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Global Fund Prospective Country Evaluation

2020 SYNTHESIS REPORT

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Acronyms and Abbreviations

AEM	AIDS Epidemic Model	NCHADS	National Centre for HIV/AIDS, Dermatology and STD
AGYW	Adolescent girls and young women	NHA	National Health Account
AIM	AIDS Impact Model	OIG	Office of the Inspector General
ART	Antiretroviral therapy	PAAR	Prioritized Above Allocation Request
CCM	Country Coordinating Mechanism	PALT	Tuberculosis Acceleration Plan
CEP	Country Evaluation Partner	PBF	Performance-Based Financing
CHW	Community health worker	PCE	Prospective Country Evaluation
CRG	Global Fund Communities, Rights, and Gender Team	PLHIV	People living with HIV
CT	Country Team	PPM	Pooled procurement mechanism
DHIS2	District Health Information System 2	PQR	Price and quality reporting
DHS	Demographic and Health Surveys	PR	Principal Recipient
DRC	Democratic Republic of Congo	PrEP	Pre-exposure prophylaxis
GAC	Grant Approvals Committee	PSM	Procurement and supply chain management
GEP	Global Evaluation Partner	PU/DR	Progress update and disbursement request
GMD	Grant Management Division	PWID	People who inject drugs
HMIS	Health Management Information System	RAI2E	Regional Artemisinin-resistance Initiative 2 Elimination Program
HRH	Human resources for health	RDT	Rapid diagnostic test
HSM	Health system modeling	RSSH	Resilient and sustainable systems for health
iCCM	Integrated community case management	SARA	Service availability and readiness assessment
IDP	Internally displaced people	SC	Global Fund Strategy Committee
IHME	Institute for Health Metrics and Evaluation	SO	Strategic Objectives
IPT	Isoniazid preventive therapy	SR	Sub-recipient
IPTp	Intermittent preventive treatment (in pregnancy)	STC	Sustainability, transition, and co-financing
KP	Key population	TERG	Technical Evaluation Reference Group
LFA	Local Fund Agent	TRP	Technical Review Panel
LIC	Low-income country	UCSF	University of California, San Francisco
LLIN	Long-lasting insecticide-treated net	UNAIDS	Joint United Nations Programme on HIV/AIDS
LMIC	Lower-middle income country	UNDP	United Nations Development Programme
M&E	Monitoring and evaluation	UQD	Register of Unfunded Quality Demand
MDR-TB	Multidrug-resistant tuberculosis	VfM	Value for Money
MECA	Monitoring, Evaluation, and Country Analysis Team	WHO	World Health Organization
MMS	Multi Month Scripting		
MOH	Ministry of Health		
MSM	Men who have sex with men		

Executive Summary

Introduction

In 2019, the PCE focused on evaluating the progress and analyzing impact thus far of Global Fund grants funded under the 2017-2019 allocation and implemented during 2018-2019. In this report, we present our synthesis of findings from eight PCE countries during the 2018-2019 grant implementation period (Cambodia, DRC, Guatemala, Mozambique, Myanmar, Senegal, Sudan and Uganda). This report presents synthesis findings in three main results chapters, structured around three of the four Global Fund Strategic Objectives: Chapter 2 on grant implementation and contribution to disease impact (SO1); Chapter 3 on grant contribution to national RSSH outcomes (SO2); and Chapter 4 on grant contribution to national program key population, human rights and gender-related outcomes (SO3).

Two supplementary chapters end the report. Chapter 5 presents findings on the role the PCE has played at the country and global levels, including the way recommendations and other inputs have been used by national program and grant managers and the inputs the PCE has made to Strategy Committee and Secretariat decisions and processes at the Global Fund Secretariat. Finally, each chapter also contains a set of key findings and associated recommendations, which are presented again in summary form in Chapter 6. In this Executive Summary, we present key findings accompanied by recommendations from each chapter.

Progress against AIDS, TB and malaria epidemic impact and service delivery goals, 2000-2018 (SO1)

The Global Fund, its partners and national programs contributed to dramatic declines in incidence and mortality from HIV, TB and malaria in all eight PCE countries. HIV, TB and malaria incidence and mortality declined in almost all PCE countries from 2010 to 2018, although progress was slower for TB than for HIV and malaria. Declines in incidence and mortality coincided with the simultaneous scale-up of key services from 2000-2018. The Global Fund was one of the primary financiers of this key service expansion for all PCE countries and made essential contributions to improvements in health outcome and impact measures.

2018-19 grant implementation progress and contribution to country outcomes (SO1)

Grant absorption: Financial absorption was generally on track compared to previous grants and increased substantially in the first semester of 2019, but many grants were still not meeting capacity targets for financial absorption. Absorption varied substantially between modules and was particularly low among key population and RSSH modules. Absorption alone represents only a partial picture of the progress made by grant recipients. Commitments and obligations (already confirmed in each grant) indicate that grant absorption will likely advance in the second half of the grant implementation period, and financial absorption alone does not reflect how well grants and programs are achieving outcomes.

Business model factors contributing to grant implementation progress: In addition to country contextual factors, complex, input-based budgeting and other challenges with grant arrangements hindered implementation progress and absorption. Some trade-offs also emerged in grant implementation. The advantages of input-based budgeting in terms of up front control and risk management did not outweigh the complexity of subsequent adaptations to implementation plans during the course of the grant cycle. Similarly, while the transfer of Principal Recipients from international organizations to national ministries supports country ownership and sustainability, realizing these advantages was impeded by other governance issues, such as sub-national decentralization and varying subnational capacity to manage Global Fund resources.

Performance against service coverage targets: Service coverage performance varied widely across grants and diseases in PCE countries and across regions or key populations within countries. For HIV, while treatment, care and support targets were often met, achievement toward prevention targets was much lower. For TB, multi-drug resistance and TB/HIV activities

were poorly implemented and for malaria, while case management targets were close to being met, performance on vector control interventions was highly variable. Furthermore, absorption was only weakly correlated with target achievement, and existing monitoring mechanisms for tracking grant progress did not adequately capture much of the important implementation progress that has been made. Weaknesses in both absorption and performance indicators as a proxy for grant implementation, together with low use of work plan tracking measures, represent gaps in monitoring.

Value for money (VfM): Among the most important successes of grant implementation during 2018-2019, our analysis suggests that grants and national programs were generally delivering good and/or increasing value for money, particularly economy, efficiency and effectiveness. In terms of economy, unit prices of key commodities declined and often met reference prices; our efficiency analysis found a generally positive relationship between utilization of inputs and achievement of outputs at the national level especially for HIV and malaria; and health systems modelling showed certain grants and national programs were leading to improved outcomes. However, improvements in VfM were not universal. In particular, we identified weaker progress towards equity objectives than other elements of VfM. This was particularly marked in relation to subnational disparities in resource allocation and performance identified in many PCE countries.

Grant revisions: During 2018-2019, PRs implemented a substantial number of revisions to PCE grants in order to adjust investments during implementation. Revisions were largely aimed at increasing grant impact through reinvestment in priority interventions, focused on high burden geographies and populations and use of portfolio optimization. Revisions also reflected grant implementation challenges. Grant revision processes were often cumbersome and may have further delayed implementation. For similar reasons, countries rarely opted for differentiated program revisions based on material change. Where revisions were based on clear evidence and had an engaged, supportive and flexible Country Team, they were less burdensome.

Matching funds: Five PCE countries benefited from catalytic matching funds, incorporating a total of US\$67 million covering HIV human rights, key populations and gender, TB missing cases, and RSSH data systems. Our analysis suggests that matching funds contributed to expanding the potential impact of country allocations through increased Global Fund investment in strategic priority areas. However, it was difficult to quantify and measure the catalytic impact of these additional resources, particularly since limited guidance exists on how matching funds are expected to be catalytic. Further, we found limited evidence that matching funds resulted in the type of ambitious and innovative programming intended through this modality. In addition, some strategic priority areas supported by matching funds experienced weak budget absorption and underachievement of performance targets during the first 18 months due to implementation bottlenecks.

Global Fund contribution to RSSH objectives (S02)

Despite the Global Fund's significant advances in setting policy for investment in RSSH, our evidence suggests that these investments remain limited. Across the eight PCE countries, US\$164 million (8% of the total US\$2.1 billion) was allocated toward 'direct' RSSH investment, with a further US\$252 million tagged as 'contributory' RSSH investments.

Cumulative absorption of 'direct' RSSH investments improved over the first 18 months, but in most PCE countries absorption remained less than 50% across most RSSH modules. Progress in RSSH implementation was mixed, with generally higher performance among multiple RSSH modules in lower middle-income countries compared to low-income countries. Common drivers of weak RSSH absorption included complex country financial processes and the need for diverse stakeholder engagement, as well as poor planning and general coordination challenges with operationalizing RSSH. Some PCE countries saw evidence of grant savings being reinvested in RSSH through various revision mechanisms; however, the UQD appears underutilized for this purpose, despite most RSSH items on the UQD rated as 'high' priority by the TRP.

The Global Fund has made significant contributions to HMIS scale up, but improving data accuracy and data use for decisions will be the next frontier for HMIS strengthening. Likewise, while Global Fund policy emphasizes the importance of community responses and systems strengthening through integrated and 'horizontal' approaches, investments remain small and the impact limited.

Global Fund contribution to key population, human rights and gender objectives (SO3)

All PCE countries improved coverage of interventions to target key and high-risk populations, particularly in their HIV programs, with some variation in the proportion of targets achieved by country and by disease. However, even where targets were met, key population service coverage levels remain low in most PCE countries. Programs focus primarily on KP service coverage and outcome targets rather than specific interventions to reduce human rights or gender-related barriers and performance indicators were not stratified by sex and few captured gender-related barriers. Coverage of interventions to address human rights barriers to accessing services remains low but has an impact across the service continuum for all three diseases and in most PCE countries.¹

Grant implementation showed progress in 2019. The Global Fund promoted strategies to increase coverage and improve targeting of key populations at the subnational level. However, grant performance against equity objectives is weak compared to other areas of VfM. Facilitating factors included grant revisions, matching funds and use of more evidence-based approaches to allocating resources at the subnational level. Hindering factors included misaligned business model incentives, poor data on KPs, lack of performance indicators to track progress related to SO3 and limited expertise on how to address human rights and gender-based barriers, despite UNAIDS guidance.

Use of findings and added value of PCE platform

As the PCE has gained credibility with national programs and with the Global Fund secretariat, there have been increased opportunities to contribute timely evidence to inform process improvement and course corrections. Chapter six describes instances where the PCE platform and its findings have been used (1) by both the Global Fund and national disease programs to influence in-country course corrections; (2) to inform Secretariat thinking and Global Fund practice in countries; (3) as a platform to aid in other Global Fund M&E activities; and (4) to respond to requests from stakeholders, including on additional analyses not related to core PCE work.

Recommendations

1. Regarding consistently **low absorbing interventions**: The Grant Management Division (GMD) should revise budgeting processes such that they are lighter, more flexible and periodically updated throughout the grant cycle. This could include requiring a detailed budget for year 1 only, while allowing indicative budgets for years 2-3. Indicative budgets could later be converted to annual detailed budgets as part of the PR reporting and monitoring process. GMD should ensure that change management takes place throughout the Secretariat and Local Fund Agents to ensure alignment regarding any updates to budgeting guidance.
2. Regarding the **gap in monitoring of grant implementation**: Monitoring, Evaluation, and Country Analysis (MECA) Team should:
 - a. Develop and use operational performance measures, for example activity and output measures, that are fit-for-purpose without placing unnecessary burden on PRs;
 - b. Continue to encourage adoption of performance indicators from the new modular framework and monitor which indicators underutilized (and why).
3. Regarding **subnational variance in resource allocation and performance**: increase emphasis in grant implementation plans on subnational data use to address within-country disparities.

- a. Where applicable, the TRP should consider whether subnational resource allocation included in the funding request is equitable as well as efficient and effective.
 - b. CTs should encourage PRs to further utilize subnational data to identify disparities both within and between regions and build strategies into implementation plans that address these disparities including those that are already in place as part of National Strategic Plans.
 - c. The Global Fund should continue to encourage the collection of subnational data by country stakeholders and facilitate its increased use for implementation targeting.
4. Regarding **grant revisions**: GMD and MECA should:
 - a. Closely monitor the new key performance indicator: 80% of portfolio optimization to be completed within 3 months from the GAC awards.
 - b. Review average completion time for material program revisions and consider developing a performance indicator to assess the timeliness of the program revision process.
 - c. Promote consistent use of grant revision terminology in the Operational Policy Manual (Oct 2019) and all related grant management documents.
 - d. Include explicit guidance in the Operational Policy Manual that matching funds can be revised within the catalytic priority area with written Global Fund approval.
5. Regarding catalytic **matching funds investments**: The Strategy Committee (SC) should define and articulate a strategy for how matching funds are expected to catalyze greater investment and impact, including accompanying criteria for review and approval of matching funds.
 - a. GMD should consider mechanisms for incentivizing investment in the strategic priority areas that might be less administratively burdensome for the Global Fund Secretariat and countries, including allocation earmarks, for example.
 - b. Relevant Secretariat teams (e.g. RSSH, CRG, MECA, CTs etc.) should strengthen country guidance on how to design innovative and ambitious programming using matching funds to catalyze greater impact, which may include monitoring and evaluation guidance for assessing the catalytic role of the funding.
6. Regarding **limited investment and weak absorption of RSSH resources**:
 - a. Country applicants and the TRP (serving as a check) should ensure that RSSH investments are included in the main grant, as well as the PAAR, consistent with the Global Fund strategy.
 - b. GMD should consider pursuing options for operational performance measures specific to RSSH, beyond short-term absorption measures.
7. Regarding **sustainable grant management**: CTs should encourage longer-term RSSH investment in financial management systems. The RSSH team should work to develop more detailed guidance on how to strengthen financial management systems to help increase investment in this critical area.
8. Regarding the distinction between **contributory vs. direct RSSH**: The RSSH division should develop a more explicit and actionable system for prospectively classifying activities as “contributory” RSSH, involving country stakeholders in the design and conceptualization of contributory vs. direct investments.
9. Regarding **low service coverage**, particularly for key population services: in order to maximize impact, and to overcome bottlenecks stemming from human rights and gender based barriers to accessing services, Secretariat country teams and national stakeholders responsible for funding requests and grant design should assign more ambitious targets for prevention service coverage, as well as for interventions to reduce human rights and gender barriers, particularly in countries that have already achieved high levels of service coverage among some populations.

10. Regarding data related to KPs, human rights, and gender: Communities, Rights and Gender Team (CRG), MECA and GMD should work together to ensure PRs and national stakeholders have sufficient capacity and data systems in place to capture and use information on interventions that address human rights and gender barriers, including as proposed in UNAIDS guidance.

Chapter 1: Introduction

1.1 Background and objectives

The Prospective Country Evaluation (PCE) is a multi-year prospective evaluation that aims to provide detailed insights into the Global Fund business model and how it contributes to impact in eight countries. The countries in which the PCE operates, 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 present an array of different disease epidemics, geographies, development status and Global Fund support (Table 1).

The PCE collects information across a variety of sources, and through analysis and data triangulation generates independent and timely evidence, supporting policy and program improvements that accelerate progress toward meeting the Global Fund's Strategic Objectives (SOs). Data collection is carried out by country-based teams comprised mainly of nationals from that country.

Each year, the PCE synthesizes country findings to present a more comprehensive assessment of the Global Fund business model. These results are presented to the Global Fund's Technical Evaluation Reference Group (TERG) who then provide highlights to the Strategy Committee for review. In 2017, during year one of the PCE, the evaluation teams focused on the funding request and grant making process for the 2017-2019 allocation period. Year two of the PCE (2018) shifted to examine early grant implementation and how the business model facilitated and/or hindered program achievement during the first six months of the grants. In addition, several thematic areas and Global Fund principles were addressed in each of our prior reports. These topics include country ownership, partnership, transition, co-financing, resilient and sustainable systems for health (RSSH), gender, human rights, and key and vulnerable populations among others. The 2019 report picks-up on many of these themes, following the grants in a prospective manner through the second year of grant implementation (except for Guatemala where the new malaria and TB grants launched during 2019). This year we have also focused particularly on independent validation of Global Fund value for money as well as implementation of various grant revision processes.

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 Congo (DRC), Guatemala, Senegal and Uganda. Prior to 2019, Mozambique and Senegal were supported by Johns Hopkins University.

Table 1. PCE Portfolio Characteristics (USD)

PCE Country	CAM	DRC	GTM	MOZ	MYN	SEN	SDN	UGA	Total
High Impact Portfolio	X	X		X	X			X	5
Core Portfolio			X			X	X		3
COE		X					X		2
Matching funds eligible	NA	\$16.0	NA	\$19.7	\$19.3	\$2.5	NA	\$9.4	\$66.9
Finalized grant budgets signed for the 2017-2019 allocation period (6) USD, millions									Total
HIV		\$ 23.9	\$ 19.6	\$ 282.5	\$ 130.0	\$ 24.5	\$ 15.4	\$ 248.2	\$ 738.9
TB		\$ 18.7	\$ 12.3	\$ 41.9	\$ 94.0	\$ 12.2	\$ 12.3	\$ 18.4	\$ 209.8
TB/HIV	\$ 55.4	\$ 149.7		\$ 30.3				\$ 21.1	\$ 256.5
Malaria	\$ 42.8*	\$ 350.6	\$ 6.3	\$ 167.9	\$ 84.6*	\$ 36.3	\$ 100.8	\$ 190.3	\$ 979.6
Total	\$ 98.2	\$ 542.9	\$ 38.2	\$ 522.6	\$ 308.6	\$ 73.1	\$ 128.4	\$ 478.0	\$ 2,184.8

*Managed as part of Regional Artemisinin-resistance Initiative (RAI)

1.2 Global Fund investments and progress towards AIDS, TB and malaria impact goals in PCE countries

The Global Fund has been one of the primary financiers of HIV, TB and malaria service expansion for all PCE countries since it was launched in 2002. Since its founding, the Global Fund has disbursed a total of US\$6.5 billion to the 8 PCE countries (2). Global Fund investments accounted for 35% of total development assistance for HIV, TB and malaria between 2010 and 2018 in PCE countries (3). By disease, the Global Fund has contributed 24% of all HIV external assistance, 52% of all TB external assistance and 54% of all malaria external assistance to PCE countries during this time. Aligned to the Global Fund's gap filling mandate, this fulfilled a wide range of purposes, including the scale up of prevention, testing, treatment, care and support interventions across all three diseases. In addition, Global Fund RSSH investments in PCE countries increased over this period, from US\$47.5M in 2010 to US\$104.4M in 2017(3).

Through these investments, the Global Fund and its partners contributed to dramatic declines in incidence and mortality from HIV, TB and malaria since 2002, reporting more than 32 million lives saved since inception¹. Corresponding to expansive scale-up of health services, all eight PCE countries experiences declines in HIV and malaria incidence from 2010-2018, with some countries experiencing annual rates of decline that exceed global trends. Improvements in TB incidence have generally been more muted, particularly in Guatemala, Mozambique and Senegal where incidence fell by less than 1% annually during the same time period. Similarly, declines in mortality from the three diseases have been noted in nearly all cases (the exception being HIV in Sudan). Despite such widespread progress, the current rates of decline in incidence and mortality will not be sufficient to meet 2030 global elimination goals across all Global Fund supported countries (1).

1.3 PCE 2019

In 2019, the PCE focused on evaluating grant progress through the first two years of grant implementation. Chapter 2 examines grant implementation, with a particular focus on absorption and performance measures through the first 18 months. This section also addresses key issues identified in the 2018-19 synthesis report, including low absorption and several notable delays in grant implementation. We assess if there has been a concentrated and successful effort to "catch up." This includes a closer examination of grant revisions and matching funds, and the way

¹ <https://www.theglobalfund.org/en/news/2019-09-19-global-fund-partnership-has-saved-32-million-lives/>

in which these investments may be leading to enhanced impact. More importantly, we also identify key hindering and helping factors related to the Global Fund business model as it pertains to grant implementation through the midpoint of the grant cycle. Lastly, we examine current investments through a value for money (VfM) lens, with a particular eye towards economy, efficiency and effectiveness in this chapter.

Chapter 3 focuses on Strategic Objective 2, building resilient and sustainable systems for health (RSSH). The report examines how grant investments in RSSH are contributing to national program outcomes and achievement of the Global Fund strategy. Particular attention is paid to challenges with operationalization of RSSH activities, which is directly related to previously noted issues around absorption. We also explore the intersection of RSSH activities and portfolio optimization as it pertains to RSSH activities being selected from the Register of Unfunded Quality Demand (UQD). Finally, we take an in-depth exploration of two RSSH investments, community response and health management information systems (HMIS), elucidating how the business model both encourages and discourages these investments.

Similarly, Chapter 4 concentrates on Strategic Objective 3, promoting and protecting human rights and gender equality. Here, we take a closer look at how grant investments in key population, human rights and gender interventions contributed to national program outcomes and achievement of the Global Fund Strategy through vignettes and cross-country analyses of the current grants. We again examine helping and hindering factors related to absorption and grant implementation, zooming in on key population, human rights and gender activities.

Each chapter includes a summary of key findings and associated recommendations. The PCE is aware that some recommendations may already be under consideration by teams within the Global Fund Secretariat. In such cases, recommendations should be seen as supportive of those efforts, and not necessarily critical of them.

1.4 Added value of the PCE

Chapter 5 presents the results of our research work in 2019, including how the PCE has contributed at the national and global level. The PCE has now become embedded to varying degrees within the Global Fund architecture in the respective countries: country partners are invited to key meetings and have built strong relationships with CCMs and other key stakeholders, including with national programs. In addition, the PCE GEPs have fostered strong relationships with the TERG through their work to support countries and through ad hoc inputs as requested for TERG engagement with the Strategy Committee. The PCE continues to build engagement amongst key Secretariat policy and grant management teams as a source of up to date information and illustrations of the realities of grant implementation across a range of country contexts.

1.5 Methods

Each GEP/CEP team employed methods appropriate to the data and expertise available (for more information on consortium and country-specific methods, please refer to the annual country reports). Briefly, each country tailored its analysis of the indicators embedded in the results chains based on an analysis of Global Fund grant investments, activities and the priorities of national stakeholders. The consortia relied on existing and/or modeled secondary data from National Health Accounts (NHAs), routine health management information systems (HMIS), retrospective surveys such as Demographic and Health Surveys (DHS) and Service Availability and Readiness Assessments (SARA), and modeling such as Spectrum/AIDS Impact model (AIM).

Analysis of retrospective sources provided context and trends, while routine data provided early indications of program outputs from the current Global Fund grant period. This year's report features new analyses using a health system modeling (HSM) approach. This analytic strategy examines how Global Fund inputs contribute to national program outputs, and how these outputs then lead to impact. HSM was used in several cases where sufficient data was available.

The process evaluation relied primarily on grant tracking, including process tracking through document review, meeting observations, key informant interviews, root cause analysis and contribution analysis. These methods were used to ascertain what, when and how efficiently grants were being operationalized, the extent to which the Global Fund business model was helping or hindering grant implementation, and the ways in which grants contributed to national program outcomes and Global Fund strategic objectives (SO1-3). We triangulated and cross-checked data from various sources within countries. Employing all data and analyses above, we explored and synthesized information on the associations between processes and outputs as well as expected outcomes and impacts. SO4 was not a core focus of PCE work in 2019, principally because little information was available on domestic resources, which would have been the main data source at the country level for the PCE. During 2020, SO4, including work to promote sustainability and increase domestic resources, will be a priority area of work for the PCE and we anticipate that more data will be available through the funding request process for the new grants.

Chapter 2: 2018-19 grant implementation progress and contribution to country outcomes (SO1)

The Global Fund contributes to national program impact through making financial grants to support program actors and activities. To understand how Global Fund grants contributed to program outcomes in 2018-2019, the PCE assessed how, and how well, grants were implemented through their first 18 months, by analyzing expenditure of funds against planned budgets and target achievement (January 2018–June 2019) and factors that helped or hindered success. Sub-sections of this chapter focus on six priority areas of grant implementation in detail (as agreed upon with the TERG): (I) factors affecting grant expenditure and absorption against budgets; (II) business model factors contributing to grant implementation performance; (III) performance against service coverage targets; (IV) the value for money of current grants; (V) midterm revisions to the current grants; and (VI) the use of matching funds to incentivize program expenditure on priority areas.

2.1 Grant absorption during 2018-2019

Key messages:

- Financial absorption was generally on track compared to previous grants.
- Although absorption has generally accelerated compared to the early implementation period, grants were falling short of financial absorption targets for some modules.
- Absorption alone serves as a weak proxy for measuring implementation progress.

Absorption increased in the most recent reporting period, with certain disease areas showing more improvement than others. For example, RSSH interventions increased from an average absorption rate of 20% over the first 12 months of the grants to 54% after 18 months of

implementation, and TB interventions (overall) have improved from 33% to 64%. HIV interventions increased from 46% to 70%, and malaria from 47% to 52%. Although, 18-month absorption rates often did not meet absorptive capacity targets of 75%(4) (mean absorption: 61%), they were similar to absorption levels at this point in previous grants from PCE countries. Absorption for RSSH interventions was weakest compared to historical levels (54% in current PCE grants vs 76% in previous grants), while HIV (70% vs 73%), TB (64% vs 60%) and malaria (52% vs 55%) were closer to historical levels of absorption.

Variance in absorption rates at the modular level is more pronounced, providing greater insight into those areas of grants where spending can present challenges. Module-level absorption ranged from 3% to 241% across all grants, in comparison to grant-level absorption, which ranged from 27%-81%². Our analysis suggests that there were some common patterns among those program areas that continued to have low absorption after 18 months. More specifically:

- **HIV:** Among HIV prevention modules, “Prevention programs for the general population” has the largest budget, when all countries are pooled together, and the lowest expenditure of HIV prevention modules (US\$512,776/\$20,037,622 or 3% absorption). Uganda had the largest investment in this module, with a planned budget of US\$18.8 million, but by June 2019 had spent minimally (US\$8,000), which is largely explained by procurement challenges for condom dispensers and delays related to the planned shift in lubricants from the government PR to the civil society PR. At the time of reporting, many HIV prevention activities were ongoing in Uganda, but not yet reflected in the latest PU/DR. If Uganda is excluded from this analysis, the total expenditure was US\$504,554, or a 42% absorption rate.
- **HIV:** The module “preventing human rights-related barriers to HIV services” had low absorption across all countries. Out of seven countries that included this module in their grants, five had absorption performance below 50% (Figure 1).
- **TB:** TB modules had the least-variable absorption when pooling all PCE grants, ranging from 38% absorption of MDR-TB modules to 68% absorption of TB/HIV modules (those embedded within TB grants). For comparison, HIV modules ranged from 2% to 80% and malaria modules ranged from 17% to 82% when pooling grants.
- **Malaria:** Although vector control had the largest overall budget of the malaria modules (US\$277 million), it reported an average absorption below 50% when pooled across all PCE countries. Some smaller interventions, like “Specific prevention interventions” (original budget US\$4 million, absorption 82%) reported higher absorption numbers.
- **RSSH:** “Health Management Information Systems and Monitoring & Evaluation” was the most commonly-budgeted RSSH module among PCE grants, and had the highest cumulative investment of all RSSH modules (US\$32 million, or 47% of all RSSH funding), which points to a promising national-level investment in information systems. However, absorption for this module was mixed, with variability between grants. “Financial systems” had much less investment across the PCE portfolio (4% of RSSH funding, or US\$3 million), despite being a common hindering factor for grant implementation. Although financial systems had limited investment, absorption for this module is strong, at 91% over the first eighteen months of implementation. Another RSSH module with limited

² Within individual grants, absorption for a single module can range from 0% to above 500%. Observations that had over 500% absorption are normally caused by budget revisions, where a large amount of money has been added to the budget for a single module. For detailed information, see annex 9.

investment across the PCE portfolio has been “Community responses and systems”, with 3% of all RSSH investment, or US\$1.7 million, but again high absorption exceeding 100%.

- **Program management:** Absorption was high across almost all grants, with six countries reporting absorption above 75%, and two countries reporting absorption between 50-75% (Figure 1). We examined whether larger investments in program management contributed to higher overall grant absorption but found no association between the percentage of budget allocated to program management and grant absorption ratio during the first 18 months of grant implementation (Annex 4).

Figure 1. Grant absorption by module for PCE countries, January 2018 - June 2019



However, absorption of funds only represents a partial picture of the important progress made by grant recipients. Analysis of commitments and obligations (already confirmed in each grant) showed that grants are likely to advance in the second half of the grant window, although this was not reflected in available absorption numbers. Additionally, as reported in the 2018-19 PCE Synthesis report (5), many key services often continue despite lower grant spending than planned (e.g., interventions delivered through the public health system by national programs such as facility-based case management). Furthermore, when absorption is high, it alone offers little insight into whether implementation progress was successful (i.e. whether outcomes are being achieved). Nevertheless, there are significant opportunity costs associated with the low levels of overall absorption across grants, which has meant that a total of US\$538 million went unspent in the first 18 months of grant implementation³.

³ This does not include data from the Guatemala grants, which is on a different grant cycle timeline.

2.2 Business model factors contributing to grant implementation progress and absorption

Key messages:

- In addition to country contextual factors, complex, input-based budgeting, delays in setting up implementation arrangements, reporting challenges at various levels, and misalignment of Global Fund disbursements with country budget processes or timelines hindered grant progress and absorption.
- Some trade-offs also emerged in grant implementation, including:
 - The need to balance the advantages of input-based budgeting in terms of up--front control and financial risk management with the challenge of monitoring progress and making necessary adaptations to implementation plans mid grant.
 - The transfer of Principal Recipients from international organizations to national ministries supports ownership and sustainability but is complicated by sub-national decentralization and capacity to manage Global Fund funds.

Country facilitating factors for grant implementation included enabling environments characterized by strong ownership and leadership from the government, effective partnerships arrangements and rigorous strategic planning processes. In addition, PR/SR implementation arrangements that supported implementation progress included decentralization and autonomy, SRs with Global Fund experience and technical and managerial expertise. In contrast, common country contextual factors that posed barriers included: complex administrative and regulatory arrangements; cumbersome procurement processes; weak financial management capacity and improper use of financial procedures; and coordination challenges such as leadership turnover, lack of harmonization and transparency of other donors and insufficient communication between all levels. Challenging operating environments also led to weak coordination (DRC) and service interruptions (see Sudan vignette below).

Several Global Fund business model factors also contributed to successes and challenges with grant absorption and implementation. A full list of the Global Fund business model factors and country contextual factors that helped or hindered grant absorption and implementation are presented in Annex 1. As reported by the PCE in 2018, delays in setting up grant arrangements caused significant implementation setbacks affecting grant absorption. Consequences of those delays continued to play out in 2019. For example, slower implementation generated savings and/or unspent balances that necessitated program revisions. While the flexibility to reallocate resources is expected to facilitate absorption, we did not find evidence of an association between the number of grant revisions and absorption. However, it may be too early to detect an improvement in absorption since most revisions were conducted in Q1 of 2019 (more details in Section 3.5). Other business model factors hindering absorption and grant implementation included reporting challenges at various levels (e.g., between disease PRs, Principal Recipients and Sub-recipients (SRs), and government and civil society PR/SRs) and erratic disbursement of Global Fund funds not aligned with country budget processes or timelines.

In some settings, for example Sudan, the balance between strong risk management controls and grant operational flexibility did not facilitate implementation. Business model factors that facilitated absorption and grant implementation included effective progress review processes with strong country team engagement in addition to grant management flexibilities. Some of these factors are discussed in greater detail in the following sections.

Vignette: In Sudan, already classified as a COE by the Global Fund, several short- and long-term political problems during 2018-19 created a less favorable environment for grant implementation, including: ongoing instability on international borders and large populations of refugees and internally displaced people (IDP); a 30-year military dictatorship under comprehensive UN sanctions; economic stagnation and fuel/cash shortages in 2018; and violent political upheavals throughout much of 2019. In this context, the National AIDS Program received relatively low priority from national stakeholders and Global Fund grants faced high risks. The Global Fund classified Sudan as both a High Impact Portfolio and COE, due to the fragilities and challenges faced by the country. As High Impact Portfolio, the country team was already provided with a differentiated and adaptive management approach and the COE policy was less relevant. In 2018, when Sudan was reclassified as a Core Portfolio, the country team engaged with the COE support team to explore adaptive and flexible approaches. Also in 2018, an OIG Review Report uncovered significant financial irregularities at both the PR (UNDP) and main SR (MOH). As a result, grant managers were unable to take advantage of COE-focused flexibilities or revisions. Amongst national stakeholders, additional safeguarding policies reduced ownership of and engagement in grant activities. In addition, the newly established Secretariat Country Team was significantly under-resourced and unable to visit Sudan from January 2018 to June 2019 due to security concerns.

Input-based budgeting may lower financial risk, but is less flexible and responsive to implementation realities. Extensive time and effort go into developing and negotiating highly granular three-year grant budgets. As reported previously, the grant-making process lasted on average 3.6 months in PCE countries (5). Grant budgets often provide comprehensive details on activity implementation in the absence of operational plans and, while financial risks may be better managed by Global Fund as a result, the process is cumbersome and inefficient considering the continuously changing implementation contexts. Greater flexibility might allow for changes in governance, epidemics, the security situation, etc. Interpreting, tracking and overseeing the intricacies of grant budgeting requires specialist knowledge. The Senegal Country Team (CT), for example, is heavily engaged in managing grant revisions because the CCM (Country Coordinating Mechanism) has had challenges with tracking grant budgets at the granular level necessary. Although procedures exist for grant revisions (as discussed Section 3.5), they are not agile processes and therefore inefficient solutions to dealing with rigid grant budgets.

The transfer of Principal Recipients from international organizations to national ministries supports ownership and sustainability but it is complicated by sub-national decentralization and capacity to manage Global Fund funds. The transfer of PR responsibilities to national programs and national systems in Mozambique, Sudan, DRC and Senegal created absorption trade-offs during grant implementation. In Mozambique, Senegal and DRC, the new implementation arrangements included decentralization of financial disbursement from Ministry of Health (MOH) PRs to Provincial Health Departments as SRs. However, government SRs struggled with knowledge and capacity to manage Global Fund funds. Weak financial management capacity impacted disbursements and service provision. Limited investment in this area could explain the poor performance; only 0-3% of the 2018-20 grants RSSH budgets in PCE countries were allocated to financial management (apart from Myanmar at 22%). Ineffective financial management capacity building is another contributor. In Sudan, capacity problems in advance of the transition of the HIV grant from the United Nations Development Programme (UNDP) to the MOH were poorly addressed. Meanwhile, other Global Fund mechanisms for reinforcing financial capacity, such as expanding the capacity building role of fiscal agents and leveraging Global Fund partners to provide technical support during grant implementation, have yet to demonstrate significant gains. By contrast, in Cambodia in 2018, the PR was transferred from the MOH to the

Ministry of Finance. While this led to some delays to grant initiation, after 2 years, we found evidence of increased ownership of the HIV and TB programs by the government overall.

Interestingly, despite perceptions that commoditization and budget revisions led to high levels of grant absorption, neither was found to be the case. The PCE found that the proportion of a grant allocated to commodity-based cost groupings appears to be unrelated to the level of absorption achieved through 18 months. As shown in Annex 7, budget variance, or the difference between the original grant budget and the budget later reported in PUDRs, does not appear to consistently precede higher levels of absorption. Finally, the PCE found that program management allocation was too variable and too confounded by other factors to be linked conclusively with absorption (see Annex 4).

Recommendation:

1. Regarding consistently **low absorbing interventions**: The Grant Management Division should revise budgeting processes such that they are lighter, more flexible and periodically updated throughout the grant cycle. This could include requiring a detailed budget for year 1 only, while allowing indicative budgets for years 2-3. Indicative budgets could later be converted to annual detailed budgets as part of the PR reporting and monitoring process. GMD should ensure that change management takes place throughout the Secretariat and Local Fund Agents to ensure alignment regarding any updates to budgeting guidance.

2.3 Performance against service coverage targets

Key messages:

- PCE countries showed little consistency regarding which targets were achieved, exceeded or under-achieved.
- Existing monitoring mechanisms for tracking grant progress did not adequately capture much of the important implementation progress that had been made. Weaknesses in both absorption and performance indicators as a proxy for grant implementation resulted in important gaps in grant monitoring.

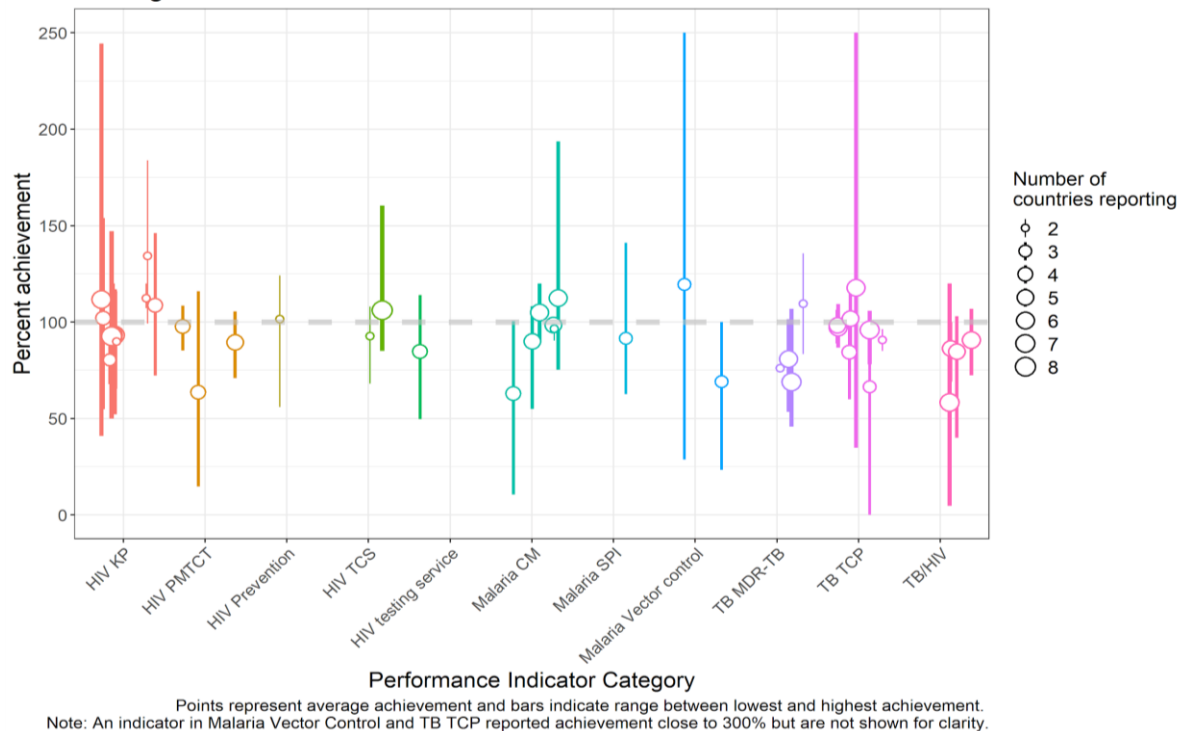
Performance against service coverage targets varied widely between disease program areas. Figure 2 shows reported performance against service coverage targets for the current Global Fund grants using indicators shared between at least two or more countries. In the figure, an achievement percentage of 100 reflects that the Global Fund target was fully achieved. Key points to note are as follows:

- **HIV**: While targets for coverage of treatment, care and support interventions were often met, performance against targets for PMTCT service coverage was much lower. Performance against targets for key population (KP)-related services were highly variable. More KP-related indicators were below target and there was less variation between countries.
- **TB**: While treatment, care and prevention targets were mostly met, most multi-drug resistant tuberculosis (MDR-TB) indicators fell short of targets, albeit often coming close. Each group of TB indicators includes several grants that fell short of their targets, often inconsistently.
- **TB/HIV**: Service coverage for TB/HIV interventions was mostly well below target.

- **Malaria:** Many case management targets were close to being met, although performance against targets for vector control interventions were highly variable across countries.

For additional details on performance indicators, see Annexes 5 and 6. For additional details on HIV KP indicators, see Chapter 4.1.

Figure 2. Achievement of performance framework targets by module among coverage indicators



While absorption is often used as a proxy measure for grant implementation, our analysis found that absorption appeared to have little correlation with target achievement. Among performance indicators that most closely match with budget modules (about 20% of PCE indicators or 113 unique indicator-budget pairs), the modules with the highest absorption did not consistently report higher performance (see Annex 5 for additional details on methodology). In fact, we found a slight negative association ($r=-0.088$) since target performance was lower among some modules with higher absorption.⁴ Some modules did have both low absorption and low target achievement, such as the vector control absorption and the number of LLINs distributed in Uganda, which was explained by a shift in timing of LLIN procurement and supply chain management (PSM) costs; however, activities are now on track with nets procured in October 2019 and distribution anticipated for March 2020; or MDR-TB absorption and the number of MDR-TB cases notified and treated in DRC. Likewise, some modules had both high absorption and high target achievement, such as HIV prevention in DRC. However, the correlation was not consistent across all data⁵; Stratifying by disease, country, and module category did not meaningfully change the association.

Although absorption is understood to be an incomplete picture of grant progress, this analysis suggests that performance indicators are not themselves particularly useful to track grant progress since they mainly apply to national disease programs rather than specifically to grant inputs. Achievement of most grant targets therefore influenced by multiple funding sources—

⁴ This correlation was not statistically significant ($p=0.36$)

⁵ It was common for modules with absorption between 25% and 75% to be meeting or close to meeting all of their targets.

both international and domestic—as reported in the 2018-19 PCE synthesis report (5). Weak alignment between performance indicators and absorption was discussed in the 2015-2017 grants at the 41st Global Fund Board Meeting in May 2019 (4), but PCE analysis suggests that it continued during the current grant period and renders monitoring of ongoing implementation challenging. Although Work Plan Tracking Measures (WPTMs) help track progress against some grant activities, only 35% of grants in PCE countries used them, as reported on the first semester of 2019 PU/DRs.

Recommendation:

2. Regarding the **gap in monitoring of grant implementation**: Monitoring, Evaluation, and Country Analysis (MECA) Team should:
 - b. Develop and use operational performance measures, for example activity and output measures, that are fit-for-purpose without placing unnecessary burden on PRs;
 - c. Continue to encourage adoption of performance indicators from the new modular framework and monitor which indicators underutilized (and why).

2.4 Value for Money

Key messages:

- Among the most important successes in grant implementation, our analysis suggests that grants and national programs are generally delivering good and/or increasing value for money (VfM) but improvements in VfM have not been universal and there are clear trade offs between efficiency and equity.

Economy: The PCE has observed that unit prices were mostly declining, and they often met or were below reference prices. Procurement arrangements in the PCE countries were highly varied, with mixed effects on procurement pricing. In Uganda, for example, the use of a local supplier for some doses of ARVs created an estimated increase in pricing (19); in some countries, however, voluntary pooled procurement has led to lower prices (20). Our analysis of prices paid for commodities with Global Fund resources shows that unit costs decreased substantially over time for most commodities (56% of commodities decreased in price in available data). However, price declines were not universal; 23% of commodities increased in price over the period of data (21% had roughly no change). Our more in--depth analysis into antiretroviral medications (ARVs) demonstrated that, despite some variance between commodities and countries, the prices paid were generally at or below the pooled procurement mechanism (PPM) reference prices published by the Global Fund. Annex 10 provides more information.

Efficiency: PCE health systems modelling and wider analysis found a generally positive and improving relationship between the utilization of inputs and achievement of outputs at the national level. This was particularly notable for HIV and malaria. More specifically:

Allocative efficiency: Our analysis presented in the 2018-19 PCE Synthesis Report showed that the Secretariat's proposed budget allocations between disease components were generally accepted without revision.⁶ The proposed allocations were derived from the 2017-19 Allocation Methodology which sought to ensure resources were allocated appropriately to maximize impact between countries and diseases based on disease burden, country capacity and total resource

⁶ Budget for RSSH activities were, however, taken from those diseases which stakeholders perceived to be over funded compared to others (e.g. malaria in Cambodia, Myanmar and Sudan).

availability, in line with the objectives of the 2017-2022 Strategy (21). The 2018-19 PCE Synthesis Report also found that decisions on the allocation of resources between interventions, geographies and population groups were evidence-based in most settings, including through the use of modelling. However, the extent to which these decisions informed ultimate resource allocation is less clear in some instances (such as in Sudan, Guatemala and Mozambique, where political decisions seemed to override cost-effectiveness considerations when allocating between states and regions). In addition, basing decisions on outdated and/or poor quality data had implications, such as in Myanmar where new prevalence survey data prompted an emergency reallocation of resources. Country reports in these countries provide more details on these observations.

Technical efficiency: PCE analysis, including through the use of health system modelling, shows that the cost per HIV and malaria output (which includes the cost of procurement, fees, transportation and service provision) generally declined over time, while the opposite was observed for TB (although not universally). For example, health systems modelling in DRC estimates that it cost US\$9.95 on average to procure and ship one LLIN during the period 2010-18. The model similarly estimates an average cost of US\$3.04 per rapid diagnostic test (RDT) and US\$1.56 per ACT procured and shipped. These estimates show a declining overall trend during this period, from approximately US\$17 to US\$7 for LLIN and from approximately US\$10 to US\$1 for RDTs. Health system modeling (HSM) in Cambodia estimates that between 2011-17, the programmatic cost of HIV testing declined from US\$73 to US\$28 per HIV test. ART declined from US\$942 to US\$625 per patient on ART and viral load testing declined from US\$19,486 to US\$995 per viral load test.⁷

On the other hand, data from Guatemala indicate that the programmatic cost (financed by the Global Fund) of each MDR-TB case started on treatment declined from US\$5,300 in 2009 to US\$3,660 in 2016, but has since risen to US\$5,150 in 2018. Increasing costs per TB output are linked to the implementation/purchasing of expensive new technologies (e.g., GeneXpert) and resource intensive strategies to identify more marginalized cases (e.g., active case finding) but must also take into account that TB spending per prevalent case is significantly lower than for HIV and malaria (see Annex 8).

Program management costs, often seen as an indicator of efficiency, varied from 0.3% in Uganda to 28% in DRC and were unrelated to disease, size of grant or level of subsequent absorption. However, these costs may be warranted and weakly-related to absorption for reasons other than efficiency (Annex 4).

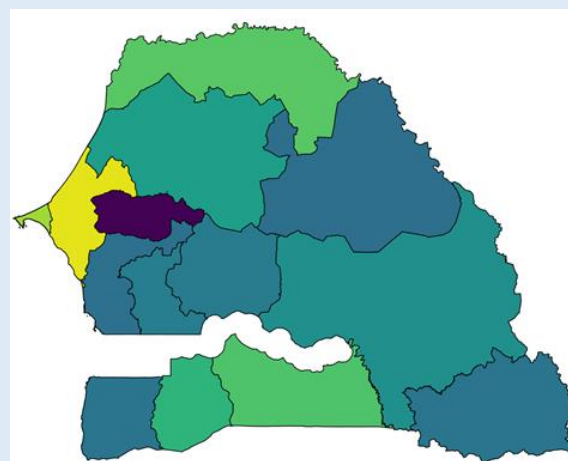
Effectiveness: PCE health systems modelling and other analysis suggests that grants and national programs were generally leading to improved outcomes, but some interventions and subpopulations deviated from that trend. Specifically, health systems models resulted in estimates of effectiveness (model coefficients near the end of the PCE results chain) that were in many cases stronger than estimates elsewhere in the results chain, when compared in standardized terms. This conclusion was not universally true however. For example, health systems modelling identified that the effect of case notification is weaker on TB treatment among prisoners than TB treatment in the general population in Guatemala but a strong link in the treatment pathway overall. We also noted the presence of highly variable sub-national effectiveness in each country where this had been examined, exemplified in the vignette on

⁷ Improvements in technical efficiency occurred during a period in which external donor funding for HIV declined substantially, but achievement of performance targets remained stable.

Senegal above. Subnational effectiveness is often difficult to assess for several reasons however, not least challenges with data quality. More information on our HSM analysis can be found in the annexes to the country reports (Cambodia, DRC, Guatemala Mozambique, Myanmar and Senegal).

Vignette: Health Systems Modeling in Senegal

The PCE used an evaluation tool known as health systems modelling to understand effectiveness. The PCE uncovered notable sub-national variation in the translation of outputs to outcomes, as exemplified in the figure on the right. In Senegal, as was the case for at least one intervention in each country-disease explored, the number of MDR-TB diagnoses had a strong correlation with MDR-TB cases cured in some geographic areas and not others. While differences in data quality and sample sizes are of concern (some areas had missing or insufficient data), the persistence of wide subnational variation speaks to the importance of country implementation-related factors as a driver of effectiveness.



Darker values in figure show higher standardized coefficients between number of cases treated, first-line and TB treatment success rate, i.e. the relative increase in TB treatment success rate per additional case treated (Senegal)

Recommendation:

3. Regarding **subnational variance in resource allocation and performance**: increase emphasis in grant implementation plans on subnational data use to address within-country disparities
 - a. Where applicable, the TRP should consider whether subnational resource allocation included in the funding request is equitable as well as efficient and effective.
 - b. CTs should encourage PRs to further utilize subnational data to identify disparities both within and between regions and build strategies into implementation plans that address these disparities including those that are already in place as part of National Strategic Plans.
 - c. The Global Fund should continue to encourage the collection of subnational data by country stakeholders and facilitate its increased use for implementation targeting.

2.5 Grant revisions

Key messages:

- Revisions to grants in PCE countries were both common and substantial during 2018-19. However the processes were burdensome and protracted with considerable opportunities for streamlining. In addition, RSSH and gender and human rights type interventions received proportionately less additional funding through revisions than other areas.

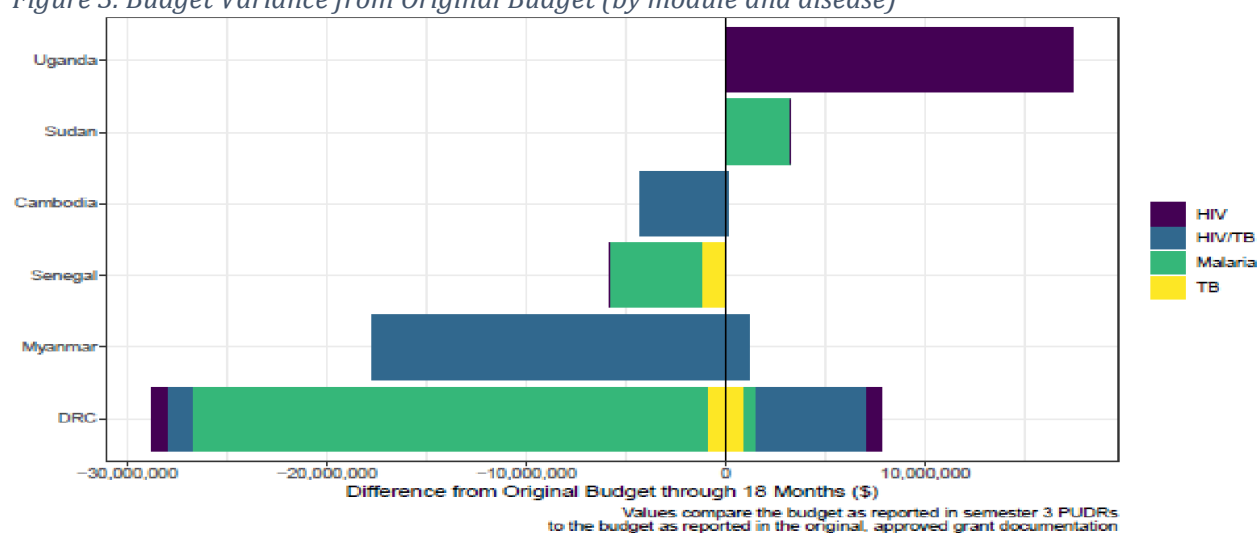
During 2018-2019, PRs implemented a wide set of revisions to PCE grants, intended to adjust investments during implementation to maximize impact.⁸ Most PCE grants underwent budget

⁸ Findings draw on 10 program revisions (formerly 'reprogramming') and 6 additional funding revisions reported across 6 PCE countries.

revisions, program revisions (formerly reprogramming) and/or additional funding revisions in the first two years. Grant revisions were undertaken for several reasons: to respond to external stimuli such as the introduction of a new programmatic strategy, an epidemic outbreak, or new epidemiological survey data; to integrate additional funding received through portfolio optimization and matching funds; and to reinvest unspent balances and savings originating from delays in implementation and/or from early grant budgeting which over- or under-estimated costs (e.g., unit costs of service delivery or drug costs) (see Annex 3 for more illustrative examples of grant revisions in PCE countries).

Grant revisions (budget, program, and additional funding) were both common and substantial through the midpoint of grant implementation. Figure 3 illustrates the magnitude of budget variance (the difference between the budgets from the first 3 semester PU/DRs and the original approved grant budgets) for grants in six PCE countries.⁹ The trends varied by country, with increases to the implementation budgets compared to the original budgets in Uganda and Sudan, and overall decreases in Cambodia, Senegal, Myanmar and DRC. Some of the positive variance can be attributed to the injection of additional grant funding: a total of US\$68.4 million was received by four countries through portfolio optimization and/or other donor funding. Budget and program revisions that reallocated funds from one module or intervention to another as well as budget shifts to account for changes in activity sequencing (for example, in DRC) also influenced the total budget variance.

Figure 3. Budget Variance from Original Budget (by module and disease)



Our findings suggest that grant revisions funded activities largely aimed at driving impact. This was evidenced through: reinvestment of grant savings to support the scale up of proven priority interventions and services focusing on high burden geographies and key populations; the integration of portfolio optimization funds to implement interventions in the Unqualified Quality Demand (UQD) register; and revised performance frameworks and increased programmatic targets in line with the additional funding, scope and interventions (vignettes below). Grant revisions also directed funds towards other strategic objectives such as RSSH and human rights, but less so (see Chapters 4 and 5).

⁹ Guatemala was excluded because the implementation period does not align with the other 7 PCE country grants. Mozambique was excluded given the latest validated PU/DR data was not available at the time of completing the variance analysis.

Illustrative examples of grant revisions undertaken in PCE countries. See **Annex 3** for a full table.

Cambodia's HIV/TB additional funding revision (US\$4.3m) undertaken to integrate funds received through portfolio optimization. *Changes include:*

- Grant Approvals Committee (GAC) approved a list of high impact activities from UQD focusing on HIV testing for KPs (US\$652K), provision of ARVs (US\$265K), TB case detection/treatment (US\$2.7m), and RSSH/HMIS (US\$760K).
- Upward revision of performance framework targets in line with increased activities for TB missing cases and HIV prevention targeting key populations.

DRC's malaria program revision (US\$9.1m) undertaken to align investments with the introduction of a new private sector strategy. *Changes include:*

- US\$7.6m reallocated from performance based financing for integration of private sector activities; performance framework targets revised accordingly.
- US\$500K for data quality review transferred from MOH to Santé Rural (SANRU, civil society PR) grant.
- US\$1m in unspent balances reinvested in malaria commodity handling costs, PSM associated with integrated community case management (iCCM), and security for LLIN distribution campaign.
- Substantial increase in testing and treatment targets following the program revision is expected and will contribute to SO1.

Myanmar's HIV/TB program revision (US\$9.3m) undertaken to reinvest savings from Year 1, fill a program gap, and revise targets due to early achievement in Semester 1. *Changes include:*

- Re-investments focused on scale up of prevention interventions targeting KPs/PWIDs .
- Scale up of MDR-TB directly observed therapy provision (gap fill) and community-based TB services (formerly funded by Challenge TB).
- Grant performance framework targets revised upwards for HIV and adjusted for TB (in light of TB prevalence survey).

The use of grant revisions appears to have been successful in recalibrating grants but it also highlights the challenges of implementing grants as planned. During grant making, the Secretariat required PRs to submit three-year grant budgets with quarterly allocation at the module-, intervention- and activity-level. Often grantees did not include specific dollar amounts for each activity in a quarter and instead divided the three-year allocation for a given module equally across each quarter in the grant. For example, in the SANRU malaria grant in DRC, the PR allocated US\$50,000 each quarter under the module "RSSH: Integrated service delivery and quality improvement", or a total of US\$200,000 every year. This is not an uncommon practice in PCE countries. Across the current grants in DRC, Guatemala, Senegal and Uganda, budgets for activity descriptions were equally divided among all quarters 17% of the time on average for HIV activities, 14% for malaria, 18% for TB, and 15% of the time for RSSH. This pattern of budgeting was much more common in some grants, such as HIV and combined HIV/TB grants in DRC (32% of activities divided evenly in each) and one HIV grant in Senegal (29% of activities divided evenly). Others, such as HIV, malaria and TB grants in Guatemala included zero activities divided in such a way.

Furthermore, the PCE has observed that PRs were more likely to divide budgets equally between later grant quarters than earlier ones. Because it is difficult to plan specific activities for a three-year grant period, discrepancies occur between planned budgets and implementation by PRs and SRs. This, in conjunction with implementation delays, led to lower absorption during the first months of the grant period and created demand for reinvesting resources later on in the grant cycle.

Despite making a significant contribution to grant implementation, grant revision processes were cumbersome. Among the nine program revisions examined by the PCE, the process took between three to 10 months from start to finish, not accounting for consultations and clarifications prior to and following the official process. Additional funding revisions were also lengthy processes, ranging from 1 to 9 months among six cases of funds received through portfolio optimization in PCE countries (see Annex 3). While there was evidence of CT Fund Portfolio Managers using flexibilities to accelerate revisions, the process was widely reported at country level as cumbersome with implications for the scheduling of revised activities, absorption rates and results in 2020.

Differentiated program revisions, based on material change, were rarely used in part due to perceptions this would delay implementation further. In two cases, CTs and PRs determined the materiality of the program revision and ensured these were aligned with agreed Funding Requests, partly to avoid extra Technical Review Panel (TRP) and GAC approval, which were perceived to impede grant absorption even further. As such, the burden associated with material change encouraged revisions to remain in scope instead of opting for new or innovative interventions that could enhance program performance.

Factors helping grant revisions included having a clear, evidence-based rationale for the revision and an engaged, flexible CT to keep grants moving. Factors hindering grant revisions included unclear guidance and/or understanding at country level of grant revision terminology, complexity of revisions (particularly if implementation arrangements were complex) and the time taken to establish savings to be revised. For more information on grant revisions and factors helping or hindering grant revisions, see Annex 3.

Recommendation:

4. Regarding **grant revisions**: GMD and MECA should:

- a. Closely monitor the new key performance indicator: 80% of portfolio optimization to be completed within 3 months from the GAC awards.
- b. Review average completion time for material program revisions and consider developing a performance indicator to assess the timeliness of the program revision process.
- c. Promote consistent use of grant revision terminology in the Operational Policy Manual (Oct 2019) and all related grant management documents.
- d. Include explicit guidance in the Operational Policy Manual that matching funds can be revised within the catalytic priority area with written Global Fund approval.

2.6 Matching Funds

Key messages:

- Matching funds increased investment in Global Fund strategic priority areas, but quantifying and measuring the catalytic impact of these additional resources remains difficult.
- We found limited evidence that matching funds resulted in the type of ambitious and innovative programming intended through this modality; further investigation is necessary to determine whether the Global Fund should continue with the matching funds approach.

Matching funds expanded the potential impact of country allocations through increased investment in Global Fund strategic priority areas. Five PCE countries benefited from matching funds intended to incentivize larger country allocations in strategic priority areas deemed critical

to achieving the Global Fund strategy 2017-2022. US\$67 million in additional funds were awarded in five strategic priority areas, representing between 2-7% of the total country allocations (Table 2). In most cases, the country applications met all four conditions for accessing matching funds (Annex 2).¹⁰ Only the DRC (human rights) and Mozambique (RSSH/HMIS) matching fund applications did not meet all four conditions but were granted exceptions by the TRP.

Table 2. Matching funds included in 2018-2020 grants in PCE countries (USD)

Country	HIV: Human Rights	HIV: AGYW	HIV: KP	RSSH: Data Systems	TB: Missing Cases	Matching Funds Total	% of Total Allocation
DRC	\$2,999,675	--	--	\$2,975,025	\$10,000,000	\$15,974,700	3.0%
MOZ	\$4,699,999	\$5,990,361	--	\$3,000,000	\$6,000,000	\$19,690,360	3.9%
MYN	--	--	\$6,300,000	\$3,000,000	\$10,000,000	\$19,300,000	7.4%
SEN*	\$1,217,950	--	\$1,094,500	--	--	\$2,312,450	3.6%
UGA	\$4,400,000	\$5,000,000	--	--	--	\$9,400,000	2.0%

**Euro to dollar conversion April 2019*

Source: Global Fund Matching Funds Tracker, 2 September 2019

Greater investments in strategic priorities through matching funds had the potential to expand the impact of country allocations. However, we did not observe these funds leading to catalytic investments in innovative and ambitious programming, as intended by the Global Fund (6). The TRP's report on observations from the 2017-2019 allocation cycle found that many matching funds requests did not "sufficiently seize the opportunity to capitalize on matching funds request," nor did they present a "coherent approach likely to catalyze better program performance."⁽⁷⁾

One contributing factor identified in PCE countries was the challenge of developing technically sound proposals. In Uganda, stakeholders struggled to reach agreement on what constitutes a human rights barrier. The TRP sent the initial matching funds application back for further iteration because most of the interventions proposed by Uganda expanded services to key populations rather than removing legal and human rights-related barriers. In Senegal, there was initial confusion over the purpose of the funds and difficulty determining which priorities would meet Global Fund requirements. Senegal and Mozambique received technical assistance through Global Fund's Community, Rights and Gender program to develop their human rights matching funds proposals; however, absorption for these activities in both countries was low, suggesting that technical assistance is needed during implementation as well.

The PCE found that Global Fund guidance lacked clarity on how matching funds were expected to be catalytic which may explain the limited investment in innovative and ambitious programming. PCE countries, however, had several examples of matching funds being used to support new and innovative approaches, such as HIV self-testing and pre-exposure prophylaxis (PrEP) for key populations in Senegal and the extension of some components of Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) programming for adolescent girls and young women (AGYW) to additional districts in Uganda. The Mozambique CT considered the

¹⁰ Conditions for accessing matching funds included demonstrating: (1) activities directly supported the strategic priority area; (2) the allocation amount in the priority area was higher than in the 2014-2016 allocation; (3) the allocation amount was equal or greater than the matching funds requested; and (4) the proposed activities would drive impact through increases in programmatic targets/coverage, quality, and/or innovative approaches in the priority area.

human rights matching funds request to be innovative since Mozambique had not previously had either human rights investments or matching funds for this purpose. However, the matching funds were approved even though the match was not demonstrated, and there was limited evidence that the activities funded were innovative rather than just new.

It is difficult to assess whether matching funds worked as intended because funds were not easily traceable once integrated within grants. Matching funds were often accompanied by increases in programmatic and coverage targets, especially for TB case detection in Mozambique, Myanmar and DRC. Other countries did not undergo target changes (e.g., DRC and Mozambique for RSSH/HMIS and human rights matching funds) and may have challenges quantifying the impact of matching funds. Once matching funds were integrated into the disease grants, the funding and performance targets were no longer distinguishable from the main grant. The ability to separately track the matching funds is likely less important since the overall performance in the strategic priority areas becomes most relevant to achieving progress towards SO1.

Figure 4. Absorption for strategic priority areas*, January 2018 - June 2019



*It is not possible to calculate absorption for missing TB cases

Strategic priority areas supported by matching funds experienced weak budget absorption and underachievement of performance indicators in the first 18 months of grant implementation due to implementation bottlenecks. Absorption of budgets associated with the five strategic priority areas supported by matching funds was low in the first 18 months of grant implementation relative to overall grant absorption (Figure 4). In most PCE countries, activities supported by matching funds were either partially implemented or delayed until the second half of 2018 and in some cases (e.g. Senegal HIV human rights and KP matching funds) did not get underway until 2019. As reported in the 2018-19 PCE synthesis report, the misalignment of timelines for approval and disbursement of matching funds from the main grants contributed in large part to implementation delays (of note, for the 2020-2022 allocation period, this issue has been addressed by the Secretariat and matching funds will be submitted within the main grant). In DRC for example, all three strategic priority areas supported by matching funds experienced delays in 2018 due to lengthy SR contracting, but demonstrated higher absorption by Q1 2019. AGYW activities were delayed in Mozambique but now have relatively strong absorption and are expected to achieve 2019 performance targets. In Senegal and DRC, the matching funds for

reducing human rights-related barriers to services mark the first time that programs of this nature have been implemented on a large scale, and in some cases has tested stakeholder capacity especially in implementing newer strategies. Senegal is receiving technical assistance with the implementation of new strategies such as PrEP for key populations.

Some countries also had challenges revising activities supported by matching funds due to confusion around the rules for revision of these investments. According to implementation letters in DRC and Uganda issued in relation to a country's matching funds approval, revised grant agreements will include a new covenant specifying that "any reprogramming of Matching Funds shall be subject to the written approval of the Global Fund" and interviews with the Secretariat indicate matching funds *can* be revised as long as they are reinvested in the same catalytic priority areas. However, in Uganda, some stakeholders' understanding varied on whether matching funds could be revised. In DRC, savings were identified from delayed implementation of RSSH/HMIS activities, which includes matching funds,, but discussions are ongoing with the CCM and CT regarding whether or not the funds can undergo program revision. Stakeholder perceived restrictions on revisions to matching funds may affect both absorption and the ability to redirect funds into potentially more innovative areas of programming and therefore poses a risk to maximizing the impact of the funds.

Recommendation:

5. Regarding catalytic **matching funds investments**: The Strategy Committee (SC) should define and articulate a strategy for how matching funds are expected to catalyze greater investment and impact, including accompanying criteria for review and approval of matching funds.
 - a. GMD should consider mechanisms for incentivizing investment in the strategic priority areas that might be less administratively burdensome for the Global Fund Secretariat and countries, including allocation earmarks, for example.
 - b. Relevant Secretariat teams (e.g. RSSH, CRG, MECA, CTs etc.) should strengthen country guidance on how to design innovative and ambitious programming using matching funds to catalyze greater impact, which may include monitoring and evaluation guidance for assessing the catalytic role of the funding.

Chapter 3: How did grant investments in RSSH (SO2) contribute to national program outcomes and achievement of the Global Fund Strategy?

Building RSSH (SO2) received renewed focus in 2019 bolstered by findings and recommendations across several RSSH reviews (Office of the Inspector General (OIG), Technical Review Panel (TRP), and TERG), which emphasized the need to invest strategically in targeted systems strengthening (versus. systems supporting) and improve performance monitoring of RSSH investments(8). The Global Fund has already made headway, for example, through revising RSSH indicators in the modular framework and releasing a new RSSH information note to guide countries in developing their next funding requests—these are critical steps to ensure countries are better prepared to develop and monitor RSSH components in the next grant cycle. This section reports on progress in operationalizing RSSH investments in PCE countries.

Key messages:

- Cumulative absorption of 'direct' RSSH investments improved over the first 18 months, but in most PCE countries absorption remained less than 50% across most RSSH modules. Common drivers of weak RSSH absorption included complex country financial processes, the need for diverse stakeholder engagement, as well as poor planning and general coordination challenges with operationalizing RSSH.
- There is some evidence of grant savings being reinvested in RSSH through various revision mechanisms; however, the UQD appears underutilized for this purpose despite most RSSH items on the UQD rated as 'high' priority by the TRP.
- The Global Fund has made significant contributions to HMIS scale up, but improving data accuracy and data use for decisions will be the next frontier for HMIS strengthening.

3.1 Global Fund contribution to national program RSSH investments and implementation

Across the eight PCE countries' combined current grant portfolio of US\$2.1 billion, US\$164.4 million (7.8%) is allocated toward direct RSSH investments and US\$251.5 million (11.9%) toward contributory RSSH investments⁽⁹⁾ (Table 3).¹¹ As in past PCE synthesis reports, our analyses focus on direct RSSH investments only, since the 'contributory' designation is applied at the Secretariat-level to help articulate Global Fund's total RSSH investment but has minimal operational relevance at the country level because it is not how RSSH investments are conceptualized, tracked, or referred to by country stakeholders.

Table 3. Total Global Fund grant portfolio for current grants, disaggregated by disease-specific, direct RSSH, and contributory RSSH investments, by country. (USD)

Country	Total Portfolio [^]	Disease Specific	Direct RSSH	Contributory RSSH
Cambodia*	55,410,211	38,186,984 (68.9%)	2,343,827 (4.2%)	14,879,400 (26.9%)
DRC	572,319,412	442,284,287 (77.3%)	68,929,240 (12.0%)	61,105,885 (10.7%)
Guatemala	31,818,707	21,509,575 (67.6%)	4,428,262 (13.9%)	5,880,870 (18.5%)
Mozambique	522,572,075	452,755,032 (86.6%)	32,761,077 (6.3%)	37,055,966 (7.1%)
Myanmar*	224,052,705	175,526,461 (78.3%)	26,747,148 (11.9%)	21,779,096 (9.7%)
Senegal	75,237,275	53,166,085 (70.7%)	12,345,952 (16.4%)	9,725,238 (12.9%)
Sudan	132,845,055	107,873,415 (81.2%)	11,322,384 (8.5%)	13,649,256 (10.3%)
Uganda	506,896,343	413,931,046 (81.7%)	5,517,655 (1.1%)	87,447,642 (17.3%)
All	2,121,151,783	1,705,232,885 (80.4%)	164,395,545 (7.8%)	251,523,353 (11.9%)

[^]Total portfolio amount and direct versus contributory RSSH, provided by Global Fund, October 2019

*HIV/TB grants only; excludes multi-country Regional Artemisinin-resistance Initiative 2 Elimination Program (RAI2E) grants for malaria which contain RSSH investments

Despite Global Fund's increased emphasis and guidance on RSSH investment, 'direct' RSSH investments remain below 8% (while no specific threshold, countries were encouraged to increase RSSH investment in the 2017-2019 allocation period). The proportion of direct RSSH investment out of the total grant portfolio was highly variable, ranging from 1% (US\$5.5 million) in Uganda to 16% (US\$12.3 million) in Senegal. The limited amount of direct RSSH investment could be attributed to a variety of reasons including challenges with operationalization, poor performance in prior RSSH grants, 'hard choices' necessitating the prioritization of funding for

¹¹ The RAI2E multi-country malaria grant, which covers Cambodia and Myanmar, was excluded from this analysis

treatment commodity gaps rather than RSSH, placing RSSH in the Prioritized Above Allocation Request (PAAR) rather than the main funding request, challenges integrating systems strengthening activities across multiple disease areas, and guidance from the CTs, among others. While several business model mechanisms were designed to increase RSSH investment (matching funds, grant revision, sustainability, transition and co-financing (STC) policy and recommended percent RSSH allocation in the funding request), RSSH gained limited traction in the investment portfolios.

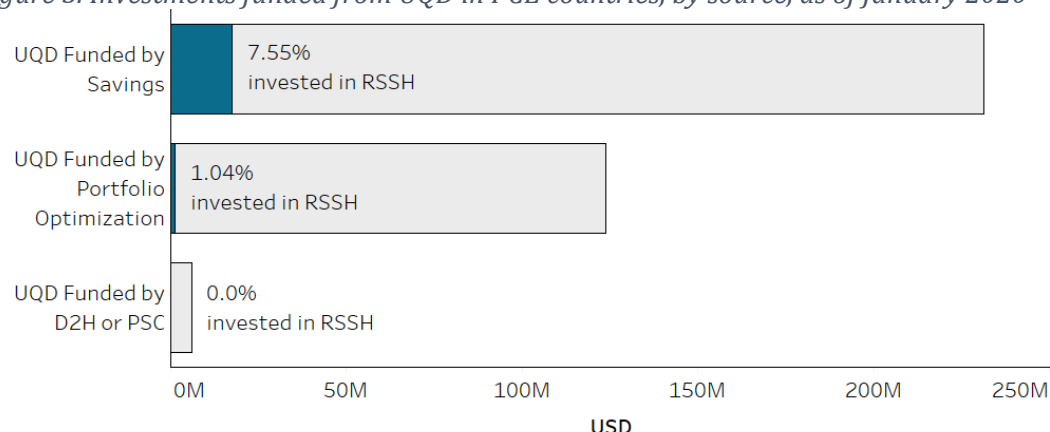
As reported in the 2018-19 PCE synthesis report, direct RSSH investments were largely concentrated within several modules: health management information systems and monitoring and evaluation (HMIS/M&E) module, procurement and supply chain management (PSM), or human resources for health (HRH). Consistent with the TRP's Observations on the 2017-2019 Allocation Cycle (7), the most under-resourced areas across most PCE countries were community systems (0.5-6% of RSSH investments, apart from Uganda at 15%) and financial management systems (0-3% of RSSH investments, apart from Myanmar at 22%). Weak and complex national financial management systems are a barrier hindering Global Fund grant implementation more generally (as discussed in section 3.1 above), and the lack of investment to strengthen financial systems is a missed opportunity. The operationalization of HMIS/M&E activities and community responses and systems are discussed further below.

Substantial investment in RSSH modules are registered in the UQD but grant managers have underused this mechanism for further investment in RSSH. A review of PCE country PAAR applications indicated US\$180 million in TRP-approved RSSH investments out of a total recommended PAAR of US\$962 million(10)¹². Of 112 RSSH intervention line items in the UQD for PCE countries, the majority were rated high (59%) or medium (27%) priority by the TRP. As of January 2020, a total of US\$361 million from the UQD had been funded, of which only US\$19 million (5%) went toward funding RSSH items, including US\$1.3 million (1%) through portfolio optimization and US\$18 million (8%) through grant savings reinvestment(11)¹³. The reinvestment of grant savings to cover RSSH activities registered in the UQD is mixed across the PCE countries with Guatemala investing substantially (70%)—and others less so—e.g., DRC (0%), Mozambique (5%), Uganda (11%), Cambodia (17%), and Myanmar (20%). Countries are starting to identify more cost savings for reinvestment in UQD activities but they may be reluctant to invest further in RSSH through UQD given the low absorption levels of RSSH investments to date (see below) and the relatively short remaining period of the grant cycle.

¹² Review of PAARs includes Cambodia (HIV PAAR); DRC (TB/HIV PAAR); Uganda (Malaria PAAR); Mozambique (TB/HIV PAAR); and Guatemala (HIV PAAR); additionally, PCE reviewed Myanmar TB/HIV and malaria PAARs; RAI2E malaria PAAR; DRC malaria PAAR; Uganda HIV PAAR; and Senegal malaria PAAR.

¹³ A caveat is that the UQD register is only updated by CTs following grant making and for relevant grant revisions. Therefore, these Amounts likely underestimate the total additional investment made in RSSH through UQD (e.g. due to grant revisions not requiring additional Secretariat review).

Figure 5. Investments funded from UQD in PCE countries, by source, as of January 2020



Cumulative absorption of most RSSH modules improved over the first 18 months of the grants, but remained low relative to disease-specific modules. Progress in RSSH implementation was mixed according to absorption data: Except for Myanmar, in most PCE countries PU/DR data from January 2018-June 2019 indicated only one or two RSSH modules with absorption above 50% (Figure 6). Continuing trends reported from January-June (Semester 1) 2018, RSSH absorption remained extremely weak in both Uganda and Sudan with seven of eight RSSH modules absorbing less than 25% of planned investments. The lowest absorption levels were observed for the integrated service delivery and national health strategies modules, with a few country exceptions (e.g., Myanmar national health strategies). Infrastructure investments contained within the integrated service delivery module explain some of the delayed absorption.

RSSH investments with low absorption were subject to grant revisions. For example, in DRC, where US\$1.3m in unspent RSSH funds were reinvested in other RSSH activities such as routine data quality assessments and DHIS2 training. In Uganda, savings from the country's largest component of direct RSSH investment (national health strategies, 33%) were reinvested in other RSSH activities, including improving data systems and support for the National Medical Stores warehouse construction.

Figure 6. Percent absorption by RSSH module, January 2018—June 2019, by country¹⁴

Income classification	LICs (%)				LMICs (%)			Key
RSSH Module	DRC	MOZ	SEN	UGA	SDN	CAM	MYN	
Community responses & systems	1251.5	101.7	49.2	5.7	2.2	91.8	92.9	Weak: <25%
Financial management	NA	44	NA	15.1	111	NA	101.3	Low: 25-49%
Human resources for health	78.5	18.3	68.8	22.9	0	NA	104.9	Average 50-75%
Information systems & M&E	35.9	13.4	57	16.9	20.8	39.3	59.6	Excellent: >75%
National health strategies	0	0.5	21.9	3.1	0	NA	66.9	
Procurement & supply chain mgmt	39.2	30.7	14.4	76	20.4	61.5	934.9	
Integrated service delivery	25.7	2.5	48.5	8.8	8.6	NA	27.7	
Total (all RSSH modules)	51.1	24.8	51	12.6	17.2	42.6	123.1	

Complex country financial processes, planning and coordination issues, the need for diverse stakeholder involvement, and implementation arrangements were drivers of low RSSH absorption. In the DRC, delayed implementation of HMIS strengthening activities was primarily due to protracted procurements through government systems. A contributing factor was that DRC's government PR was balancing multiple concurrent and complex processes grant closures, an external audit, migration to a new accounting database and concurrent grant revisions.

¹⁴ Guatemala's grants were excluded from 18-month absorption analysis due to the difference in grant cycle timing

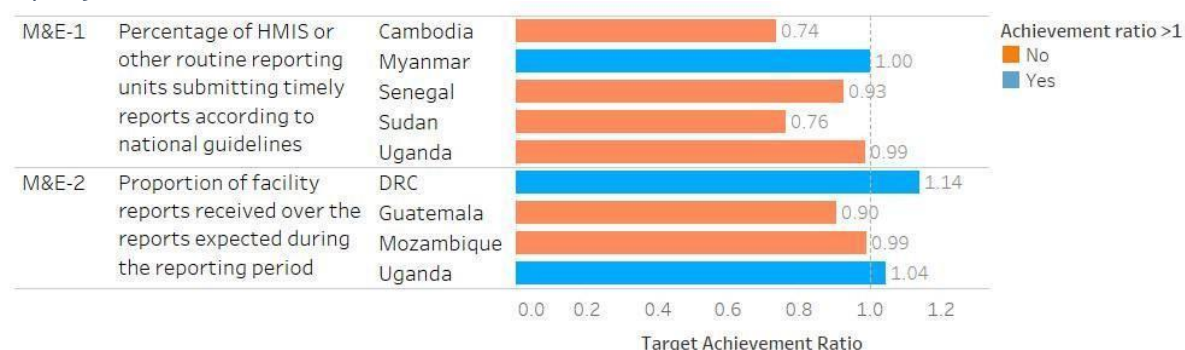
Complex country processes, including cumbersome approvals and signoff required for implementing RSSH activities, were also observed in Uganda; in addition, the initial delays in SR selection in Year 1 contributed to low absorption given that SRs are responsible for implementing 67% of RSSH investments. General coordination challenges also hindered implementation of integrated RSSH activities. In both Cambodia and Sudan, investments in community systems were stymied by poor planning and coordination by PRs, as well as political and social upheavals in the case of Sudan. Within human resources for health, low absorption was often due to slow hiring and/or high turnover of personnel or volunteers, while higher absorption was due to paying community health worker (CHW) salaries and conducting outreach activities. In the current cycle, all RSSH funds were embedded in disease-specific grants in PCE countries, which resulted in some difficulty in operationalizing integrated investments. For example, in Senegal's implementation arrangements, the funds that support DHIS2 were split across three disease grants but there have been challenges in transferring RSSH funds to the HMIS implementing unit within MOH, thereby resulting in poor spending on RSSH activities. In part due to the challenges with operationalizing RSSH, some countries (DRC, Senegal, Uganda) are considering developing stand-alone RSSH grants for the next funding cycle.

3.2 Operationalizing investments in RSSH: Spotlight on HMIS

Global Fund investments significantly contributed to HMIS scale up in PCE countries, including improvements in data reporting. In four of eight PCE countries, the HMIS/M&E module comprised over half of the total RSSH investment, with Cambodia (90%), Guatemala (63%), DRC (51%) and Senegal (50%). (Note: Unlike other RSSH modules, for the HMIS module, all investments are considered "direct" as investments in HMIS are crosscutting the three diseases and therefore there is no distinction for "contributory" HMIS investment). Data system strengthening was also supported by RSSH matching funds (US\$3 million per country) focusing on reducing fragmentation and parallel reporting systems in DRC, Mozambique and Myanmar. Investments to strengthen HMIS resulted in significant progress toward improving completeness and timeliness of DHIS2 reporting. Global advocacy for this was an important contributing factor. In Mozambique, the percent of districts sending complete and timely malaria data increased recently, suggesting Global Fund investments in RSSH and data quality assessments contributed to improved reporting on case notification. Similarly, Global Fund investments in Senegal sought to improve data quality in terms of completeness, timeliness and accuracy by establishing an efficient and unified information system for all programs. In DRC, broad adoption of DHIS2 and improved reporting completeness and timeliness for all three diseases was facilitated by simplification of data collection and reporting tools, harmonizing the national health pyramid, implementation of data road maps, multi-donor financial support, strong political will and coordination of actors around a clear set of priorities and actions under the national HMIS reinforcement plan.

The majority of PCE countries (6 of 8) have >90% achievement on RSSH coverage indicators related to HMIS reporting (Figure 7), and as noted in the 2018-19 PCE synthesis report (5), there is minimal correlation between RSSH absorption and target achievement for RSSH indicators. The Global Fund's addition of new RSSH indicators to the module framework will support improved monitoring and measurement of the contribution of RSSH investments to outcome achievement, if countries are able to adopt and institute the new metrics.

Figure 7. Progress on RSSH HMIS indicators, by PCE country, January 2018-June 2019 (Source: PU/DR)



Vignette: Integration of routine data systems in Guatemala. Nearly two-thirds (63%) of RSSH investments in Guatemala are supporting HMIS/M&E, with all three disease grants containing investments to strengthen SIGSA (the national HMIS). In the previous HIV grant, the HIV PR operated a separate information system, SIGPRO, but due to concerns over the costs of the platform and lack of interoperability with SIGSA, the new HIV PR opted to instead introduce DHIS2. While it required more time to roll-out DHIS2 than anticipated, the change of system (from SIGPRO to DHIS2) is widely viewed as a positive development which will reduce reliance on parallel data systems and improve integration with the national HMIS. An unintended consequence of the lengthy rollout is that HIV SRs reverted to using paper-based reporting systems, adding significantly to their workload.

Although the completeness and timeliness of HMIS reporting improved across national programs, improving data accuracy and use will be a critical next step in strengthening HMIS systems. Commonalities underlying the limited use of routine data for decision making, particularly at sub-national levels, including internet connectivity issues in peripheral locations, concerns about data quality and reliability, continued use of parallel data systems by PRs, complex data collection and reporting tools, lack of political buy-in to demand data use coupled with limited ownership for data use at lower levels. For example, Cambodia and Myanmar reported testing, treatment and viral load suppression data but with limited analysis and use of data to inform programmatic decisions. As their HIV epidemics recede, use of high-quality evidence-based information will be required for targeted approaches.

Vignette: Opportunities for strengthening District Health Information System 2 (DHIS2) data quality and use in DRC. Despite strong improvements in reporting completeness in DRC, stakeholders report that data quality is poor and there is limited use of DHIS2 data for analysis and decision-making. This is partially attributed to stakeholders that do not feel involved in data analyses and discussions at lower levels of the health system because they transmit reports to the central level as required but do not use the data locally for improving implementation, with one stakeholder saying, *"the data are like a DHL service."* In response, cost savings from early implementation will be used to conduct routine data quality assessments and train specialized program managers on increasing capacity around the use of data. In addition, the Global Fund CT has leveraged its influence by requiring that PRs calculate progress against performance indicators in PU/DRs using DHIS2 data. However, while national programs complied with the requirement, the HIV and TB data in DHIS2 was not considered reliable enough to use for implementation.

3.3 Operationalizing investments in RSSH: Spotlight on Community Systems

The Global Fund increasingly emphasizes the importance of community responses and systems strengthening but investments remain small, and impact limited. As highlighted above, the community responses and systems module accounted for 1% to 6% of direct RSSH investment, in most PCE countries, apart from Uganda (15%). Among the four sub-modules, investments were relatively more concentrated in institutional capacity building (22%), community-led advocacy (26%), or social mobilization (32%) than in community-based monitoring (15%). Confusion over the difference between community responses and community systems strengthening may help explain the minimal investment in this RSSH module, and why investments instead tend to target community health worker programming within disease-specific modules.

Recent guidance from the Global Fund acknowledged that community responses have historically been vertically-oriented around a single disease area (12). Furthermore, they emphasized that such approaches are generally less effective and instead promoted horizontal/integrated programming. However, in our evaluation of community responses and systems in several PCE countries, we found limited examples of integrated approaches. In Uganda, district-level data collection in six districts explored drivers of suboptimal TB treatment success, uncovering limited community response to TB, lack of integration of TB activities with other programs (e.g. HIV), and limited funding for addressing TB as root causes. In Guatemala, community-based volunteers (ColVols) are integral for malaria case-detection and treatment, and as the country moves toward malaria elimination, identifying opportunities for greater integration between the ColVols and other health areas could help to sustain this approach. Increased Global Fund investment in community systems strengthening, ideally integrated with other community-based responses, is critical for inclusion in the upcoming funding request.

Recommendation:

6. Regarding **limited investment and weak absorption of RSSH resources**:
 - a. Country applicants and the TRP (serving as a check) should ensure that RSSH investments are included in the main grant, as well as the PAAR, consistent with the Global Fund strategy.
 - b. GMD should consider pursuing options for operational performance measures specific to RSSH, beyond short-term absorption measures.
7. Regarding **sustainable grant management**: CTs should encourage longer-term RSSH investment in financial management systems. The RSSH team should work to develop more detailed guidance on how to strengthen financial management systems to help increase investment in this critical area.
8. Regarding the distinction between **contributory vs. direct RSSH**: The RSSH team should develop a more explicit and actionable system for prospectively classifying activities as “contributory” RSSH, involving country stakeholders in the design and conceptualization of contributory vs. direct investments.

Chapter 4: How did grant investments in human rights and gender (SO3) contribute to national program outcomes and achievement of the Global Fund Strategy?

The Global Fund SO3 is to promote and protect human rights and gender equality, including introducing and scaling up programs that remove human rights barriers to accessing HIV, TB and malaria services. It also aims to increase service coverage among key populations, by allocating resources to national disease program interventions focused in this area, and thereby contributing to reduced disease incidence and mortality. During the period of this grant, SO3 received increased input from the Global Fund through strategic initiatives such as the “Breaking Down Barriers” initiative focused on human rights (operating in DRC, Mozambique and Senegal) as well as various matching funds and catalytic funding opportunities focused on adolescent girls and young women. The Global Fund also published a substantial quantity of new guidance during 2019 but that will be more useful for the next grants than the ones currently operating in PCE countries.

4.1 National program coverage of services for key populations and reducing human rights and gender-based barriers

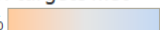
Key messages:

- All PCE countries improved coverage of interventions to target key or high-risk populations, particularly in their HIV programs, with some variation in the proportion of targets achieved by country and by disease.
- However, even where targets are met, their level of ambition is insufficient to reach impact objectives and coverage levels for key populations remain low in most PCE countries.
- Programs focus primarily on KP service coverage and outcome targets rather than specific interventions to reduce human rights or gender-based barriers
 - Gender-based barriers to accessing services remain significant in all countries with limited coverage of relevant activities across all three diseases. Performance indicators are not yet stratified by sex and few capture gender-related barriers.
 - Coverage of interventions to address human rights barriers to accessing services remains low but has an impact across the service continuum for all three diseases and in most PCE countries.

All PCE countries improved coverage of interventions to target key or high-risk populations, particularly in their HIV programs, with some variation in the proportion of targets achieved by country and by disease. PCE lower-middle income countries (LMICs) – Myanmar, Cambodia, Sudan and Guatemala – have disease epidemics that are more concentrated in specific populations compared to PCE low income countries (LICs) – Senegal, DRC, Uganda and Mozambique – that have more generalized epidemics. This is reflected in the Global Fund performance indicators captured in each country, with more HIV KP indicators measured in LMICs (N=46) compared to LICs (N=26). However, even in the LICs in the PCE, KPs play an important role in driving the epidemics, which may not be sufficiently recognized in their indicators. In both LICs and LMICs, 46% of the HIV KP indicator targets were met (Figure 8).

Figure 8. Number of indicators related to key populations, gender or human rights where targets were met, stratified by low- and middle-income PCE countries (source: PU/DRs for most recent semester)

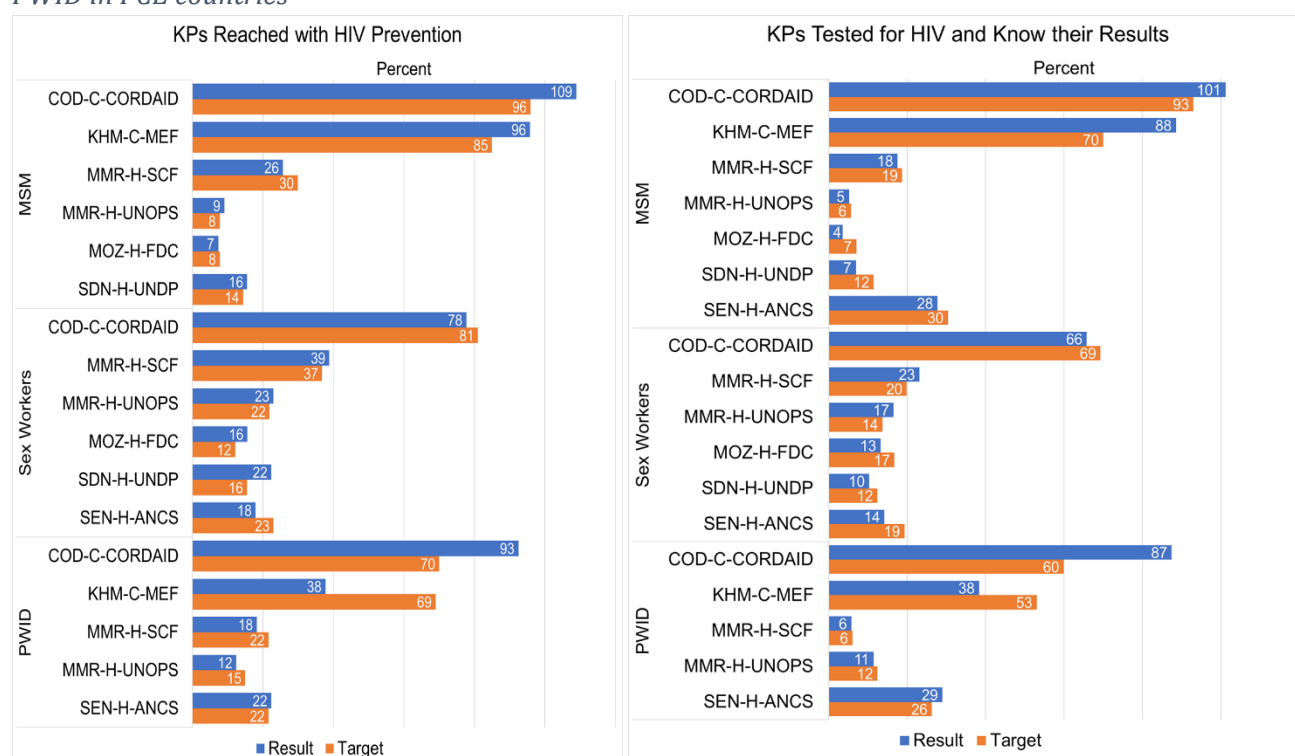
Module	Indicator key population (KP)	Low income countries				Lower-middle income countries			
		DRC	MOZ	SEN	UGA	CAM	GTM	MMR	SDN
HIV KP	MSM	2/2	0/3	0/1	1/2	2/2	0/3	1/4	1/2
	Other KP			0/2			0/1	1/2	
	Prisoners							1/1	
	PWID	2/2		4/5		0/3		2/8	
	Sex workers	0/2	2/3	0/2	1/2	1/2	0/2	4/4	1/2
	Transgender					2/2	3/4		
HIV Prevention	Gender	4/4	0/1		1/2				
Malaria Outcome	Gender		1/1		0/2				
Malaria SPI	Gender	1/1	0/1	0/1					
Malaria Vector control	Other KP	0/4		2/2	1/2		0/1		
TB TCP	Other KP					0/1		0/1	
	Prisoners	0/1		1/1	1/1			0/1	1/1

% of targets met
0%  100%

HIV programs contain more KP indicators than the other diseases, reflecting the greater depth of focus on KPs in Global Fund guidance and performance frameworks for HIV compared to TB and malaria. Within HIV grants, PCE countries captured data on more indicators related to men who have sex with men (MSM), sex workers (SW), and people who inject drugs (PWID) (total indicators across all grants MSM N=19; SW N=19; PWID N=18) than for transgender people, other KPs or prisoners (N=6; N=5; N=1, respectively). However, within malaria and TB, PCE countries are capturing some indicators related to prisoners and other KPs.

However, even where targets are met, their level of ambition is insufficient to reach impact objectives and coverage levels for key populations remain low in most PCE countries. Figure 9 shows data on proportion of MSM, sex workers and PWID reached by HIV prevention and testing interventions respectively. Other than Cambodia and DRC, most countries are either not measuring coverage of key population interventions or they are low. For example, Cambodia, Uganda and Guatemala HIV grants do not measure the proportion of sex workers that are tested and know their HIV status. Amongst the five countries that do measure this outcome, only DRC set a target for more than 20% of sex workers to be tested and know their HIV status.

Figure 9 HIV prevention, testing and status knowledge outcomes amongst MSM, sex workers and PWID in PCE countries



Across PCE countries, performance against targets varied by type of KP. For example, DRC met all HIV targets related to MSM, PWID and gender but did not meet targets for sex workers, prisoners or other KPs. The DRC program did not meet its target for sex workers because testing activities were inadvertently excluded from the grant budget but were later reallocated through a 2019 program revision. Likewise, in Mozambique, significant human rights barriers to HIV service access remain for some KPs, with only 9% of MSM and 22% of SW knowing their status, but have improved for PWID, amongst whom 62% know their status. Opioid substitution treatment targets for people who inject drugs (PWID) were not being met in multiple countries. HIV testing and prevention services for transgender people were meeting or exceeding targets across multiple countries.

The modular framework for 2020-2022 includes more categories for key populations under each of the target diseases, as well as the ability to disaggregate HIV interventions meaningfully by gender and age. These indicators are necessary to enable national programs to better track progress against longer-term investments in fostering more sustainable human rights and gender-responsive approaches.

Vignette: In Cambodia, despite U.S. President's Emergency Plan for AIDS Relief (PEPFAR) cutting its contribution to HIV KP services, progress towards 90-90-90 targets is on track and several provinces have exceeded targets. Changes in outreach strategies for HIV and focus on case detection for TB contributed to strong performance on ambitious KP targets. In addition, political leadership by the Ministry of Finance, strong technical partnerships and investments in key areas of the health system also contributed to this success.

Programs focus primarily on KP coverage and outcome targets rather than specific interventions to reduce human rights or gender-based barriers, although in many cases these populations overlap as KPs often suffer specific human rights or gender barriers to accessing care. On the

whole, however, disease programs in PCE countries tend to focus on addressing the supply of services to KPs rather than reducing access barriers to those services. For example, in Myanmar, only US\$1 million was allocated to activities to reduce human rights related barriers from an HIV grant totaling US\$130 million. While stakeholders noted that human rights interventions were embedded within other budget lines, it remains hard to track budgets and expenditure in this area.

Gender-based barriers to accessing services remained significant in all countries, with limited coverage of relevant activities across all three diseases. Investment in reducing gender-based barriers to accessing services in country programs remained low, contributing to uneven progress against HIV, TB, and malaria. For HIV, PCE evidence suggests that gender inequality is a significant barrier to both prevention and treatment services, particularly in the African PCE countries. In Mozambique and Senegal, subnational data suggested that incidence is correlated with gender disparities on treatment: in Mozambique, quantitative analysis revealed that HIV incidence was lower in those provinces where gender differentials in access to ART was also lower. For TB, PCE evidence from Myanmar and Cambodia suggests that, while there are a higher number of men than women living with TB, a significantly lower proportion of men than women are on treatment, partly due to men of working age having limited access to healthcare outside working hours. In Cambodia, a grant revision attempted to address this situation but results are not yet available. For malaria, limited information is available on gender barriers to accessing services: relevant performance framework indicators only collect data on pregnant women; coverage of LLINs and preventive therapy during pregnancy was mixed. Performance indicators in this grant were not stratified by sex and few capture gender-related barriers.

Coverage of interventions to address human rights barriers to accessing services also remained low, with resulting impact across the service continuum for all three diseases and in most PCE countries. Earlier PCE findings demonstrated a consistent lack of investment across PCE countries in reducing human rights barriers to accessing services, which is further confirmed in 2019. Ongoing barriers reported by local stakeholders included legal fears for MSM and PWID, health worker stigma, financial constraints and lack of services for refugees and internally displaced people (IDPs). PCE evidence documents human rights barriers affecting uptake across the service continuum. For example: reduced linkage from testing to treatment services for PWID in Mozambique; language barriers for migrants in Myanmar to access TB treatment; and resistance to providing HIV prevention and testing services to refugees in Sudan. Local stakeholders continue to express a lack of understanding of human rights frameworks and how they might invest in programs to reduce barriers.

4.2 Global Fund role in delivering national program KP, human rights and gender outcomes in PCE countries

Key messages:

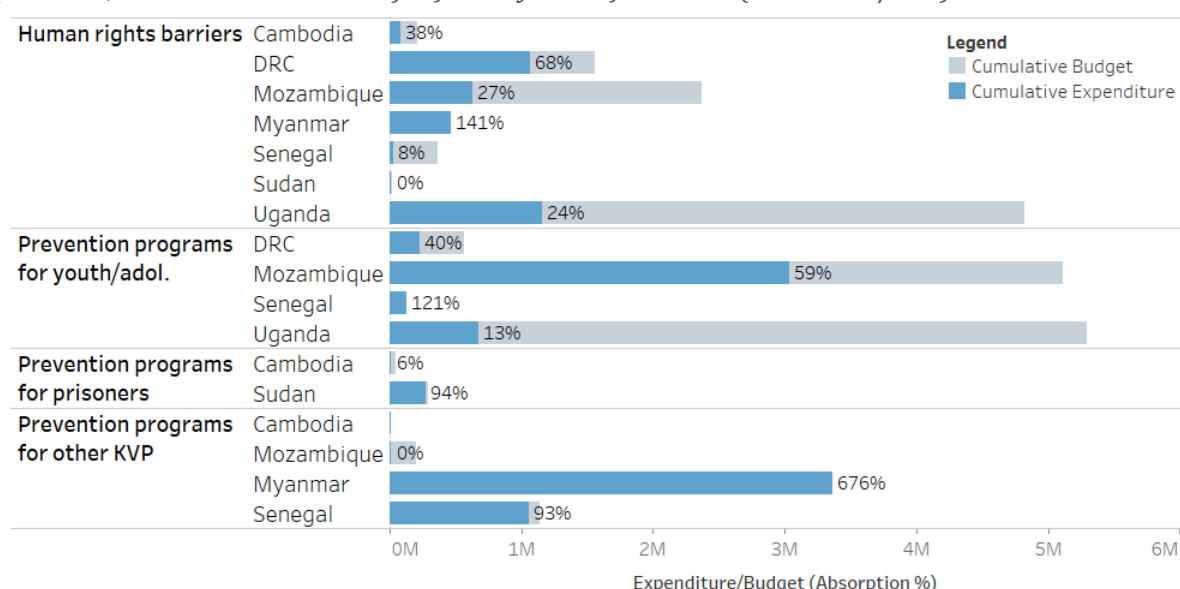
- With low grant allocation to key populations, human rights and gender modules, grant implementation began slowly but is now in progress relative to 2018 implementation.
- The Global Fund has promoted and supported new strategies that have contributed to increased coverage and better targeting of key populations at the subnational level. However, grant performance on equity objectives is weak compared to other areas of value for money.
- Factors facilitating Global Fund grant implementation and contribution to coverage include matching funds and other grant revisions as well as use of more evidence-based approaches to allocating resources at the subnational level.
- Factors hindering Global Fund grant implementation and contribution to coverage include misaligned business model incentives, poor quality data on KPs, lack of performance indicators to track progress related to SO3 and limited expertise on how to address human rights and gender-based barriers to service access.

As noted in previous PCE reports, grant allocation to HIV and HIV/TB grant modules related to SO3 (human rights, youth/adolescents, prisoners and other KPs) was low¹⁵ and in most countries absorption during 2018-2019 was slow relative to other areas of grant expenditure (Figure 10). Mozambique and Sudan are notable exceptions where absorption for these SO3-related modules was higher than overall grant absorption (462% vs. 83% in Myanmar; 88% vs. 57% in Sudan) but grant allocations were small. Uganda has the lowest overall grant absorption of the PCE countries (46%; absorption by country can be found in Annex 9) as well as the lowest absorption for SO3-related modules (18%). Low absorption in Uganda was driven by a number of factors: reconciliation of PSM costs, particularly within the HIV program, at different levels was delayed to December 2019; some large budget activities only took place in late 2019 (e.g. LLIN procurement in October 2019); and slow start up of some SRs responsible for these modules, including those with a focus on SO3. For prisoners and other KPs, absorption rates are higher than for human rights and AGYW modules, particularly in Sudan and Senegal, although they remain low in Cambodia and Mozambique. For youth/adolescents and human rights modules, absorption is generally low, with most countries below 50%. The four PCE low-income countries (all in Africa) invested in youth/adolescents, reflecting the key role of youth in driving the generalized epidemics.

TB grant KP absorption showed mixed progress through 2018-2019, with extremely low grant allocations to these interventions and absorption ranging from 0% for TB/HIV prisoners in Sudan and DRC to 100% for MDR-TB in Myanmar.

¹⁵ As discussed in Chapter 3, the Global Fund uses absorption against grant module budgets as a proxy for implementation progress. The modular framework has KP, human rights and gender modules for HIV and HIV/TB but not for TB alone or malaria, making it challenging to track budgets or expenditures in these areas. Although this has been revised in the latest Modular Framework released in October 2019, it has been difficult to report summary numbers on key population, human rights and gender allocation and absorption for these diseases in the current grants.

Figure 10. Absorption of HIV and HIV/TB budgets devoted to human rights, youth/ adolescents, prisoners, and other KP modules for January 2019-June 2019 (source: PU/DRs)



The Global Fund promoted and supported new strategies that contributed to increased coverage and better targeting of key populations at the subnational level. However, grant performance on equity objectives was weak compared to other areas of value for money. The Global Fund played a critical role in expanding coverage of services for KPs by advocating for new strategies to reach marginalized people and increasing the targeting of resources at the subnational level. For example, in Sudan, the Global Fund advocated for a new testing strategy that included payments to key populations to cover their costs to access care. In Senegal and DRC, the Global Fund supports new HIV self-testing strategies for difficult to reach KPs, enabling them and/or their partners to self-administer an HIV test and interpret their results in private. In Cambodia and Myanmar, the Global Fund contributed to expansion of finding, testing and treatment services for HIV and TB KPs as well as their partners and contacts. Despite these efforts, PCE VfM analysis across grants demonstrated that they performed less well in general on equity compared to effectiveness and efficiency.

Vignette: In Cambodia, impressive gains towards 90-90-90 targets were accompanied by improvements in equity, although significant disparities in service coverage remain among some KPs and in some geographic areas. Grant activities and program services were targeted to KPs and to high burden states, which is leading to improvements in allocative efficiency and reduced subnational disparities in the proportion of people living with HIV who know their status and are virally suppressed. However, substantial disparities remain: 37% of PWID are currently reached with an HIV test and 33% are reached by prevention interventions, well below grant targets.

Factors facilitating Global Fund grant implementation and contribution to coverage included matching funds and other grant revisions as well as use of more evidence-based approaches to allocating resources at the subnational level. In the 2017-2019 allocation cycle, matching fund priority areas for HIV included: KP impact; programs to remove human rights-related barriers to health services; and AGYW. Of PCE countries, DRC, Mozambique, Myanmar, Senegal and Uganda were chosen to receive matching funds in these areas (Table 2). In addition, Mozambique and Myanmar also received matching funds for TB/missing men, which in Mozambique enabled the

program to scale up proven TB approaches developed and implemented by Challenge TB from a few provinces to nationwide. Matching funds successfully increased resources for human rights, AGYW, and KP activities and emerging evidence from DRC and Senegal suggests matching funds contributed to elevating the visibility and scale of human rights programming. However, as noted in section 3.6, the implementation of these funds has suffered from overall grant implementation challenges and evidence suggests that they have done little to stimulate innovative approaches.

Vignette: In Myanmar, grant revisions have facilitated scale-up of KP-focused interventions, reflecting the Global Fund's and the national program's commitment to KPs. Most of the original KP targets in the HIV grant have been achieved or exceeded, and, as a result, targets have been increased for 2019 and 2020. A budget of US\$1.26 million was proposed as budget revision for Pyi Gyi Khin (a SR/lead national non-governmental organization and human rights advocate) for "expansion of prevention services and strengthening/scaling up of human rights related activities." US\$1.8 million has been proposed for finding missing TB cases in hard to reach communities

The Global Fund also promoted the prioritization of resources in a more evidence-based way using modelling. In Mozambique, Myanmar and Sudan, effective use of data for prioritization increased allocative efficiency. For example, in Sudan, despite decreasing grant allocations overall compared to the last grant, resources now target eight priority states which have data on significant populations of MSM and sex workers. Similarly, evidence-informed targeted testing strategies have worked to identify more KPs who are HIV positive in DRC and in Guatemala, targeting malaria screening to migrant workers in sugar-cane plants was a successful strategy to decrease malaria cases.

Factors hindering Global Fund grant implementation and contribution to coverage include misaligned business model incentives. The Global Fund business model includes a range of perverse incentives that, in the context of resource constraints, benefit service coverage expansion over investing in reducing access barriers. For example, the heavy reliance on absorption targets as a measure of grant performance can favor investments (such as commodity procurement) that are easier to quantify and deliver over those that require more difficult advocacy and political engagement and lack clear performance indicators, such as human rights interventions. Furthermore, areas of the grant that lend themselves to rapid absorption tend also to be relatively short term objectives, and possible to implement during a three-year grant period, rather than the longer term investments in fostering more sustainable programs.

Another underlying challenge cited in most PCE countries was lack of quality data on KP size and disease prevalence for setting targets and measuring progress. For example, Senegal only began capturing routine TB program data that was sex -stratified in the last few years. Inadequate data hindered target setting for grant performance framework indicators. In some PCE countries, unrealistic targets for KPs combined with nonspecific indicators that did not directly focus on KPs (e.g. number of HIV tests performed or number of sputum samples processed) led to mass screening rather than targeted testing of KPs.

Vignette: In DRC, targeted HIV testing strategies are showing some success but are hindered by the targets and indicators in the performance based funding framework that incentivize mass screening rather than targeted testing of key populations. Data on the targeted testing strategy indicates it is working to identify more KPs who are HIV positive, in part due to investments in community response systems. However, the indicator target is for the number of HIV tests performed – regardless of HIV status – which incentivizes health workers to perform mass

screening to meet targets, rather than targeting tests to KPs. Moreover, this resulted in stockouts of HIV testing kits in some health facilities when they were used to screen the general population, despite being ordered under the Global Fund grants for risk-based HIV testing.

A final critical factor hindering Global Fund grant implementation for reducing human rights and gender barriers was limited expertise amongst program managers to develop interventions targeting human rights and gender barriers, as well as lack of priority relative to scaling up services more generally. In addition, program managers may not have prioritized these activities in the context of significant political sensitivity. As a result, fear of discrimination by local communities and service providers continued to inhibit the access of marginalized groups to services. Volatile security situations in several PCE countries further contributed to both weak state performance on human rights overall and low service coverage for conflict-affected populations.

Recommendation:

9. Regarding **low service coverage**, particularly for key population services: in order to maximize impact, and to overcome bottlenecks stemming from human rights and gender based barriers to accessing services, Secretariat country teams and national stakeholders responsible for funding requests and grant design should assign more ambitious targets for prevention service coverage, as well as for interventions to reduce human rights and gender barriers, and particularly in countries that have already achieved high levels of service coverage among some populations.*
10. **Regarding data related to KPs, human rights, and gender:** Communities, Rights and Gender Team (CRG), MECA and GMD should work together to ensure PRs and national stakeholders have sufficient capacity and data systems in place to capture and use information on interventions that address human rights and gender barriers, including as proposed in UNAIDS guidance.

**This recommendation is relevant to, and repeated in, other chapters of this report*

Chapter 5: Use of findings and added value of the PCE platform

The rising credibility of the PCE country based teams, which are largely comprised of country nationals, has benefited from stronger relationships with national stakeholders in most PCE countries. This has created increased opportunities to access additional data sources and to validate and contextualize evidence through observation and ongoing interaction. As a result, the embedded evaluation teams have increasingly been able to contribute timely evidence for in-country use. So far, the PCE platform and its findings have been used (1) by both the Global Fund and national disease programs to influence in-country course corrections; (2) to inform Secretariat thinking and Global Fund practice in countries; and (3) to respond to requests from stakeholders, including on additional analyses not related to core PCE work.

A core aim of the PCE is to use findings generated to contribute to process improvement. This chapter highlights instances of improvements pertaining to the design of Global Fund policies, processes and structures, country programs and Global Fund grants, and of evaluation capacity in countries more broadly. This is not an exhaustive list but is intended to highlight the value of the PCE platform in contributing to improvements.

Influenced in-country course corrections

The PCE has contributed to improvements in both the design and implementation of Global Fund grants, and to national programs and health strategies more broadly.

Improvements to Global Fund grants:

- CT endorsement of PCE recommendations to revise the district prioritization in the TB grant in Guatemala resulted in subsequent revisions to the priority districts in the grant.
 - This improvement was influenced by the PCE identifying a statistical problem with the district prioritization calculation for the new TB grant, and then providing that feedback to the CT and to country stakeholders.
- A workshop was convened to discuss opportunities for addressing bottlenecks to implementation of the TB/RSSH grant in Senegal, informing course correction and discussions for the next grant.
 - The PCE presented a root cause analysis highlighting challenges underlying RSSH implementation. The workshop discussion, based on some of the PCE findings and recommendations, resulted in a roadmap, a Technical assistance plan and a TB Acceleration Plan.
- Decisions during grant revision of the HIV grant in Sudan and Mozambique to increase the investment in prevention.
 - This was influenced by the PCE highlighting the implications of a significant cut in funds for HIV prevention in the 2018 funding request in Sudan.
 - In Mozambique, the PCE highlighted that HIV prevention activities focused mainly on PMTCT, key and vulnerable populations and condom distribution, but less on the general population. As a result, the new funding request process prioritized IEC activities for general population and involvement of civil society organizations into the proposed grant.
- Decision by DRC's national HIV program, the CT and the Performance-Based Financing (PBF) Technical Unit to revise the indicator financed through PBF to "Number of people tested positive for HIV," which better supports implementation of the targeted testing strategy.

- DRC has experienced persistent stock outs of HIV test kits, as reported by both the 2019 OIG audit in DRC and the PCE. The OIG determined a lack of proper implementation of the targeted testing strategy. Evidence from the PCE suggests the PBF-indicator “Number of people tested for HIV” may have created a perverse incentive to test the general population.
- Decision by the CCM to commission an in-depth assessment of SR selection in Uganda for both public and civil society PRs.
 - The CCM built upon PCE findings from early grant implementation highlighting protracted processes of selecting and onboarding SRs as a key barrier to implementation. In addition to using PCE findings to inform the SR assessment, PCE recommendations on SR selection have been put into consideration as the PRs plan to onboard SRs early for the 2021-2023 grants, in line with Global Fund’s new emphasis on preparing for “implementation ready” grants.
- Decision by the Malaria Program in Mozambique to reallocate resources in both the current and new grants to prioritize provinces with rising malaria prevalence, and adapting the color of bednets and the insecticide used to take into account local preferences and resistance issues.
 - This decision was informed by PCE findings that although national malaria prevalence remains stable, pyrethroid resistance and local beliefs affecting bednet use have led to significant subnational variation in prevalence.

Improvements to national programs:

- Improvements to the HIV National Program in Cambodia:
 - The PCE team analyzed the 12-month and 60-month retention rates of PLHIV that was subsequently used as evidence to support development of national program initiatives to influence on-site health care providers to improve retention.
 - NCHADS used PCE findings from two studies on differentiated care models as input to scale up the implementation of Multi-Month Scripting (MMS) at ART sites nationwide.
 - The PCE analysis of the 90-90-90 cascade illustrated sub-national disparities. The findings were used by the National AIDS Authority to demonstrate gaps and the need for geographical targeting of services.
- Promoting a culture around the benefits of stakeholder validation of analyses and evidence to ensure accuracy of findings and to co-create recommendations for program improvement.
 - In Myanmar, the PCE periodically brings together all Global Fund supported program managers and implementers as well as other development partners working on the three diseases to validate data, findings and analysis on the HIV and TB grants.
- PCE evidence for program planning and strategy development in DRC, Myanmar, Uganda and Senegal:
 - In DRC, the national malaria program director requested that the PCE annual reports be used for consultation during development of the Malaria National Strategic Plan (NSP) for 2021-23. The PCE reports are listed as a key reference document for both the new Malaria NSP and malaria funding request.
 - In Myanmar, PCE reports are listed as reference documents in national program reviews as well as strategy reviews by other development partners. In addition, the National AIDS

Program invited the PCE to take part in a small team tasked to conduct AIDS Epidemiological Model (AEM) optimization analysis to inform the National Strategic Plan on HIV and AIDS (2021-2025) and development of the Global Fund funding request (2021-2023).

- In Uganda, during the Malaria Program Review, the MOH requested the PCE share the malaria resource tracking findings to inform the development of both the Malaria NSP and funding request.
- In Senegal, using PCE findings, the Ministry of Health and Social Action, with the support of the CCM and the Global Fund, requested the TB Program organize a workshop with the country's main stakeholders to develop a Tuberculosis Acceleration Plan (PALT) to identify concrete and pragmatic actions to improve the 2018-2020 grant implementation and for the upcoming allocation period 2020-2022. The workshop culminated in an agreed action plan and a joint technical support plan between PR, SRs and PNT, as well as non-Global fund implementers.
- Guidance on improving the 2020 funding request and grant making process in DRC, Myanmar, Sudan, Mozambique and Uganda
 - In DRC and Uganda, the PCE teams recirculated their Year 1 annual reports on the 2017 funding request and grant making phase to key stakeholders. Similarly, in Myanmar, the report was shared with the concept note writing team before the preparation for developing the new funding requests.
 - In Sudan and Uganda, the PCE team presented highlights from the 2017 findings to the CCM to consider prior to launching the 2020 application phase.
 - In Mozambique, the PCE demonstrated that PEPFAR concentration of support to high volume ART sites contributed to reduced equitable access to quality HIV services. As a result of PCE findings, the MOH is planning how to support these sites to counter the effect of reduced PEPFAR support as part of the next funding request.

Influenced Secretariat thinking and Global Fund practice in countries

The work of the PCE has also highlighted strengths and weaknesses pertaining to the structures, policies and processes that make up the Global Fund business model. Through our reporting and dissemination activities, PCE findings have influenced the approach of Secretariat teams to bottlenecks encountered.

- Urging countries to prepare 'implementation ready' grants (rather than 'disbursement ready' grants as in the 2017-2019 allocation period)
 - This change was influenced by the PCE synthesis of early grant implementation findings (2018) on lengthy start up delays in grant implementation due to SR contracting and other issues.
- Shift to matching funds application being integrated in main funding request (rather than submitted as a separate matching funds funding request in the 2017-2019 application cycle)
 - This change was influenced by PCE synthesis of 2017 assessment that matching funds application was unnecessarily repetitive with the main application, thereby incurring high transaction costs relative to the amount of additional funding available.

- Program Continuation: the performance framework and budget are now required at the time of funding request submission (rather than developed during grant making as in the 2017-2019 application cycle)
 - This change was influenced by PCE findings that Program Continuation was perceived 'lighter' during funding request stage, but that efficiency gains were 'offset' during the grant making stage when PRs had to complete the core set of grant documents typically required during the funding request stage.
- Changes to the type of application approaches in the 2020-2022 application cycle
 - The 'Tailored for Material Change' application approach has been dropped, which was a decision partly influenced by PCE findings from the DRC that the process was overly complex and time consuming and did not result in intended efficiencies.
- The Sourcing Department of the Global Fund updated the PQR database with the correct, up-to-date reference prices and committed to updating them at least annually.
 - This change was prompted by a PCE inquiry to the Global Fund's Sourcing Department to obtain reference prices after they had disappeared from the online PQR database, which led to the Global Fund 1) realizing that the reference prices had disappeared from PQR, 2) realizing that the references prices were outdated by at least 5 years, 3) realizing that Global Fund PPM and GDF reference prices should be used in the PQR rather than the international reference prices.

Provided a credible, country-based platform to respond to requests from other stakeholders (e.g. additional analyses not related to core PCE work)

In some cases, Secretariat teams, national programs, PRs and other stakeholders have reached out to PCE teams for support related to other Global Fund evaluation activities.

- Preliminary review of the new WHO TB treatment guidelines
 - PCE teams in Myanmar, Sudan and Uganda mobilized at short notice to facilitate a preliminary review of the feasibility and bottlenecks of transition to and implementation of the new guidelines.
- Review of baseline human rights survey tools
 - In Uganda, consultants engaged by the Global Fund Community, Rights, and Gender team to conduct the Human Rights baseline assessment requested technical assistance from the PCE team in reviewing the tools.
- In Cambodia, the PCE provided Temporary Technical Assistance to the National Centre for HIV/AIDS, Dermatology and STD (NCHADS).
 - The PCE lent support to NCHADS' Logistics Management Unit to offset the effects from the departure of skilled staff.
 - The PCE delivered several outputs including customizing the logistics ARV request form and monitoring the stock dashboard for HIV test kits and commodities, creating training materials, creating a transition plan to mitigate the problem of ARV shortage and providing counselling on ARV forecasting.
- In DRC, the PCE supported the national TB program to clean and validate 2018 TB program data. This highlighted the gap between DHIS2 and programmatic data, and a decision was taken to enter historical data into DHIS2. As a result, this triggered the national TB program

M&E division to notify the TB provincial coordination units with the lowest data completeness to improve their data reporting in DHIS2.

- In Guatemala, INCAP (the HIV PR) requested assistance from the PCE in exploring different methodologies to inform estimation of key populations. Analysts at IHME and CIESAR collaborated to analyze detailed data on HIV testing and test positivity rates from both the national HMIS system and an internal reporting system provided by the Principal Recipient. These analyses prompted further discussion regarding methods and next steps for KP estimation.
- In Mozambique, the MOH requested the PCE to expand VfM analysis to include other donors. CDC-PEPFAR in Mozambique requested the PCE team together with the HIV Platform of the National Health Observatory to expand the retention analysis in order to provide more in-depth evidence on the influence of health system performance on retention. The PCE also provided input for the development of the first Atlas-Report of triangulation of various HIV indicators at district level, which will be disseminated in March 2020.
- In Senegal, the PCE has highlighted bottlenecks for stakeholders to accelerate procedures, e.g. accountabilities such as memos to send supporting documents on-time to ensure timely disbursements and improve absorption rates
- In Myanmar, the PCE is increasingly seen as a platform with capacity to support other assignments including for issues of a highly sensitive nature (e.g. CCM review and restructuring).
- In Sudan, the PCE team analyzed and visualized data for subnational variation in HIV testing and linkage to care.
- In Uganda, the PCE assisted the national TB program in analyzing some of their GeneXpert data by providing new/different subnational analyses that could inform programming.

Built credibility as a national platform (e.g. strength of relationships, ability to access data, country specific analyses of importance)

The many applications of PCE evidence and expertise (such as those described above) have contributed to building strong rapport between PCE teams and country stakeholders, and to the growing credibility of the PCE platform as it relates to Global Fund investments broadly, and disease-specific programs and cross-cutting issues in countries. The strength of these relationships has enabled unprecedented access to observe internal meetings and processes, as well as access to program and administrative data. This has in turn facilitated analyses of importance and sometimes of a sensitive nature. For instance, in Cambodia after years of limited communication with the TB national program, the PCE team was able to obtain access to data which was critical to informing the contribution analysis and deep dive, and to generating recommendations to inform further program improvements. There are similar examples across PCE countries, which only serves to underscore the added value of the PCE as a platform.

Chapter 6: Recommendations and conclusions

6.1 Recommendations table

1. Regarding consistently low absorbing interventions : The Grant Management Division (GMD) should revise budgeting processes such that they are lighter, more flexible and periodically updated throughout the grant cycle. This could include requiring a detailed budget for year 1 only, while allowing indicative budgets for years 2-3. Indicative budgets could later be converted to annual detailed budgets as part of the PR reporting and monitoring process. GMD should ensure that change management takes place throughout the Secretariat and Local Fund Agents to ensure alignment regarding any updates to budgeting guidance.
2. Regarding the gap in monitoring of grant implementation : Monitoring, Evaluation, and Country Analysis (MECA) Team should: a. Develop and use operational performance measures, for example activity and output measures, that are fit-for-purpose without placing unnecessary burden on PRs; b. Continue to encourage adoption of performance indicators from the new modular framework and monitor which indicators underutilized (and why).
3. Regarding subnational variance in resource allocation and performance : increase emphasis in grant implementation plans on subnational data use to address within-country disparities. a. Where applicable, the TRP should consider whether subnational resource allocation included in the funding request is equitable as well as efficient and effective. b. CTs should encourage PRs to further utilize subnational data to identify disparities both within and between regions and build strategies into implementation plans that address these disparities including those that are already in place as part of National Strategic Plans. c. The Global Fund should continue to encourage the collection of subnational data by country stakeholders and facilitate its increased use for implementation targeting.
4. Regarding grant revisions : GMD and MECA should: a. Closely monitor the new key performance indicator: 80% of portfolio optimization to be completed within 3 months from the GAC awards. b. Review average completion time for material program revisions and consider developing a performance indicator to assess the timeliness of the program revision process. c. Promote consistent use of grant revision terminology in the Operational Policy Manual (Oct 2019) and all related grant management documents. d. Include explicit guidance in the Operational Policy Manual that matching funds can be revised within the catalytic priority area with written Global Fund approval.

5. Regarding catalytic **matching funds investments**: The Strategy Committee (SC) should define and articulate a strategy for how matching funds are expected to catalyze greater investment and impact, including accompanying criteria for review and approval of matching funds.
 - a. GMD should consider mechanisms for incentivizing investment in the strategic priority areas that might be less administratively burdensome for the Global Fund Secretariat and countries, including allocation earmarks, for example.
 - b. Relevant Secretariat teams (e.g. RSSH, CRG, MECA, CTs etc.) should strengthen country guidance on how to design innovative and ambitious programming using matching funds to catalyze greater impact, which may include monitoring and evaluation guidance for assessing the catalytic role of the funding.

Building RSSH

6. Regarding **limited investment and weak absorption of RSSH resources**:
 - a. Country applicants and the TRP (serving as a check) should ensure that RSSH investments are included in the main grant, as well as the PAAR, consistent with the Global Fund strategy.
 - b. GMD should consider pursuing options for operational performance measures specific to RSSH, beyond short-term absorption measures.
 7. Regarding **sustainable grant management**: CTs should encourage longer-term RSSH investment in financial management systems. The RSSH team should work to develop more detailed guidance on how to strengthen financial management systems to help increase investment in this critical area.
 8. Regarding the distinction between **contributory vs. direct RSSH**: The RSSH division should develop a more explicit and actionable system for prospectively classifying activities as “contributory” RSSH, involving country stakeholders in the design and conceptualization of contributory vs. direct investments.
9. Regarding **low service coverage**, particularly for key population services: in order to maximize impact, and to overcome bottlenecks stemming from human rights and gender based barriers to accessing services, Secretariat country teams and national stakeholders responsible for funding requests and grant design should assign more ambitious targets for prevention service coverage, as well as for interventions to reduce human rights and gender barriers, particularly in countries that have already achieved high levels of service coverage among some populations.
 10. Regarding **data related to KPs, human rights, and gender**: Communities, Rights and Gender Team (CRG), MECA and GMD should work together to ensure PRs and national stakeholders have sufficient capacity and data systems in place to capture and use information on interventions that address human rights and gender barriers, including as proposed in UNAIDS guidance.

6.2 Conclusion

This report has explored changes in disease outcomes and intervention coverage within the eight PCE countries as they relate to achievements towards three of The Global Fund Strategic Objectives, focusing on the second year of the 2018-2020 grant cycle. While financial absorption was on track compared to the first year of the grant cycle, there was substantial variation between modules and some areas experienced higher rates of expenditure. Input-based budgeting, which provides benefits for risk mitigation and implementation planning, sometimes represented a barrier to financial absorption and the necessary adaptation of implementation plans during the course of the grant cycle.

Among the most important grant implementation successes of the 2019 implementation period was increasing value for money: unit prices for key commodities declined and there was a positive relationship between outputs and outcomes over time. RSSH (S02) performance, however, was more variable. While cumulative absorption improved in 2019, complex national financial processes, the need for diverse stakeholder engagement and limited coordination represented ongoing implementation challenges. All PCE countries increased intervention coverage for key and high-risk populations (S03), especially for HIV-related interventions. However, national programs and strategies tended to focus on increasing service coverage of outputs, rather than specific interventions related to reducing human rights and gender-related barriers to healthcare access, and these interventions were not reflected in performance indicators. While grants exhibited increasingly efficient use of resources over the course of the grant cycle, performance against equity objectives remains lower than other areas.

Finally, this report presents key findings and associated recommendations, as well as a summary of the way these results were used by national programs and other implementing partners. At the global level, the report summarizes the inputs the PCE has made to the Global Fund Secretariat and Strategy Committee and as an ongoing platform to inform monitoring and evaluation. The PCE looks forward to examining implementation progress and the upcoming funding request and grant making process during the final year of the 2018 – 2020 grant implementation period.

References

1. The Global Fund. Results Report 2019 [Internet]. 2019. Available from: https://www.theglobalfund.org/media/8752/corporate_2019resultsreport_report_en.pdf?u=637146355110000000
2. The Global Fund. Global Fund Data Explorer [Internet]. [cited 2019 Dec 30]. Available from: <https://data.theglobalfund.org/investments/locations/SDN,UGA,MOZ,GTM,SEN,COD,KHM,MMR>
3. Institute for Health Metrics and Evaluation (IHME). GBD Results Tool | GHDx [Internet]. IHME, University of Washington, 2017.; Available from: <http://ghdx.healthdata.org/gbd-results-tool>
4. The Global Fund. Strategic Performance Reporting - end 2018 [Internet]. 41st Board Meeting; 2019 May 15. Available from: https://www.theglobalfund.org/media/8532/bm41_14-strategic-performance-reporting-board-kpi-q4-2018_report_en.pdf
5. EHG, ITAD, UCSF, IHME, PATH, Johns Hopkins University, Bloomberg School of Public Health. Global Fund Prospective Country Evaluation: 2019 Synthesis Report. 2019 Feb.
6. The Global Fund. Catalytic Investments [Internet]. The Global Fund; 2020. Available from: <https://www.theglobalfund.org/en/funding-model/before-applying/catalytic-investments/#matching-funds>
7. The Global Fund. The Technical Review Panel's Observations on the 2017-2019 Allocation Cycle [Internet]. Geneva, Switzerland: The Global Fund; 2019 Oct. Available from: https://www.theglobalfund.org/media/8965/trp_2017-2019observations_report_en.pdf?u=637111549440000000
8. Technical Evaluation Reference Group. Thematic Review on Resilient and Sustainable Systems for Health (RSSH) [Internet]. The Global Fund; 2019 Jul. Available from: https://www.theglobalfund.org/media/8793/terg_resilientsustainablehealthreview_paper_en.pdf?u=637066527850000000
9. The Global Fund. Direct vs. Contributory Investment Database. 2019.
10. Postma S, Rock J. Consultant Report on TERG/RSSH Evaluation of 8 Countries. p. November 11 2018.
11. The Global Fund Register of Unfunded Quality Demand. RSSH funded from UQD. 2020.
12. The Global Fund. Building Resilient and Sustainable Systems for Health (RSSH) Information Note [Internet]. 2019. Available from: https://www.theglobalfund.org/media/4759/core_resilientsustainablehealth_infonote_en.pdf
13. Ministerio de Finanzas Públicas Gobierno de Guatemala. Sistema Integrado de Administración Financiera (SICOIN). 2018.
14. Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2017 (GBD 2017). Institute for Health Metrics and Evaluation (IHME); 2018.
15. The Global Fund. Price & Quality Reporting [Internet]. Sourcing & Management of Health Products. 2020 [cited 2020 Feb 12]. Available from: <https://www.theglobalfund.org/en/sourcing-management/price-quality-reporting/>
16. Updated recommendations on first-line and second-line antiretroviral regimens and post-exposure prophylaxis and recommendations on early infant diagnosis of HIV. Geneva: World Health Organization; 2018 Jul. Report No.: WHO/CDS/HIV/18.18.
17. Boston Consulting Group. TERG Market-Shaping Strategy Mid-Term Review. Paris, France: Boston Consulting Group; 2019 Jul.
18. Strategy Committee with the Technical Evaluation Reference Group (TERG). Technical Evaluation Reference Group: Market Shaping Strategy Mid-Term Review. 2019.

19. PEPFAR. PEPFAR Uganda Country Operational Plan (COP) 2019 Strategic Direction Summary [Internet]. 2019. Available from: https://www.state.gov/wp-content/uploads/2019/09/Uganda_COP19-Strategic-Directional-Summary_public.pdf
20. Kim SW, Skordis-Worrall J. Can voluntary pooled procurement reduce the price of antiretroviral drugs? a case study of Efavirenz. *Health Policy Plan*. 2017 May 1;32(4):516–26.
21. The Global Fund. 35th Board Meeting: Allocation Methodology 2017-2019 [Internet]. Report No.: GF/B35/05-Revision 1. Available from: https://www.theglobalfund.org/media/4224/bm35_05-allocationmethodology2017-2019_report_en.pdf