentage of health facilities providing diagnostic services with tracer items available on the day of the visit or day of reporting; **PSM-4**: Percentage of health facilities with tracer medicines for the 3 diseases available on the day of the visit or day of reporting; **SD-5**: Percentage of facilities that receive supportive supervision at least 1 per quarter; **CSS-1**: Percentage of community-based monitoring reports presented to relevant oversight mechanisms; **HSG-1**: Percentage of district health management teams or other administrative units that have developed a monitoring plan, including annual work objectives and performance measures. **Custom** indicates countries included a custom indicator. **WPTM** = Work Plan Tracking Measures. Myanmar and Cambodia include budget and indicators for TB/HIV grants only.

[21] In Cambodia, the TB/HIV grant and the separate RSSH grant are now supervised by the same CT. Both grants use the PMTCT module and both grants apply RSSH specific modules. The TB/HIV grant used three RSSH modules in NFM2 and in NFM3. The RSSH grant used three RSSH modules in NFM2 and five modules in NFM3. NFM3 grant retained the NFM2 activity (sole CSO) under RSSH-CRS, although shifted to the *Removing Human Rights Barriers* module. Modules in the stand-alone RSSH grant are implemented by separate departments within the MOH, and performance indicators in this grant are linked only to the PMTCT module. PMTCT procurement of RDT is made via the TB/HIV grant previously included via *Treatment Care Support* module but now shifted to the PMTCT module in NFM3. Meanwhile training and related ANC activities are channeled via the PMTCT module in the RSSH grant.

Chapter 4: Discussion and conclusions

In this chapter we set out our overall conclusions in relation to how the Global Fund business model is facilitating and impeding the achievement of Strategic Objectives across the grant cycle. The focus is primarily on RSSH and HRG-equity, paralleling Global Fund SO2 and SO3, and examining the degree to which business model incentives that operate through these areas indirectly affect the achievement and acceleration of sustained impact on the three diseases (SO1). Overall, the PCE evidence suggests that the Global Fund business model has facilitated improvements across the grant cycle in design and implementation during these past 3-4 years. However, these trends appear unlikely to deliver the sustained improvements in equity and/or health system strengthening needed to achieve the Strategic Objectives and 2030 goals.

Grant Design

Conclusion 1: Improvements to the business model between NFM2 and NFM3 contributed to more efficient and inclusive funding request processes. However, NFM3 saw limited adoption of changes in the design of performance monitoring, particularly for HRG-equity and RSSH.

The NFM3 funding request process was generally more efficient and benefited from changes that meant a wider set of stakeholders were included, despite COVID-19 interruptions to the process. The tailored to NSP and full review differentiated application approaches were viewed positively relative to NMF2, particularly as relates to inclusion, although stakeholders reported inclusion declined at later stages of grant making. Most PCE countries also showed evidence of increased national ownership of Global Fund grants and disease programs, perhaps reflecting gradual country familiarity and adaptation during the third round of NFM grants. Incorporating matching funds within the main funding request in NFM3 improved alignment and the efficiency of the design process, a key improvement over NFM2, as well as catalyzed increased investment for HRG-Equity. However, despite some increases in data quality and use, particularly for KVPs, performance frameworks, indicators and targets changed surprisingly little—particularly for HRG-Equity and RSSH interventions. Measuring Global Fund impact on other areas of equity beyond KVP service delivery, whether due to socioeconomic status, gender barriers or ethnic group discrimination, remains challenging.

Conclusion 2: In NFM3, both RSSH and HRG-Equity investments rose, in many cases as a result of overall allocation increases. An increased proportion of RSSH investment is directed toward activities that support rather than strengthen the health system.

Many new grants include large increases in KVP HIV prevention investments but smaller increases in reducing HRG barriers (from a lower base). Despite revised guidance and greater emphasis in the funding request template, it remains unclear if or how VfM considerations are systematically and holistically considered in prioritization and decision making. The funding requests do demonstrate some evidence of growing expertise and investment in areas of the health system (CSS, HMIS, PSM), but overall there was a lack of clear and consistent consensus on the ultimate purpose of RSSH investments. RSSH investments continue to be owned and designed by disease-specific stakeholders, with limited evidence of an integrated and aligned approach within wider health planning and financing systems, which likely contributed to a tendency toward designing supporting rather than strengthening interventions. Collectively, the PCE country NFM3 funding requests demonstrated relatively little evidence that they were designed specifically to promote programmatic sustainability beyond the grant horizon, even in countries close to transition.

Grant Implementation

Conclusion 3: Implementation of NFM2 grants faced significant start-up delays and COVID-19 interruptions. Absorption was overall weaker for RSSH and HRG-Equity interventions.

The NFM introduced a fixed implementation period compared to the previous round's system and, alongside the introduction of portfolio optimization, strong incentives to maximize resource utilization within a relatively short three-year time period. The increased predictability of funds is perceived as a positive development, although the NFM grant cycle has also had some unintended consequences linked to Conclusion 4. The Global Fund Country Team structure is a critical element of the business model that generally works to support grant implementation, particularly where regular reviews and coordination meetings, tailored to the country context, take place.

However, a number of areas of the business model were less supportive of efficient grant start-up, including lengthy selection and contracting processes for implementers and issues with disbursements between PRs and SRs, as well as weak coordination functions, which particularly affected RSSH and HRG-Equity interventions.

Conclusion 4: Multiple barriers and challenges exist for undertaking revisions to the scope and/or scale of grants mid-cycle, such as in response to new evidence or emerging performance issues.

Incentives acting on grant implementers to achieve high levels of absorption, which is rigorously measured and reported on, are relatively strong. In contrast, incentives for grant managers to undertake substantial mid-cycle program revisions to the grant scope (objectives or key interventions) or scale (targets) to maximize impact are relatively weak. Firstly, the administrative requirements for doing so are burdensome; and secondly, grant-specific performance monitoring data to guide revision decision making is fairly limited.

As a result, two unintended consequences emerged during NFM2:

- decisions around grant revisions appear driven by the short implementation cycle and the associated need to maximize absorption, and instead PRs and Country Teams tend to rely on multiple, smaller budget revisions to influence implementation and for financial management to maximize absorption; and
- where new survey and evaluation data emerged, grant revisions to scope or scale appear to have been deferred to the NFM3 funding request cycle, rather than undergoing burdensome but innovative revisions.

Revisions were often used to shift budgets to later in the grant cycle, having the effect of making absorption appear higher in earlier years. Overall, in PCE countries, the cumulative effect was small net increases allocated to HRG-Equity interventions, compared to grant awards, but a more mixed picture for RSSH with decreases in some countries and increases in others. It remains to be seen how these shifts will affect Year 3 budgets and absorption, in the context of COVID-19.

Chapter 5: Strategic recommendations/considerations

The purpose of these recommendations is to engage in a dialogue with the TERG and the Secretariat on ways to respond to the conclusions in Chapter 4.

Recommendation 1: Improve grant-specific performance monitoring to inform implementation decisions.

- Establish routine grant review processes at the country level with a quality improvement lens, emphasizing grant-specific performance data and drawing on emerging evidence and

data to better inform revisions that maximize impact. (PRs, Grant Management Division including Country Teams)
- Implement proposed reforms of the grant rating system to reflect both grant-specific performance and contribution of Global Fund grants to national program performance. Additionally, this should draw upon qualitative inputs, including expertise of the CCM, LFA, Country Team and wider Secretariat. (Grant Management Division, Strategy Committee, Board)
- Based on the revised grant rating system, the Secretariat should also develop a set of indicative options to demonstrate how good and poor performance could be responded to, and a framework for deciding when and how to introduce these measures in different contexts and circumstances (Grant Management Division, Strategy Committee, Board).
- Strengthen the use of revised RSSH indicators to address delayed implementation and potential deprioritization throughout grant implementation. (PRs, Grant Management Division including Country Teams)

Recommendation 2: **Build in more flexibility and responsiveness in implementation by simplifying grant revision processes to encourage their use throughout the grant cycle.**
- Consider flexibilities and streamlining of material program revision process to encourage/reward earlier introduction of innovative programming that maximizes impact and limits non-strategic budgetary shifts to later in the 3-year grant cycle. (Secretariat)
- Introduce flexibilities to PR and SR contractual arrangements and performance frameworks that can be used to introduce mid-term changes as required. (PRs, Grant Management Division)
- Through the Secretariat's planned grant revision review (mid-2021), examine how countries could strengthen data-driven revision decisions (thereby avoiding the over-reliance on financial data to guide revision decisions), in line with establishing a more streamlined, flexible process for program revision. (Secretariat)

Recommendation 3: In order to reduce gaps between policy guidance and grant design, improve communication around how to invest more strategically in RSSH, including CSS.
- In the next Strategy, the Global Fund board in collaboration with the Secretariat should clarify their position on whether the primary objective of RSSH is to support the three disease programs or to invest more holistically in health systems strengthening. (Board, Secretariat RSSH team)
- Clarify specific Global Fund RSSH priority areas and what strengthening as opposed to supportive investment would look like for these, including specific purpose, indicators and targets in performance frameworks. (Secretariat RSSH team, Country Teams)
- To facilitate integration and strengthening RSSH, ensure proper engagement and ownership from health system planning experts and leaders to support health sector-wide programming decisions, including alignment of grant design and sustainable financing within wider national health, health system and UHC policy context, and the timelines associated with broader strengthening efforts. (PRs, Country Teams)

Recommendation 4: In order to improve grant contribution to equity and SO3, explicitly promote grant investments in these areas, including through more direct measurement of the drivers of inequity and of outcomes of human rights and gender investments.
- Invest more in data and data use, including up-to-date KVP surveys as well as other data sources that shed light on socio-economic, gender, geographical and ethnic differences in disease burden and access to services that grants are aiming to contribute to. (Country Teams, national stakeholders)
- Ensure performance frameworks incorporate existing data including on human rights and political commitment as well as disease burden and service access amongst different

population groups and use this data effectively to monitor grant contribution to both SO3 and SO1 or disease impact. (Country Teams, national stakeholders)

- Recognizing the success of strategic initiatives and/or matching funds in incentivizing grant investments in reducing equity, human rights and gender related barriers to accessing services, prioritize scaling up across the portfolio and incentivizing such investments through mainstream grant management operations. This should include explicit efforts to improve implementation and where necessary, timely revisions to maximize grant contribution to reducing barriers to care and disease impact. (Grant Management Division, Strategic Initiatives team)

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Annexes

Annex 1. Summary of countries eligible for matching funds in NFM2 and NFM3 by type.

Country	**Funding Cycle**	**TB: Missing cases**	**Human Rights**	**HIV: AGYW**	**HIV: KP**	**HIV: self-testing**	**RSSH: Data systems**	***Totals***
Cambodia^	NFM2							***$0.0***
	NFM3	$6.0						***$6.0***
DRC	NFM2	$10.0	$3.0				$3.0	***$16.0***
	NFM3	$10.0	$2.6					***$12.6***
Mozambique	NFM2	$6.0	$4.7	$6.0			$3.0	***$19.7***
	NFM3	$6.0	$4.0	$9.5		$2.9		***$22.4***
Myanmar^	NFM2	$10.0			$6.3		$3.0	***$19.3***
	NFM3	$6.0			$6.3			***$12.3***
Senegal	NFM2		$1.5		$1.2			***$0.0***
	NFM3		$1.2					***$1.2***
Uganda	NFM2		$4.4	$5.0				***$9.4***
	NFM3	$6.0	$4.4	$7.2		$2.9	$3.0*	***$23.5***
Totals	**NFM2**	**$26.0**	**$13.6**	**$11.0**	**$7.5**	**$0.0**	**$9.0**	**$67.1**
	NFM3	**$34.0**	**$12.2**	**$16.7**	**$6.3**	**$5.8**	**$3.0**	**$78.0**

*Improved data science in community health

^In NFM3, excludes catalytic element of multi-country RAI in Cambodia ($15 million) and Myanmar ($40 million)

Annex 2. Qualitative data collected by PCE countries

	CAM	DRC	GTM	MOZ	MYN	SEN	SUD	UGA
KIIs	20	33	36	24	68	25	98	21
Fact checking	50	10	35	18	63	7	8	23
meetings observed	30	5	27	17	35	93	78	14
documents reviewed	150	116	135	60	102	81	100	60

Annex 3. Approach to identification of human rights, gender, and other equity-related investments

The PCE relied upon the Global Fund gender and human rights disease-specific technical briefs to initially identify modules and interventions which contain investments related to human rights, gender and other equity (HRG-Equity). (18–21) The list of these HRG-Equity-related modules and interventions were shared with the Global Fund Secretariat and the Community, Rights and Gender (CRG) team for review and feedback. After a consultative discussion and receiving a draft methodology of how the CRG team has proposed tracking human rights-related investments, a sub-categorization of these modules and interventions was included to allow for a clearer understanding of the types of investments captured within the PCE's HRG-Equity-related investments. The sub-categories include 1) human rights-related investments, which align with the CRG's proposed methodology of "Opt-in modules and interventions," 2) key and vulnerable populations-related investments, and 3) other equity-related investments. Table 2.1 below shows examples of modules and interventions included in each category; while the full list is extensive (138 module/interventions pairs in total) and unable to be included in the text of the report, it can be made available upon request.

Annex Table 2.1

Module	Intervention	Human rights funding	Key and vulnerable populations funding	Other equity related investments
Comprehensive prevention programs for men who have sex with men	Addressing stigma, discrimination and violence against men who have sex with men	TRUE	FALSE	FALSE
Comprehensive prevention programs for men who have sex with men	Behavioral interventions for men who have sex with men	FALSE	TRUE	FALSE
Comprehensive prevention programs for men who have sex with men	Condoms and lubricant programming for men who have sex with men	FALSE	TRUE	FALSE
Comprehensive prevention programs for men who have sex with men	Diagnosis and treatment of sexually transmitted infections and other sexual health services for men who have sex with men	FALSE	TRUE	FALSE
Comprehensive prevention programs for men who have sex with men	HIV testing services for men who have sex with men	FALSE	TRUE	FALSE
Comprehensive prevention programs for men who have sex with men	Interventions for young men who have sex with men	FALSE	TRUE	FALSE
Comprehensive prevention programs for people who inject drugs and their partners	Behavioral interventions for people who inject drugs	FALSE	TRUE	FALSE
Comprehensive prevention programs for people who inject drugs and their partners	Community empowerment for people who inject drugs	FALSE	TRUE	FALSE
Comprehensive prevention programs for people who inject drugs and their partners	Condoms and lubricant programming for people who inject drugs	FALSE	TRUE	FALSE
Comprehensive prevention programs for people who inject drugs and their partners	Diagnosis and treatment of sexually transmitted infections	FALSE	TRUE	FALSE

	and other sexual health services for people who inject drugs			
Comprehensive prevention programs for people who inject drugs and their partners	HIV testing services for people who inject drugs	FALSE	TRUE	FALSE
Comprehensive prevention programs for people who inject drugs and their partners	Interventions for young people who inject drugs	FALSE	TRUE	FALSE
Comprehensive prevention programs for people who inject drugs and their partners	Needle and syringe programs for people who inject drugs and their partners	FALSE	TRUE	FALSE
Comprehensive prevention programs for sex workers and their clients	Behavioral interventions for sex workers	FALSE	TRUE	FALSE
Comprehensive prevention programs for sex workers and their clients	Condoms and lubricant programming for sex workers	FALSE	TRUE	FALSE
Comprehensive prevention programs for sex workers and their clients	HIV testing services for sex workers	FALSE	TRUE	FALSE
Comprehensive prevention programs for sex workers and their clients	Interventions for young people who sell sex	FALSE	TRUE	FALSE
Comprehensive prevention programs for transgender people	Behavioral interventions for transgender people	FALSE	TRUE	FALSE
Comprehensive prevention programs for transgender people	Condoms and lubricant programming for transgender people	FALSE	TRUE	FALSE
Comprehensive prevention programs for transgender people	HIV testing services for transgender people	FALSE	TRUE	FALSE
Prevention of mother-to-child transmission	Prong 1: Primary prevention of HIV infection among women of childbearing age	FALSE	FALSE	TRUE
Prevention of mother-to-child transmission	Prong 3: Preventing vertical HIV transmission	FALSE	FALSE	TRUE
Prevention of mother-to-child transmission	Prong 4: Treatment, care and support to mothers living with HIV, their children and families	FALSE	FALSE	TRUE
Prevention programs for adolescents and youth, in and out of school	Other interventions for adolescent and youth	FALSE	FALSE	TRUE
Prevention programs for general population	Gender-based violence prevention and treatment programs for general population	FALSE	FALSE	TRUE
Prevention programs for other vulnerable populations	Behavioral interventions for other vulnerable populations	FALSE	TRUE	FALSE
Prevention programs for other vulnerable populations	HIV testing services for other vulnerable populations	FALSE	TRUE	FALSE
Prevention programs for other vulnerable populations	Male and female condoms for other vulnerable populations	FALSE	TRUE	FALSE

Programs to reduce human rights-related barriers to HIV services	HIV and HIV/TB-related legal services	TRUE	FALSE	FALSE
Programs to reduce human rights-related barriers to HIV services	Improving laws, regulations and polices relating to HIV and HIV/TB	TRUE	FALSE	FALSE
Programs to reduce human rights-related barriers to HIV services	Sensitization of lawmakers and law enforcement agents	TRUE	FALSE	FALSE
Programs to reduce human rights-related barriers to HIV services	Stigma and discrimination reduction	TRUE	FALSE	FALSE
TB/HIV	Key populations (TB/HIV) - Others	FALSE	TRUE	FALSE
TB/HIV	Key populations (TB/HIV) - Prisoners	FALSE	TRUE	FALSE
Treatment, care and support	Prevention, diagnosis and treatment of opportunistic infections	FALSE	FALSE	TRUE
Multidrug-resistant TB	Community MDR-TB care delivery	FALSE	FALSE	TRUE
TB care and prevention	Community TB care delivery	FALSE	FALSE	TRUE
TB care and prevention	Key populations (TB care and prevention) – Others	FALSE	TRUE	FALSE
Differentiated HIV Testing Services	Community-based testing	FALSE	TRUE	FALSE
Differentiated HIV Testing Services	Facility-based testing	FALSE	TRUE	FALSE
Differentiated HIV Testing Services	Self-testing	FALSE	TRUE	FALSE
PMTCT	Prong 2: Preventing unintended pregnancies among women living with HIV	FALSE	FALSE	TRUE
PMTCT	Prong 3: Preventing vertical HIV transmission	FALSE	FALSE	TRUE
PMTCT	Prong 4: Treatment, care and support to mothers living with HIV, their children and families	FALSE	FALSE	TRUE
Prevention	Addressing stigma, discrimination, and violence	TRUE	FALSE	FALSE
Prevention	Behavior change interventions	FALSE	TRUE	FALSE
Prevention	Community empowerment	FALSE	TRUE	FALSE
Prevention	Condom and lubricant programming	FALSE	TRUE	FALSE
Prevention	Gender-based violence prevention and post-violence care	FALSE	FALSE	TRUE
Prevention	Harm reduction interventions for drug use	FALSE	TRUE	FALSE
Prevention	Interventions for young Key Populations	FALSE	TRUE	FALSE
Prevention	Needle and syringe programs	FALSE	TRUE	FALSE
Prevention	Opiod substitution therapy and other medically assisted drug dependence treatment	FALSE	TRUE	FALSE

Prevention	Overdose prevention and management	FALSE	TRUE	FALSE
Prevention	Pre-exposure prophylaxis	FALSE	TRUE	FALSE
Prevention	Prevention and management of co-infections and co-morbidities	FALSE	TRUE	FALSE
Prevention	Sexual and reproductive health services, including STIs	FALSE	TRUE	FALSE
Reducing human rights-related barriers to HIV/TB services	Human rights and medical ethics related to HIV and HIV/TB for health care providers	TRUE	FALSE	FALSE
Reducing human rights-related barriers to HIV/TB services	Legal Literacy (""Know Your Rights"")	TRUE	FALSE	FALSE
Reducing human rights-related barriers to HIV/TB services	Reducing HIV-related gender discrimination, harmful gender norms, and violence against women and girls in all their diversity	TRUE	FALSE	FALSE
Reducing human rights-related barriers to HIV/TB services	Stigma and discrimination reduction	TRUE	FALSE	FALSE
Treatment, care and support	Prevention and management of co-infections and co-morbidities	FALSE	TRUE	FALSE
Removing human rights and gender related barriers to TB services	Legal aid and services	TRUE	FALSE	FALSE
TB care and prevention	Key populations - Children	FALSE	TRUE	FALSE
TB care and prevention	Key populations - Prisoners	FALSE	TRUE	FALSE
PMTCT	Prong 1: Primary prevention of HIV infection among women of childbearing age	FALSE	FALSE	TRUE
Reducing human rights-related barriers to HIV/TB services	Improving laws, regulations, and policies relating to HIV and HIV/TB	TRUE	FALSE	FALSE
Community responses and systems	Community-led advocacy	FALSE	FALSE	TRUE
Case management	Integrated community case management (iCCM)	FALSE	TRUE	FALSE
Specific prevention interventions	Intermittent preventive treatment – In pregnancy	FALSE	TRUE	FALSE
Specific prevention interventions (SPI)	Intermittent preventive treatment (IPT) - In infancy	FALSE	TRUE	FALSE
Specific prevention interventions (SPI)	Intermittent preventive treatment (IPT) - In pregnancy	FALSE	TRUE	FALSE
Integrated service delivery and quality improvement	Quality of care	FALSE	FALSE	TRUE
TB/HIV	Community TB/HIV care delivery	FALSE	FALSE	TRUE
TB/HIV	Key populations (TB/HIV) – Prisoners	FALSE	TRUE	FALSE
Removing human rights and gender related barriers to TB services	Human rights, medical ethics and legal literacy	TRUE	FALSE	FALSE

Removing human rights and gender related barriers to TB services	Reform of laws and policies	TRUE	FALSE	FALSE
Removing human rights and gender related barriers to TB services	Stigma and discrimination reduction	TRUE	FALSE	FALSE
TB care and prevention	Key populations - Miners and mining communities	FALSE	TRUE	FALSE
TB care and prevention	Key populations - Mobile populations: refugees, migrants, and internally displaced people	FALSE	TRUE	FALSE
Community systems strengthening	Community-led advocacy and research	FALSE	FALSE	TRUE
TB/HIV	Key populations - Children	FALSE	TRUE	FALSE
Comprehensive prevention programs for men who have sex with men	Community empowerment for men who have sex with men	FALSE	TRUE	FALSE
Comprehensive prevention programs for men who have sex with men	Other interventions for men who have sex with men	FALSE	TRUE	FALSE
Comprehensive prevention programs for men who have sex with men	Pre-exposure prophylaxis (PrEP) for men who have sex with men	FALSE	TRUE	FALSE
Comprehensive prevention programs for men who have sex with men	Prevention and management of coinfections and co- morbidities men who have sex with men	FALSE	TRUE	FALSE
Comprehensive prevention programs for sex workers and their clients	Diagnosis and treatment of sexually transmitted infections and other sexual and reproductive health services for sex workers	FALSE	TRUE	FALSE
Comprehensive prevention programs for sex workers and their clients	Other interventions for sex workers and their clients	FALSE	TRUE	FALSE
Comprehensive prevention programs for transgender people	Community empowerment for transgender people	FALSE	TRUE	FALSE
Comprehensive prevention programs for transgender people	Diagnosis and treatment of sexually transmitted infections and sexual health services for transgender people	FALSE	TRUE	FALSE
Comprehensive prevention programs for transgender people	Interventions for young transgender people	FALSE	TRUE	FALSE
Comprehensive prevention programs for transgender people	Other interventions for transgender people	FALSE	TRUE	FALSE
Comprehensive prevention programs for transgender people	Pre-exposure prophylaxis (PrEP) and other biomedical interventions for transgender people	FALSE	TRUE	FALSE
Comprehensive prevention programs for transgender people	Prevention and management of co-infections and co-morbidities for transgender people	FALSE	TRUE	FALSE

Comprehensive prevention programs for transgender people	Prevention and management of co-infections and co-morbidities for transgender people	FALSE	TRUE	FALSE
Comprehensive programs for people in prisons and other closed settings	Behavioral interventions for people in prisons and other closed settings	FALSE	TRUE	FALSE
Comprehensive programs for people in prisons and other closed settings	Community empowerment for people in prisons and other closed settings	FALSE	TRUE	FALSE
Comprehensive programs for people in prisons and other closed settings	Condoms and lubricant programming for people in prisons and other closed settings	FALSE	TRUE	FALSE
Comprehensive programs for people in prisons and other closed settings	Diagnosis and treatment of sexually transmitted infections and other sexual and reproductive health services for people in prisons and other closed settings	FALSE	TRUE	FALSE
Comprehensive programs for people in prisons and other closed settings	Other interventions for people in prisons and other closed settings	FALSE	TRUE	FALSE
HIV Testing Services	Differentiated HIV testing services	FALSE	TRUE	FALSE
Prevention of mother-to-child transmission	Other interventions for PMTCT	FALSE	FALSE	TRUE
Prevention programs for adolescents and youth, in and out of school	Gender-based violence prevention and treatment programs for adolescents and youth	FALSE	FALSE	TRUE
Programs to reduce human rights-related barriers to HIV services	Legal literacy (“Know Your Rights”)	TRUE	FALSE	FALSE
Programs to reduce human rights-related barriers to HIV services	Other intervention(s) to reduce human rights- related barriers to HIV services	TRUE	FALSE	FALSE
Programs to reduce human rights-related barriers to HIV services	Training of health care providers on human rights and medical ethics related to HIV and HIV/TB	TRUE	FALSE	FALSE
Integrated service delivery and quality improvement	Supportive policy and programmatic environment	FALSE	FALSE	TRUE
Reducing human rights-related barriers to HIV/TB services	Community mobilization and advocacy	TRUE	FALSE	FALSE
Reducing human rights-related barriers to HIV/TB services	Sensitization of law-makers and law-enforcement agents	TRUE	FALSE	FALSE
Community responses and systems	Social mobilization, building community linkages, collaboration and coordination	FALSE	FALSE	TRUE
TB care and prevention	Key populations (TB care and prevention) – Prisoners	FALSE	TRUE	FALSE
TB care and prevention	Removing human rights- and gender-related barriers to TB care and prevention	TRUE	FALSE	FALSE

Comprehensive prevention programs for people who inject drugs and their partners	Addressing stigma, discrimination and violence against people who inject drugs	TRUE	FALSE	FALSE
Comprehensive prevention programs for people who inject drugs and their partners	Opioid substitution therapy and other drug- dependence treatment for people who inject drugs	FALSE	TRUE	FALSE
Comprehensive prevention programs for sex workers and their clients	Addressing stigma, discrimination and violence against sex workers	TRUE	FALSE	FALSE
Comprehensive prevention programs for sex workers and their clients	Community empowerment for sex workers	FALSE	TRUE	FALSE
Comprehensive prevention programs for sex workers and their clients	Pre-exposure prophylaxis (PrEP) for sex workers	FALSE	TRUE	FALSE
Prevention programs for other vulnerable populations	Other interventions for other vulnerable populations	FALSE	TRUE	FALSE
Prevention	Integration into national multi-sectoral responses of AGYW programs	FALSE	FALSE	TRUE
Reducing human rights-related barriers to HIV/TB services	HIV and HIV/TB related legal services	TRUE	FALSE	FALSE
Community systems strengthening	Social mobilization, building community linkages, and coordination	FALSE	FALSE	TRUE
Comprehensive prevention programs for people who inject drugs and their partners	Other interventions for people who inject drugs and their partners	FALSE	TRUE	FALSE
Comprehensive prevention programs for people who inject drugs and their partners	Overdose prevention and management	FALSE	TRUE	FALSE
Comprehensive prevention programs for people who inject drugs and their partners	Prevention and management of co-infections and co-morbidities for people who inject drugs	FALSE	TRUE	FALSE
Prevention programs for adolescents and youth, in and out of school	Behavioral change as part of programs for adolescent and youth	FALSE	FALSE	TRUE
Prevention programs for adolescents and youth, in and out of school	HIV testing services for adolescents and youth, in and out of school	FALSE	FALSE	TRUE
Prevention programs for other vulnerable populations	Diagnosis and treatment of sexually transmitted infections and other sexual health services for other vulnerable populations	FALSE	TRUE	FALSE
MDR-TB	Key populations - Prisoners	FALSE	TRUE	FALSE
TB care and prevention	Key populations - Others	FALSE	TRUE	FALSE
TB/HIV	Key populations (TB/HIV) – Others	FALSE	TRUE	FALSE
Prevention programs for adolescents and youth, in and out of school	Addressing stigma, discrimination and legal barriers to care for adolescents and youth	TRUE	FALSE	FALSE

Prevention programs for adolescents and youth, in and out of school	Community mobilization and norms change	FALSE	FALSE	TRUE
Prevention programs for adolescents and youth, in and out of school	Keeping girls in school	FALSE	FALSE	TRUE
Prevention programs for adolescents and youth, in and out of school	Socioeconomic approaches	FALSE	FALSE	TRUE
Programs to reduce human rights-related barriers to HIV services	Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity	TRUE	FALSE	FALSE
Prevention programs for adolescents and youth, in and out of school	Linkages between HIV programs and RMNCH	FALSE	FALSE	TRUE
Specific prevention interventions	Intermittent preventive treatment – In infancy	FALSE	TRUE	FALSE
Specific prevention interventions (SPI)	Removing human rights and gender related barriers to specific prevention interventions	TRUE	FALSE	FALSE

Annex 4. PCE 2020 Guidance on Operationalizing the 2S Framework

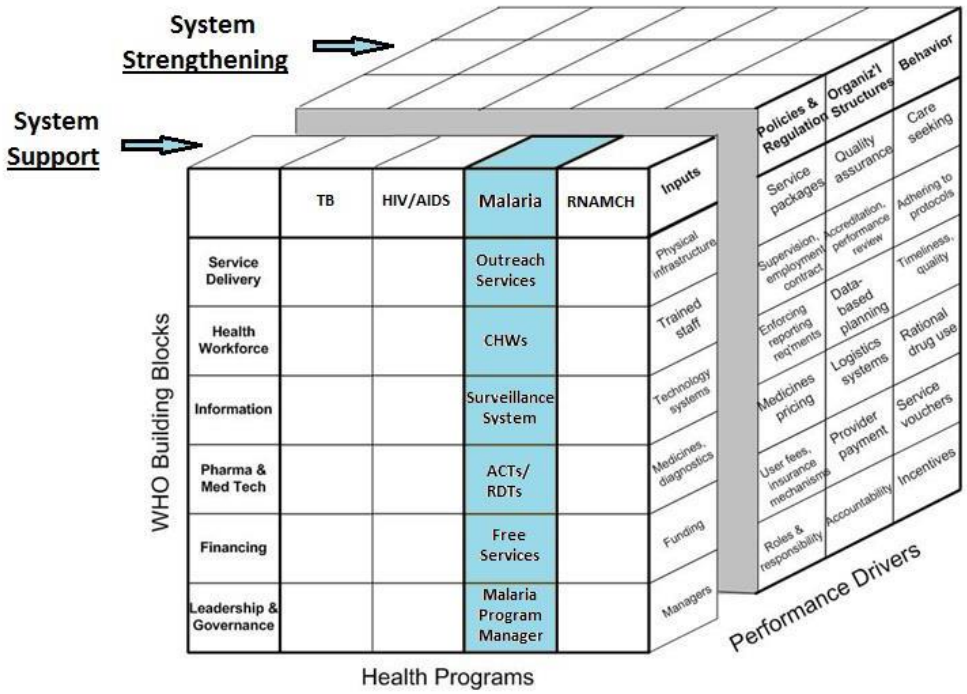
1. Purpose of this document

This document provides guidance for how to analyze whether "direct" RSSH investments in current and upcoming Global Fund grants constitute health systems support or health systems strengthening This guidance builds from references to 4S in both the RSSH and sustainability guidance documents. Given the need for consistency in applying the framework to budgets in the 2017 and 2020 funding requests and across the four countries, GEP and CEP will work together closely on the coding process. By examining the change over time, we will assess whether countries have increased the proportion or Global Fund RSSH investments contributing to health systems strengthening (versus support).

2. Health system investments: supporting vs. strengthening

The TRP report on RSSH investments in the 2017-2019 funding cycle applied the 4S framework (start-up, support, strengthening, sustainability), which was an expansion of the framework proposed by Grace Chee et al. (2013) describing systems support vs. systems strengthening (hereafter "2S") as visualized through the health systems cube (Figure 1). Through the TRP's review, it was noted that the 'start-up' and 'sustainability' categories of 4S (the outer two S) were not applied very often, meaning that most Global Fund investments fell into either the 'support' or 'strengthening' categories (the middle two S) within the 4S continuum. For that reason, and in consultation with the TRP, the PCE will apply the 2S framework, which will also help to increase coding consistency by having fewer categories.

Figure 3.1. Systems Support and Systems Strengthening: Health Systems Cube (Chee et al. 2013).



The health system cube Y-axis includes the *WHO building blocks*, which are considered key functions of the health system. The X-axis includes illustrative *disease-specific programs* that deliver critical services, while the third dimension along the Z axis includes *performance drivers*, including inputs (systems support), policies, and regulations, organizational structures, and behaviors (systems strengthening) (Chee et al. 2013). Our analysis will **assess whether proposed RSSH activities contribute to systems support versus system strengthening** in line with Figure 1 above. Per Chee et al. (2013):

- "Supporting the health system can include any activity that improves services, from distributing mosquito nets to procuring medicines. These activities improve outcomes primarily by increasing inputs."
- "Strengthening the health system is accomplished by more comprehensive changes to performance drivers such as policies and regulations, organizational structures, and relationships across the health system to motivate changes in behavior and/or allow more effective use of resources to improve multiple health services."

The TRP methodology notes that funding requests examples that were health systems support oriented included requests for cars, computers, phones, travel costs for routine monitoring, furniture and office equipment, payments for fuels and maintenance of vehicles, cost for regular training or overseas training, software, reimbursement for importation, among others. Whereas funding requests characterized by more health systems strengthening interventions included requests for upscaling of volunteer networks; developing protocols for data quality monitoring; developing standard operating procedures for quality control in laboratories; transferring of the procurement system of Global Fund into the national procurement systems; digitizing HMIS data; developing strategies to engage with the private sector; providing technical assistance for DHIS2 roll-out, improving procurement and supply chain procedures including e-LMIS, and establishing medicine regulatory authority, among others.

3. Data Sources for RSSH interventions/activities

PCE will rely on up to three budget types as source documents for applying 2S, pending data availability:

1. Final approved budgets following grant making (2017)
    - To be independently coded by two GEP and compared to review any inconsistencies and reach consensus on 2S codes.
    - The final approved grant making budget is preferable to the funding request budget, as it represents the RSSH allocation actually planned for implementation.
2. Funding request budgets submitted to TRP (2020)
    - To be independently coded by GEP and CEP (and then compared in small working group to review inconsistencies in coding and to reach consensus on 2S codes).
3. Final approved budgets following grant making (2020) for HIV in GTM
    - This may not be available for all countries by the end of 2020. Where available following grant making, to be independently coded by GEP and CEP (and then compared to review inconsistencies in coding and to reach consensus on 2S codes).

In addition to the budget data, the funding request narrative description of RSSH investments should be used as a secondary source for triangulating with budget information when examining interventions (or activities) and applying the 2S framework. The funding request narrative is often not well aligned with the budget, unfortunately, but can still often be helpful in understanding the overall scope of the RSSH interventions.

4. Steps for operationalizing 2S application to RSSH activities in Global Fund grants

4.1 Review the RSSH budget data

Relevant budget data will be extracted by GEP for each country to ensure we are using a systematic data format across countries. In line with the detailed budgets, the template includes columns (shaded green) for the extracted data: Grant, Grant Period, Module, Intervention, Activity Description, Cost Input, and Budget. Additional columns (shaded blue or purple) for data entry

by coders include Scope, Longevity, Approach, Designation (Supporting vs. Strengthening) and Justification.

Review budget data for each line item, examining the module, intervention, and activity description. In addition, review the Cost Input categorization. Together, these four data elements should yield sufficient information to understand the RSSH activity. In some cases, where this data is insufficient, the funding request narrative can be referred to for additional description of the RSSH interventions.

HMIS/M&E Investments

RSSH investments in many PCE countries contain substantial investments in HMIS/M&E modules. While as for other modules, determining whether HMIS/M&E investments are strengthening or supporting requires careful review of the activity description, our review of the 2017 budgets has revealed a few patterns. Generally speaking, activities (meetings, etc) related to data validation (especially when part of the analysis/review intervention category) can be considered strengthening. Activities related to monitoring the performance of the Global Fund grants themselves (as opposed to strengthening country M&E systems) should be considered supporting. Some activities aimed at improving internet connectivity to support information systems strengthening can also be considered strengthening because, although an input, efforts to improve the collection and use of data is persistently hampered by poor connectivity, and therefore this may be a foundational investment upon which broader strengthening efforts are dependent. Other activities (training, supervision, etc) related to the roll-out of DHIS2 (or similar system) can be considered strengthening.

4.2 Consider the Scope, Longevity, and Approach of each RSSH intervention/activity pair, and the cost input category

Drawing from the TRP's methodology, we will apply three criteria--scope, longevity, and approach--to assess each RSSH intervention/activity pair in the budget. These three criteria, along with the Cost Input categorization, will be taken together in determining the designation of "supporting" or "strengthening". With the exception of Justification (which requires the coder to type a justification for why they selected supporting or strengthening, these columns all contain dropdown menus for the definitions of Scope, Longevity, Approach, and Designation to ease the coding process. The criteria for a system strengthening intervention include:

- **Scope**: activities have impact across health services and outcomes
- **Longevity**: effects will continue after activities end
- **Approach**: revise policies and institutional relationships to change behaviors and resource use to address identified constraints in a more sustainable manner

The definitions of Scope, Longevity, and Approach included in the table below will be used for determining whether an activity is systems support versus systems strengthening.

Parameter	System Support	System Strengthening
Scope	May be focused on a single disease or intervention	Activities have impact across health services and outcomes; and systems may be integrated into the overall health sector
Longevity	Effects limited to period of funding	Effects will continue after funded activities end

Approach	Provide inputs to address identified system gaps	Revise policies and institutional relationships to change behaviors and resource use to address identified constraints in a more sustainable manner

In many cases, if the majority of the three (scope, longevity and approach) criteria are designated support or strengthening (i.e. at least 2 out of 3), that will be sufficient to determine the final designation for the row. There are some cases, where one or more of the criteria may be designated as unclear, even after considering the cost input category (see below), resulting in a 1-1 tie. These instances will require more of a qualitative judgment to arrive at a final determination and should be discussed between coders to ensure agreement.

Cost input categories

There are minimum budget requirements for Global Fund funding request submissions, including modules and their related interventions (selected from prescribed list in the Modular Framework Handbook) and cost groupings and cost inputs selected from a prescribed list (see Appendix 1, p. 77 of Global Fund guidelines for budgeting). In addition to considering the scope, longevity and approach criterion in determining whether an activity is supporting or strengthening, certain cost categories (as indicated in the Table below) can inform this categorization.

Cost Grouping	**Cost Input Categories**	**Supporting / Strengthening**
1. Human resources	1.1 Salaries - program management 1.2 Salaries -outreach workers, medical staff and other service providers 1.3 Performance-based supplements, incentives 1.4 Other human resources costs 1.5 Severance costs *(added to 2019 guidelines)*	1.1/1.2 Considered ***supporting*** as a health system input--including payment for salaries and other financial incentives 1.3 Performance-based supplements and incentives are the exception to this rule and can be considered ***strengthening***.
2. Travel-related costs	2.1 Training-related per diems/transport/other costs 2.2 TA-related per diems/transport/other costs 2.3 Supervision/surveys/data collection-related per diems/transport/other costs 2.4 Meeting/advocacy-related per diems/transport/other costs 2.5 Other transportation costs	Most often considered ***supporting*** as a health system input. 2.1 Training-related per-diems/transport/other costs should be considered ***supporting***, unless activity description clearly describes strengthening capacity in relation to data use, data validation meetings, financial management, PSM, M&E, or other systems strengthening related area) 2.4 Meeting related costs generally considered ***supporting*** unless the activity description indicates that the purpose is for policy change or development.

3. External professional services	3.1 Technical assistance fees/consultancy fees 3.2 Fiscal/fiduciary agent fees 3.3 External audit fees 3.4 Other external professional services 3.5 Insurance related costs	3.1 Technical assistance may be considered ***strengthening*** but this determination depends upon review of the activity description.
4. Health products -- pharmaceutical products	4.1 Antiretroviral medicines 4.2 Anti-tuberculosis medicines 4.3 Antimalarial medicines 4.4 Opioid substitutes medicines 4.5 Opportunistic infections and STI medicines 4.6 Private sector subsidies for ACTs (co-payment to 4.3) 4.7 Other medicines	Most often considered ***supporting*** as a health system input (e.g. medicines for HIV, TB, malaria); *unlikely to be tagged within RSSH modules*
5. Health products -- non-pharmaceuticals	5.1 Insecticide-treated nets (long-lasting insecticidal nets/insecticide-treated nets) 5.2 Condoms –male 5.3 Condoms –female 5.4 Rapid diagnostic tests 5.5 Insecticides 5.6 Laboratory reagents 5.7 Syringes and needles 5.8 Other consumables 5.9 Private sector subsidies for rapid diagnostic tests (Co-payments to 5.4)	Most often considered ***supporting*** as a health system input (e.g. bednets, condoms, RDTs, insecticides, reagents, syringes); *unlikely to be tagged within RSSH modules*
6. Health products -- equipment	6.1 CD4 analyzer/accessories 6.2 HIV viral load analyzer/accessories 6.3 Microscopes 6.4 TB molecular test equipment 6.5 Maintenance and service costs for health equipment 6.6 Other health equipment	*Unlikely to be tagged within RSSH modules*
7. Procurement and supply chain management costs	7.1 Procurement agent and handling fees 7.2 Freight and insurance costs (health products) 7.3 Warehouse and storage costs 7.4 In-country distribution costs 7.5 Quality assurance and quality control costs 7.6 Procurement and supply management customs duties and clearance charges 7.7 Other procurement and supply management costs	Cost inputs in this group are most often considered ***supporting*** 7.5 (quality assurance and quality control costs) and 7.7 (other procurement and supply management costs) are possible exceptions which might be considered ***strengthening***, depending on the activity description
8. Infrastructure	8.1 Furniture	

	8.2 Renovation/constructions 8.3 Infrastructure maintenance and other infrastructure costs	
9. Non-health equipment	9.1 IT -computers, computer equipment, software and applications 9.2 Vehicles 9.3 Other non-health equipment 9.4 Maintenance and service costs non-health equipment	9.1 IT equipment can typically be categorized as ***strengthening*** if it is intended to build data systems capacity. Equipment to facilitate stand-alone disease-specific activities may be considered support, but we haven't seen examples of this yet. 9.2 Vehicles are always ***support***. 9.3 Varies, so closely review activity descriptions. Lab-strengthening equipment purchases are generally considered to be strengthening, and tend to fall within this cost input category
10. Communication material and publications	10.1 Printed materials (forms, books, guidelines, brochure, leaflets, etc.) 10.2 Television/radio spots and programs 10.3 Promotional material (t-shirts, mugs, pins, etc.) and other communication material and publications costs	All inputs within this cost grouping are generally considered to be ***supporting***
11. Indirect and overhead costs	11.1 Office-related costs 11.2 Unrecoverable taxes and duties 11.3 Indirect cost recovery -% based 11.4 Other PA costs 11.5 Shared costs	All inputs within this cost grouping are generally considered to be ***supporting***
12. Living support to client/target population	12.1 Support to orphans and other vulnerable children (school fees, uniforms, books, etc.) 12.2 Food and care packages 12.3 Cash incentives/transfer to patients/beneficiaries/counselors/ mediators 12.4 Microloans and microgrants 12.5 Other costs related to living support to client/target population	*Unlikely to be tagged within RSSH modules*
13. Payment for results	*Added to 2019 guidelines:* 13.1 Results Based Financing 13.2 Activity Based Contracts, Community Based Organizations and other service providers	13.1 and 13.4 are generally considered to be considered ***strengthening***

	13.3 Incentives for Principal Recipient and Sub-Recipients staff members 13.4 Incentives for Community Health Workers (CHW), outreach workers, medical staff and other service providers	

4.3 Review the funding request narrative to inform categorization

In some cases, the intervention/activity description and cost-inputs are very vague and provide insufficient information on which categorize activities as supporting or strengthening. In these instances, before making a final determination refer back to the funding request narrative to see if there is additional context around interventions to help inform the final categorization. If no such information exists, then apply the 'unclear' category. *Note: In our review of the 2017 budgets, we found very few interventions which required us to return to the funding request narratives, and that could not be categorized after exhausting all of these options*.

4.4 Review the other coder's categorization and identify any discrepancies

Each budget will be coded twice, by one CEP and one GEP member. After completing coding of the budgets, assign one person to compare and identify any lines where the final designation of supporting vs. strengthening is not consistent between coders. Schedule a call to discuss each of those discrepancies and align on the final designation. If needed, consult with other members of the 2S working group to see if parallels can be drawn with other countries.

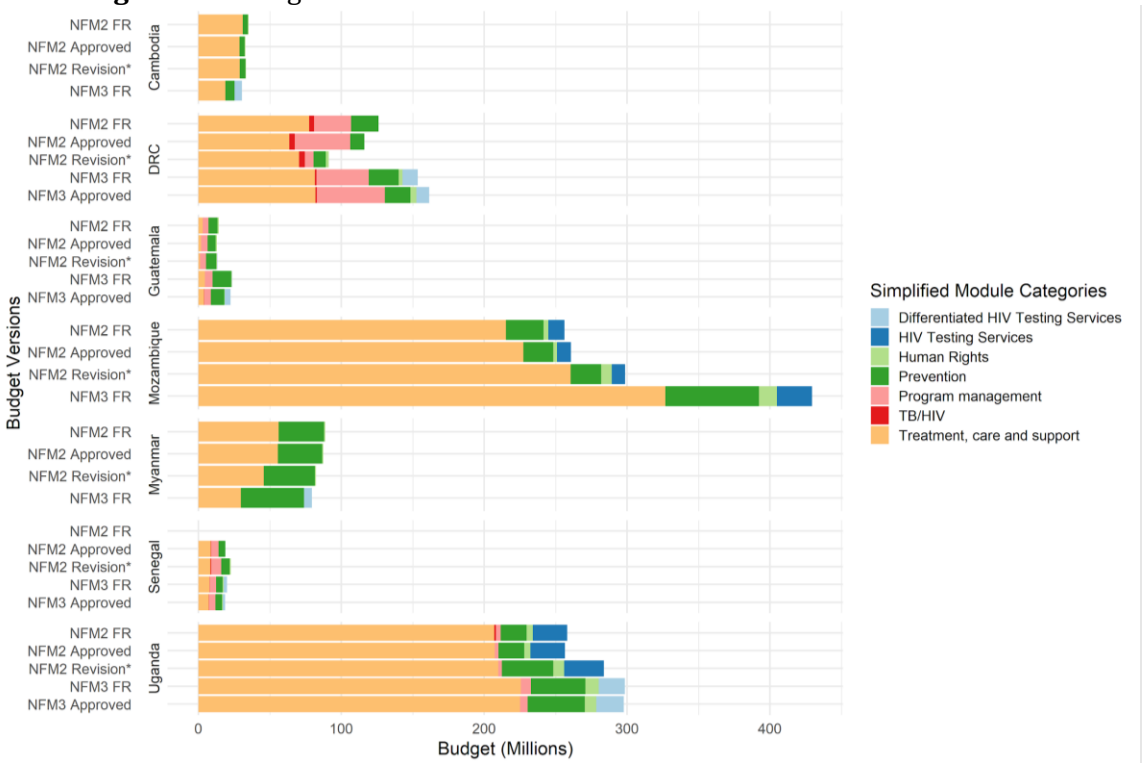
4.5 Quantify the proportion of the RSSH funds allocated to supporting vs. strengthening investments.

When final designations have been determined, quantify the proportion of funds going to supporting vs strengthening investments. This can then be compared to 2017 investments to see whether there is evidence of increased allocation of funds toward strengthening (which could be considered evidence of a 'changing trajectory', or whether the allocations are similar to 2017 (which could be considered evidence of 'business as usual'). Depending on what we find, we may drill down to look in greater detail at change for specific modules or intervention categories (which may be related to focus topics, e.g. HMIS/M&E) and may consider using Tableau to help illustrate some of these findings. We will continue to build out our approach to this as we explore the data and patterns or findings begin to emerge.

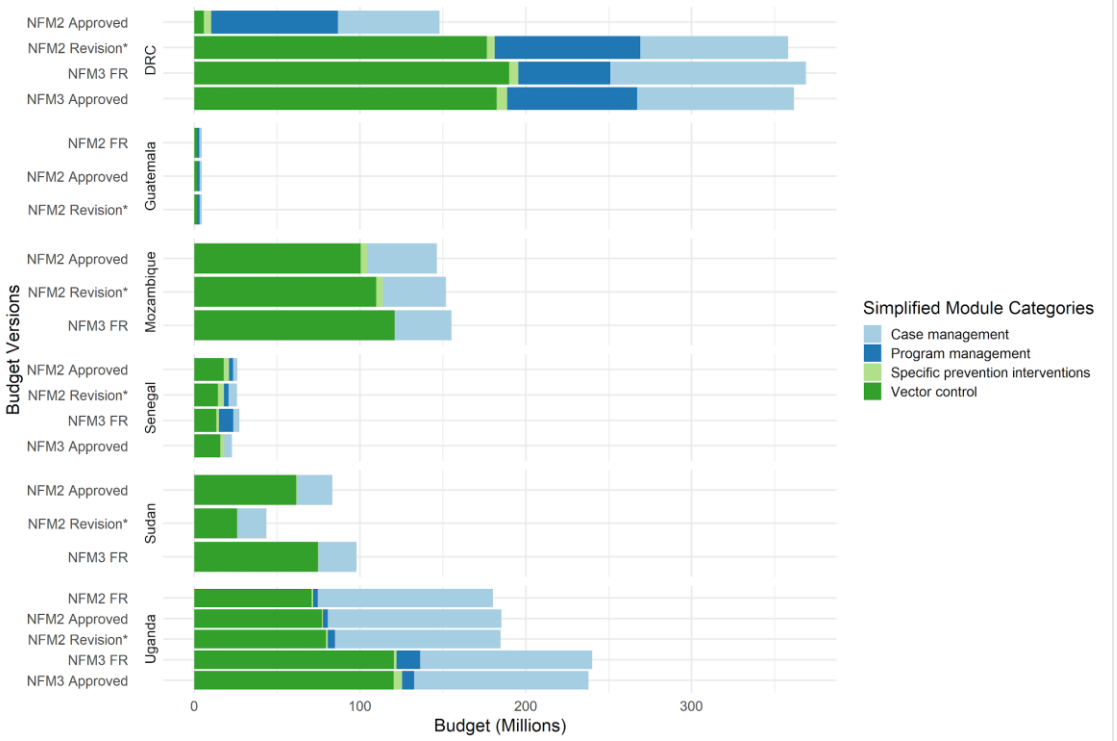
Annex 5. Supplemental figures of budget changes by disease and RSSH

In all figures, revision is the most recent official budget revision.

Annex Figure 5.1. Budget variance in HIV investments between NFM2 and NFM3.



Annex Figure 5.2. Budget variance in malaria investments between NFM2 and NFM3.

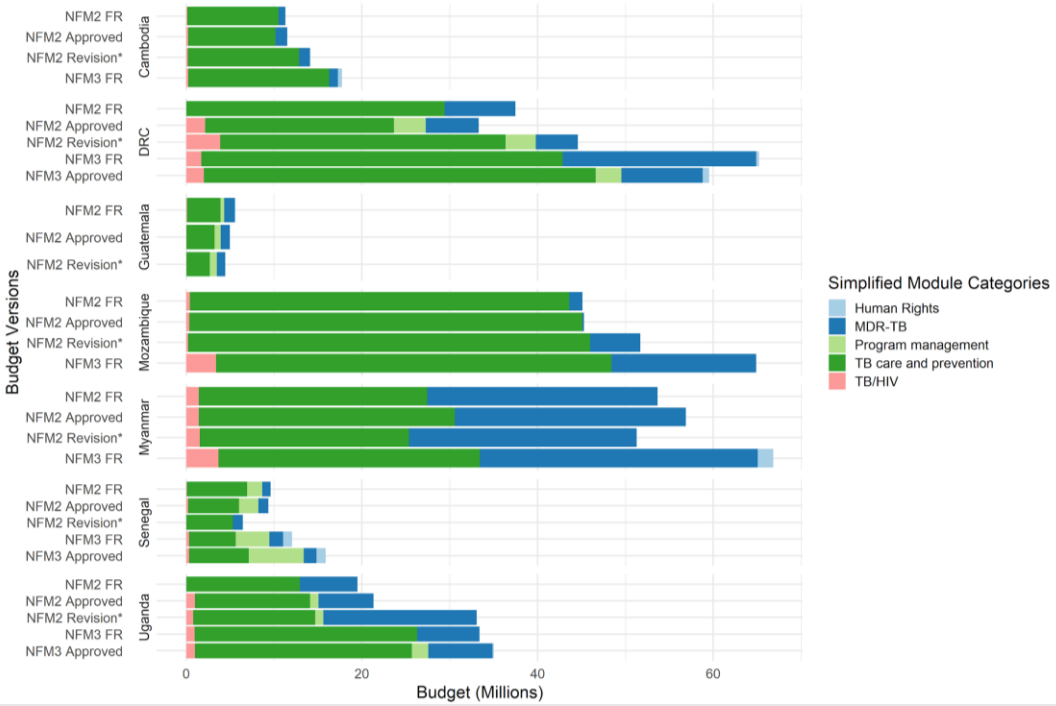


*Program Continuation in NFM2 did not require budget as part of the Funding Request; this data is not available for DRC, Mozambique, Senegal and Sudan

**The first revision in DRC added an additional US$141,533,250 for the bed net mass distribution campaign that was originally going to be implemented by PSI and was instead implemented by Global Fund PRs

***Funds for malaria, TB, and RSSH in Senegal remained unchanged between NFM3 FR and Approved Budgets. However, program management funds for malaria are collapsed with those for TB in these figures due to the integration of some of the malaria component within the TB/RSSH grant.

Annex Figure 5.3. Budget variance in TB investments between NFM2 and NFM3.



Annex Figure 5.4. Budget variance in RSSH investments between NFM2 and NFM3[22,23]

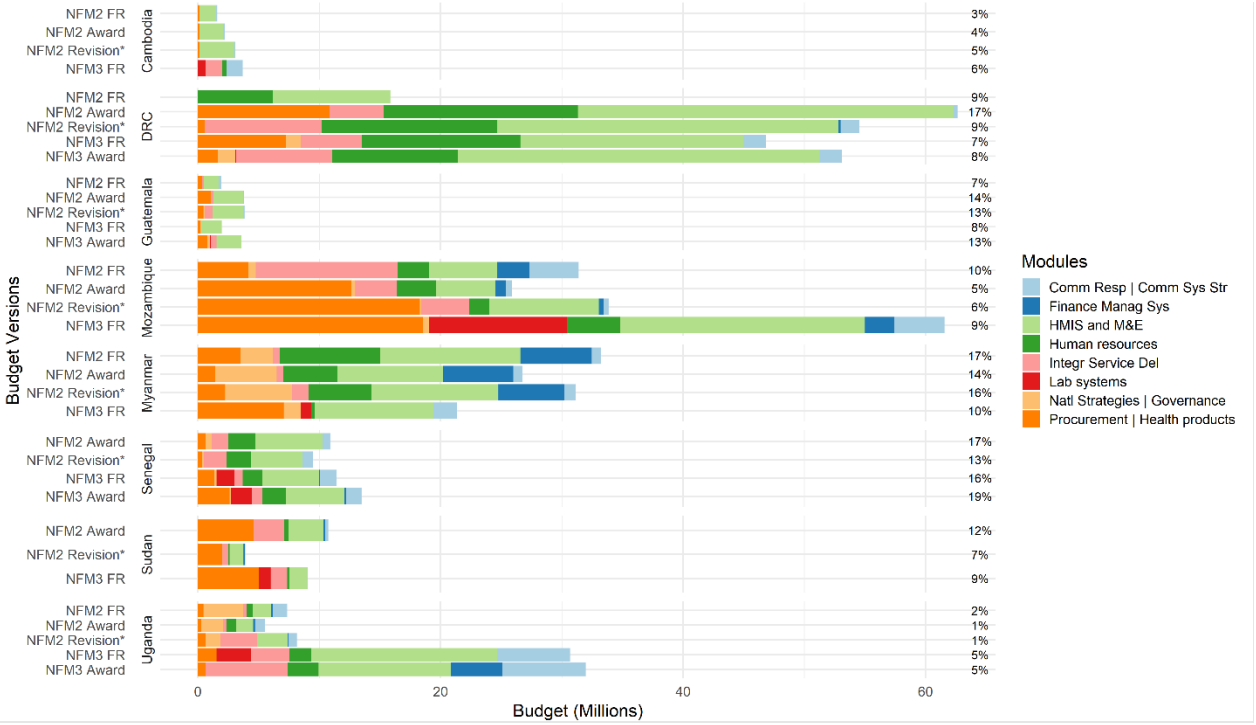


Figure note: Percentages represent the share of total budget RSSH modules made up for each respective budget version. NFM2 Funding Requests (FR) could not be included for grants which were continuations from NFM1—specifically for DRC, Senegal, and Sudan.

[22] Given updates to the Modular Framework in 2019, for comparing similar RSSH modules across NFM2 and NFM3, we aligned across funding cycles, e.g., "community responses and systems" (NFM2) comparable to "community systems strengthening" (NFM3); "national health strategies" (NFM2) comparable to "health sector governance and planning" (NFM3); "procurement and supply chain" (NFM2) comparable to "health products management systems" (NFM3). In addition, "laboratory systems" (red) was added as a distinct module in NFM3, but in NFM2 was included as an intervention within the "Integrated Service Delivery" (pink) module.

[23] The data presented does not include all disease components in some countries. Cambodia and Myanmar do not include data for malaria. Sudan does not include data for HIV and TB. Only HIV is included for Guatemala in NFM3.

Annex 6. Table of cumulative absorption by year for all modules, RSSH modules, and HRG-Equity-related modules[24]

	Country	Modules	Year	Cumulative Expenditure	Cumulative Budget	Absorption
1	All Countries	All modules	2018	$ 435,221,116	$ 637,529,912	68%
2	All Countries	All modules	2019	$ 1,010,827,839	$ 1,243,020,973	81%
3	All Countries	All modules	2020	$ 774,919,591	$ 1,033,503,661	75%
4	All Countries	RSSH	2018	$ 24,252,479	$ 59,818,215	41%
5	All Countries	RSSH	2019	$ 40,085,859	$ 79,182,340	51%
6	All Countries	RSSH	2020	$ 38,861,769	$ 71,864,527	54%
7	All Countries	HRG-Equity	2018	$ 26,490,910	$ 54,175,617	49%
8	All Countries	HRG-Equity	2019	$ 81,579,875	$ 116,076,973	70%
9	All Countries	HRG-Equity	2020	$ 40,967,119	$ 80,258,075	51%
10	Cambodia	All modules	2018	$ 11,788,588	$ 22,030,647	54%
11	Cambodia	All modules	2019	$ 33,449,455	$ 45,208,043	74%
12	Cambodia	RSSH	2018	$ 269,245	$ 707,626	38%
13	Cambodia	RSSH	2019	$ 1,161,296	$ 2,127,055	55%
14	Cambodia	HRG-Equity	2018	$ 1,504,385	$ 2,855,512	53%
15	Cambodia	HRG-Equity	2019	$ 4,119,724	$ 5,901,577	70%
16	DRC	All modules	2018	$ 123,142,804	$ 187,137,531	66%
17	DRC	All modules	2019	$ 271,907,215	$ 341,325,377	80%
18	DRC	All modules	2020	$ 412,216,321	$ 565,885,160	73%
19	DRC	RSSH	2018	$ 11,745,365	$ 23,005,174	51%
20	DRC	RSSH	2019	$ 15,191,099	$ 24,878,992	61%
21	DRC	RSSH	2020	$ 31,165,051	$ 54,150,564	58%
22	DRC	HRG-Equity	2018	$ 4,771,951	$ 12,737,267	37%
23	DRC	HRG-Equity	2019	$ 14,521,128	$ 23,683,135	61%
24	DRC	HRG-Equity	2020	$ 16,915,414	$ 28,104,393	60%
25	Guatemala	All modules	2019	$ 12,568,696	$ 21,025,472	60%
26	Guatemala	All modules	2020	$ 6,653,971	$ 13,364,136	50%
27	Guatemala	RSSH	2019	$ 806,011	$ 1,998,652	40%
28	Guatemala	RSSH	2020	$ 441,170	$ 2,084,918	21%
29	Guatemala	HRG-Equity	2019	$ 2,218,054	$ 3,526,162	63%
30	Guatemala	HRG-Equity	2020	$ 3,108,291	$ 6,804,475	46%
31	Mozambique	All modules	2018	$ 90,247,014	$ 134,362,850	67%
32	Mozambique	All modules	2019	$ 319,921,010	$ 357,429,377	90%
33	Mozambique	RSSH	2018	$ 1,811,418	$ 13,645,166	13%
34	Mozambique	RSSH	2019	$ 11,349,364	$ 26,997,164	42%
35	Mozambique	HRG-Equity	2018	$ 3,841,326	$ 6,331,732	61%

[24] HRG-Equity investments in Sudan were only analyzed for malaria, and were very small. Nonetheless, absorption against these areas was 0%. 2020 expenditure, budget, and absorption figures only reflect the first semester.

36	Mozambique	HRG-Equity	2019	$ 18,964,823	$ 21,238,368	89%
37	Myanmar	All modules	2018	$ 54,094,227	$ 73,507,181	74%
38	Myanmar	All modules	2019	$ 52,175,815	$ 78,649,237	66%
39	Myanmar	RSSH	2018	$ 7,362,593	$ 9,458,290	78%
40	Myanmar	RSSH	2019	$ 3,686,430	$ 7,620,775	48%
41	Myanmar	HRG-Equity	2018	$ 11,386,127	$ 14,968,265	76%
42	Myanmar	HRG-Equity	2019	$ 23,740,879	$ 28,033,573	85%
43	Senegal	All modules	2018	$ 18,994,323	$ 30,327,752	63%
44	Senegal	All modules	2019	$ 43,548,244	$ 51,378,861	85%
45	Senegal	All modules	2020	$ 77,008,620	$ 85,834,261	90%
46	Senegal	RSSH	2018	$ 2,026,230	$ 4,538,079	45%
47	Senegal	RSSH	2019	$ 5,037,052	$ 7,392,846	68%
48	Senegal	RSSH	2020	$ 5,705,050	$ 9,457,464	60%
49	Senegal	HRG-Equity	2018	$ 3,010,466	$ 3,892,393	77%
50	Senegal	HRG-Equity	2019	$ 6,747,325	$ 8,167,893	83%
51	Senegal	HRG-Equity	2020	$ 6,472,849	$ 9,754,681	66%
52	Sudan	All modules	2018	$ 28,408,002	$ 39,989,280	71%
53	Sudan	All modules	2019	$ 43,720,610	$ 53,498,940	82%
54	Sudan	RSSH	2018	$ 775,227	$ 4,552,725	17%
55	Sudan	RSSH	2019	$ 1,390,904	$ 3,017,984	46%
56	Sudan	HRG-Equity	2018	$ -	$ -	0%
57	Sudan	HRG-Equity	2019	$ -	$ 91,282	0%
58	Uganda	All modules	2018	$ 108,546,157	$ 150,174,671	72%
59	Uganda	All modules	2019	$ 233,536,793	$ 294,505,666	79%
60	Uganda	All modules	2020	$ 279,040,679	$ 368,420,104	76%
61	Uganda	RSSH	2018	$ 262,400	$ 3,911,156	7%
62	Uganda	RSSH	2019	$ 1,463,702	$ 5,148,873	28%
63	Uganda	RSSH	2020	$ 1,550,498	$ 6,171,580	25%
64	Uganda	HRG-Equity	2018	$ 44,551,947	$ 75,761,952	59%
65	Uganda	HRG-Equity	2019	$ 23,610,161	$ 28,606,493	83%
66	Uganda	HRG-Equity	2020	$ 33,098,451	$ 49,673,788	67%

Annex 7: Application of the Global Fund's performance-based funding model

Introduction

The annual funding decision and disbursement processes are key to the Global Fund Secretariat's grant management function and performance-based funding model. The objective of these processes is to: (6)

- review grant implementation progress (including achievement of programmatic targets, and financial and management issues) and assign an overall grant rating;
- determine the funding to be disbursed for each grant for the following 12-month period; and
- identify implementation issues, risks and mitigating measures.

The annual funding decision is intended to encourage grant recipients to focus on results and timely implementation by being based on the principle of performance-based funding—i.e., where funding is reduced for poor performance and increased for high performance. (6)

Grant ratings in PCE countries

The grant rating is based on:

- **Indicator rating:** Quantitative assessment of progress against the targets in the Performance Framework which is adjusted based on the Country Team's understanding of the quality of data and programmatic performance of the grant.
- **Grant management issues:** Qualitative assessment of whether issues exist across the areas of M&E, program management, financial management and systems, and health product management.

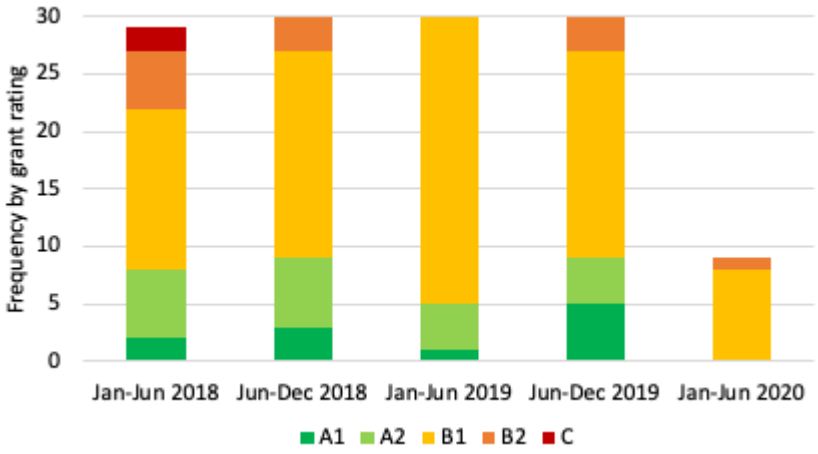
As shown in Table 1.1, across all grants in the eight PCE countries over the period 2018 to mid-2020, the majority of grant ratings are applied to the B1 and A2 categories reflecting moderate performance.

Annex Table 6.1: Frequency of grant ratings for all grants in PCE countries (2018-20)

Rating	Description	Frequency	%
A1	Exceeds expectations	11	9%
A2	Meets expectation	20	16%
B1	Adequate	83	65%
B2	Inadequate but potential demonstrated	12	9%
C	Unacceptable	2	2%

Of interest, and as partly shown in Annex Figure 6.1, grant ratings change dramatically between semesters in some instances (such as the TASO TB/HIV grant in Uganda which moved from a C rating in Jan-Jun 2018 to a B2 rating in Jun-Dec 2018 to a B1 rating in Jan-Jun 2019 to an A1 rating in Jun-Dec 2019), although there are no clear trends to discern across all countries.

Annex Figure 6.1: Frequency of grant ratings by semester for all grants in PCE countries



Disbursements

According to the Operational Policy Note on Annual Funding Decisions and Disbursements, the annual funding amount should be based on: (a) an indicative annual funding range based on the indicator rating; (b) the rate of expenditure/absorption; and (c) the presence of grant management issues. Table 1.2 sets out how the indicator rating is used to derive an annual funding range, with a clear link between indicator performance and the proportion of the budget to be disbursed in the following reporting period.

Annex Table 6.2: Use of indicator ratings to determine the indicative funding range

Indicator rating	Target achievement	Indicative funding range
a1	>100%	Between 90-100% of Cumulative Budget through the next reporting period
a2	90-100%	
b1	60-89%	Between 60-89% of Cumulative Budget through the next reporting period
b2	30-59%	Between 30-59% of Cumulative Budget through the next reporting period
c	<30%	To be discussed individually

As shown in Table 1.3, in the vast majority of instances where a grant attained an indicator rating of b1 or b2 at the end of 2018, the level of funding disbursed in 2018 and 2019 exceeded the indicative funding range, often dramatically. As such, the indicative funding range does not appear to have influenced the annual funding decision and level of disbursements made. Rather, evidence suggests that disbursement decisions are made by Country Teams primarily based on financial needs, and possibly also qualitative information on performance.

Analysis suggests that this may be appropriate given that indicator performance is often not a good proxy for what grants have implemented and achieved. It can also be reasonable not to reduce funding to poorly performing grants after only a year of implementation. As such, the utility of the indicator rating and how this is used to incentivize performance is unclear.

There are two important caveats to this analysis:

- The budgets used for this analysis are as at the grant award, and could have changed by the time (i.e., after the end of 2018) the annual funding decision was made.
- The indicative funding ranges are designed to serve as a "starting point" for the Country

Team in determining the annual funding amount, and there may be valid reasons for disbursing outside these ranges. We would nonetheless expect the analysis to show some pattern between the indicator rating and the level of disbursements made.

Annex Table 6.3: Actual % of budget disbursed in 2018-19 compared to indicative funding range for 2018-19, based on the indicator rating at end-2018

Grant	Indicator rating (end-2018)	Indicative funding range for 2018-19 budget	Actual % of budget disbursed (2018-19)
KHM-C-MEF	**b1**	60-89%	105%
MOZ-C-CCS	**b2**	30-59%	92%
MOZ-H-FDC	**b1**	60-89%	128%
MOZ-H-MOH	**a2**	90-100%	61%
MOZ-M-MOH	**a2**	90-100%	62%
MOZ-M-WV	**a1**	90-100%	93%
MOZ-T-MOH	**b1**	60-89%	76%
MMR-H-UNOPS	**b1**	60-89%	83%
MMR-T-SCF	**a2**	90-100%	92%
MMR-H-SCF	**a1**	90-100%	93%
MMR-T-UNOPS	**b1**	60-89%	84%
SDN-H-UNDP	**b1**	60-89%	113%
SDN-T-UNDP	**b1**	60-89%	120%
SDN-M-MOH	**b1**	60-89%	107%
UGA-H-MoFPED	**b1**	60-89%	98%
UGA-T-MoFPED	**a2**	90-100%	110%
UGA-C-TASO	**b2**	30-59%	144%
UGA-M-MoFPED	**b1**	60-89%	165%
UGA-M-TASO	**b1**	60-89%	163%
SEN-Z-MOH	**b2**	30-59%	117%
SEN-H-ANCS	**a1**	90-100%	106%
SEN-H-CNLS	**b1**	60-89%	104%
SEN-M-PNLP	**b1**	60-89%	80%
GTM-T-MSPAS	**b1**	60-89%	310%
GTM-M-MSPAS	**b1**	60-89%	147%
COD-H-MOH	**b1**	60-89%	93%
COD-C-CORDAID	**b1**	60-89%	119%
COD-M-SANRU	**a2**	90-100%	93%
COD-M-MOH	**a2**	90-100%	99%
COD-T-MOH	**b1**	60-89%	99%