

Technical Evaluation Reference Group: COVID-19 Response Mechanism (C19RM) 1.0

TERG Position Paper, Management
Response and Final Report

June 2023

TERG Position Paper on COVID-19 Response Mechanism (C19RM) Evaluation

Executive Summary

Context

The evaluation of COVID-19 Response Mechanism (C19RM) was commissioned by the Technical Evaluation Reference Group (TERG) in response to a request from the Board. This evaluation covers C19RM 1.0 (between April 2020 and June 2021), and not the second period of C19RM 2.0. It was designed to provide key inputs for the Strategy Committee (SC) in the form of lessons that could be extracted, as well as to track what the response of the Global Fund has already been.

Questions this paper addresses

- How relevant and appropriate was C19RM 1.0?
- How effective was C19RM 1.0 in mitigating COVID's negative impacts on HIV, TB, and malaria (HTM) programs?
- How effective was C19RM 1.0 in directly fighting COVID-19?
- How effective was C19RM 1.0 in strengthening health and community systems to battle COVID and build more resilient systems for future pandemics?
- Did the GF via C19RM 1.0 contribute meaningfully to ACT-A, and did ACT-A help the Global Fund to design and implement C19RM 1.0?
- What are the lessons and recommendations for improving C19RM and future GF investments in pandemic preparedness and response?

Conclusions

The TERG recognizes that this evaluation is, in many ways, different to the ones it usually commissions. First, C19RM was set up very rapidly and not within the usual business model, even though there was considerable overlap. Second, it came into being due to the crises triggered by the new little-understood epidemic. Third, while time constraints are frequent companions to evaluations, the busyness of many Secretariat staff and everyone to deal with the pandemic and its impact on the three diseases meant this evaluation operated under unusually challenging conditions.

Despite these constraints, the evaluation team found some interesting findings that can be translated into lessons and recommendations to inform the role of the Global Fund in future pandemics. The evaluation team identified 10 main findings grouped around five themes: M&E; Global Fund and Country Processes Governance; Mitigation; Procurement/ Direct Covid Response; and Health and community systems. These findings are developed into 10 recommendations, and while there are another 6 recommendations in the final report, this position paper focuses on those 10, which the evaluation team called Tier 1.

The review's findings do suggest overall that C19RM 1.0 was an important investment in 2020/2021. Whether the response was exactly what was needed to mitigate impact of COVID on HTM programs will need to be further analyzed when appropriate data become available. That said various innovations during the first year of the pandemic were initiated, a large quantity of commodities were purchased and distributed and significant progress was made towards developing skills and skill sets at the global level to help manage responses to a global epidemic.

Input Received

The scope of work and the evaluation questions were developed through extensive consultations with the Secretariat and the SC. The Global Fund Secretariat and stakeholders at the global and country levels provided substantial contributions to the evaluation work. The Office of Inspector

General was also consulted to ensure that this C19RM evaluation adds value and duplication is avoided.

Report

Part 1: Background:

1. To respond to the COVID-19 pandemic, the Global Fund committed to protect the gains made in HTM programs from the impacts of the COVID pandemic while assisting countries to fight COVID-19 directly and build stronger, more resilient health and community systems. In March 2020 the Global Fund decided to allow reprogramming of existing grants (\$232 million in “flexibilities” were ultimately approved), and in April 2020 mounted a new financing facility, the COVID-19 Response Mechanism (C19RM). Under the C19RM, \$757 million was granted in 2020 and \$3.2 billion in 2021 to support 129 countries and regions. This close on \$4 billion is in addition to grant “flexibilities”.

2. The Board agreed the need for the TERG to develop an appropriately flexible and timely approach to evaluating the impact of C19RM investments in the longer-term under the oversight of the Strategy Committee.¹

3. The evaluation’s **key objectives** were:

- a. Determine the relevance and appropriateness of C19RM investments;
- b. Analyze whether, how well, and why the C19RM was effective in mitigating the impact of the COVID-19 pandemic on HTM and broader public health, with special attention to the protection of human rights and key and vulnerable populations;
- c. Assess how effectively C19RM assisted low- and middle-income countries to fight COVID-19 directly and to strengthen health and community systems to prepare these countries to prevent, detect, and respond to future pandemics;
- d. Examine the results and merits of global coordination to roll out the C19RM grants through the ACT-A partnership, with attention to possible duplications and important gaps at the interface with other financiers; and
- e. Provide lessons learned to inform enhancements to future C19RM grants and in the Global Fund’s capacity to respond to future pandemics, especially in the light of the major ongoing global conversation regarding a new architecture and financing for pandemics.

3. The **Methods** used by the evaluation team included an assessment of quantitative data using descriptive analytical approaches and through employing trend analysis of temporal trends. Qualitative data was analyzed using thematic analysis. In addition, the evaluation created a retrospective Theory of Change (TOC) that incorporated elements of the C19RM Monitoring and Evaluation Framework (April 2021) to inform the approach. This TOC is contained in Annex1 of the report.

4. **Quantitative and qualitative data sources** were public and confidential documents and databases relating to: global investments and services; reports on C19RM allocations; expenditures; procurement and supply chain activities; civil society organizations (CSOs); CCM involvement at the

¹ GF/B44/ER12

global level; grant approvals; disbursements; procurement; and disaggregated data on HIV/TB/malaria (HTM) and COVID-related service delivery and health status at the country level. Eighty-one key informants were interviewed in global and regional institutions (technical agencies and partners) and Secretariat staff.

5. Across the eight **country case studies** (in Angola, El Salvador, Malawi, Peru, Rwanda, South Africa, Ukraine and Viet Nam) the team completed over 100 key informant interviews (KIIs) with officials from Ministries of Health (leadership and technical staff in the responses to HTM and COVID-19), the CCMs, Principal Recipients (PRs), CSOs and International Non-governmental organization (INGOs), and development partners. In addition to the KIIs, the team reviewed numerous country documents (e.g., C19RM grant proposals, performance reports, and letters); policies of national government institutions (e.g., national strategies and plans for the COVID-19 response, plans to mitigate disruptions of service delivery for HTM); and also global and national documents from partners (e.g., the African Development Bank, World Bank, WHO and PAHO).

6. The evaluation took place during a period in which Country Teams were under considerable pressure to catch-up and deliver results on HTM grants and C19RM and thus were very busy. As a result, not all *first choice* countries could be included as case studies. Alternative countries were found but the process of country case selection required significant negotiation between evaluators, TERG and Secretariat. This delayed the start of the evaluation and meant the time available for this work was shortened. In some cases, data required by the evaluators were unavailable. Typically, these data were in the process of being verified and quality assured by the Secretariat. Data related to C19RM 1.0. were also stored across many centers in the Secretariat and there were some delays in data being shared with evaluators.

Part 2: Key Findings and Recommendations from the Evaluation Report

7. The following main findings were presented in the evaluation report and are summarized below:

1. How relevant and appropriate was C19RM 1.0?

The investments included in C19RM 1.0 were highly relevant to the three overarching goals of the program and were appropriate areas for GF grant awards, given the needs of the countries to respond to the pandemic, and the GF's core competencies in areas including pooled procurement, HTM service delivery, health systems areas relevant to pandemics (labs, surveillance, outreach workers), and community mobilization.

2. How effective was C19RM 1.0 in mitigating COVID's negative impacts on HTM programs?

In general, the GF did an effective and expeditious job of soliciting, reviewing, and approving new C19RM 1.0 grants, reprogramming NFM grants and making disbursements.

There is no systematic evidence to date to show that GF C19RM 1.0 investments in mitigation (and related investments by governments and other donors) helped to cushion downturns in HTM services or enabled countries to bounce back faster once lockdowns ended. **However, we were able to identify numerous examples where GF investments in innovative service delivery and infection prevention and control contributed to the protection of HTM programs and mitigation of the negative effects of COVID-19.**

3. How effective was C19RM 1.0 in directly fighting COVID-19?

The GF's monitoring in the first year explicitly did not attempt to measure if and how much C19RM 1.0 investments reduced COVID-19 infections, mortality, or morbidity. No data are available to answer this question. However, the GF did invest heavily in this area, allocating \$458 million (about 60% of C19RM 1.0 awards) for procurement and supply chain management (PSM) of health products including COVID-19 diagnostics, personal protective equipment (PPE), oxygen equipment, and corticosteroids. The GF's Pooled Procurement Mechanism (PPM) rapidly and effectively mobilized to deliver \$309 million worth of quality-assured COVID-19 health products with a mix of funding from C19RM 1.0 and grant flexibilities. We were unable to evaluate the value, volumes, effectiveness, and cost-effectiveness of an estimated \$122 million of the C19RM 1.0 PSM budget through local procurement. While the WHO and Stringent Regulatory Authorities accelerated regulatory approval pathways, non-harmonized national regulatory environments and COVID-19 testing policies were a barrier to the faster introduction of novel health products. Lengthy global supply chain disruptions significantly delayed the timely delivery of health products despite the best efforts by the GF, Procurement Service Agent (PSA), and supplier's best efforts. Pre-existing regional stockpiles of essential health products with longer shelf lives would have helped.

4. How effective was C19RM 1.0 in strengthening health and community systems?

While the 9.8% of C19RM 1.0 grant awards reported by the GF as being invested in health and community systems strengthening (HSS/CSS) could not be systematically evaluated (the GF were not able to provide how this \$75 million was split between health and community systems), **the evaluators did find significant anecdotal evidence at country level of money being directed towards systems improvements such as COVID-19 surveillance and modeling, training and deployment of additional frontline health workers, and risk communications activities implemented by civil society organizations (CSOs).** Key and vulnerable population (KVP) communities and other civil society groups were involved in C19RM 1.0 grant design in most countries, but several factors (short timelines, government focus on emergency COVID-19 commodity supplies, communications challenges, lack of clear guidelines on eligible activities) reduced their level of participation and the resources allocated to CSS.

5. Did the GF and ACT-A contribute meaningfully to each other?

There was a positive symbiotic relationship between C19RM and the ACT-A consortium of multilateral agencies and global philanthropies, but the consortium failed to deliver in several key areas. ACT-A boosted the GF's effectiveness in C19RM 1.0 by legitimizing the GF's new role in fighting the pandemic and by providing technical support in several areas including oxygen equipment PSM. At the same time, the GF contributed to ACT-A's goals by committing over \$3 billion of the \$17 billion pledged by external funders to fight the pandemic, serving as co-convenor (with FIND) of ACT-A's Diagnostics Pillar, and playing a major role in the consortium's efforts to procure and supply PPE. However, ACT-A did not significantly add value to C19RM implementation at country level and only produced limited results in coordinating and integrating monitoring information from the different partners.

6. Additional overarching finding on evolving monitoring systems and data for C19RM

While monitoring in the first year of C19RM was relatively weak, the GF began to invest in a more comprehensive Monitoring & Oversight (M&O) system from April 2021 onward, once it realized that the fight against COVID-19 was going to last and there would be growing accountability for additional external funding for C19RM 2.0. While a detailed review of the new system is outside the scope of this evaluation, the evaluation team noted

positively that several new tools (including Pulse Checks and Supply Chain and Health Services Spot Checks (HSSCs) have begun to generate valuable information for quarterly reviews by the Investment Committee (IC) to steer C19RM implementation. Supply Operations (SO) is simultaneously working toward an integrated health product demand forecasting and planning management system that will bring together PPM and non-PPM PSM data. The GF will need to guard, however, against the risk that the new M&O system could become overly complicated and burdensome. The GF will also want to ensure that it meets country M&O needs, those of development partners working alongside the GF, as well as the needs of the Secretariat and GF Board.

8. Based on the report's findings, 10 priority first-tier recommendations are presented together with the evaluator's commentary on progress of these (See Table 1). The progress column signifies progress already made by the Secretariat in implementing each recommendation.

Table 1: Findings and recommendations, organised by thematic area, and progress on recommendations.

	Theme	Finding	Recommendation	Progress
1	Monitoring and Evaluation	1.0 monitoring system nascent, weak ability to systematically track inputs, outputs, outcomes and impact which affected implementation, budgeting and prioritization	Complete the implementation of C19RM M&O framework developed for 2.0 (April 2021), with a focus on downstream implementation, impact and quality	
2	Monitoring and Evaluation	Time to design and develop an M&O system is limited during a crisis and takes a backseat to rapid execution	Develop a basic turnkey M&O system for any type of pandemic that the GF might be called upon to respond to in the future	
3	Global Fund and Country Processes Governance	Limited toolkit for C19RM 1.0 costing, budgeting, and priority setting among competing demands inhibited investment optimization and reduced downstream ability to assess efficiency of grants.	Develop and disseminate tools and technical assistance for C19RM grant costing, budgeting, optimization, and expenditure tracking and reporting.	
4	Global Fund and Country Processes Governance	While C19RM 2020 guidance envisioned flexible reallocation of grants to respond agilely during an emergency, this option of continuous reprogramming was not used	Develop processes to allow for PRs and CTs to make more frequent adjustments to activities and budgets, on a quarterly basis or more often if required	
5	Mitigation	No clear evidence or ability to understand whether C19RM 1.0 investments have had an impact on mitigation; Surveys and analysis fragmented among multiple agencies	Create a stronger, more coherent, and coordinated system for monitoring HTM services and disruption/recovery, both within the GF and with countries and other leading organizations	
6	Mitigation	Ecological evidence of investments in innovative service delivery suggests that some of innovations/adaptations may have contributed to mitigation, but there has been no systematic effort to capture learnings	Sponsor and establish a knowledge repository and learning hub for good practices in HTM innovation, adaptation, and mitigation in the face of COVID-19.	
7	Procurement/ Direct Covid Response	Price and quality reports (PQRs) not required from PRs for COVID-19 products in C19RM 1.0. Reports from country informants of limited stocks, price fluctuations, and inconsistent quality have not been documented. This compromised GF's ability to track non-PPM procurement.	Invest in an integrated health product demand forecasting and planning management system	

8	Procurement/ Direct Covid Response	While the GF did a commendable job on procuring COVID-19 tests and on volume commitments, the lack of stockpiles of PPE cost the GF and its client countries time in completing in-country deliveries for urgently requested commodities.	Develop and implement agile instruments for pandemic procurement including stockpiles and hold limited buffer stocks in suitable LMIC hubs for health products that do not have short shelf lives.	
9	Procurement/ Direct Covid Response	The ACT-A consortium did not set up clear decision rules for PSM roles under COVID-19. Several actors established parallel structures rather than optimizing existing ones such as PPM. This fragmented health products procurement, caused confusion for countries and suppliers, and delayed efficient pooled procurement of PPE and oxygen equipment.	ACT-A partners, global health security key stakeholders, and agencies with emergency response mandates should develop clear decision rules for PSM roles in a pandemic/ emergency context	
10	Health and community systems	C19RM 1.0 HSS/CSS investments were only 10% of total grant awards, in part because of bias in favor of short-term emergency actions plus unclear guidelines and more deliberate processes to design HSS activities and to fully engage KVPs and Civil Society	Consider a set-aside or earmark for HSS and CSS in future C19RM and PPR grants, including special incentives and separate timelines that encourage and enable countries to submit strong HSS/CSS proposal.	

- Progress is measured by the four quadrants of the circle with all four quadrants filled equaling full implementation of recommendation and no filling meaning no progress.

Part 3: Discussion and TERG POSITION

General comments

9. The TERG considers that the evaluation was rigorous and completed under considerable time constraints, and generally agrees with the following overarching statements on findings: **“overall, the GF showed through C19RM 1.0 that it could leverage many of its existing strengths (technical, operational, partnerships) and adopt new ways of doing business to respond rapidly and effectively to a global pandemic like COVID-19.** At the same time, the GF struggled in several areas to utilize its pre-existing model to act effectively during a fast-moving pandemic.”

10. The TERG acknowledges the evaluation reports’ reference to country case selection as sub-optimal with opportunities for improvement in selecting a more balanced sample in the future. Although, the TERG emphasizes that country selection process took place through an agreed process with the Secretariat’s Grant Management Division, the time taken to get consensus on countries available to participate in the evaluation was unduly long and delays from one to three months were experienced. The ultimate selection was not as balanced as the TERG would have desired with consequences to the evidence available to be collected. One mitigating factor was that countries were not selected because Country Teams were challenged by operational realities and were focusing on delivery against the backdrop of Covid-related disruptions. The TERG recognizes that data sharing could have occurred more rapidly, but most documents that were available were shared with the evaluators, albeit some of these were very late in the evaluation process, which made it difficult for them to be properly analyzed.

Recommendations

11. The evaluation team prioritized ten recommendations as their priority Tier 1 recommendations. The Discussion and TERG Position on these ten Tier 1 recommendations follows. As shown in the Table 1 above six out of ten recommendations are being acted upon already. Of these one is nearly complete, two are half complete, and three are in progress. The TERG position on these ten Tier 1 recommendations follows.

Improving C19RM impact on mitigation

1. **Create a stronger, more coherent, and coordinated system for monitoring HTM services and disruption/recovery, both within the GF and with countries and other leading agencies.**

The TERG recommends that the Global Fund participates in global level discussions on IHR assessment revisions. Within that context Global Fund could adopt indicators relevant to and adapted to HTM context as appropriate and in line with countries' own M&E systems. This would avoid the risk of duplication of M&E systems and processes for PPR. The TERG notes that the current evaluation focused on Data Driven Decision-Making will articulate complementary recommendations.

2. **Help to sponsor and establish a knowledge repository and learning hub for good practices in HTM innovation, adaptation, and mitigation to COVID-19.**

Recommendation 2 is accepted and in line with the general principle that the Global Fund is a learning organization. The nascent independent evaluation structures are well-placed to enhance this concept of continuous learning and improvement. However, this repository should not be owned by the Global Fund only but should be available to all global partners as well. It will play a role in establishing and contributing to the knowledge repository and learning hub globally. The TERG notes that an on-going evaluation focused on accelerating equitable deployment and access to innovation will articulate complementary recommendations.

Improving C19RM impact on direct COVID response

3. **Complete the ongoing implementation of an integrated health product demand forecasting and planning management system** that provides routine and frequent data for both PPM and non-PPM procurement and enables timely, complete and useful access to and utilization of data for decision making on supplier diversity, product quality, product price, as well as supply chain performance from purchase order (PO) to delivery and utilization.

Recommendation 3 is accepted. The TERG notes that the Sourcing Department is already working on establishing this system.

4. **Develop and implement new and more agile instruments for pandemic procurement including stockpiles, and support limited buffer stocks in suitable LMIC hubs for health products that do not have short shelf lives.**

The TERG does not accept this recommendation for a number of reasons. Stockpiling is considered by the TERG to be costly to procure, store and distribute, with demonstrated limitations which need to be considered. A global stockpile initiative cannot be the

responsibility of the Global Fund alone, but the TERG encourages the Global Fund to consider how it might contribute to such an initiative. For instance, it may be preferable to undertake pre-qualification of companies with the capacity to manufacture PPE rapidly in a diversity of regions to ensure that PPE supplies are accessible equitably across all countries or through Advance Market Commitments with PPE manufacturers. Complementing this approach, the TERG recommends maintaining up-to-date information about evolving need/demands and identification of suppliers that can furnish that need.

Improving the effectiveness of the ACT-A partnership with C19RM

5. **ACT-A partners, global health security key stakeholders, and agencies with emergency response mandates should adopt clear decision rules for PSM roles in a pandemic/emergency context.**

While the TERG endorses this recommendation, we note that the Global Fund's ability to influence partners has boundaries that need to be taken into consideration.

Improving the effectiveness of C19RM for health and community systems strengthening

6. **Given the importance of using C19RM to build long-term health systems resilience to pandemic threats and tap the knowledge and capabilities of civil society, consider a set-aside or earmark for each country for this purpose within future C19RM (and possible PPR) grants. At the same time, develop clear and consistent definitions and ways to measure the HSS investments within C19RM.**

In principle the TERG accepts recommendation 6 focused on earmarking, which aims to increase the amount of funding dedicated to community response systems and health systems strengthening. The TERG notes that SC and Board have approved catalytic investments of substantial sums to go towards both HSS and CSS. The TERG supports the recommendation, which, if well designed, could ensure that HSS and CSS efforts contribute to strengthening PPR efforts. In addition, the TERG strongly endorses the recommendation that there needs to be clearer and more consistent definitions of what constitutes HSS, so that the current uncertainty around this is eliminated.

Improving the effectiveness of C19RM overall

7. **Complete the implementation of the M&O framework developed for C19RM 2.0 (April 2021), with a focus on downstream implementation, impact, and quality, being careful not to overload databases and dashboards to the point where country implementers and GF Country Teams (CTs) are overwhelmed by having too much data to interpret.**

This recommendation is accepted.

8. **Develop a basic turnkey M&O system for any type of pandemic that the GF might be called upon to respond to in the future.**

Recommendation 8 is considered to be particularly relevant by the TERG. The TERG emphasizes the importance of developing this turnkey M&O system in conjunction with other health security and PPR funding agencies. It is essential that this system is coordinated to ensure a common set of indicators. The TERG suggests that given that WHO is in the process of revising International Health Regulations (IHR) it will be beneficial to critically participate in

and review the assessment tool(s) emerging from that process. Some elements of that assessment tool could potentially be monitored as part of the Global Fund C19RM grant implementation.

9. **Give CCMs, Principal Recipients (PRs), and CTs tools and leeway to make frequent adjustments to C19RM-financed activities and budgets, on a quarterly basis or more often if required.**

This recommendation is accepted with the caveat that it is the CTs that are responsible for the decision-making around adjustments and PRs responsible for requests around adjustments.

10. **Design and disseminate tools and technical assistance for C19RM grant costing, priority setting, budgeting, and expenditure tracking and reporting.** Improvements in budgeting and expenditure tracking are already taking place under C19RM 2.0 but should be complemented with tools and processes for pandemic costing and priority-setting, value for money (VfM), and efficiency analysis.

Recommendation is accepted.

12. The six second tier recommendations and the TERG's response to them were:

Develop and publish a Theory of Change for C19RM retrospectively, as the main touchstone for all future monitoring and independent evaluations of the program.

In relation to the TOC it is important to review how the C19RM PPR approach is positioned within the overall Global Fund TOC. It is additionally important to align this work with the development of a TOC for the PPR 'emerging objective'. The TERG acknowledges the lack of a TOC was a limitation of C19RM 1.0, but considers this to be a more minor concern given the unprecedented situation and the emergency nature of C19RM 1.0, without understanding around Covid19 in April 2020.

Adapt the current traditional model around grant implementation to include a new process for quality at entry, and policies and incentives for continuous adjustment and reprogramming.

The TERG accepts the recommendation.

Reform CCM membership to align it better with national PPR knowledge and skills.

The TERG accepts recommendation on the inclusion of experts in Health Systems Strengthening in CCMs. TERG notes that these experts will often be key actors involved in national pandemic coordination efforts.

Use the Health Product Management Template (HPMT) as a key "source of truth" for PSM budgets and require timely, complete, and correct submission.

The TERG observes that insufficient evidence and rationale is provided to support this recommendation. HPMT is one of many processes/tools used to capture and analyze key information. It is not clear why HPMT is being elevated to a position of significant importance and what role HPMT will play in adding value.

Continued and increased efforts are needed for regulatory harmonization at the country and regional levels across LMICs.

The TERG accepts the recommendation.

Accessible ethical and standardized processes to report, address and close out quality incidents should be adopted

The TERG accepts the recommendation.

General comments on recommendations

13. The TERG notes that this C19RM 1.0 was an emergency situation and the Global Fund managed to get resources to countries swiftly, in a relevant and appropriate manner, when they needed these the most and other organisations were not able to do this.

14. The TERG encourages the Global Fund Secretariat to consider future pandemic preparedness strategies and to ramp up emergency pandemic systems, based on the experience of the C19RM. This evaluation has identified some lessons and relevant recommendations. In addition, the TERG notes that there are Global Strategies (e.g., around International Health Regulations) which will assist the Global Fund to coordinate and synergise its role in relation to PPR alongside other global partners.

15. Further, the TERG notes and welcomes the fact that the Independent Panel for Pandemic Preparedness & Response, have called for a political declaration and a “roadmap for coherent and transformative reform” and have also recommended an independent evaluation of the Access to COVID-19 Tools Accelerator (ACT-A).

16. Recommendations related to PSM are partial and only marginally respond to challenges outlined in findings.

17. The TERG notes that the evaluation is fairly silent on how well the C19RM performed in relation to CSS and HSS strengthening. The reality is that in 2020 the world was in chaos in relation to Covid-19 with little knowledge and understanding of the epidemic. The bulk of the funding went to mitigating the impact through the purchase of commodities required for this. However, HSS is essential to the new GF strategy going forward and PPR is a component of this. The TERG feels that in order for the GF to impact significantly on HSS it will need to put more funding into this and will need to be able to be transparent about what this funding is for, through better classification and standardization of the elements of HSS.

18. Similarly, the TERG also notes that there is insufficient evidence for this evaluation to make definitive findings on the impact of C19RM 1.0 grants on the mitigation of HTM diseases, or on country investments on HTM.

Document Classification: Internal.

Document Circulation: Board Members, Alternate Board Members, Constituency Focal Points and Committee Members.

This document may be shared by the Focal Points within their respective Board constituency. The document must not however be subject to any further circulation or otherwise be made public.

Annexes

The following items can be found in Annex:

Annex 1: Relevant Past Board Decisions

Annex 2: Links to Relevant Past Documents & Reference Materials

Annex 3: List of Abbreviations

Annex 1 – Relevant Past Board Decisions

Relevant past Decision Point	Summary and Impact
	The Board acknowledges that the Covid-19 pandemic constitutes a public health emergency. The Board acknowledges that failure to control the pandemic threatens to derail the Global Fund's mission to fight HIV/AIDS, tuberculosis, and malaria and strengthen systems for health. As a major actor in global health, the Global Fund is uniquely positioned to deliver rapid support to countries developing responses to control the COVID-19 pandemic. As a result, the Board: 1. Approves the creation of a temporary COVID-19 response mechanism (C19RM) to provide additional support for country responses to the pandemic and to ensure the continuity of the fight against HIV, tuberculosis, and malaria. C19RM will: 2. Support the rapid deployment of funds to support implementer countries' COVID-19 responses; 3. Finance interventions consistent with World Health Organization (WHO) guidance on COVID-19 and national Strategic Preparedness and Response Plans; 4. Be additional to amounts approved by the Global Fund for programming towards COVID-19 interventions under existing grants. a. Approves initial funding for C19RM of up to USD 500 million. b. Agrees that C19RM funds may be used to procure COVID-19 products approved under relevant emergency procedures.

Relevant past Decision Point	Summary and Impact
	c. Agrees that C19RM is a Board-approved initiative for which the Global Fund may mobilize additional resources. d. Agrees that the Secretariat may approve requests for C19RM funds for an initial six-month period through 30 September 2020, and that C19RM funds may be used through 30 June 2021.
<u>GF/B43/EDP12. Extension of C19RM Timeline and Operational Flexibility for COVID-19</u> Approved by the Board on: 30 September 2020	The Board acknowledges its previous decisions establishing the Global Fund COVID-19 Response Mechanism (C19RM) to provide additional support for country responses to COVID-19 (GF/B42/EDP11), and approving certain time-bound operational flexibilities to ensure the continued delivery of the Global Fund mission during the pandemic (GF/B42/EDP10). The Board: a. Approves that the Secretariat may approve requests for C19RM funds through 15 April 2021; b. Affirms that all other previously approved principles under GF/B42/EDP11 will continue to apply to C19RM; c. Requests the Secretariat to return to the Board, through its Committees as relevant, for additional consideration and approval should further extensions of C19RM be required as the pandemic continues to evolve; d. Approves operational flexibility under paragraph 3 of GF/B42/EDP10.

GF/B44/EDP18. Second Extension of C19RM Timeline and Operational Flexibility for COVID-19

Approved by the Board on: 30 March 2021

The Board acknowledges its previous decision establishing the Global Fund COVID-19 Response Mechanism (C19RM). The Board agrees that additional funding to support country responses to COVID-19 is necessary to safeguard the USD 14 billion raised through the 6th replenishment for HIV, tuberculosis, and malaria (HTM) programs. The Board therefore approves the following:

1. Timelines:

- a. The Secretariat will, through 31 December 2021, continue to mobilize additional funds;
- b. C19RM funds may be awarded through 31 March 2022;
- c. While C19RM funding is expected to be used rapidly for emergency needs, the final deadline for use of C19RM funds will be 31 December 2023.

2. Use of funding:

1. C19RM funding will finance interventions consistent with applicable World Health Organization (WHO) guidance, including on COVID-19;
2. C19RM funding must be aligned with national Strategic Preparedness and Response Plans;
3. C19RM funding may be used for the following types of interventions:
 1. COVID-19 control and containment interventions;
 2. COVID-19-related risk mitigation measures for programs to fight HTM; and
 3. Expanded reinforcement of key aspects of health systems;
4. C19RM funds may be used to procure COVID-19 products approved under relevant procedures;
5. The Secretariat will develop detailed technical guidance on eligible C19RM interventions for countries, in consultation with relevant partners.

3. Allocations:

- a. C19RM funding awards will use countries' 2020-2022 allocations as a starting basis; and
- b. C19RM funding awards will be qualitatively adjusted to better reflect countries' COVID-19 needs using the following factors.

4. Funding requests:

- C19RM funding requests must be endorsed by Country Coordinating Mechanisms;
- C19RM funding requests must be developed through appropriate consultation and must

Relevant past Decision Point	Summary and Impact
	engage communities and civil society, and ensure coordination with the national COVID-19 response coordinator; • C19RM funding request development must include consideration of appropriate community, rights, and gender-related interventions. 5. C19RM Funding Request Review and Approval: a. GAC: . C19RM funding requests will be shared with partners on the Grant Approvals Committee (GAC) for review and input; a. C19RM funding requests will also be shared with a technical advisory group composed of relevant ACT-Accelerator partners with technical COVID-19 expertise (CTAG) for review and input; b. The Secretariat will consider input from GAC partners and CTAG in determining C19RM funding awards or recommendations. 6. Reporting, Monitoring and Evaluation: 1. The Board emphasizes the need for comprehensive reporting, monitoring and evaluation of C19RM investments; 2. The Board emphasizes the need for enhanced transparency on C19RM. The Secretariat will provide monthly detailed reporting to the Board on C19RM operationalization.

Relevant past Decision Point	Summary and Impact
GF/B45/EDP12. Increases to the COVID-19 Response Mechanism's (C19RM) Fast-track Investment Ceiling Approved by the Board on: 18 August 2021	Based on the rationale provided in GF/B45/ER11, the Board delegates authority to the Audit and Finance Committee (the "AFC") to increase the overall ceiling amount to be made available through the C19RM Fast-track investment channel established under paragraph 5.c of GF/B44/EDP18.
GF/B46/EDP06. Extension of the COVID-19 Response Mechanism and COVID-19 Operational Flexibility Approved by the Board on: 22 December 2021	1. Based on the rationale provided in GF/B46/ER06, the Board: 0. Approves that any additional 6th Replenishment pledges received through 30 September 2022 will be used to support the COVID-19 Response Mechanism (C19RM); 1. Approves that any additional C19RM funds may be awarded through 31 March 2023; 2. Approves to revise the thresholds for Board approval of C19RM awards set out in paragraph 5.d of GF/B44/EDP18 based on the total additional C19RM funding made available, 3. Agrees that all other parameters of C19RM under GF/B44/EDP18 remain unchanged.
GF/B46/EDP12. Approval of the Secretariat's Recommendation on Funding from the COVID-19 Response Mechanism Approved by the Board on: 25 February 2022	The Board: I. Notes its decision in GF/B44/EDP18, which requires the Secretariat to recommend to the Board, for its approval, any COVID-19 Response Mechanism ("C19RM") awards exceeding US\$35 million, as measured in aggregate by country (not including any funding awarded for COVID-19 commodities through fast-track investments or C19RM funding awarded in 2020); II. Approves the funding recommended for each country, as listed in Table 1 of GF/B46/ER10; and III. Delegates to the Secretariat authority to redistribute the overall upper-ceiling of funding available for each country among its constituent grants in accordance with the previously approved principles under GF/B44/EDP18.

Annex 2 – Relevant Past Documents & Reference Materials

[ACT-Accelerator Strategic Review. An independent report prepared by Dahlberg.](#) (8 October 2021)
 The Global Fund. [The Impact of COVID-19 On HIV, TB and Malaria Services and Systems For Health: A Snapshot From 502 Health Facilities Across Africa and Asia](#) (April 2021)

The Global Fund. [COVID-19 Disruption](#) (Accessed on September 28, 2021)

Annex 3: List of Abbreviations

ACT-A	Access to COVID-19 Tools Accelerator
AfDB	African Development Bank
AIDS	Acquired Immunodeficiency Syndrome
C19RM	COVID-19 Resource Mechanism
CCM	Country Coordinating Mechanism
CSS	Community Systems Strengthening
CT	Country Team
FR	Funding Requests
GAVI	Global Alliance for Vaccines and Immunizations
HIV	Human Immunodeficiency Virus
HP	Health Product
HPMT	Health Product Management Template
HPWM	Health Products & Waste Management
HTM	HIV, TB, Malaria
IC	Investment Committee
KII	Key Informant Interview
KP	Key Populations
KPI	Key Performance Indicator
KVP	Key and Vulnerable Population
LFA	Local Fund Agent
M&E	Monitoring & Evaluation
M&O	Monitoring & Oversight
NSP	National Strategic Plan
OIG	Office of the Inspector General
OTIF	On-Time In-Full
PO	Purchase Order

PPE	Personal Protective Equipment
PPM	Pooled Procurement Mechanism
PPR	Pandemic Preparedness and Response
PQR	Price and Quality Reports
PR	Principal Recipient
PSA	Procurement Service Agent
PSM	Procurement & Supply Chain Management
PU/DR	Progress Update/Disbursement Request
QA	Quality Assurance
R&D	Research & Development
RDT	Rapid Diagnostic Tests
RFP	Request for Proposal
RSSH	Resilient & Sustainable Systems for Health
SO	Supply Operations
TAP	Technical Advice & Partnerships
TB	Tuberculosis
TERG	Technical Evaluation Reference Group
TOC	Theory of Change
TRP	Technical Review Panel
WHO	World Health Organization

Secretariat Management Response

COVID-19 Response Mechanism (C19RM) Evaluation

Introduction

The Technical Evaluation Reference Group (TERG) is a critical component of the Global Partnership, providing independent evaluations of the Global Fund's business model, investments, and impact to the Global Fund Board through its Strategy Committee. The Global Fund values transparency and publishes TERG reports according to the TERG Documents Procedure approved by the Strategy Committee.

In response to the COVID-19 pandemic, the Global Fund moved quickly to introduce flexibilities to grants to ensure business continuity and country support in early March 2020, followed closely by the establishment of the COVID-19 Response Mechanism (C19RM) in April 2020 (GF/B42/EDP11).

In March 2021, the Board requested that the Secretariat and TERG develop an evaluation approach for C19RM (GF/B44/EDP18). In line with the approach agreed with the Board's Strategy Committee (SC), this evaluation covers the initial period of C19RM period between April 2020 and June 2021.

The Secretariat welcomes the TERG evaluation and Position Paper and notes that the findings and conclusions are valuable for the continuous learning and evolution of C19RM 2021. As this evaluation covers the period mentioned above, many of the recommendations have already been or are being addressed in the context of C19RM 2021. Some recommendations can be translated into lessons to inform the role of the Global Fund's response to future pandemics and have the potential to enhance the implementation of C19RM 2021 and beyond.

Areas of agreement

Recommendation 1: Create a stronger, more coherent, and coordinated system for monitoring HIV, TB, and malaria services and disruption/recovery, both within the Global Fund and with countries and other leading organizations. [Timeframe: 2023]- The Secretariat agrees with this recommendation and notes the TERG recommendation that the Global Fund participate in global level discussions on International Health Regulations (IHR) assessment revisions. The Secretariat notes that the IHR is primarily focused on pandemic preparedness not emergency response, the M&E Framework has recently been updated to reflect COVID-19 response learnings, such as the importance of continuity (or maintenance) of essential health services, including HIV, TB, and malaria. It also includes indicators related to case management and utilization of health services, lab capacity, and others, that could be linked to Global Fund support to RSSH but not specific to HIV, TB, and malaria.

The Secretariat participated directly in the WHO/WHE-convened global consultations on JEE and SPAR revisions during 2021, including multiple concurrent technical working group discussions based on learnings from the COVID-19 response. Furthermore, the updated SPAR guidelines (December 2021) were used as the primary reference within the pandemic preparedness measurement consultation process under the new strategy delivery. Select SPAR indicators were selected as the strategy outcome KPIs for relevant RSSH-PP modules and interventions such as Lab, HRH, and pandemic surveillance. Medical oxygen and respiratory care are not specifically reflected in the monitoring framework and were thus not reflected. The Secretariat will continue to engage in global level discussions on IHR assessment revisions to ensure alignment with Global Fund Pandemic Preparedness efforts. This will help to ensure that future Global Fund financing for HTM-RSSH-PP is focused on preparedness related to program and service delivery mitigation and adaptation in the context of new pandemics, including surge personnel and medical countermeasures, among other key aspects. Additional SPAR indicators and/or complementary timeliness metrics such as 7-1-7 (which have also been endorsed by WHO through the World Bank-based financing intermediary fund (FIF) results framework) may also be considered depending on programmatic scope.

Recommendation 2: Help to sponsor and establish acknowledge repository and learning hub for good practices in HIV, TB and malaria innovation, adaptation, and mitigation of impact on COVID-19 and HIV, TB and malaria programs. [Timeline: 2023]

The Secretariat partially agrees with this recommendation. The Secretariat agrees with and supports the dissemination of best practices in this area. However, the Secretariat does not feel that it is appropriate for the Secretariat to be the sponsor of this effort to avoid duplication of efforts and diverting Secretariat focus on execution and implementation of C19RM funding. There is overlap between recommendations 1 and 2; partners such as WHO and others are already collecting best practices and examples. These examples are being shared at country-level through relevant partners and the Secretariat will continue to share updated technical guidance.

Recommendation 3: Complete the ongoing implementation of an integrated health product demand forecasting and planning management system. [Timeframe: 2023]

The Secretariat agrees with this recommendation and is embarking on implementing processes and tools to better manage end-to-end health product budget, demand and delivery that will also include a system element as part of a larger digitization effort.

The deployment of the first substantive elements is expected to be operational during Q4 2023 in time for implementation of the 2023-2025 allocation cycle. The Secretariat also notes that implementation of an integrated health product demand forecasting and planning management system is a complex workstream that will require effective change management and support.

Recommendation 4: Develop and implement new and more agile instruments for pandemic procurement.

The Secretariat agrees with the recommendation that new and more agile procurement mechanisms are required in times of global health crisis and emerging pandemics. There is need to develop and implement more agile procurement and supply chain instruments to support countries to respond more effectively and efficiently at the onset of emerging pandemics. However, the Secretariat also shares the concerns expressed by the TERG with regards to stockpiling – and agrees that the evaluator’s recommendation should not be accepted for the reasons outlined by the TERG. Such an initiative would require steer from the Board and a thorough cost/benefit analysis. The Global Fund is well positioned to contribute to such an initiative, building on lessons learned from C19RM.

Recommendation 5: ACT-A partners, global health security key stakeholders, and agencies with emergency response mandates should develop clear decision rules for PSM roles in a pandemic/ emergency context.

The Secretariat agrees with the recommendation on the need for better alignment and clear roles and responsibilities among partners, noting that there are limitations in decision-making by the Global Fund as it pertains to what others partners can or cannot do. The recommendation preempts discussions that would need to take place in response to any given emergency, by leveraging the strengths and capabilities of those organizations involved. The Secretariat acknowledges that clarity on roles and responsibilities, for example on the procurement of oxygen, would have certainly facilitated a faster response at the beginning of the pandemic.

Recommendation 7: Complete the implementation of the M&O framework developed for C19RM 2.0 (April 2021), with a focus on downstream implementation, impact and quality, being careful not to overload databases and dashboards to the point where country implementers and Global Fund Country Teams are overwhelmed by having too much data to interpret. [Timeframe: 2023]

The Secretariat agrees with this recommendation and agrees with the importance of reflecting ongoing implementation, lessons learned (including strengthening data collection tools) in the M&O framework on a timely basis. Within the context of an evolving pandemic, the Secretariat notes the importance of continuous implementation of the M&O framework while simultaneously strengthening data collection tools. Improvements to data collection

tools such as the Pulse Checks and Spot Checks are ongoing and are part of regular practice by the Global Fund to constantly improve and adapt its processes and tools.

Recommendation 9: Give CCMs, Principal Recipients, and Country Teams tools and leeway to make frequent adjustments to C19RM-financed activities and budgets, on a quarterly basis or more often if required. [Timeframe: 2023]

The Secretariat agrees, in principle, with this recommendation, and implementation is already in progress. The C19RM Operational Procedures adopted in May 2020, as well as the C19RM Guidelines which replaced the Procedures from April 2021 onwards, did not restrict the CCMs and PRs from making frequent adjustments to the C19RM-financed activities and budgets. Both documents also integrated flexibility for the PR to approve revisions up to certain thresholds for swifter and agile revisions. Revisions must be for C19RM eligible activities and appropriately tracked. Reinvestment decisions above these thresholds require Global Fund's written approval. In addition, the 2021 guidelines were complemented by technical guidance outlining strategic investment priorities to guide CCM and PR's reinvestment efforts on budget revisions to respond to changes in COVID-19 epidemiology, new science and technologies, country health system contexts and funding landscape. The reinvestment process has been further streamlined in May 2022 and information sessions for CTs, LFA and country stakeholders have taken place or are underway.

Recommendation 10: Design and disseminate tools and technical assistance for C19RM grant costing, priority setting, budgeting, and expenditure tracking and reporting. Improvements in budgeting and expenditure tracking are already taking place under C19RM 2.0 but should be complemented with tools and processes for pandemic costing and priority-setting, value for money (VfM), and efficiency analysis. [Timeframe: 2023]

The Secretariat partially agrees with this recommendation. The Global Fund continuously works to incorporate lessons and best practices in its operations. Improvements in budgeting and expenditure tracking are already taking place under C19RM 2021 as noted by the Evaluation. The Secretariat notes that expenditure tracking and reporting for C19RM funds have been in place since 2020. In 2020, tracking and reporting was subsumed under the existing HTM/RSSH grant modality with information available as part of regular progress updates/disbursement requests (PU/DRs). In line with business process improvements implemented in 2021, C19RM funds are now captured in the C19RM Budget for tailored costing and budgeting for C19RM interventions and activities only.

However, the Secretariat notes that given the uncertain future of the COVID-19 pandemic, time-limited nature of C19RM and the risk of detracting from implementation, there may be limited added value in designing and disseminating new COVID-19 specific costing and budgeting tools at this stage. The Secretariat nonetheless acknowledges the need to develop tools and processes for broader pandemic preparedness costing and priority-setting, value for money and efficiency analysis, as well as technical assistance - as part of a broader effort for strengthening future pandemic preparedness.

Observations on other recommendations

Recommendation 6: Consider a set-aside or earmark for HSS and CSS in future C19RM and PPR grants.

The Secretariat does not agree with this recommendation. This recommendation preempts outcomes of country dialogue and prioritization and does not consider the Global Fund's model and approach to funding, as well as the investment agility that allows for reinvesting as the epidemic shifted from the acute phase (high demand for COVID-19 health products) to longer-term (higher demand for strengthening system capabilities and pandemic preparedness).

While the Secretariat agrees with the importance of using C19RM to build long-term health system resilience to pandemic threats and tap knowledge and capabilities of civil society, it does not agree with earmarking for each country. Given the diversity of country contexts, earmarking and a prescriptive set-aside would undermine prioritization and optimization of available C19RM and HIV, TB and malaria funds in line with individual country epidemiology, health systems capabilities and funding landscape.

The Secretariat further notes that the TERG position on Catalytic Investments cites a recommendation that applies to HIV, TB and malaria grants rather than C19RM funding that is governed by a separate Board decision.

Recommendation 8: Develop a basic turnkey M&O system for any type of pandemic.

The Secretariat does not agree with this recommendation. The Secretariat believes this recommendation is not feasible and that such an initiative should not be led by the Global Fund. Other technical partners may be better suited to lead this initiative.

While acknowledging the value of a turnkey M&O system, the Secretariat has concerns around a basic turnkey M&O system suited to any type of pandemic. However, any future M&O system could expand on lessons learned from C19RM. The Secretariat also notes that there are resource implications to this recommendation which have not been fully considered or costed.

The Secretariat will continue to a) document lessons learned from the design and implementation of the C19RM M&O system so that these can be adapted to the specific type of pandemic threat (e.g., blood-borne, airborne, or vector-borne) and incorporated into future systems; and b) continue to promote investment in country data systems to strengthen program monitoring, including C19RM investments and future pandemic program monitoring.

Following consultations on KPIs measurement, the Secretariat has identified potential KPIs to measure pandemic preparedness, including ones based on the IHR M&E framework and through consultation with WHO/WHE and other external technical partners.

Conclusions

The Secretariat thanks the TERG for its continuous partnership and close collaboration on this evaluation. The Secretariat agrees or partially agrees with several of the recommendations, in particular those that have the potential to enhance the implementation of C19RM 2021 and/or inform the operationalization of the Pandemic Preparedness and Response evolving objective of the 2023-2028 Strategy. The recommendations that have not been accepted or fully accepted have considered the Global Fund's role in the global response, the evolving COVID-19 pandemic and ACT-A strategic planning context, and the overall policy context .

Considering variability of epidemiological trends and country contexts, C19RM is currently focused on a dynamic approach to implementation, reinforcing system capabilities and mitigation / recovery of HIV, TB and malaria programs including:

- Rapid translation of budgets into purchase orders to ensure absorption;
- Tracking supply chain issues due to impact of COVID-19 and removing bottlenecks to systems to ensure effectiveness;
- Mobilizing implementation support and TA, delivering on CMLI projects including BOXER, STELLAR and Test and Treat;
- Reprogramming and reinvesting underutilized funds and procurement savings towards identified strategic priorities, such as establishing test and treat programs, procurement of oral antivirals, TB/COVID-19 bi-directional testing equipment, oxygen investments, and others; and
- Maximizing opportunities to support countries build resilient systems, such as community health workers, lab strengthening, surveillance, waste management, and infrastructure against COVID-19, and strengthen preparedness for future pandemics.

Summary of Recommendations

Recommendation	Level of Agreement	Level of Control
Recommendation 1: Create a stronger, more coherent, and coordinated system for monitoring IV, TB and malaria services and disruption/recovery, both within the Global Fund and with countries and other leading organizations.		
Recommendation 2: Help to sponsor and establish a knowledge repository and learning hub for good practices in HIV, TB and malaria innovation, adaptation, and mitigation of impact on COVID-19 on HIV, TB and malaria programs.		

Recommendation 3: Complete the ongoing implementation of an integrated health product demand forecasting and planning management system.		
Recommendation 4: Develop and implement new and more agile instruments for pandemic procurement.		
Recommendation 5: ACT-A partners, global health security key stakeholders, and agencies with emergency response mandates should develop clear decision rules for PSM roles in a pandemic/ emergency context.		
Recommendation 6: Consider a set-aside or earmark for HSS and CSS in future C19RM and PPR grants.		
Recommendation 7: Complete the implementation of the M&O framework developed for C19RM 2.0 (April 2021), with a focus on downstream implementation, impact, and quality, being careful not to overload databases and dashboards to the point where country implementers and GF Country Teams (CTs) are overwhelmed by having too much data to interpret.		
Recommendation 8: Develop a basic turnkey M&O system for any type of pandemic.		
Recommendation 9: Give CCMs, Principal Recipients (PRs), and CTs tools and leeway to make frequent adjustments to C19RM-financed activities and budgets, on a quarterly basis or more often if required.		
Recommendation 10: Design and disseminate tools and technical assistance for C19RM grant costing, priority setting, budgeting, and expenditure tracking and reporting. Improvements in budgeting and expenditure tracking are already taking place under C19RM 2.0 but should be complemented with tools and processes for pandemic costing and priority-setting, value for money (VfM), and efficiency analysis.		

Evaluation of Global Fund COVID-19 Response Mechanism (C19RM) 1.0

Final Report

26 May 2022



**Pharos
Global Health
Advisors**

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LIST OF ABBREVIATIONS

ACT-A	Access to COVID-19 Tools Accelerator
AfDB	African Development Bank
Ag RDTs	Antigen Rapid Diagnostic Tests
AIDS	Acquired Immunodeficiency Syndrome
AOM	Accelerated Order Mechanism
APC	Advance Purchase Commitment
ART	Antiretroviral Therapy
ARV	Antiretroviral
AsDB	Asian Development Bank
BMGF	Bill & Melinda Gates Foundation
C19RM	COVID-19 Response Mechanism
CARICOM	Caribbean Community
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control
CEPI	Coalition for Epidemic Preparedness Innovations
CHW	Community Health Workers
COVAX	COVID-19 Vaccines Global Access
CRG	Community, Rights and Gender
CSO	Civil Society Organization
CSS	Community Systems Strengthening
CT	Country Team
EUL	Emergency Use Listing
FA	Framework Agreement
FR	Funding Requests
Gavi	Gavi, the Vaccine Alliance
GDP	Gross Domestic Product
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMD	Grant Management Division
GNI	Gross National Income
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HPMT	Health Product Management Template
HPWM	Health Products & Waste Management
HQ	Headquarters
HRH	Human Resources for Health
HSA	Health Surveillance Assistants
HSS	Health Systems Strengthening
HSSC	Health Services Spot Check
HTM	HIV, TB, and Malaria
IC	C19RM Investment Committee

IIT	Interruption in Treatment
IMF	International Monetary Fund
IPTp	Intermittent Preventive Treatment in Pregnancy
IRS	Indoor Residual Spraying
IT	Information Technology
ITN	Insecticide-treated Mosquito Net
KI	Key Informant
KP	Key Populations
KPI	Key Performance Indicator
KVP	Key and Vulnerable Population
LFA	Local Fund Agent
LMIC	Low- and Middle-Income Country
LMIS	Logistics Management Information Systems
M&E	Monitoring & Evaluation
M&O	Monitoring & Oversight
MDR-TB	Multidrug-Resistant Tuberculosis
MER	Middle East Response
MOH	Ministry of Health
NGCAs	Non-Government-Controlled Areas
NDOH	National Department of Health
NFM	New Funding Model
NGO	Non-Governmental Organization
OIG	Office of the Inspector General
OTIF	On-Time In-Full
PAHO	Pan American Health Organization
PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Plan for AIDS Relief
PFSCM	Partnership for Supply Chain Management
PIU	Project Implementation
PMI	President's Malaria Initiative
PO	Purchase Order
PPE	Personal Protective Equipment
PPM	Pooled Procurement Mechanism
PPR	Pandemic Preparedness and Response
PQR	Price and Quality Reports
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
PSA	Procurement Service Agent
PSM	Procurement & Supply Chain Management
PU/DR	Progress Update/Disbursement Request
QA	Quality Assurance
RDT	Rapid Diagnostic Test
RFP	Request for Proposal
RSSH	Resilient & Sustainable Systems for Health

SARS	Severe Acute Respiratory Syndrome
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SMC	Seasonal Malaria Chemoprevention
SO	Supply Operations
SPIU	Single Project Implementation Unit
TAP	Technical Advice & Partnerships
TB	Tuberculosis
TERG	Technical Evaluation Reference Group
TRP	Technical Review Panel
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VfM	Value for Money
VMMC	Voluntary Medical Male Circumcision
WBG	World Bank Group
WHO	World Health Organization

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EXECUTIVE SUMMARY

Introduction and Study Objectives. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GF)'s COVID-19 Response Mechanism (C19RM) was a bold effort launched in April 2020 designed to play a crucial role in addressing the COVID-19 pandemic in low- and middle-income countries (LMICs) by contributing to efforts to control and contain the pandemic itself (direct COVID-19 response), protect past and ongoing investments in HIV, TB and malaria (HTM) control (mitigation), and help countries to build more resilient health and community systems to address COVID-19 and other future pandemics. C19RM 1.0 was approved by the Global Fund Board on 9 April 2020 and extended in November 2020.¹ Nearly US\$757 million was approved for C19RM 1.0 from April 2020 to December 2020. This was additional to the use of grant flexibilities for COVID-19 response (US\$232 million) under the 2017-2019 allocation period grants, summing to nearly US\$1 billion.

Pharos Global Health Advisors (Pharos) was selected by the Technical Evaluation Reference Group (TERG) in October 2021 to evaluate C19RM 1.0 in its first year and answer six core questions:

1. How relevant and appropriate was C19RM 2020?
2. How effective was C19RM 2020 in mitigating COVID-19's negative impacts on HTM programs?
3. How effective was C19RM 2020 in directly fighting COVID-19?
4. How effective was C19RM 2020 in strengthening health and community systems to battle COVID-19 and build more resilient systems for future pandemics?
5. Did the GF via C19RM 2020 contribute meaningfully to the Access to COVID-19 Tools Accelerator (ACT-A), and did ACT-A help the GF to design and implement C19RM 2020?
6. What are the lessons and recommendations for improving C19RM and future GF investments in pandemic preparedness and response (PPR)?

Limitations and Challenges. The findings of the evaluation are nuanced by the fact that the GF's monitoring system for C19RM 2020 was and remains very limited, the final sample of 8 countries for study (Angola, El Salvador, Malawi, Peru, Rwanda, South Africa, Ukraine and Vietnam, accounting for just 16% of C19RM 2020 awards) was distorted by restrictions from the GF in selecting a very narrow set of countries to evaluate, and the key documents requested were not always swiftly forthcoming or made available. The paucity of information both from a lack of documentation and from delays from the GF actors limited the ability of the evaluation team to fully use data and evidence to assess the performance of C19RM 2020.

Of course, the evaluation team's assessment factored in the pandemic emergency context that prevailed throughout 2020 and well into 2021. In launching C19RM, the GF faced a host of externally imposed constraints, including lack of information about the virus and its spread,

¹ GF/B42/EDP11, <https://www.theglobalfund.org/board-decisions/b42-edp11/> and GF/B43/EDP12, <https://www.theglobalfund.org/board-decisions/b43-edp12/>.

limited understanding of the medical and behavioral interventions that could help prevent and treat COVID-19, chaos in global supply chains, and the absence of vaccines until late 2020. The GF was compelled to launch C19RM 2020 with very few additional staff while at the same time implementing a new grantmaking cycle for the 2020-2022 allocation period.

The evaluation was constrained by the decision to approve C19RM grants without having a distinct and customized monitoring system in place, relying instead on existing HTM monitoring which was not well adapted to the special features of C19RM (for example, different health products, greater use of national procurement, new and innovative mitigation activities). While this may have been a rational response to the urgency to “get the money out the door” to respond to a rapidly unfolding global health crisis, such a decision accelerated grant approvals but ultimately slowed downstream implementation, hampered the ability of the GF to take early corrective actions, and reduced the level of accountability and understanding of impact.

In this context, the GF’s decision to tackle a completely new and deadly pathogen was brave, and the speed of the reengineering of internal processes was remarkable. We offer the following findings in support of the GF’s culture as a continuous learning organization, not as criticisms but as opportunities to honestly reflect upon the successes and pain points so the GF can continue to be more effective in its ongoing response to endemic COVID-19 and to respond better when the next pandemic comes.

Main Findings

1. How relevant and appropriate was C19RM 2020?

The investments included in C19RM 2020 were highly relevant to the three overarching goals of the program and were appropriate areas for GF grant awards, given the needs of the countries to respond to the pandemic, and the GF’s core competencies in areas including pooled procurement, HTM service delivery, health systems areas relevant to pandemics (labs, surveillance, outreach workers), and community mobilization.

In general, the GF did an effective and expeditious job of soliciting, reviewing, and approving C19RM 2020 funding, reprogramming NFM grants and making disbursements. Over 80% of grants progressed from the receipt of C19RM Funding Requests (FRs) to issuance of the Notification Letter in less than 10 working days. However, downstream performance lagged, with only 55% of C19RM 2020 portfolio absorbed by 30 June 2021.

2. How effective was C19RM 2020 in mitigating COVID’s negative impacts on HTM programs?

There is no systematic evidence to date to show that GF C19RM 2020 investments in mitigation (and related investments by governments and other donors) helped to cushion downturns in HTM services or enabled countries to bounce back faster once lockdowns ended. **However, we were able to identify numerous examples where GF investments in innovative service delivery and infection prevention and control contributed to the protection of HTM programs and mitigation of the negative effects of COVID-19.**

3. How effective was C19RM 2020 in directly fighting COVID-19?

The GF's monitoring in the first year explicitly did not attempt to measure if and how much C19RM 2020 investments reduced COVID-19 infections, mortality, or morbidity. No data is available to answer this question. However, the GF did invest heavily in this area, allocating \$458 million (about 60% of C19RM 2020 awards) for procurement and supply chain management (PSM) of health products including COVID-19 diagnostics, personal protective equipment (PPE), oxygen equipment, and corticosteroids. The GF's Pooled Procurement Mechanism (PPM) rapidly and effectively mobilized to deliver \$309 million worth of quality-assured COVID-19 health products with a mix of funding from C19RM 2020 and grant flexibilities. We were unable to evaluate the value, volumes, effectiveness, and cost-effectiveness of an estimated \$122 million of the C19RM 2020 PSM budget through local procurement. While the WHO and Stringent Regulatory Authorities accelerated regulatory approval pathways, non-harmonized national regulatory environments and COVID-19 testing policies were a barrier to the faster introduction of novel health products. Lengthy global supply chain disruptions significantly delayed the timely delivery of health products despite the GF, Procurement Service Agent (PSA), and supplier's best efforts. Pre-existing regional stockpiles of essential health products with longer shelf lives would have helped.

4. How effective was C19RM 2020 in strengthening health and community systems?

While the 9.8% of C19RM 2020 grant awards reported by the GF as being invested in health and community systems strengthening (HSS/CSS) could not be systematically evaluated (the GF could not even split this \$75 million between health and community systems), **the evaluators did find significant anecdotal evidence at country level of money being directed towards systems improvements such as COVID-19 surveillance and modeling, training and deployment of additional frontline health workers, and risk communications activities implemented by civil society organizations (CSOs).** Key and vulnerable population (KVP) communities and other civil society groups were involved in C19RM 2020 grant design in most countries, but several factors (short timelines, government focus on emergency COVID-19 commodity supplies, communications challenges, lack of clear guidelines on eligible activities) reduced their level of participation and the resources allocated to CSS.

5. Did the GF and ACT-A contribute meaningfully to each other?

There was a positive symbiotic relationship between C19RM and the ACT-A consortium of multilateral agencies and global philanthropies, but the consortium failed to deliver in several key areas. ACT-A boosted the GF's effectiveness in C19RM 2020 by legitimizing the GF's new role in fighting the pandemic and by providing technical support in several areas including oxygen equipment PSM. At the same time, the GF contributed to ACT-A's goals by committing over \$3 billion of the \$17 billion pledged by external funders to fight the pandemic, serving as co-convenor (with FIND) of ACT-A's Diagnostics Pillar, and playing a major role in the consortium's efforts to procure and supply PPE. However, ACT-A did not significantly add value to C19RM implementation at country level (based on the in-depth look at the sample of 8 countries) and only produced limited results in coordinating and integrating monitoring information from the different partners.

6. Additional overarching finding on evolving monitoring systems and data for C19RM

While monitoring in the first year of C19RM was relatively weak, the GF began to invest in a more comprehensive Monitoring & Oversight (M&O) system from April 2021 onward once it realized that the fight against COVID-19 was going to last and there would be growing accountability for additional external funding for C19RM 2021. While a detailed review of the new system is outside the scope of this evaluation, Pharos noted positively that several new tools (including Pulse Checks and Supply Chain and Health Services Spot Checks (HSSCs) have begun to generate valuable information for quarterly reviews by the C19RM Investment Committee (IC) to steer C19RM implementation. Supply Operations (SO) is simultaneously working toward an integrated health product demand forecasting and planning management system that will bring together PPM and non-PPM PSM data. The GF will need to guard however against the risk that the new M&O system could become overly complicated and burdensome and will want to ensure that it also meets needs of country implementers and development partners working alongside the GF, as well as the needs of the Secretariat and GF Board.

Lessons and Recommendations

Overall, the GF showed through C19RM 2020 that it could leverage many of its existing strengths (technical, operational, partnerships) and adopt new ways of doing business to respond rapidly and effectively to a global pandemic like COVID-19. At the same time, the GF struggled in several areas to utilize its pre-existing model to act effectively during a fast-moving pandemic. Two key examples: (a) Country Coordinating Mechanisms (CCMs) in many countries had only limited input from the national COVID-19 response leadership (this improved somewhat in the second year); and (b) while initial guidance alluded to importance of adjusting C19RM grants during implementation in response to quickly changing pandemic conditions on the ground, in practice the GF did not implement frequent, if not continuous, reprogramming of C19RM financing, something that country-based informants and GF staff pointed to as critically needed.

Sixteen recommendations were selected from a long list of potential recommendations to improve the effectiveness of C19RM and enhance the GF's ability to help countries prepare for and respond to future pandemics. Selection was based on expected benefits to C19RM effectiveness and GF PPR capacities, feasibility, and balance across thematic areas. The ten below are highlighted as being the highest priorities for the GF (all 16 recommendations are shown in Chapter 11). For the 10 priority recommendations, this summary ends with a matrix showing the level of fulfilment to date for each one. Two recommendations are substantially under way and need to be swiftly completed. The others should be pursued as soon as possible.

Improving C19RM impact on mitigation

- 1. Create a stronger, more coherent, and coordinated system for monitoring HTM services and disruption/recovery, both within the GF and with countries and other leading agencies.** The GF should play a leading role – working with others such as PEPFAR, UNAIDS,

and WHO – to support country-designed and managed monitoring systems that generate the needed data that is useful for in-country decision making (including but not limited to HTM) and concurrently meets the HTM-specific needs of the GF as a financier.

2. **Help to sponsor and establish a knowledge repository and learning hub for good practices in HTM innovation, adaptation, and mitigation to COVID-19.** Experiences – both positive and negative – and lessons learned need to be better collected, documented, vetted, published, taught, and discussed by countries as they design their mitigation measures.

Improving C19RM impact on direct COVID-19 response

3. **Complete the ongoing implementation of an integrated health product demand forecasting and planning management system** that provides routine and frequent data for both PPM and non-PPM procurement and enables timely, complete and useful access to and utilization of data for decision making on supplier diversity, product quality, product price, as well as supply chain performance from purchase order (PO) to delivery and utilization. We note this process has already started. In addition, **the GF and other development partners should intensify investments in national supply chain system strengthening including logistics management information systems (LMIS)** that are interoperable with the global system highlighted above and incorporate on-shelf and service availability into standard and routine metrics.
4. **Develop and implement new and more agile instruments for pandemic procurement including stockpiles, and support limited buffer stocks in suitable LMIC hubs for health products that do not have short shelf lives.** This will help to buy time if future health emergencies cause similar widespread disruptions. This includes deepening and improving the supply agreements developed for C19RM, including long-term agreements and volume commitments, as appropriate for market conditions and specific health products. The use of catalytic funding for stockpiles and Advance Purchase Commitments (APCs) for HTM health products under NFM3 has already been proposed, and this could be extended to pandemic health products. Stockpiles and improved supply agreements should be coordinated with ACT-A members with related mandates.

Improving the effectiveness of the ACT-A partnership with C19RM

5. **ACT-A partners, global health security key stakeholders, and agencies with emergency response mandates should adopt clear decision rules for PSM roles in a pandemic/emergency context,** prioritizing agencies with proven, robust PSM capabilities versus setting up parallel structures that further fragment health product procurement.

Improving the effectiveness of C19RM for health and community systems strengthening

6. **Given the importance of using C19RM to build long-term health systems resilience to pandemic threats and tap the knowledge and capabilities of civil society, consider a set-aside or earmark for each country for this purpose within the remaining expenditures under C19RM (and possible future PPR) grants.** Developing special incentives (for example,

matching resources from Catalytic Funding and giving countries additional time and technical assistance to develop and submit proposals) that encourage CCMs to submit HSS/CSS investment proposals would help compensate for the natural bias to request funds during an emergency largely for short-term commodity focused needs for direct pandemic response and HTM mitigation. **At the same time, develop clear and consistent definitions and ways to measure the HSS investments within C19RM.**

Improving the effectiveness of C19RM overall

7. **Complete the implementation of the M&O framework developed for C19RM 2021 (April 2021), with a focus on downstream implementation, impact, and quality,** being careful not to overload databases and dashboards to the point where country implementers and GF Country Teams (CTs) are overwhelmed by having too much data to interpret. Ensure that the input/output/outcome indicators chosen relate equally to all three components of C19RM (direct COVID-19 response, mitigation, and community and health systems), selecting a small number of the most important and measurable indicators for each area. The emerging findings and action points from monitoring analysis should be relayed to CTs and CCMs for quick action, and findings shared in the public domain.
8. **Develop a basic turnkey M&O system for any type of pandemic that the GF might be called upon to respond to in the future,** so that it can be rapidly activated without having to start from scratch. For each of the main classes of pathogens with pandemic potential, including respiratory, enteric, hemorrhagic and vector-borne, develop initial frameworks to monitor likely outputs and impacts, budget templates, preliminary allocation criteria, and expenditure tracking categories. Include easily activated ways to measure the disruptions of future pandemic pathogens on HTM services and outcomes (new infections, deaths), improving on what has been done for COVID-19 disruptions. Coordinate and partner with other global organizations conducting similar exercises.
9. **Give CCMs, Principal Recipients (PRs), and CTs tools and leeway to make frequent adjustments to C19RM-financed activities and budgets, on a quarterly basis or more often if required.** CTs could be given discretion for reprogramming up to a certain percentage of the C19RM grants without having to return to the IC, while still being subjected to spot checks and other accountability measures. Seek frequent input from PRs and CCMs on this “real time” reprogramming.
10. **Design and disseminate tools and technical assistance for C19RM grant costing, priority setting, budgeting, and expenditure tracking and reporting.** Improvements in budgeting and expenditure tracking are already taking place under C19RM 2021 but should be complemented with tools and processes for pandemic costing and priority-setting, value for money (VfM), and efficiency analysis.

Conclusion

By implementing the recommendations contained in this evaluation, the GF can strengthen the effectiveness and enhance the benefits of ongoing and any future C19RM investments. The C19RM 2021 awards amounting to \$3.5 billion (and still growing today) have another 19 months to run, and much can be done to raise their effectiveness and impact. By adopting these recommendations, the GF can expand the gains from C19RM investments in saving lives from COVID-19, better sustain HTM programs, and go farther in building systems for future pandemics; amplify its ability to monitor and learn from C19RM implementation; and continue to demonstrate through real measurable results that it is capable of capitalizing on its legacy business model while adapting its operating practices to better help countries to prepare for, prevent, and respond to the next pandemic. With active discussions currently taking place among countries and multilateral agencies about future global pandemic financing options, the recommendations in this report can support the GF to strengthen its capability and processes for PPR and position itself to utilize any possible additional resources to make a critical difference in the global response to COVID-19 and future pandemics.

Findings (as of May 2022)	Recommendation	Progress
2020 monitoring system nascent, weak ability to systematically track inputs, outputs, outcomes and impact which affected implementation, budgeting and prioritization	1. Complete the implementation of C19RM M&O framework developed for 2021 (April 2021), with a focus on downstream implementation, impact, and quality	
Time to design and develop an M&O system is limited during a crisis and takes a backseat to rapid execution	2. Develop basic turnkey M&O system for any type of pandemic the GF might be called upon to respond to in future	
Limited toolkit for C19RM 2020 costing, budgeting, and priority setting among competing demands inhibited investment optimization and reduced downstream ability to assess efficiency of grants.	3. Develop and disseminate tools and technical assistance for C19RM grant costing, budgeting, optimization, and expenditure tracking and reporting.	
While C19RM 2020 guidance envisioned flexible reallocation of grants to respond agilely during an emergency, this option of continuous reprogramming was not used	4. Develop processes to allow for PRs and CTs to make more frequent adjustments to activities and budgets, on a quarterly basis or more often if required	
No clear evidence or ability to understand whether C19RM 2020 investments have had an impact on mitigation; Surveys and analysis fragmented among multiple agencies	5. Create a stronger, more coherent, and coordinated system for monitoring HTM services and disruption/recovery, within the GF and with countries and other leading organizations	
Ecological evidence of investments in innovative service delivery suggests that some of innovations/adaptations may have contributed to mitigation, but there has been no systematic effort to capture learnings.	6. Sponsor and establish a knowledge repository and learning hub for good practices in HTM innovation, adaptation, and mitigation in the face of COVID-19.	
PQRs not required from PRs for COVID-19 products in C19RM 2020. Reports from country informants of limited stocks, price fluctuations, and inconsistent quality have not been documented. This compromised GF's ability to track non-PPM procurement.	7. Invest in an integrated health product demand forecasting and planning management system	
While the GF did a commendable job on procuring COVID-19 tests and on volume commitments, the lack of stockpiles of PPE cost the GF and its client countries time in completing in-country deliveries for urgently requested commodities.	8. Develop and implement agile instruments for pandemic procurement including stockpiles and hold limited buffer stocks in suitable LMIC hubs for health products that do not have short shelf lives.	
The ACT-A consortium did not set up clear decision rules for PSM roles under COVID-19. Several actors established parallel structures rather than optimizing existing ones such as PPM. This fragmented health products procurement, caused confusion for countries and suppliers, and delayed efficient pooled procurement of PPE and oxygen equipment.	9. ACT-A partners, global health security key stakeholders, and agencies with emergency response mandates should develop clear decision rules for PSM roles in a pandemic/emergency context	
C19RM 2020 HSS/CSS investments were only 10% of total grant awards, in part because of bias in favor of short-term emergency actions plus unclear guidelines and more deliberate processes to design HSS activities and to fully engage KVPs and Civil Society.	10. Consider a set-aside or earmark for HSS and CSS in future C19RM and PPR grants, including special incentives and separate timelines that encourage and enable countries to submit strong HSS/CSS proposals.	

PART A: INTRODUCTION

Chapter 1: Problem, Rationale, and Objectives

The Challenge of COVID-19

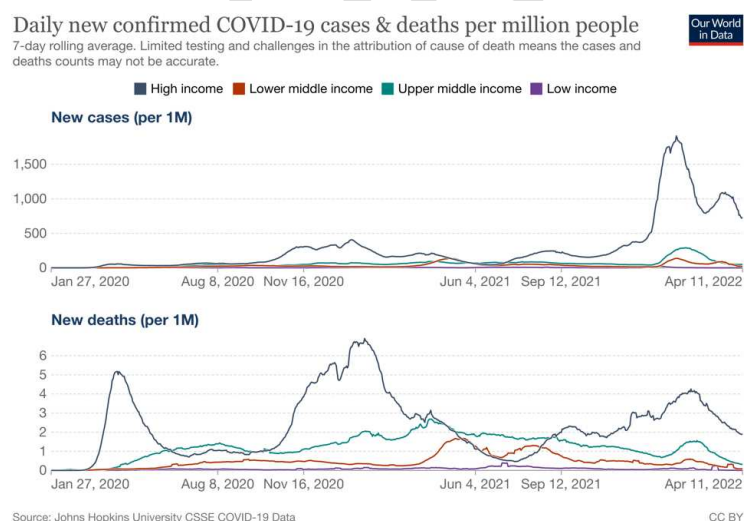
In December of 2019, a cluster of cases of viral pneumonia was detected in Wuhan, China, later identified to be caused by the novel coronavirus SARS-CoV-2.² By March 11th, 2020, cases of the coronavirus disease 2019 (COVID-19) had been confirmed in 114 countries and the World Health Organization (WHO) declared COVID-19 a global pandemic.³

COVID-19 has become the most severe threat to global health security since the 1918 influenza pandemic and has heavily impacted LMIC countries' economies and health systems. Further, several variants of concern have caused additional surges in case counts worldwide, such as the Delta variant in India which peaked on May 7th, 2021, at 400,000 daily cases.⁴

Common policy responses to COVID-19 have included testing and contact tracing efforts, social distancing measures such as curfews and gathering limitations, masking mandates, travel restrictions, and more. Despite these efforts, there have been over 500 million confirmed cases and 6.1 million deaths globally as of April 12, 2022.⁵

Figure 1 and Figure 2 show the COVID-19 situation across regions and income groups.

Figure 1. Daily new confirmed COVID-19 cases and deaths per million people



² CDC Museum COVID-19 Timeline. US Centers for Disease Control.

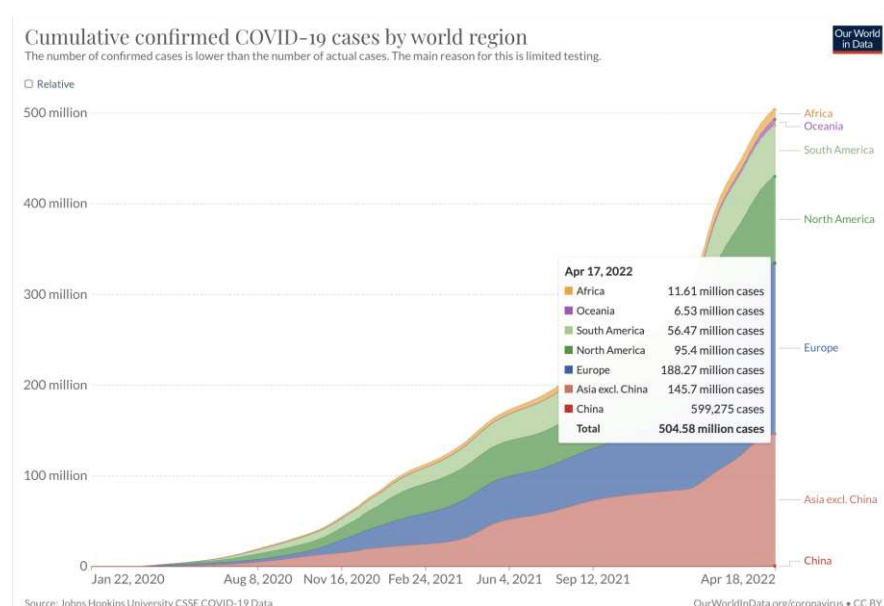
<https://www.cdc.gov/museum/timeline/covid19.html>.

³ <https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>.

⁴ <https://www.nature.com/articles/s41591-021-01618-w>.

⁵ <https://www.nytimes.com/interactive/2021/world/covid-cases.html>.

Figure 2. Cumulative confirmed COVID-19 cases by world region



Impacts of COVID-19 on Health Systems and Economies

The devastating impacts of COVID-19 on the global society and economy have been well documented. The decline in global gross domestic product (GDP) in 2020 was 4.9 percent, resulting in almost 3.94 trillion US dollars of lost economic output.⁶ Human capital has also been adversely impacted as 1 billion children globally have been denied a year of schooling leading to projected losses of US 10 trillion dollars in lifetime earnings.⁷

The Global Fund Response to the Pandemic

To respond to the COVID-19 pandemic, the GF made a commitment through its Board to actively protect the gains made in HTM programs during the past two decades from the impacts of the COVID-19 pandemic^{8,9} while assisting countries to fight COVID-19 directly and build stronger, more resilient health and community systems to address COVID-19 and future pandemics. The Board's statement of 7 April 2020 gives the rationale for this commitment and forms the backdrop to this evaluation: "The Board agrees that the COVID-19 pandemic poses a global public health emergency and that failure to control the pandemic **threatens to derail the Global Fund's mission to fight HTM and strengthen systems for health... As a major actor in global health, the Global Fund is uniquely positioned to deliver rapid support to countries developing responses to control the COVID-19 pandemic**" (our bold highlights).

⁶ World Economic Outlook, International Monetary Fund at <https://www.imf.org/en/Publications/WEO>.

⁷ Learning Losses due to COVID-19. <https://www.brookings.edu/blog/future-development/2020/07/30/learning-losses-due-to-covid-19-could-add-up-to-10-trillion/>.

⁸ The Global Fund. COVID-19 Disruption. <https://www.theglobalfund.org/en/covid-19/covid-19-disruption/>. Accessed on September 28, 2021.

⁹ McDonnell A. et al. A Path to Resiliency: Mitigating the Impacts of COVID-19 on Essential Medicines Supply Chains. <https://www.cgdev.org/publication/path-resiliency-mitigating-impacts-covid-19-essential-medicines-supply-chains>. Accessed on September 28, 2021.

The Board statement also captures the three broad areas where the GF has allocated C19RM resources to LMICs, and which are explored in separate chapters below, namely to:

“Finance interventions consistent with World Health Organization (WHO) guidance on COVID-19 and national Strategic Preparedness and Response Plans, including:

- a. **COVID-19 control and containment interventions**, including personal protective equipment, diagnostics, treatment, communications and other public measures as specified in WHO guidance;
- b. **COVID-19-related risk mitigation measures for programs to fight HIV/AIDS, tuberculosis, and malaria**; and
- c. **Expanded reinforcement of key aspects of health systems**, such as laboratory networks, supply chains, and **community-led response systems**, to address advocacy, services, accountability, and human-rights based approaches.”

To back up this intention with its resources, the GF agreed in March 2020 to reprogram parts of its existing grants (\$232 million in such “flexibilities” were approved) and in April 2020 the GF mounted a new grant facility, C19RM. Through the mechanism, \$759 million in notification letters were awarded in 2020 and \$3.5 billion (with 0.4 billion of funds still available) in 2021 to support a total of 130 countries and multicountries.¹⁰

Table 1. Total C19RM funding approved in 2020 and 2021

Total Grant Flexibilities 2020 approved in US\$ equivalent	231,699,586
Total COVID-19 RM 2020 approved in US\$ equivalent	759,000,003
Total COVID-19 RM 2021 approved in US\$ equivalent	3,368,971,949
Total approved in US\$ equivalent	4,358,002,800
Total countries and multicountries	131

Source: Funding Approved for the COVID-19 Response, as of 16 May 2022. <https://www.theglobalfund.org/en/our-covid-19-response/>.

An explanation of the global COVID-19 aid landscape can be found in Annex E.

Rationale and Objectives of the Evaluation

In October 2021, Pharos Global Health Advisors was selected by the GF’s TERG to conduct such an evaluation, focusing on the 2020 cohort of roughly US\$1 billion in grants for 2020 (“C19RM 2020” plus flexibilities), while also considering whether and how lessons from the first year were helping to shape the design and grantmaking of C19RM in 2021.

The objectives of the evaluation, as agreed with the TERG, were to:

¹⁰ Funding Approved for the COVID-19 Response. <https://www.theglobalfund.org/en/our-covid-19-response/>.

1. Determine the *relevance and appropriateness* of C19RM investments;
2. Analyze whether, how well, and why the C19RM was *effective in mitigating* the impact of the COVID-19 pandemic on HTM and broader public health, with special attention to the protection of human rights and KVPs;
3. Assess how *effectively C19RM assisted LMIC countries to fight COVID-19 directly*;
4. Evaluate *the effectiveness of C19RM in strengthening health and community systems* to prepare these countries to prevent, detect, and respond to future pandemics;
5. Examine the *results and benefits of the relationship between C19RM and the ACT-A partnership*; and
6. Provide *lessons learned and recommendations to inform enhancements* to future C19RM grants and in the GF's capacity to respond to future pandemics, especially in the light of the major ongoing global conversation regarding a new architecture and financing for pandemics.¹¹

The evaluation aims to generate insights that can be used to strengthen implementation of C19RM and improve the design of future pandemic financing efforts, focusing on the GF's areas of strength related to pandemic preparedness, prevention, and response.

Organization of the Report

This report is organized in three parts, with chapters in each that hew closely to the agreed scope and objectives. Part A covers the Problem, Rationale, and Objectives (Chapter 1) and Methods and Limitations (Chapter 2). Part B contains the main findings from the evaluation, comprising chapters on the overarching Monitoring and Data Challenges (Chapter 3) and Global and Country Governance (Chapter 4). Five of the six evaluation objectives are directly addressed in the chapters that follow: Appropriateness and Relevance of C19RM (Chapter 5), the Effects of C19RM on HTM Mitigation (Chapter 6), the Effects of C19RM on Direct COVID-19 Response via PSM (Chapter 7), the Effects of C19RM on Health and Community Systems (Chapter 8), and the Results/Benefits of C19RM and ACT-A (Chapter 9). Part C, consisting of Lessons Learned (Chapter 10) and Recommendations (Chapter 11), match the final agreed evaluation objective.

¹¹ <https://www.g20.org/wp-content/uploads/2021/07/G20-HLIP-Report.pdf>.

Chapter 2: Methods and Limitations

Theory of Change

The evaluation team sought to undertake a theory-based evaluation of the C19RM. However, there was neither a Theory of Change underpinning the C19RM at its inception nor an explicit design of a prospective evaluation. Therefore, the evaluation team retroactively developed a Theory of Change (Annex A) that incorporated but was not limited to elements of the GF's C19RM Monitoring and Evaluation (M&E) Framework (published April 2021, near the end of the first year of C19RM).¹² Some of the indicators in the Framework were not suitable for the evaluation, either because causal links from the C19RM to those indicators were tenuous at best, or because their measurement would be impractical within the scope and timeline of the evaluation (for example, COVID-19 cases and deaths averted).

The TERG commented on a draft of the Theory of Change. While the evaluation team considered those comments, it alone decided the final version of the Theory of Change. Furthermore, the TERG asked the evaluation team to consider whether it was possible to look at what comparable organizations have done in response to the emergency of COVID-19. The evaluation team notes the use of theories of change in such organizations' work on COVID-19. For example, the African Development Bank (AfDB) noted that the evaluation of its COVID-19 response would be theory-based and use a Theory of Change.¹³ The World Bank's COVID-19 Strategic Preparedness and Response Program includes an explicit Theory of Change.¹⁴

Since the time elapsed since the C19RM's initiation is short and given the multiple financiers of the overall COVID-19 response, the evaluation included neither assessments of its effects on aggregate health outcomes (such as those in the last column of Annex A) nor attributions of changes in such indicators to the C19RM alone.

The evaluation is retrospective. The design has no control group because all GF-eligible countries could participate in C19RM. The approach to this evaluation regarded the C19RM as a test of concept, and the evaluation is partly formative in that it sought to identify lessons that the GF might use to improve the mechanism. Emphasis was on the design, processes, and outputs (subject to data availability) in Annex A with attention to the key assumptions and counterfactuals.

¹² Global Fund. COVID-19 Response Mechanism Guidelines. 2021. M&E section.

https://www.theglobalfund.org/media/10759/covid19_c19rm-guidelines_external_en.pdf.

¹³ African Development Bank. 2021. Request for Expression of Interest African Development Bank Group (AfDB). Independent Development Evaluation department (IDEV) Consultancy services: Evaluation of the Africa Development Bank Group's COVID-19 Response. https://www.afdb.org/sites/default/files/reoi_covid-19_response_evaluation_27th_oct_2021_003.pdf. Accessed on April 5, 2022.

¹⁴ World Bank. 2020. COVID-19 Strategic Preparedness and Response Program and Proposed 25 Projects Under Phase 1 Using the Multiphase Programmatic Approach. <https://documents1.worldbank.org/curated/en/993371585947965984/pdf/World-COVID-19-Strategic-Preparedness-and-Response-Project.pdf>. Accessed on April 5, 2022.

Data Sources and Collection

I. Supra-national (global and regional) levels

Quantitative data were obtained from publicly available documents and a mix of public and confidential GF documents and databases made available to Pharos. Qualitative data were obtained from interviews with key informants (KIs) in global and regional institutions (technical agencies, partnerships, and financiers) and from more than 35 GF staff. Annex F shows a list of the interviewees and their institutions.

II. Country level

The scope included quantitative data (mainly from records of grant approvals, disbursements, procurement, and country-level aggregated data on HTM and COVID-related service delivery and health status) and qualitative data (from in-depth interviews and focus group discussions at country levels). Quantitative data were collected for the baseline (situation before C19RM started) and end-point data (status at the time of data collection, most of which took place between January and March 2022, depending on when the GF approved the inclusion of each country in the evaluation). The list of documents is included as Annex H. Qualitative data were obtained from more than 120 in-depth interviews and focus group discussions with key country informants, such as officials from Ministries of Health (leadership and technical staff in the responses to HTM and COVID-19), the CCM, PRs, CSOs, international non-governmental organizations (NGOs), and representatives of development partners.

III. Country selection

The evaluation team proposed in early October 2021 a list of 12 countries for inclusion in the study. This initial list underwent multiple reviews in consultation with the GF Secretariat's Grant Management Division (GMD) and the TERG, and Pharos was eventually requested to drop 8 of the 12 countries (retaining El Salvador, Malawi, Ukraine, and Vietnam) and to search for others. The final list of countries included in this evaluation is shown below (Table 2). The accompanying Table 3 shows the COVID-19 profiles for the eight countries. Table I-1 in Annex I summarizes the economic impacts of the COVID-19 pandemic on the selected case study countries.

Table 2. List of countries examined in depth for the evaluation.

Country	Region	GF grant allocation 2020-2022 (US\$ m)	HTM components in order of size in GF HTM grants	Flexibilities awarded 2020 (US\$ m)	C19RM 2020 awarded (US\$ m)	% of global C19RM 2020 awards	C19RM 2021 awarded as of 16 May 2022 (US\$ m)
Angola	Africa	82.6	HIV, TB, malaria	1.6	6.2	0.8%	23.0
El Salvador	LAC	19.3	HIV, TB	1.0	0.89	0.1%	4.8
Malawi	Africa	512.9	HIV, TB, malaria	0.74	30.8	4.1%	102.6
Peru	LAC	19.9	TB, HIV	1.2	1.8	0.2%	14.9
Rwanda	Africa	190.2	HIV, TB, malaria	5.5	11.4	1.5%	47.5
South Africa	Africa	536.8	HIV, TB	12.3	52.2	6.9%	186.0
Ukraine	Europe	119.5	HIV, TB	1.9	10.8	1.4%	41.8
Vietnam	Asia	114.8	TB, HIV	3.0	8.8	1.2%	34.6
8 countries	-	1,595.9	HIV, TB, malaria	27.3	122.9	16.2%	455.3
Global total	-	12,659.3	HIV, malaria, TB	231.7	757.3	100%	3,369.0

Sources: C19RM 2020 and 2021 allocations as of 16 May 2022; GF Data Explorer – Allocations: <https://data.theglobalfund.org/viz/allocations>

Table 3. COVID-19 in the case study countries, as of early April 2022

Country	GNI per capita (US\$ thousands)	Cumulative cases (thousands)	Cumulative cases per 1M population	Cumulative deaths (thousands)	Cumulative deaths per 1M population	Estimated excess deaths per 1M people	Vaccine doses per 100 population	Persons fully vaccinated per 100 population
Angola	2.1	99	2,923	1.9	56	1,320	53	18
El Salvador	3.6	161	24,786	4.1	632	3,660	160	66
Malawi	0.6	86	4,360	2.6	134	1,390	10	5
Peru	6.0	3,547	106,374	212	6,355	6,570	201	78
Rwanda	0.8	130	9,771	1.5	110	1,990	153	63
South Africa	6.0	3,719	62,006	100	1,666	4,220	56	31
Ukraine	3.6	4,969	115,962	108	2,587	4,970	72	35
Vietnam	2.7	9,565	100,015	42	434	2,520	207	78

Sources:

GNI per capita: <https://data.worldbank.org/indicator/NY.GNP.PCAP.CD?locations=SV-PE-UA-AO-MW-ZA-VN-RW>; World Bank income classification: <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups>; Cumulative cases and deaths and vaccination rates as of 4 April 2022: <https://covid19.who.int/table>; Cumulative cases and deaths per 1M population as of 3 April 2022: <https://ourworldindata.org/covid-cases>; Estimated cumulative excess deaths per 100,000 people from *The Economist* as of 28 March 2022: <https://ourworldindata.org/grapher/excess-deaths-cumulative-per-100k-economist>

This evaluation draws from two Office of the Inspector General (OIG) reports on C19RM^{15,16} and complements and extends OIG analyses by including: (1) a more in-depth look at procurement and supply chain performance; (2) a separate examination of GF partnerships under ACT-A; (3) deeper probes into the community engagement and country governance aspects of C19RM; (4) a more documented assessment of M&O systems; (5) the use of more country cases and examples to obtain a “country-centric” view of C19RM; (6) compilation of lessons learned from C19RM 2020 and analysis of their application in the second year; (7) additional and more explicit recommendations to the GF for enhancing C19RM implementation and building GF capacity to support country pandemic preparedness.

This C19RM evaluation also draws from the recently published TERG-Secretariat Thematic Review¹⁷ of the GF’s abilities to support PPR. That report documents the GF’s ongoing efforts and capacities to use the Resilient and Sustainable Systems for Health (RSSH) components of its regular HTM grants and the extra resources of C19RM to drive improvements in PPR performance in LMIC countries, and points to areas where the GF would need to change its organizational structures, processes, and skill sets to play an expanded role in this area.

Study Limitations

I. Country selection

The finalization of country selection for the evaluation was difficult and time-consuming, largely because of feedback from GMD that certain countries selected by Pharos TERG were seen by GMD as already overburdened with 2020-2022 allocation period grantmaking, other evaluations, and special initiatives. Sometimes, the rationale for objections was unclear. As

¹⁵ Audit of COVID-19 Response Mechanism (C19RM). April 2021.

¹⁶ Audit of the COVID-19 Response Mechanism 2021. 29 March 2022.

¹⁷ Thematic Review of Global Health Security (Pandemic Preparedness and Response), May 2022. https://www.theglobalfund.org/media/11996/terg_global-health-security-ppr_report_en.pdf.

such, the evaluation experienced delays that ranged from 1-3 months before the team could start working.

II. Study design

As mentioned above, the lack of Theory of Change and of a prospective study design limited the rigor that could be applied to the evaluation. This evaluation's recourse is to a single-group, post-test only design, with a convenience sample of countries. The design provides no basis for rigorous inferences of causal relationships between the C19RM and outcomes of interest. Therefore, discussions and conclusions about the effects of C19RM are limited to the more immediate activities, processes, and (sometimes) outputs that are most directly traceable to inputs financed by the C19RM. Even those must be interpreted with caution.

III. Data availability

There were significant delays in securing access to certain data and records within the GF Secretariat, including but not limited to: C19RM 2020 country and aggregate procurement data; country data on COVID-19 and C19RM 2020 implementation from spot checks and Progress Update/Disbursement Requests (PU/DRs); and detailed country data on financial performance during the first year of the new grant facility. As shown in Annex H, while some internal documentation on C19RM guidance, monthly updates and country FRs were readily provided, critical historical indicator reports and assessments were only shared months after initial requests, and as late as the end of April when the evaluation was nearly complete. This limited the depth of the analysis that the evaluation could perform.

A lack of access to country-level service delivery data for HIV/AIDS, TB, and malaria (on a quarterly or even 6-monthly basis) in 2020 and 2021 prevented the preferred approach of studying the trajectory of such services from the period before COVID-19 started, to the time of the evaluation. Underlying the data challenges was the fact that the monitoring and reporting systems for C19RM—especially for the first year of the program—were not very developed and records related to procurement (especially national procurement), finances, and programmatic performance and impact are few and scattered. This is discussed in Chapter 3 below.

IV. The war in Ukraine

The war in Ukraine prevented the evaluation team from doing all that it planned to do in that country. Nevertheless, the team adapted and was able to conduct a core of the evaluation in Ukraine.

PART B: FINDINGS

Chapter 3: Monitoring and Data Challenges

In many evaluation reports, monitoring and underlying data collection and analysis would be relegated to a late chapter that provides limited comments and suggestions on how to further enhance a functional monitoring system. In the case of C19RM 2020, however, the design and limitations to monitoring are so fundamental to the rest of the evaluation – since the incompleteness of the data, underscored by the absence of a theory of change and M&E framework for the first year of the program – that we cover this topic up front before turning to our assessment of the effectiveness of C19RM 2020 in achieving its stated goals.

Context and Purpose

When the WHO declared a PHEIC on March 11th, 2020, it was not yet known how long or what scale would be required from the global response to COVID-19. The GF recognized that a large international response would be urgently required and moved to rapidly make funds available to countries to protect their HTM programs with the primary goal of mitigating the effects of COVID-19 on health systems, as it was clear from the beginning that lockdowns, infections and deaths among health workers, and disruptions to the global pharma supply chains would disrupt HTM and other health programs.

Given the emergency context, and the fact that the GF was responding for the first time in its history to a pathogen that was not HIV, TB, or malaria, rapid approval and disbursement of funds was prioritized without much thought or planning for program monitoring. This makes the task of retrospectively trying to understand what the C19RM 2020 money was spent on and the true impact the additional funding had on HTM mitigation, direct COVID-19 response, and health and community systems improvements extremely difficult.

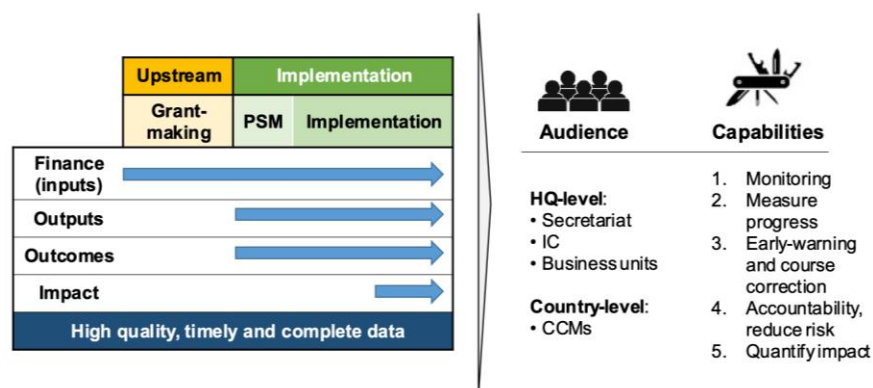
Approach

To conduct this analysis, it is important to imagine what an ideal M&O system for C19RM would look like, and to compare this with what existed in 2020. A strong system would:

- a) cover a range of different kinds of information important for successful planning and implementation, including data on finances, procurement and supply chain, delivery of services and their impact on overall program coverage and on disease including COVID-19 and HTM;
- b) cover information at different stages of grant development and execution (upstream and downstream) and examine inputs, outputs, outcomes, and processes;
- c) be of excellent quality and timeliness – in the case of a fast-moving pandemic, this would mean weekly and monthly if not daily information during the acute phase, in contrast to the six monthly and annual reporting that traditionally has been done by the GF for HTM;
- d) reach different audiences in a timely way, including country actors (e.g., CCM and PRs), GF CTs, the Secretariat's senior management, and other audiences including the Board and key (ACT-A and other) partners including major donors to C19RM;

Figure 3 shows the ideal M&O system, and subsequent figures in this chapter show what actually emerged in 2020-21 and in the second year of the C19RM program.

Figure 3. The ideal M&O system



M&O in C19RM 2020

C19RM M&O initially began with reports by the secretariat on amounts of funding approved, commodities ordered, and state of the COVID-19 pandemic, with a focus performance defined as the speed of FR and approval. Ad-hoc reporting, including increased remote engagement with CCMs/PRs/Partners, secretariat-led surveys of country stakeholders, CSO round table discussions, and CCM engagement were also conducted.¹⁸ These ad-hoc exercises were used to assess the dynamic situation in-country, identify issues, troubleshoot and course-correct, and while unstructured and not systematized initially, provided critical real-time observational information when structured data inputs were not available.

The main structured M&O inputs for C19RM 2020, initiated between March and November of 2020 (see timeline) included the following:

1. Order summary and delay dashboard
2. Bi-weekly country monitoring surveys
3. Monthly grant monitoring surveys
4. Quarterly spot check surveys

1. Procurement order summary and delay dashboard

This dashboard was rolled out starting in Q4 2019 and provided some visibility into product delivery and enabled forecast on delays. The dashboard was only able to provide information on procurements through Wambo and not to track TB medicines or other products procured through the Global Drug Facility, UN pooled procurement (UNICEF and UNDP), or via national systems. The inability to track purchases outside of PPM has been a significant obstacle in understanding what commodities were purchased with C19RM 2020 funding. A more detailed description and analysis of PSM during C19RM 2020 can be found in Chapter 7.

¹⁸ OIG Audit report – 27 May 2021

II. Bi-weekly country monitoring surveys

This tool was first launched in May 2020 and was composed of an online survey completed by Local Fund Agents (LFAs) every two weeks.¹⁹ The results were consolidated and presented to the Management Executive Committee and included in bi-weekly COVID-19 situation reports. The survey tracked health service disruption at global, regional and country levels with a focus on HTM disruption risk. It did not include COVID-19-related indicators. The survey was designed to be a light lift for the LFA respondents to encourage timeliness of response. The main limitations of this survey are that there are no standards for the risk levels, and only capture LFA impressions at that moment in time and may not be comparable from one LFA to another.

III. Monthly grant indicator surveys

These surveys were conducted monthly and published every quarter for 38 high-impact and core countries and tracked selected HTM indicators. These trend data complement the bi-weekly country surveys by providing more specificity around selected outcome metrics such as numbers of people reached with prevention, testing and treatment services. The monthly grant indicator tool was a simplified but accelerated version of existing HTM grant monitoring exercises. The main limitations were that the indicators tracked per country are not uniform, with some countries tracking several and others tracking only a few, indicating that the degree of granular visibility into service disruption is not equal between countries.

IV. Quarterly spot check surveys

As part of the effort to strengthen operational oversight, supply chain and service spot checks were initiated sporadically before being formalized in Q4 of 2020, and gave some information on disruption of services, availability of key commodities, and effects of adaptive measures at facility level. The facility questionnaires reviewed aspects of 1) Supply chain management; 2) Distribution; and 3) Commodity-based service delivery. The survey had 27 questions.

Table 4. Overview of C19RM 2020 M&O components

Component	Contents	Frequency
Order summary dashboard	Lead times for key HTM and COVID-19-related commodities	TBD
Country monitoring survey	28 traffic light indicators on aspects of grant creation and implementation for HTM and RSSH	Bi-weekly
Grant indicator survey	Selected HTM coverage indicator trends for the country	Monthly
Facility spot checks	27 questions on facility-level management and service delivery of COVID-19-related commodities	Quarterly

V. Other monitoring inputs

PU/DRs. These are already conducted every 6-12 months for the regular HTM grants and provide detailed information on coverage, outcome, impact, budget, expenditure, absorption, procurement, forecasts and LFA recommendations for HTM grants. At the outset of C19RM, they were the only source of information on service disruption, but it was clear that the level of

¹⁹ Global Fund COVID-19 Country Monitoring Tool Guidance Note for LFAs – March 1, 2021.

detail was too onerous and the reporting frequency too slow to be of any use as a foundation for C19RM M&O.

Ad-hoc check-ins with CCMs, PRs, and CSO surveys. In addition to the tools described above, many KIs reported that frequent, ad-hoc check-ins with PRs, LFAs and other local contacts were critical, especially in the acute phase of the pandemic, to understand what was happening at country level before official data became available.

Financial monitoring and reporting. When the C19RM 2020 mechanism was launched, there was no time to develop budget templates or adapt systems to accommodate the new grant pillar. A budget module was created for COVID-19 and added to the NFM2 budget system in excel, tracking just two categories for direct COVID-19 support and HTM mitigation. Reporting and reconciliation were complicated by the fact that the C19RM 2020 grantmaking period from April 2020-June 2021 does not follow the NFM2/3 periods but overlaps the grant cycles

A major limitation of C19RM 2020 financing monitoring is the fact that there is no ability to separate C19RM 2020 funding from grant flexibilities that were authorized due to how the C19RM funds were budgeted and integrated in 2020.²⁰ Furthermore, there is limited and delayed visibility on what C19RM 2020 funding was actually used for purchases made outside of Wambo. This has affected the GF's ability to monitor absorption by countries and respond in a timely way to address bottlenecks or reallocate unspent funding elsewhere.

We received late in the evaluation process a country-by-country table showing the level of absorption of C19RM 2020 and a revised table in the final days of the exercise. It shows overall absorption (defined as the share of the grant award that was spent by 30 June 2021) at 57% of the roughly \$990 million approved for 2020 Flexibilities plus C19RM 2020, and a wide range of levels in the 8 cases study countries, from a low of 7% in El Salvador²¹ to a high of 78% in South Africa and Ukraine. We have not been able to verify the underlying amounts by component, activity, or input, or whether absorption has continued to improve over the past 9 months.

VI. Strengths and weaknesses of 2020 M&O

The GF's initial set of grant monitoring measures were not designed for a pandemic context and required the GF to rapidly adapt existing measures and design and implement new ones as well. Measured against the goals of speed, the 2020 system did a reasonably good job of rapidly approving and disbursing funding to countries as evidenced by the rapidity of grant approvals especially compared to peer organizations and by allowing countries to reprogram grant funds immediately through grant flexibilities. Although the GF was one of the slowest to initially approve a COVID-19-specific grant mechanism²² following the WHO declaration of a pandemic (29 days after the declaration relative to 35 days before the declaration by BMGF²³), the GF had

²⁰ OIC Audit of COVID-19 Response Mechanism 2021

²¹ Since El Salvador reports annually, this amount is for spending only through 31 December 2020.

²² Grant flexibilities were approved on 4 March 2020.

²³ OIG report April 2021

caught up and was a leader at the end of August 2020, having approved 100% of funds compared to 7-65% of other peer organizations.

However, measured against the goals for tracking of inputs and facilitating accountability, the 2020 system had little capacity to meet these requirements. There was only a basic ability to track funding approvals, and visibility into absorption became murky particularly for purchases made outside of Wambo.

Interviewees reported that data quality and completeness issues were a significant impediment to making sense of the data that was coming in. Efforts have since been made to improve data quality and completeness by providing technical support to PRs and LFAs as they gain familiarity with the new tools and requirements, but quality and completeness remain an ongoing concern.

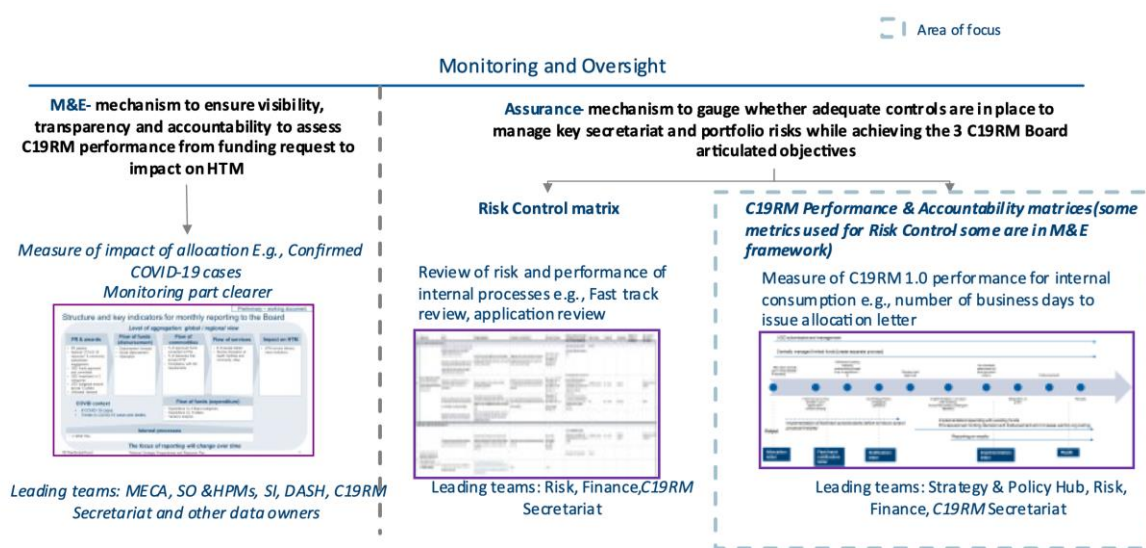
M&O Part 2: From Basic Reporting to Robust Continuous Learning System

Beginning in January of 2021, it was becoming increasingly clear that the COVID-19 pandemic was going to continue to grind on, and that support to direct COVID-19 relief and COVID-19 HTM mitigation efforts was going to continue. The GF learned that it might be asked to carry out with a second year of C19RM grants at a high level of funding with increased anticipated demands for reporting and accountability from donors, and this, combined with the known challenges of getting clear visibility into 2020 implementation, motivated the Secretariat to begin developing a more robust M&O system.

A workstream was created in Q1 of 2021 to develop an M&O system that could ensure visibility, transparency and accountability end-to-end from FRs all the way to HTM impact, as well as provide assurance that adequate controls were put in place to manage secretariat and portfolio risk while achieving C19RM objectives. Towards the end of the 2020 reporting period, a new M&O framework was developed, made up of enhanced reporting tools, and launched in April 2021. There is however no plan to apply the 2021 new metrics and systems retrospectively to C19RM 2020 grants.

The new 2021 M&O framework shown in Figure 4 below aims to more clearly articulate what the 2021 funding was spent on, whether it had impact on COVID-19 pandemic mitigation and minimizing HTM service disruption, and the reasons for success or challenges. The framework differentiates between upstream processes involving speed and timeliness of award making, and the downstream dimensions of implementation. The main inputs at the upstream level include award and investment dashboards which will be used for monthly reporting to the MEC and quarterly cross-cutting reports to the IC. At the downstream level, the main inputs will include the harmonized supply chain and HSSCs and regular pulse checks, in addition to strengthened expenditure reporting. COVID-19 morbidity and mortality reports are being collected from partners Pulse check and spot check data and other sources are being merged in country dashboards and are being used for internal Secretariat analyses and reporting, grant implementation reviews, and quarterly updates to the IC.

Figure 4. New C19RM 2021 M&O framework



While the 2021 system has been greatly strengthened with regular and systematized data inputs compared with the nascent 2020 system, there are still some issues and challenges:

1. The current M&O system is focused primarily on headquarters (HQ)-level monitoring, with data flowing upwards from country-level. Informants report that the needs of country level actors, including CCMs, PRs, and even the Secretariat's CTs are not being fully met. Reporting requirements place a lot of burden on country governments and PRs and may be of limited direct benefit to these in-country actors, who do not yet have access to the full set of dashboard data. We learned that some country CCMs like South Africa are developing and maintaining their own parallel M&O dashboards, as they are not familiar with the centralized data of the GF.
2. The amount of data being collected is becoming richer and growing; however, it is still not clear who should have access to the data and for what. We learned from interviews that some Fund financial analysts without experience in public health concepts were analyzing data inputs incorrectly which have led to confusion.
3. It is also not yet clear to us how exactly the increasingly rich data is being used to quickly and appropriately course correct.
4. Although data sharing agreements are currently being negotiated, we noted that data being collected is not routinely being shared with other partners, leading to unnecessary duplication of efforts and frustration by certain partners that they are not able to use this information to assist the GF or coordinate their own country-based activities with C19RM.

Chapter 4: Effectiveness of Global and Country Governance and Coordination

Introduction

The governance arrangements and processes surrounding C19RM 2020, both at Geneva Secretariat HQ and country levels, were marked by several clear characteristics: a focus on speed, especially up front in funding request development, review, and IC approval; less emphasis on downstream implementation, including in the monitoring of financial, procurement, and programmatic performance; and an attempt to use existing arrangements while selectively innovating and adapting.

The observations and analysis below are based on a combination of review of documents such as terms of reference for new management and coordination structures within the Secretariat and guidelines for C19RM grant requests, and interviews with Secretariat staff and country and global stakeholders and partners.

Global Governance and Processes

While the Secretariat issued a general guidance note for C19RM 2020 in April 2020, justifying the need for the additional funding, highlighting the three broad areas for potential investment, and outlining the steps from grant design to notification and integration in existing NFM2 grants, there was little practical guidance to countries and CCMs. The pre-existing HTM grantmaking approach was used and adapted to C19RM 2020. Some components of regular HTM FRs, including detailed budgets and procurement plans, funding landscape tables for COVID-19, and a C19RM specific performance framework were not required in 2020.

Two important changes in governance were the establishment of a C19RM Secretariat and the use of the Secretariat's IC review to approve FRs—based on concurrent review by a technical advisory group drawn from CTs, Technical Advice and Partnerships (TAP), Community, Rights, and Gender (CRG), SO, Risk, CCM Hub, and Finance—without calling on the Technical Review Panel (TRP) for input. Most FRs could also be signed off by the Secretariat, without the need to go to the Board for final approval. The Secretariat briefed the Board frequently on C19RM 2020, with briefing meetings taking place monthly or even more often.

In its C19RM 2020 processes, the Secretariat consciously chose to utilize several pre-existing features of the GF's operations that helped to expedite the first year of supplementary grant-making. These included the services and practices of SO (primarily PPM), reliance on current PRs rather than selecting new implementing partners, and tapping the leadership and endorsement of the CCMs.

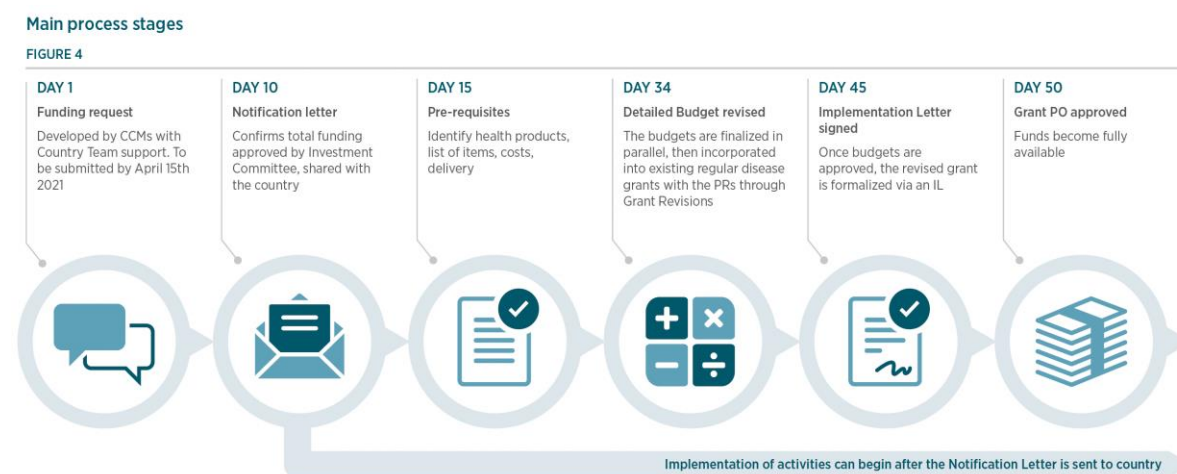
At the same time, there were important adaptations that improved C19RM effectiveness:

- Monitoring and factoring in the new COVID-19 pandemic, both in its burden and impacts and the potential of pharmaceutical and non-pharma interventions such as distancing, masks, hygiene, and ventilation

- Forming new partnerships with expert groups on COVID-19 and health emergencies, including through ACT-A.
- Incorporating new commodities (COVID-19 tests, PPE, COVID-19 therapeutics) and HTM interventions in its list of investments eligible for C19RM financing.

The Secretariat set standards for elapsed time for each of the early steps in grantmaking (review and approval of FR, issuance of notification letter) and later added key performance indicators (KPIs) related to disbursement (processing of PO) and grant revision. The OIG has already analyzed and commented favorably on the GF's ability to meet these targets in a timely way (for example, 72% of grants converted to Pos within the 50-day limit) and on the decision to add KPIs in July 2020 including a 15-business day target to send a notification template requesting grant budget details, and the percentage of grant budgets completed and signed within 38 working days after issuance of the notification letter.²⁴ COVID-19-specific KPIs and targets were not set for C19RM 2020 given the fluid and unpredictable nature of the pandemic, and the lack of an established theory of change between COVID-19 inputs and impact.²⁵

Figure 5. Main process stages of C19RM 2020



Source: OIG Review of C19RM 2020, April 2021.

Numerous Secretariat and country-based stakeholders interviewed for this evaluation acknowledged that CCMs had little guidance to go on in developing their C19RM 2020 FRs but argued that there was not enough time or technical knowledge of exactly what to do to be able to guide countries effectively.

“Everyone was operating in the dark”

“We prioritized speed in getting the money out over everything else”

“Our CCM received only minimum instructions from Geneva.”

—Kis

²⁴ OIG Audit of COVID-19 Response Mechanism – April 2021

²⁵ C19RM Monitoring and Evaluation Framework – April 2021

The absence of budgets of the kind normally used by the GF for regular HTM grants (and by other donors such as the World Bank and PEPFAR) made it difficult to judge FRs at the IC stage. Countries were asked to create more detailed budgets when NFM2 grants were revised to reflect the new C19RM 2020 activities, but again the level of detail was low and did not include specific quantities and unit costs. One of the steps mentioned in the C19RM guidance was to “agree on breakdown of C19RM funding, activities, and health products”. This was not done in the first year of the program but has been implemented in the second year.

One area of proposed innovation mentioned in the initial guidance for 2020 was “Reinvesting C19RM Funds”, including savings that arose in the course of implementation. This could potentially have been used to implement continuous and flexible reprogramming of C19RM funds as the situation on the ground and needs for COVID-19 support evolved during 2020 and 2021. While there were more than 40 cases of countries receiving “top ups” following their initial award, we did not come across examples of CTs practicing continuous reprogramming. Several FPMs mentioned that such reprogramming would be desirable but were concerned that this would be too time-consuming if it required another sign off by the IC.

Country Governance and Processes

To optimize C19RM performance, it was expected that three key governance processes would function effectively: the CCM as an inclusive and effective body, increased coordination between the CCM and the national COVID-19 response leadership team, and harmonized actions between the CCM and externally financed activities of other partners in the COVID-19 response.

II. CCMs and C19RM

CCMs were able to mobilize rapidly for C19RM 2020 grants, with mixed results. Their experience with HTM was an asset in developing investments in HTM mitigation. The civil society representatives in the CCMs were well suited to addressing the negative effects of COVID-19 on KVPs but did not reflect the view of other population segments disproportionately affected by COVID, such as undocumented immigrants, ethnic minorities, and the elderly.

The challenges of including CSOs in the design of C19RM 2020 FRs and in implementing 2020 activities are covered in Chapter 8.

In response to these challenges, C19RM 2021 included a 25% increase in funding to reinforce CCMs for PPR by hiring engagement officers and other short-term support. The GF also set new requirements in 2021 to improve coordination, requiring the sign-off of the national COVID-19 response body (C19RM FR, 2021). Together these three changes made a significant difference across the portfolio in the C19RM 2021 applications. In Ukraine, for example, all sectors (government, international partners, civil society and communities) were actively engaged in the FR process in 2021. One CCM member estimated that there were over 50 meetings to prepare the C19RM funding request. In Rwanda, the FR process in 2021 was also much more extensive, with increased involvement of CSOs leading to specific initiatives advocated by civil

society (e.g., awareness campaigns at decentralized levels, provision of PPE to ensure community interventions).

II. CCMs and COVID-19 Command Centers

Regarding integration with the national COVID-19 response overall, one key informant stated that “by taking applications through the CCM, we forced an institutional link between the CCMs and the national COVID-19 bodies”. During the early days of the pandemic in the first half of 2020, however, many countries did not have national COVID-19 strategies in place, CCMs did not have the right mix of stakeholders with pandemic control knowledge, and countries requiring funding request signoff from government representatives sometimes suffered long delays in getting approvals.

Despite the general issues on C19RM linkages to national COVID-19 response agencies, we came across some positive examples in our case studies:

- Malawi stakeholders confirmed that the activities in the FRs for C19RM 2020 were taken from the national COVID-19 plan.
- The CCM and Project Implementation Unit (PIU) in Malawi used the first national COVID-19 plan to inform the FR development, filling resource gaps identified in the plan including communications, community engagement, case management, risk planning, infection prevention and control, and additional staffing, as well as procurement of equipment, oxygen, gas plants, medical drugs, and PPE.
- In Rwanda, the close connection between the individuals in the PR, the Ministry of Health (MOH), and the leadership of the COVID-19 response in the Ministry led to a tight focus on C19RM activities that were included in the national COVID-19 plan. The writers of the FR for C19RM 2020 included the chairs and co-chairs of the COVID-19 National Command Post and advisors to the National Steering Committee on COVID-19 management strategies.
- In Togo, several members of the PR/CCM were also directly involved in developing and implementing the national COVID-19 program.

II. Partner coordination at country level

To a certain degree, the long-standing representation of partners in the CCM (especially WHO, UNAIDS, PEPFAR) ensured that they followed and signed off on C19RM 2020 funding request development. We came across examples of this in most of the case study countries:

- In Vietnam, WHO helped with technical advice in proposal development. The WHO Representative also serves as Vice-Chair of the CCM.
- In South Africa, the Funding Review process for 2021 included the Health Partners Forum for development partners working in South Africa such as BMGF, USAID, CDC, and UK DFID. WHO also advised on the alignment of C19RM with the WHO’s COVID-19 response guidance.

However, there was no formal guidance on involvement of other partners in C19RM 2020 or to increase their involvement in the CCMs in countries where they play a smaller role. A regional

head confirmed that the GF prioritized funding the countries immediately and that “coordination was needed later.”

Chapter 5: Relevance and Appropriateness of C19RM Investments

Definitions

For purposes of this evaluation, by “relevance” we mean: did the scope, mix, and balance of investments in C19RM match the needs of LMIC countries in fighting COVID-19 and its consequences for HTM? Are there approved investments in C19RM 2020 that were not important in achieving these goals and might have been dropped, or important investments that were not recommended or were not approved that should have been included?

Similarly, by “appropriateness” we mean: were the investment areas in C19RM 2020 ones where the GF had a strong pre-existing competence that it could use to support the LMIC countries and their grants, or could quickly adapt an existing domain of comparative advantage to be effective? Conversely, were there any investment areas that seem inappropriately beyond the mandate and competence of the GF and might have been better left out of the approved grants?

Relevance and appropriateness of C19RM 2020 investments must be judged in terms of what would have been reasonable under the exceptional circumstances prevailing in early 2020: the lack of information about COVID-19 and what would work in COVID-19 prevention and treatment, limited coordination structures between countries and partners and among partner agencies; and the constrained capacity of LMIC countries to flexibly adapt to the pandemic and implement the chosen C19RM 2020 investments. In such an emergency situation, there was a need for speed, and the more deliberate regular processes of the GF and of countries had to be streamlined while at the same time minimizing consequential reductions in quality and effectiveness.

On this basis, we found that the C19RM investments—based on the limited data available and judgments of reasonableness—were largely relevant to the needs of countries and to the stated triple objectives of C19RM (fighting COVID-19, mitigating impact on HTM, building systems). They were also appropriate to the GF’s comparative strengths in combatting the three major epidemics of HTM, large scale commodity procurement, and HSS/CSS.

In terms of relative allocations across the three main components, the latter (systems strengthening) received little attention in 2020. This may be understandable and explained by the fact that direct COVID-19 response was an urgent necessity and the GF and its country stakeholders associated with the CCM and regular HTM grants focused on avoiding a disaster via major disruption or collapse of HTM services; and the fact that the systems-building agenda is by its nature more long-term and requires patient investment more associated with multi-year capacity building grants rather than short-term emergency funding. At the same time, C19RM 2020 might have focused greater investments on selected health and systems areas that could have directly supported the first two objectives, such as COVID-19 surveillance and

health management information systems (HMIS) modules and stronger and more coordinated monitoring and analysis of disruptions and recovery of HTM services.

2020 Flexibilities

There is no detailed breakdown of the US\$232 million in COVID-related flexibilities (reprogramming of existing grants) by component and activity. Based on interviews with GF CTs and regional managers, it seems that this money was mostly redirected into urgently requested COVID-19 commodities, mainly PPE and polymerase chain reaction (PCR) diagnostic tests. At the time the flexibilities were approved (Q1 and Q2 2020), countries were struggling to put in place lockdowns and social distancing measures and to protect health and outreach workers from COVID-19 infection, and the flexibilities enabled them to move quickly—to the extent that commodities like PPE, tests, and hand sanitizer was available in the market. It would thus be hard to say that the flexible use of NFM2 funds for these commodities was not relevant to fighting COVID-19. Commodity procurement is also a core competence of the GF, and thus to the degree that the GF was able to pivot its PSM machinery to COVID-19 commodities (see Chapter 7), using flexibilities to enable countries to buy PPE and COVID-19 diagnostics also seems appropriate as a Fund activity.

Several persons interviewed for the country cases and global overviews mentioned the value of the flexibilities in enabling the GF to move quickly. A GF regional manager explained that *“Flexibilities worked very well as they enabled resources to be deployed quickly and were largely country driven. The GF got a lot of deserved credit for being the first one on the scene in my countries”*.

Our country case studies corroborated this finding. Ukraine was one of the first 15 countries to benefit from flexibilities in response to COVID-19. Over half of these US\$2.7 million in Ukraine went to urgently needed PPE. A PR in Ukraine said that *“The flexibilities made a huge difference in allowing our outreach workers to feel confident in continuing to meet KVPs”*. CSOs, some as PRs, received desperately needed support to stay open during the beginning of the pandemic, and in-country stakeholders explained that grant flexibilities to pay for mobility allowances enabled lab staff to continue working despite full lockdowns including closures of public transport.

A similar situation unfolded in Peru. Interviewees from the PRs explained that they used grant flexibilities to buy PPE and COVID-19 tests and health and life insurance for field staff. The PRs additionally used the flexibilities to train HIV field workers to identify potential COVID-19 cases and refer them to the nearest health center” As such, the flexibilities, although a small funding pool, benefited the countries by protecting the HIV and TB workers from the start.

Even though spending from the flexibilities was not tracked separately by the GF or by PRs in the countries, as this was part of the regular NFM2 grants and was integrated into overall financial reporting and quality assurance (QA) by LFAs, it would be valuable for the GF to conduct some additional forensic checks on the use of the flexibilities in selected countries, in order to be able to learn lessons that could shape the use of similar flexibilities in the future.

2020 Grants

According to GF classification prevailing in 2020, the total funding awarded went 58% to “reinforcing the national COVID-19 response”, 32% to mitigation measures designed to lessen the negative effects of the pandemic on HTM services, and 10% for “urgent improvements in health and community systems”. The table below shows this breakdown for the 8 countries.

Table 5. Total C19RM funding approved in 2020-21 for case countries, US\$ millions

Country	Mitigating COVID-19 impact on HIV, TB and malaria (% of 2020 total)	Reinforcing national COVID-19 response (% of 2020 total)		Urgent improvements in health and community systems (% of 2020 total)	Total immediate funding for 2020	Total immediate funding for 2021
		Other response	COVID-19 diagnostic tests			
Angola	2.06 (33%)	1.08 (17%)	2.95 (47%)	0.12 (2%)	6.21	22.98
El Salvador	0.76 (85%)	0.03 (3%)	0.11 (12%)	-	0.89	4.81
Malawi	9.90 (32%)	14.36 (47%)	3.00 (10%)	3.51 (11%)	30.78	102.56
Peru	0.08 (5%)	1.73 (95%)	-	-	1.81	14.94
Rwanda	3.52 (31%)	5.95 (52%)	0.75 (7%)	1.20 (10%)	11.42	47.54
South Africa	13.62 (26%)	19.69 (38%)	11.23 (22%)	7.62 (15%)	52.16	186.03
Ukraine	2.68 (25%)	3.06 (28%)	4.59 (42%)	0.51 (5%)	10.84	41.82
Viet Nam	3.53 (40%)	4.66 (53%)	0.57 (7%)	-	8.76	34.63
8 country subtotal	36.16 (29.4%)	50.56 (41.1%)	23.19 (18.9%)	12.97 (10.6%)	122.87	455.30
Global total	243.06 (32%)	259.38 (34%)	182.23 (24%)	74.33 (10%)	759.00	3,457.59

Source: Funding Approved for the COVID-19 Response, as of 16 May 2022. <https://www.theglobalfund.org/en/our-covid-19-response/>.

It is important however to interpret these numbers with caution, as the definitions of the three areas are subject to interpretation and may have led to some inconsistency in accounting. For example, PPE and COVID-19 tests counted under “reinforcing national responses” may have gone to health workers generally or to outreach personnel focusing on HTM, in which case such commodities could also have been attributed to “mitigation”. Similarly, investments in COVID-19 treatment facilities were sometimes counted as “reinforcing national responses”, while in other instances they were classified as “health systems strengthening”.

In assessing the optimal allocation of C19RM 2020 funds, the GF was also limited by the lack of C19RM planning, budgeting, and prioritization tools in 2020. Unit costs and prices for new commodities (e.g., COVID-19 tests) and services (e.g., telemedicine, COVID-19 risk communications) were unknown or only vaguely known, at the time. There were no detailed C19RM budget templates. And there were no guidelines or algorithms (based on criteria such as expected lives saved, HTM service declines averted, and increased system resilience – which remain challenging to measure but for which modeling, coordinated data collection and analysis, and careful qualitative assessment are feasible) for CCMs and for Fund technical reviewers to set priorities among the many competing uses for C19RM funds. While this situation has improved under C19RM 2021, there is still a lack of tools for prioritization and evaluating tradeoffs.

Relevance

Given the severe shortages of masks and gowns, COVID-19 diagnostics, and (toward the end C19RM 2020) oxygen in LMICs, purchasing these commodities made sense for reinforcing the COVID-19 response and mitigating its impact on HTM. In addition, there were other investments in direct responses with spillover systems benefits, such as supporting decentralized COVID-19 treatment centers in Peru, building a hospital based infectious disease isolation ward/infection control unit in Rwanda, and upgrading COVID-19 surveillance and reporting in Malawi; as well as investments in mitigation activities with wider RSSH benefits, such as telemedicine in Ukraine and El Salvador and hiring additional COVID-19/primary care outreach workers in South Africa.

Even though only a third of the money was counted as going to “mitigating”, numerous interviews with GF officials in the GMD highlighted what was for them the compelling logic of C19RM 2020, namely, to try to protect HTM services to sustain past gains and to stay on track in achieving 2020 HTM targets. A regional head at the GF explained that the GF was able to use the funds offered by C19RM to “*refocus the health sector response*” away from just COVID-19 concerns to include HTM mitigation.

The needs of GF-eligible countries in fighting COVID-19 and protecting their HTM programs were—and continue to be—enormous and the C19RM funding represents only a tiny fraction of this larger need. In most of the countries we evaluated, total financial requirements as costed in the national COVID-19 response plans were at least 10-100 times the C19RM 2020 allocation. In this situation, it would be hard to argue that the GF overspent in any area of the C19RM program.

Appropriateness

Our evaluation did not come across a significant intervention under C19RM at global or country level where we found that the GF approved funding for an activity where it did not have experience and comparative strengths. SO, Disease Advisory Teams, and RSSH specialists in e.g., labs, HMIS, human resources for health (HRH), and CRG staff had the necessary skills and experience to back the C19RM 2020 portfolio.

Areas where the GF awarded little grant funding in 2020 and might have done more to build on its comparative advantages (according to interviews) were: procurement of therapeutic oxygen, which was limited in 2020; greater investments in COVID-19 diagnostics; support to rapid development of COVID-19 surveillance and HMIS modules: expanded CSO/community-based organization (CBO) activities to reach KVPs with COVID-19 information, maintain HTM services, and conduct community monitoring of delivery of COVID-19 services and enforce greater accountability; and communications campaigns around COVID-19 testing and vaccination. It was decided that Gavi would finance COVID-19 immunization, but GF and others could have invested more in communication and promotion. The relatively limited funding for CSOs may have been exacerbated by the limited involvement of civil society in the 2020 grant request process (Chapter 8). Similarly, the omission of testing and vaccination communications and

COVID-19 surveillance) may have been aggravated by the low participation in CCMs of national COVID-19 emergency response personnel (Chapter 4).

Chapter 6: Effects of C19RM on HIV, TB, and Malaria

Introduction

Beyond the morbidity and mortality directly attributed to SARS-CoV-2 infection, reports at the global level indicate that the COVID-19 pandemic has had a negative aggregate effect on avoidable illnesses and deaths from HIV/AIDS, TB, and malaria. The dimensions are multiple and documented in the published literature.

Since there was no theory of change at the start of C19RM, it was not possible to strictly trace a causal pathway from its design and inputs to the expected outcomes and impacts. Also, it would not be appropriate to seek to directly attribute to C19RM any changes in aggregate health outcomes or impacts listed under the “Outcome/Impact” column of the April 2021 “list of indicators to monitor the GF investments in COVID-19 response.”²⁶

Since the quantitative data are secondary data, they vary in scope, method of collection, source, content, and completeness. Nevertheless, the findings provide a global context, which is followed by a country-level perspective from case studies on whether and how well C19RM affected and mitigated disruptions of service delivery at the country level. They include descriptions and temporal associations between C19RM-funded programs, activities, and results at the country level, using quantitative and qualitative findings. No causal inference should be assumed unless it is explicitly stated.

Global Disruptions of Health Service Delivery and Public Health

The COVID-19 pandemic disrupted health service delivery because of the combined effects of sudden increases in patients seeking care for COVID-19, supply chain disruptions, various degrees of shutdowns to enforce social distancing, transportation disruptions that curbed access to health facilities, redeployment of health workers from pre-pandemic routines to direct pandemic response duties, and illnesses and deaths among health workers. As a result, in addition to direct morbidity and mortality caused by COVID-19, the pandemic has exacerbated other health conditions in ways that could increase the burden of the disease over the coming years.

In a systematic review²⁷ of 81 studies across 20 countries and 143 estimates of changes, healthcare utilization decreased by about a third during the pandemic, with considerable variation, and with greater reductions among people with less severe illness. Among 35 studies reporting secondary outcomes, there were 60 estimates, with 27 (45%) reporting larger

²⁶ Global Fund. COVID-19 Response Mechanism Guidelines. 2021. M&E section.

https://www.theglobalfund.org/media/10759/covid19_c19rm-guidelines_external_en.pdf.

²⁷ Moynihan R, Sanders S, Michaleff ZA, et al. Impact of COVID-19 pandemic on utilization of healthcare services: a systematic review. *BMJ Open* 2021;11:e045343.

<https://bmjopen.bmj.com/content/bmjopen/11/3/e045343.full.pdf>.

reductions in utilization among people with a milder spectrum of illness, and 33 (55%) reporting no difference.

WHO implemented a series of “pulse surveys” of the continuity of essential health services during the pandemic. The survey method had several limitations regarding self-assessment, which might be prone to bias and lacked validation.²⁸ In April 2021, the second round of a WHO “pulse survey” showed over one year into the COVID-19 pandemic, substantial disruptions remained, with about 90% of countries still reporting one or more disruptions to essential health services, marking no substantial global change since the first survey conducted in the summer of 2020.²⁹ Within countries, however, the magnitude and extent of disruptions had generally decreased. In 2020, countries reported that, on average, about half of essential health services were disrupted. Two years into the pandemic, results from the third round of the pulse survey (for November–December 2021) suggested that COVID-19 continued to challenge health systems, countries were adopting short-term strategies and innovations, to not only overcome disruptions and recover services, but also to solve bottlenecks to scale up of essential COVID-19 tools. They were also devising longer-term strategies and investing to build health service resilience and strengthen their preparedness for future health emergencies.³⁰

Disruptions of Services for HIV/AIDS, TB, and Malaria

II. HIV/AIDS service disruptions

UNAIDS reported³¹ that the COVID-19 pandemic had disrupted HIV-related services, especially during the first six months of the crisis. Harm reduction services for people who use drugs were disrupted in nearly two thirds (65%) of 130 countries surveyed in 2020. Voluntary medical male circumcision (VMMC) programs were severely affected. The targets set for VMMC in 15 priority countries in eastern and southern Africa were missed by a large margin, but as social restrictions were relaxed, these programs showed signs of recovery towards the end of 2020. Pre-exposure prophylaxis (PrEP) programs expanded in 2020, but PrEP access remained far off global targets. The pace of HIV testing declined almost uniformly, HIV diagnoses decreased, and fewer people living with HIV initiated treatment in 2020 compared to 2019 in 40 of the 50 countries that reported those data to UNAIDS. The biggest disruptions were in the first half of 2020, when many countries were in their first lockdowns and HIV programs were struggling to adapt. The number of people living with HIV receiving antiretroviral therapy (ART) increased by just 1.9% between January and June 2020, from 25.5 million people to 26.0 million people. This

²⁸ WHO. 2022. Third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November–December 2021. https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2022.1.

²⁹ WHO. 2021. COVID-19 continues to disrupt essential health services in 90% of countries. <https://www.who.int/news/item/23-04-2021-covid-19-continues-to-disrupt-essential-health-services-in-90-of-countries>.

³⁰ WHO. 2021. COVID-19 continues to disrupt essential health services in 90% of countries. <https://www.who.int/news/item/23-04-2021-covid-19-continues-to-disrupt-essential-health-services-in-90-of-countries>.

³¹ UNAIDS. World AIDS Day Report. 2021. https://www.unaids.org/sites/default/files/media_asset/2021_WAD_report_en.pdf.

was followed by a 4.9% increase from July 2020 to December 2020, reaching 27.3 million people, and then a 3.4% increase during the first six months of 2021.

A study of seven PEPFAR-supported countries sought to determine whether the COVID-19 pandemic caused interruption in HIV services.³² Overall, in the quarter before the lockdowns (P1 vs. P2), 23% more patients experienced interruption in treatment (IIT); in the quarter after the lockdowns (P3 vs. P2), 10% fewer patients experienced IIT. Although results varied by country, the number of patients experiencing IIT after the lockdown was either less than that during the lockdown or remained lower than before the lockdown, except for one country. Programs used alternate facility refills, multi-month dispensation, community-based ART refills, and social distancing and mitigation measures in clinics to adapt to the COVID-19 pandemic. In sum, during the initial COVID-19 lockdowns, treatment interruptions did not increase across PEPFAR-supported countries with high ART coverage. These results suggest that the rapid adoption of innovative strategies including policies around multi-month dispensing and community ART access sustained HIV treatment during the initial months of the COVID-19 pandemic.

II. Tuberculosis service disruptions

In the 2021 Global Tuberculosis Report,³³ WHO reported that the COVID-19 pandemic had reversed years of progress in providing essential TB services and reducing TB disease burden. The most glaring impact was a large global decline in notification – the number of people newly diagnosed with TB and reported. It fell from 7.1 million in 2019 to 5.8 million in 2020, an 18% decline back to the level of 2012 and far short of the approximately 10 million people who developed TB in 2020. Provisional data up to June 2021 show ongoing shortfalls. Declines in TB incidence achieved in previous years had slowed almost to a halt and the impacts were forecast to worsen in 2021 and 2022. Other impacts included reductions between 2019 and 2020 in the number of people provided with treatment for drug-resistant TB (-15%, from 177,100 to 150,359, about 1 in 3 of those in need) and TB preventive treatment (-21%, from 3.6 million to 2.8 million).

II. Malaria service disruptions

According to WHO,³⁴ survey and routine data indicated that most malaria endemic countries experienced moderate levels of disruptions to the provision of malaria services. Of the 31 countries that had planned insecticide-treated mosquito net (ITN) campaigns in 2020, 18 (58%) completed their campaigns by the end of that year; 72% (159 million) of the ITNs from the planned campaigns had been distributed by the end of 2020. Thirteen of the 31 countries (42%) were left with 63 million ITNs that were initially planned for distribution in 2020 but spilled over

³² Mehta N, Stewart A, Fisher K, et al. Impact of COVID-19 on HIV treatment interruption in seven PEPFAR countries, April-June 2020. Presented at IAS 2021. <https://theprogramme.ias2021.org/Abstract/Abstract/2641>. Accessed on March 30, 2022.

³³ WHO. Global Tuberculosis Report. 2021. <https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2021>. Page 1.

³⁴ WHO. World Malaria Report. 2021. <https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2021>.

to 2021. Seasonal malaria chemoprevention (SMC) was distributed as planned in 2020, and an additional 11.8 million children were protected with SMC in 2020 compared with 2019. Planned indoor residual spraying (IRS) campaigns were also on target in most countries in 2020.

II. Did the worst-case scenarios happen?

The GF provided the evaluation team with its calculation of the change between 2018 (the baseline data at the time of the initial projection was done) and 2020, using the latest published estimates from WHO/UNAIDS (2021 releases) for the same set of countries. Their findings are shown in Table 6 below and indicate that the dire projections (assuming unmitigated COVID-19) did not happen. The GF staff acknowledge that this difference cannot be attributed to the GF alone, or even to the larger group of financiers who support programs at country level, given the many other factors that could have played a role. Similarly, the evaluation team's position is that there is no evidence to justify any statement of a causal relationship between the GF's financing and those aggregate differences between the projected and actual scenarios. These findings must be treated with caution because the "actual" number of deaths remains unknown.

Table 6. Percent change in absolute number of deaths from 2018 to 2020

	Region	Projection assuming unmitigated COVID-19	Actual
HIV	Sub-Saharan Africa	+115%	-9.2%
TB (including HIV+)	World	+32%	+1.4%
Malaria	Sub-Saharan Africa	+99%	+13%

Source: The Global Fund. Unpublished data.

Synthesis of C19RM, Service Disruption, and Mitigation at Country Level

The COVID-19 pandemic disrupted health service delivery in all 8 countries (Angola, El Salvador, Malawi, Peru, Rwanda, South Africa, Ukraine, and Vietnam). Comparisons between pre-COVID-19 and intra-COVID-19 years (specifically, 2019 and 2020) show different country experiences as shown in the three tables in Annex D. TB case notifications declined in all countries between 2019 and 2020. Reported malaria cases (presumed and confirmed) showed a mixed picture across countries but, assuming the reports are accurate, it is unclear whether these findings were due to diagnostic inaccuracies, disparate successes of malaria prevention, or both.

Pre-existing capacity building and health system preparedness reforms mitigated service disruption in Ukraine before the war started in 2022. The pre-COVID-19 capacity building was funded from domestic budgets and several donors, including the GF, PEPFAR, and USAID. In Peru, stakeholders had divergent opinions about the fact that the C19RM investments were designed to prevent and contain COVID-19. In South Africa, even in the second round of C19RM funds, little funding went to mitigating the impact of COVID-19 on HIV and TB services, despite that being a priority area for the C19RM. In Vietnam, the combination of C19RM funding and the work of malaria program staff were perceived to have enabled some progress in malaria control and elimination.

In several of the study countries, Kis surmised that service disruption could have been worse without the measures that were implemented, and the support received from the GF.

Context-specific combinations of the following factors appeared key to mitigating the disruptive effects of COVID-19 on service delivery:

1. The easing of lockdowns, which made it possible for health facilities to re-open and for the population to physically seek services.
2. Adaptations and innovations by service providers and country authorities, combined with flexibilities allowed in GF grants, were important mitigating factors. They included changes in the modality of delivery (e.g., going door-to-door in South Africa); virtual supervision of treatment compliance via video; provision of self-test kits; mobile laboratories; multi-month dispensing of medicines (Malawi, South Africa, Ukraine); and shifts from hospital-centric to PHC/community-centric services, sometimes including mobile vans and social workers, which helped bring services to where the people were, thus reducing barriers to access (Malawi, Peru, Ukraine).
3. The supply of protective equipment (PPE) for health workers was helpful to mitigate the disruption of services for HIV and TB. In Peru, those protective measures included the provision of PPE and training.
4. The provision of new or increased quantities of medical equipment and support for staff remuneration helped the system to cope with increased demand for services.

The C19RM contributed to the second, third, and fourth factors outlined above. Several other financiers contributed to the reported response to the pandemic. More direct contributions (to disease control programs) came from entities such as PEPFAR and USAID. Less direct contributions (via budget support and sector programs) came from entities like development banks.

Conclusions

Much like the global experience, the COVID-19 pandemic caused various types of service disruption within and across the countries in this evaluation. There are specific instances in which programs or activities financed by the GF, including the C19RM, enabled countries to respond to the COVID-19 pandemic. The findings point to C19RM as an important contributor to a multi-party effort that enabled countries to mitigate the negative impacts of the COVID-19 pandemic. However, this evaluation could not be designed to provide evidence that would justify broad conclusions of causality between C19RM and the mitigation of service disruption at the country level. The “compared to what?” question remains unanswered because the evaluation could not quantitatively assess what would have happened without the C19RM. It is reasonable to qualitatively surmise that, on balance, the responses would have been weaker without C19RM. However, the evaluation found no evidence that the GF alone made the difference.

Chapter 7: C19RM 2020 Procurement and Supply Management

Overview of C19RM 2020 PSM

The GF allocated US\$458 million³⁵ or 60 percent of all C19RM 2020 funding for PSM for COVID-19 health products, i.e., PPE, COVID-19 diagnostics, oxygen equipment, corticosteroids, and other COVID-19 products. Of this, \$276 million (60%) was initially allocated for PPE and \$182 million (40%) for COVID-19 diagnostics. Additionally, PRs utilized grant flexibilities for COVID-19 related PSM.

Several of the GF's longstanding PSM initiatives and timely adaptations added significant value to global and country responses to COVID-19, particularly through rapid disbursement of funds to LMICs, early and strong global leadership for procurement of COVID-19 diagnostics, and agile adaptation to procure PPE via the PPM when countries struggled to secure these scarce supplies independently. The GF faced and, in many instances, overcame significant and unprecedented global PSM challenges. Even higher-income countries experienced challenges, although they rebounded quicker to initial shocks and benefitted from local manufacturing, advance purchase agreements, greater purchasing power, cash on hand, and lower price sensitivity. LMICs bore the brunt of travel restrictions, export bans for some COVID-19 health products, freight stoppages and slowdowns, raw material shortages, and lack of local production capacity. A heavy pre-pandemic emphasis on PSM cost-effectiveness also meant limited redundancy in production and distribution globally. Without the ACT-A's and the GF's intervention, inequities in access to COVID-19 health products would likely have been even more extreme.

However, C19RM 2020 was also characterized by insufficient M&O of local procurement, expenditures, and country absorptive capacity despite the existence of standard PSM KPIs, against a known backdrop of pre-existing PSM gaps in many LMICs. We recognize COVID-19 related mobility restrictions contributed to some of this, and yet there is room for improvement. Some funding recipients experienced a rush to disburse funds versus taking a more consultative approach, and the GF had a steep learning curve with a number of novel health products in a complex and rapidly spreading respiratory pandemic. The ACT-A's insufficient initial response to growing needs for oxygen equipment and other therapeutics impeded the GF's ability to ramp up PSM for these health products during C19RM 2020.

The GF has taken steps to address several key PSM challenges described in this section. These efforts should be sustained for COVID-19 and pandemic response PSM in general, and to strengthen M&O of country PSM operations and spending in particular.

C19RM Procurement Channels

Below, we describe PSM via each procurement channel for COVID-19 health products during C19RM 2020.

³⁵ OIG report, April 2021, Executive Summary (page 4).

II. Pooled Procurement Mechanism

Strategic sourcing leverages the large collective purchasing power of GF grants and has an impact on shaping the market and driving the price of many health products. The GF's PPM was established in 2007 for HTM product procurement and is implemented via its online wambo.org procurement platform. The PPM provides access to negotiated reference prices with suppliers for quality-assured products, eliminates procurement delays, supports timely grant expenditure, and ensures that quality assured goods and medicines reach those most in need in a timely manner. To ensure rapid availability of quality-assured COVID-19 products, the GF expanded³⁶ its wambo.org pilot for eligible entities in June 2020 to allow the purchase of eligible COVID-19 health products with non-GF funds. This was important to improve equitable access; a separate evaluation of the pilot is ongoing. A total of \$308.95 million (67% of the C19RM 2020 PSM allocation) was expended via the PPM (Table 7). This was a mix of C19RM 2020 and grant flexibilities funding and, because the funding source was not specified, we are unable to disaggregate the data further.

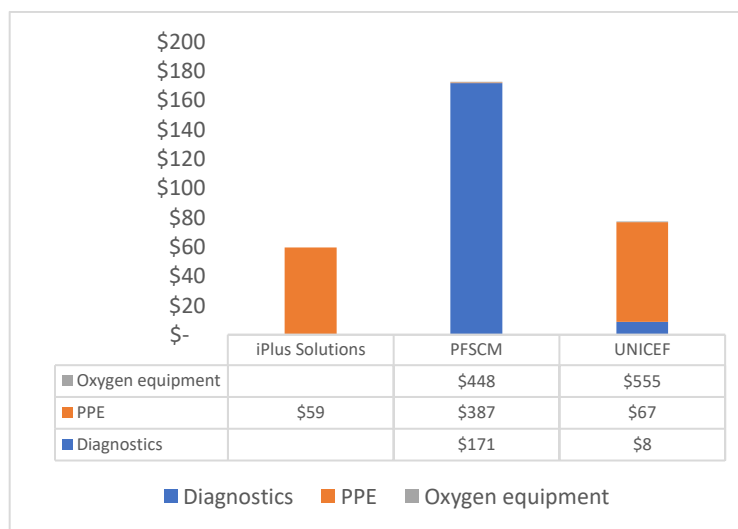
Table 7. COVID-19 commodities procured via PPM, April 2020 to June 2021

Product	Product cost	PSM cost*	Total cost	Percentage
Ag RDTs	\$ 69,368,456	\$ 8,842,100	\$ 78,210,555	58.4%
Automated PCR	\$ 68,687,255	\$ 11,832,709	\$ 80,519,963	
Manual PCR	\$ 19,022,091	\$ 2,547,004	\$ 21,569,095	
PPE	\$ 107,161,034	\$ 20,485,887	\$ 127,646,920	41.3%
Oxygen equipment	\$ 833,414	\$ 169,877	\$ 1,003,291	0.3%
TOTAL	\$ 265,072,249	\$ 43,877,577	\$ 308,949,826	

Procurement Service Agents (PSAs) are external service providers contracted by the GF to perform procurement and delivery services on behalf of PRs who participate in PPM. For C19RM 2020, PSAs and the percentage of PSM each handled were iPlus Solutions (19%), Partnership for Supply Chain Management (PFSCM, 56%) and UNICEF (25%) (Figure 6).

Diagnostics. PRs were advised from the outset to procure COVID-19 diagnostics via PPM/ wambo.org as these products were scarce on the global market and needed to be closely coordinated for ACT-A partner volume agreements. Initial orders were placed in April 2020 and the webpage was launched in May 2020 with orders rapidly ramping up. Shortly thereafter, the Accelerated Order Mechanism (AOM) was launched with a 3-day request-to-order timeline for

Figure 6. C19RM 1.0 PPM PSM value by Procurement Service Agent



³⁶ https://www.theglobalfund.org/media/10004/bm43_edp07_report_en.pdf

automated PCR tests from Cepheid and Abbott. The GF was the lead procurer on behalf of the WHO Consortium for Cepheid and Abbott PCR tests in 2020.

PPE. PRs were advised to procure PPE locally from April-July 2020. Beginning in July 2020, the GF launched PPE procurement via PPM³⁷ and encouraged PRs to procure via PPM/wambo.org. PPE orders delivered via PPM totaled \$127 million. The breakdown of C19RM versus grant flexibilities cannot be provided as the funding source was not specified.

Oxygen. Via PPM, the GF procured just over \$1 million worth of oxygen equipment. The GF periodically publishes current reference prices for oxygen products.³⁸

II. UNDP Procurement

UNDP has mature PSM and demand aggregation capabilities. Their framework agreement (FA) with the GF permitted them to independently procure COVID-19 health products for the 19 countries in which they were the C19RM 2020 PR³⁹. UNDP accounted for \$26.37 million (6%) of the C19RM 2020 PSM allocation of \$458 million and spent an additional \$8.6 million via grant flexibilities to procure and deliver COVID-19 health products (Table 8).

Table 8. UNDP COVID-19 PSM expenditures, April 2020 – June 2021

Health product/budget line	C19RM 2020 funding (US\$)	Grant flexibilities (US\$)	Total (US\$)
PPE	\$10,967,660	\$5,806,067	\$16,773,727
Diagnostics	\$8,529,159	\$1,606,053	\$10,135,212
Oxygen equipment	\$640,775	\$62,600	\$703,375
Other COVID-19 supplies ⁴⁰	\$836,382	\$1,141,593	\$1,977,975
HTM products	\$4,265,178	\$ -	\$4,265,178
Logistics	\$1,132,499	\$-	\$1,132,499
Total by funding source	\$26,371,653	\$8,616,313	\$34,987,966

II. Local Procurement and Supply Chain Management

At the country level, Health Product Management Specialists are CT members responsible for PSM topics. For HTM PSM budgeting and tracking, a Health Product Management Template (HPMT) is used. Non-PPM global and national procurers are required to submit price and quality reports (PQRs) to provide public transaction-level procurement data.

³⁷

https://www.theglobalfund.org/media/10161/covid19_personalprotectiveequipmentoxygentproducts_list_en.pdf

³⁸ https://www.theglobalfund.org/media/10579/covid19_oxygenproducts_list_en.pdf

³⁹ Afghanistan, Angola, Belize, Bolivia, Burundi, Chad, Congo, Cuba, Djibouti, Egypt, Guinea-Bissau, Iran, Kyrgyzstan, Panama, Sao Tome and Principe, South Sudan, Sudan, Zimbabwe, multi-country Pacific.

⁴⁰ Other COVID-19 products include infrared thermometers, pulse oximeters, EKG machines, UV lights, and other miscellaneous equipment and consumables.

The GF initially issued guidance encouraging PRs to source PPE locally given that the global PPE supply chain faced raw material and finished product shortages, stockpiling of scarce PPE supplies by higher income countries, export bans from some PPE-producing countries, and freight disruptions. Countries were also encouraged to procure oxygen equipment and corticosteroids locally. As described earlier, all COVID-19 diagnostics were procured via PPM or UNDP.

Data are unavailable at the Secretariat level for local procurement of PPE, oxygen equipment and corticosteroids since PQRs were not required for COVID-19 health products under C19RM 2020. We are therefore unable to evaluate local procurement.

Evaluation of C19RM PSM

The GF's contributions to COVID-19 PSM consist of three main components spanning all commodity types: 1) provision of PSM implementation tools and guidance, 2) direct facilitation of PSM through the PPM, and 3) financial and other support for non-PPM PSM and in-country supply chain systems. Below, we highlight key strengths and areas for improvement identified for each of these components, rating them as **effective, partially effective, needs improvement, or ineffective**. Wherever possible, we use the GF's quantitative **measures of and benchmarks for effectiveness**⁴¹ and, where there are data gaps, we assess available qualitative information. We also highlight where specific actions have been taken in C19RM 2021 to address areas for improvement.

II. Core PSM implementation tools and guidance

Effective: The GF disseminated timely and useful C19RM 2020 PSM information through several channels including its website, letters to PRs, email updates, and inclusion in the GF's regular COVID-19 Updates and Situation Reports.⁴² Since 12 March 2020, the SO team has provided assessments and recommendations on the impact of the pandemic on COVID-19 health products and supplies⁴³ that cover manufacturing delays, procurement requisition and PO deadlines, delivery delays and lead time implications, and challenges related to freight and logistics. On April 7, 2020, the COVID-19 health product supply webpage was launched and on April 14, 2020, new information and recommendations were published for grant implementers on financing and procuring COVID-19 control measures consistent with WHO guidance, including PPE and other emergency medical supplies. In May 2020, the COVID-19 Diagnostics webpage was launched and shortly thereafter the AOM was launched with a 3-day request-to-order timeline for automated PCR tests from Cepheid and Abbott. In July 2020, the new wambo.org PPE channel launched; PRs were strongly encouraged to use it moving forward and were advised more products would be added in August 2020.

⁴¹ https://www.theglobalfund.org/media/7062/bm38_05b-2017-2022strategickpiperformancetargets_report_en.pdf

⁴² <https://www.theglobalfund.org/en/covid-19/news/>

⁴³ <https://www.theglobalfund.org/en/covid-19/health-product-supply/>

Effective: The SO team published PPM reference pricing for diagnostics⁴⁴ and PPE⁴⁵; updated PSAs' and partner organizations' product allocations and reference fees⁴⁶; published freight, insurance, QA/quality control indicative reference costs⁴⁷; and provided category and product-level procurement and delivery planning guides with indicative lead times.⁴⁸ The PSA model enabled rapid scaling to respond to supply chain challenges and enabled the GF to use them to source and conduct Requests for Proposals (RFPs) for new product categories. All aspects of supplier relationship management were followed.

Effective: The SO team played a key early role for strategic sourcing of COVID-19 diagnostics as the lead procurers of automated PCR, along with UNICEF, of the WHO-convened and led COVID-19 Supply Chain System Diagnostics Consortium and subsequently as the co-convenor, with FIND, of the ACT-A Diagnostics Pillar. To secure scarce Cepheid automated PCR tests at competitive prices (\$12-15 each⁴⁹), the GF made volume commitments for two million PCR tests and set up an AOM to process PCR test orders within three days. The GF also made available an initial US\$50 million from C19RM 2020 to enable countries to purchase at least 10 million of the new antigen rapid diagnostic tests (Ag RDTs) for LMICs at the guaranteed price of \$5 secured by BMGF on behalf of the Diagnostics Pillar.⁵⁰ Within days of WHO's interim guidance on antigen-detection in the diagnosis of COVID-19 on 11 September 2020, the GF announced its support for procurement of Ag RDTs at a negotiated cost of ~\$5 per test. Two WHO Emergency Use Listing (EUL) Ag RDTs were available on wambo.org within six weeks of the first EUL.

Partially effective: The Guide to GF Policies on Procurement and Supply Management of Health Products underwent a modest update in November 2020 and a more substantive update, which included sufficient core PPE PSM guidance⁵¹, was published in June 2021.

Partially effective: The overarching Quality Assurance Policy for Pharmaceutical Products⁵² has not been comprehensively updated since 2010. Interim QA requirements for procurement of COVID-19 pharmaceutical products⁵³ were published in June 2021; this delay is attributed to the absence of pharmaceutical products recommended for use by WHO at the time. The GF

⁴⁴ https://www.theglobalfund.org/media/10233/covid19_diagnosticsreferenceprices_table_en.pdf

⁴⁵

https://www.theglobalfund.org/media/10161/covid19_personalprotectiveequipmentoxygentproducts_list_en.pdf

⁴⁶ https://www.theglobalfund.org/media/8668/ppm_procurementservicesagentfees_list_en.pdf

⁴⁷ https://www.theglobalfund.org/media/8985/ppm_freightinsurancequalityreferencecosts_list_en.pdf

⁴⁸ https://www.theglobalfund.org/media/10755/psm_categoryproductlevelprocurementdeliveryplanning_guide_en.pdf

⁴⁹ <https://www.devex.com/news/where-is-the-money-for-covid-19-diagnostics-97833>

⁵⁰ <https://www.who.int/news/item/28-09-2020-global-partnership-to-make-available-120-million-affordable-quality-covid-19-rapid-tests-for-low--and-middle-income-countries>

⁵¹ https://www.theglobalfund.org/media/5873/psm_procurementsupplymanagement_guidelines_en.pdf?u=636663947340000000

⁵² https://www.theglobalfund.org/media/5894/psm_qapharm_policy_en.pdf

⁵³ https://www.theglobalfund.org/media/11061/covid19_interimqualityassurancerequirements-pharmaceuticalproducts_guidance_en.pdf

issued interim guidance on medical devices in June 2021 and an update in October 2021 following the issuance of WHO guidance.

Partially effective: Internal processes are in place to maintain and update a repository of country QA points of contact. However, Kis suggested there is a lack of standardized processes to report and close out quality incidents, and that this may be related to insufficient QA bandwidth. Four QA team members were added in 2021, including one with a COVID-19 focus.

Needs improvement: Kis expressed that disbursement felt rushed and top-down rather than consultative. There was limited early guidance from the GF on what to purchase and insufficient time allowed to assess needs. There was also a felt disconnect at times between GF processes and country COVID-19 task force priorities.

II. Pooled Procurement Mechanism

Effective: Overall, PSAs adapted to several significant challenges including disrupted delivery schedules, shipping container shortages, and anticipated freight provider changes. PRs were repeatedly urged by the SO team to ensure timely in-country stakeholder approval of expiry dates, greenlighting shipments and obtaining necessary waivers but delays became inevitable. While PSA performance metrics are confidential, the GF's SO team confirmed targets were largely met by PSAs that reported on these metrics despite all the challenges faced. KPIs and targets for PSAs include:

- On-Time In-Full (OTIF) gross shipments: Shipment delivered OTIF gross if original client promised delivery date < delivery date + 14 days; target is 75%.
- OTIF gross quantity: Number of ordered units (unit = product pack, test kit etc.) delivered OTIF gross if original client promised delivery date < delivery date + 14 days; target is 75%.
- OTIF net shipments: Shipment delivered OTIF net if client promised delivery date < delivery date + 14 days; target is 75%.
- OTIF net quantity: Number of ordered units (unit = product pack, test kit etc.) delivered OTIF net if client promised delivery date < delivery date + 14 days; target is 75%.
- Price quote (PQ) turnaround for PSA FA: Time taken by PSA to get a shipment's (product and logistics) PQ for PSA FA from receiving the request for a PQ (request actionable date) to sending the complete PQ with all applicable information to the GF; target is 7 days.
- PQ turnaround for GF framework: Time taken by PSA to get a shipment's (product and logistics) PQ for GF FA from receiving the request for a PQ (request actionable date) to sending the complete PQ with all applicable information to the GF; target is 3 days.

We examined 52 Pos placed via wambo.org by seven countries—El Salvador, Malawi, Peru, Rwanda, South Africa, Ukraine, Vietnam. We found that all COVID-19 health products ordered, with a total value of US\$ 30.1 million, were delivered to these countries prior to June 30, 2021 with the exception of two orders placed on February 5, 2021 and March 11, 2021 respectively (value of both orders: US\$ 1.08 million) for which delivery was made on July 8, 2021.

Partially effective: There were initial delays by PRs in submitting procurement requisitions. Kis shared this was due to unclear guidance about funding allocations. Once requisitions were submitted, Pos were efficiently raised.

Needs improvement: Some country key informants felt they were not sufficiently educated on the full implications of increased cost of air freight for PPM-procured health products. As a result, they spent far more on freight than planned and, in some instances, had to reduce procurement of additional health products. We note this was a common experience and not unique to the GF or PPM as the full extent and unexpectedly long duration of global supply chain disruptions became evident.

Other observations:

1. Some PSAs reported duplication of certain processes, e.g., raising Pos, by both the GF and by PSAs. However, we note this process is necessary for the GF to mitigate its risk of holding inventory.
2. By end of July 2021, 94.6 million tests (37.8 million PCR tests and 56.8 million Ag RDTs) had been procured by ACT-A for LMICs—achieving 19 percent of the mid-2021 ACT-A target of 500 million tests and falling well short of the 900 million tests targeted for LMICs by end-2021.⁵⁴ Of these, PPM sourced and supplied approximately 20 million tests or 21 percent (5.4 million PCR tests and 14.6 million Ag RDTs). Lack of harmonization across country regulatory environments and testing policies were a significant barrier to timelier rollout. There was also variable demand for tests from countries and, ultimately, insufficient resources to procure 900 million tests.
3. With hindsight, ACT-A may have responded earlier in the COVID-19 pandemic to countries' critical need for oxygen equipment during a respiratory pandemic. There is longstanding recognition of widespread oxygen supply challenges in LMICs. In turn, this impacted the GF's ability to ramp up oxygen equipment PSM under C19RM 2020. The GF also had to build the internal expertise to assess therapeutics-related needs.

II. Support for Non-PPM PSM and In-Country Supply Chains

Partially effective: Prior to the COVID-19 pandemic, the GF procured very modest amounts of PPE for TB programs. At the start of C19RM 2020, the GF enabled PRs to have cash on hand—a vital advantage in a supply-constrained environment—to procure PPE locally while simultaneously building its capacity to offer PPE via wambo.org. Kis shared initial guidance on product specifications and procurement channels was not clear. When countries faced increasing challenges in procuring PPE, and driven by concerns on global shortages, price, quality, timeliness and procurement related fraud risk, the GF shifted PPE procurement largely to PPM. Once the decision was made to use PPM for PPE, negotiated competitive pricing, and ensured compliance with product quality requirements.

Needs improvement: A C19RM Supplementary Template or List of Health Products was disseminated to C19RM PRs for initial use. It was inconsistently populated, and budget

⁵⁴ https://www.theglobalfund.org/media/11265/covid19_diagnostics_explainer_en.pdf

information was, in some instances, inconsistent and misaligned with Notification Letters. The HPMT was subsequently updated following the OIG report in April 2021. Since the HPMT is used as a key “source of truth” for PSM budgets, these deficiencies seriously impacted the GF’s ability to track country PSM expenditures.

Needs improvement: Kis shared that the GF did not sufficiently consider the baseline absorptive capacity of country supply chain systems and prior performance of PRs. In some countries, there was a disconnect between CCM-led and HTM-focused PRs, and COVID-19 Task Forces comprised largely of health and humanitarian emergency response organizations.

- ⇒ **Improvements and learnings applied to C19RM 2021:** In April 2021, as the GF prepared for C19RM 2021, the Health Product Segmentation Framework was published and provided further clarity that countries are required to use PPM/wambo.org for diagnostics and other scarce health products for as long as the supply dynamics and constraints remain. If PPM/wambo.org cannot be used for valid reasons, an existing UN entity procurement channel is permitted where the UN entity is also a PR, provided the PR agrees to provide monthly reporting on visibility from procurement to delivery. If a PR elects not to use PPM/ wambo.org, the CT must confirm to the C19RM IC that there is confidence in terms of procurement performance (QA compliance, speed, volume, price and overall risk) and the C19RM IC must approve the alternative procurement channels.

Needs improvement: Two key metrics were not systematically tracked during C19RM 2020 and we were therefore unable to evaluate overall effectiveness of PPM in delivering COVID-19 health products to their intended beneficiaries:

- Product availability: Percentage of health facilities with tracer products available on the day of a survey or visit.
- Service availability: Percentage of health facilities providing diagnostic services and/or treatment services on the day of a survey or visit.

We acknowledge that mobility restrictions at the country level further limited the GF’s ability to track on-shelf availability of COVID-19 health products and COVID-19 related diagnostics and treatment service availability.

- ⇒ **Improvements and learnings applied to C19RM 2021:** In 2021, through the Supply Chain and HSSCs, the GF started systematically monitoring the downstream effectiveness of the supply chain with four metrics: (1) Stocking at the central store (Stocked According To Plan), (2) Delivery to health facilities (On Time and In Full), (3) Availability at health facilities (On Shelf Availability), and 4) effectiveness of supply chain reporting systems (LMIS reporting rate).

Needs improvement: The 6–12-month PU/DR cycle was insufficient to track performance during a rapidly evolving pandemic and, when PU/DRs were submitted, C19RM 2020 PSM data were sparse or absent.

Other observations: Since PQRs were not required from PRs for COVID-19 products in C19RM 2020, we were unable to evaluate non-PPM procurement. Reports from country Kis of limited stocks, price fluctuations, and inconsistent quality have either not been documented or shared only in anecdotal form. Had these data been reported in PQRs, a meaningful analysis would have been possible. With hindsight, this compromised the GF's ability to track non-PPM procurement. Even for priority HTM health products, issues such as late or no submission, errors, and incomplete PQRs have been identified as ongoing and major weaknesses going back to 2017⁵⁵, and again in the December 2019 mid-term review of the Market Shaping Strategy.

- ⇒ **Improvements and learnings applied to C19RM 2021:** The SO team is working toward an **integrated health product demand forecasting and planning management system** to strengthen grant implementation and impact (plan-to-report). This goes beyond PQR limitations and takes a holistic view. The need for such a system emerged through the SO As-Is/To-Be Process Mapping project, which performed a holistic review of the institutional Procurement and Supply Chain (PSC) processes and the integration with the management of the grant lifecycle to develop the future operating model of the SO. The success of this effort is defined by the overall reduction of the procurement and supply chain cycle-time, and effectiveness and efficiency to ensure access and supply of quality-assured health products to/in the countries supported by the GF.

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https://www.theglobalfund.org/media/7062/bm38_05b20172022strategickpiperformance targets_report_en.pdf

Chapter 8: Effects of C19RM on Health and Community Systems

Introduction

This chapter of the report addresses C19RM investments in health and community systems. It includes descriptions and analyses of C19RM-financed work in these domains, any verifiable effects to date, and their plausible future benefits for longer-term HTM program implementation and PPR.

C19RM Investments in Health and Community Systems

In the first round of C19RM, \$74.3 million US\$ or 9.8% of total approved allocations were designated for “urgent improvements in health and community systems”, according to the GF’s own categories. There was no granular breakdown of health and community systems allocations into subcategories for C19RM 2020 (such as laboratories, human resources, and HMIS), as existed in the second year of the program. This limited any global analysis of the reach and impact of C19RM 2020 investments in HSS/CSS.

The allocations classified as health and community systems may be an underestimate as it does not include the fraction of mitigation and direct response investments that could be considered as contributing to health and community systems. For instance, in Peru, a significant portion of C19RM 2020 funding was allocated towards the support of 15 COVID-19 hubs for the treatment of hypoxia.⁵⁶ While grant support for these sites was approved under the direct, “reinforcing national COVID-19 response” category, many of the specific activities may have cross-cutting health systems implications. The development of tele-medicine components and training of staff to manage tele-visits can help to promote digital health accessibility in Peru more broadly. The “direct response” budget also went towards strengthening labs associated with the COVID-19 hubs, including equipment like biochemical and hematological analyzers, blood gas analyzers, and other equipment for oxygen therapy and other respiratory interventions that can continue to be used after the pandemic. Training of primary care health workers on hypoxia management and of public health managers on infection control protocols, and health education campaigns financed through C19RM 2020 may have positive benefits for Peru beyond direct COVID-19 management and containment. If the Secretariat were to review and re-classify C19RM 2020 budgets, more of the financing could potentially be counted as contributing to strengthening national health systems.

Despite this lack of granularity in overall program data, some understanding of the focus of health and community systems investments in C19RM 2020 could be gained from the country case studies. Among the eight full country case studies and two “light-touch” cases, six received funding in C19RM 2020 that was counted as “strengthening health and community systems” while the other four countries did not have HSS/CSS resources in the first year of the program.

⁵⁶ Peru C19RM 2020 Notification Letters and Funding Request; Peru Country Case Study Report.

Table 9. C19RM 2020 allocations in health and community systems in case study countries

Country	Urgent improvements in health and community systems, US\$ thousands	Share of total C19RM 2020 award
Angola	122.9	1.98%
Malawi	3,514.2	11.42%
Rwanda	1,198.2	10.50%
South Africa	7,618.5	14.61%
Togo	186.0	2.82%
Ukraine	513.5	4.74%

Source: Covid_approved_funding_report.xlsx

Procurement of laboratory equipment, especially non-consumable materials for diagnostic testing, was among the most common C19RM investments relevant to HSS and applicable to long-term PPR. For example, investments in Malawi and Ukraine included the procurement of GeneXpert and Abbott machines. The strengthening of specimen transport systems (purchasing more vehicles and improving fleet management, not paying transport costs) was another notable HSS investment. In Rwanda, funding was approved for the purchase of motorcycles to assist in medical commodity resupply to health centers in rural areas, along with vehicles for sample transportation to testing hubs across the country.

This situation changed in C19RM 2021, with a slightly larger share (14.3%) of funding and a larger absolute amount (\$456 million) categorized by the GF as going to health and community systems. Budgets were further classified as either CRG or RSSH: \$334 million US\$ or 10.5% of total approved funding for the former and \$122 million or 3.8% for the latter. In addition to assigning more funding to these areas, the C19RM 2021 grants for RSSH and CRG were broken down into 9 “interventions” categories as shown in the table below. This allowed for better tracking of HSS/CSS investments.

Table 10. C19RM 2021 intervention mapping for CRG and RSSH

Community Systems	Health Systems	Other Health/Community Systems
- Community-led monitoring - Community-led advocacy and research - CBO's institutional capacity building - Social mobilization	- Surveillance systems - Laboratory systems - Health products and waste management systems	- Gender-based violence prevention and post violence care - Respond to human rights and gender related barriers to services

Source: C19RM 2021 Interventions Mapping.xlsx

The three health systems intervention categories, as defined by the GF, encompass the following activities⁵⁷:

- Surveillance systems, including technical assistance for the development of SARS-CoV-2 sequencing strategies; procurement of resources for transportation and testing of samples; training and hiring of staff; integration of COVID-19 surveillance and reporting in existing

⁵⁷ C19RM 2021 Interventions Mapping.xlsx.

HMIS platforms; and top-up funding for routine surveillance and data systems that were impacted by the pandemic.

- Laboratory systems, including strengthening of specimen transport networks; technical assistance for linking laboratory and epidemiological data; improving information system interconnectivity; procurement of equipment and software; strengthening supply chain management for lab equipment; and hiring and training of laboratory staff.
- Health products and waste management (HPWM) systems, including QA and supply chain activities for health products such as PCR assays, PPE, medical devices, and other COVID-19 related diagnostics, therapeutics, and vaccines; the development of waste management frameworks and operational plans; training of human resources; procurement of infrastructure and equipment; and fostering the implementation of sustainable waste management practices.

While these definitions from the GF itself could be seen as generous in assigning investments to HSS (for instance, genomic sequencing and paying for specimen transport could both be considered as direct COVID-19 response), they do indicate that in the second year of C19RM, the GF focused more on building systems for COVID-19 and larger pandemic response.

We note that in C19RM 2021 (outside of the scope of our evaluation) all 10 case study countries received allocations for “urgent improvements” to health and community systems (Table 11), accounting for a low of 0.6% of the grant award (Angola) to a high of 42.2% (El Salvador).

Table 11. C19RM 2021 allocations in health and community systems in case study countries

Country	Urgent improvements in health and community systems, US\$ thousands				Share of total C19RM 2021 award
	CRG	RSSH			
		HPWM	Labs	Surveillance Systems	
Angola	56.9	81.9	0	0	0.6%
El Salvador	232.2	0	0	1,798.8	42.2%
Malawi	7,374.6	1,891.3	2,008.9	104.6	11.1%
Nepal	601.5	1,123.8	1,149.6	928.1	13.1%
Peru	1,067.6	51.2	586.6	0	11.4%
Rwanda	657.1	4,413.9	359.4	693.1	12.9%
South Africa	3,504.6	19.2	571.7	11,661.1	8.5%
Togo	1,340.8	261.5	355.6	929.5	10.6%
Ukraine	4,146.5	95.1	0	1,703.1	14.2%
Viet Nam	507.2	193.6	6.1	724.8	4.1%
10 country total	19,489.0	8,131.5	5,037.9	18,543.1	10.7%

Source: Covid_approved_funding_report.xlsx as of 16 May, C19RM 2021 Awards by Intervention and Cost Grouping.xlsx

In the final weeks of the evaluation, the Secretariat shared with Pharos an analysis of line items (at the activity level) in the C19RM 2021 budgets, tagging all investments in the 18 intervention categories that they viewed as contributing to HSS. The GF argued in this analysis that \$1.23 billion (36% of C19RM 2021 awards) should be counted RSSH investments, nearly four times the \$334 million they budgeted as RSSH. Pharos did not have time to validate these numbers.

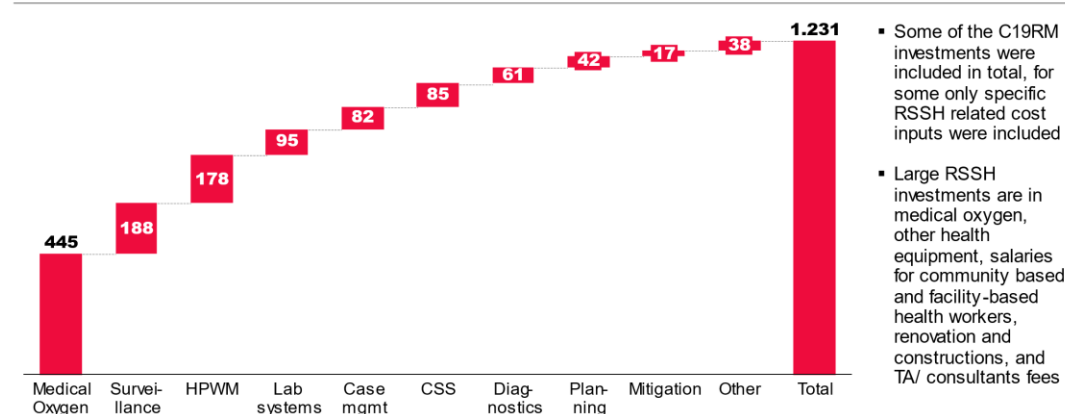
This analysis of C19RM 2021 funding, as well as the challenges of classifying C19RM 2020 grants according to overarching program goals and more specific objectives, points to the need for the GF to define more clearly, unambiguously, and consistently how it budgets and tracks C19RM money.

Figure 7. Secretariat analysis of all C19RM 2021 investments related to RSSH

~36% of C19RM investments are related to RSSH, mainly driven by case mgmt./oxygen, surveillance and HPWM

C19RM investments in RSSH

Key insights



- Some of the C19RM investments were included in total, for some only specific RSSH related cost inputs were included
- Large RSSH investments are in medical oxygen, other health equipment, salaries for community based and facility-based health workers, renovation and constructions, and TA/ consultants fees

THE GLOBAL FUND

NB: explanation on calculation of RSSH related C19RM investments in Appendix

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Source: Resilient and Sustainable Systems for Health (RSSH) implementation for the new Strategy – Informal Pre-Board Retreat, 8 May 2022

Community Engagement in C19RM

When the C19RM was first launched in 2020, the GF issued guidelines asking CCMs, CRMs and implementation partners to prepare funding requests utilizing the steps^{58,59,60} that required consultations with the HTM stakeholders and an inclusive decision-making process. The call was repeated in 2021, but this time the GF reinforced the guidelines about community engagement, asking countries and implementation partners to pay a deeper attention to CRG issues.^{61,62,63}

⁵⁸ The Global Fund. 2020. COVID-19 Response Mechanism. Operational Procedures. For External Use.

⁵⁹ The Global Fund. 2020. COVID-19 Guidance Note: Community, Rights and Gender.

⁶⁰ The Global Fund. 2020. COVID-19 Guidance Note: Human Rights in the Times of COVID-19.

⁶¹ The Global Fund. 2021. COVID-19 Response Mechanism Guidelines.

⁶² The Global Fund. 2021. Audit Report: Continuity and oversight of the country programs during the COVID-19 Pandemic. Office of the Inspector General.

⁶³ The Global Fund. 2021. Examples of Community, Rights and Gender-related Investments during COVID-19: Summary of COVID-19 Guidance Notes and Recommendations from Civil Society and Communities.

Information obtained from multiple sources indicate that community engagement in the grant-making of the C19RM 2020 varied from country to country. In countries where communities are integrated in the national health systems at all levels (South Africa), they were more engaged in the needs assessment and prioritization process. At the other end of the spectrum, in countries where communities are only engaged in certain areas of the disease responses (prevention and testing, patient support), the grant-making process was basically led by the MOH and the PRs, with formal consultations with CSOs and CBOs which are members of the CCM to obtain their endorsement only, but without real influence over the process. This was the case in Angola, Peru, and El Salvador. In other cases (Ukraine), there was no clear line in the first year of C19RM about who should be considered the community to be engaged and which demands had to be considered, as the PRs are large CSOs (more than 100 employees) that have their own interests to pursue (this changed dramatically in C19RM 2021, with very widespread CSO involvement (see below)). Finally, in context of fragile states and conflict (e.g., multi-country grant to Middle East MER), defining, identifying and engaging the suitable communities for dialogue and input prove very challenging: many KVPs are violently prosecuted and criminalized, and the national authorities do not recognize related community organizations.

According to the Kis from the 8 case studies, the main reasons for community representatives to have felt that the C19RM application in 2020 was not satisfactory was due to difficulties in accessing information and virtual decision-making spaces, limited information technology (IT) equipment and literacy, the complexity and ambiguity of the GF instructions, lack of time to digest those instructions, the need to respond to urgent personal and community demands, and the personal and community impact of COVID-19 (in terms of health and socio-economic consequences).

A survey led by CRG and the CCM Hub (GMD) found that while the majority (56%) of the CCM community members were satisfied with the GF's efforts to engage them, only 36% of the non-CCM community people were. Similarly, 76% of the first category found that they received timely and relevant information, while only 35% of the second group felt the same. Taken per type of community group, malaria-focused civil society, faith-based organizations, and networks of TB survivors/activists were the respondents who reported feeling involved the most, while human rights groups, CBOs and youth organizations were the least.⁶⁴

The reviewed documents, the country cases and the informants agree that community engagement was better in 2021 than it was in 2020. There were specific instructions from the GF to pay more attention to meaningful community participation, accompanied by the document "Examples of Community, Rights and Gender-related Investments during COVID-19". This included specific orientations to integrate activities to address the increase of gender-based violence in general, that would also include KVPs.⁶⁵

⁶⁴ The Global Fund. 2020. Civil Society and Community Engagement–COVID-19 Response Mechanism Survey Results.

⁶⁵ The Global Fund. 2021. Examples of Community, Rights and Gender-related Investments during COVID-19: Summary of COVID-19 Guidance Notes and Recommendations from Civil Society and Communities

Also in 2021, as explained in the country cases, communities in multiple countries received support from several partners (UNAIDS, PEPFAR, the GF) to prepare broad consultations with the civil society groups. The report of the OIG details how the organization made significant efforts to enhance the inclusiveness of the C19RM 2021 process through increasing CCM budgets in 2021 to support improved engagement of CSOs and KVPs; improvements to application material and guidelines, including mandatory lists of communities' priorities in FRs and; increasing funding from Centrally Managed Limited Investment funds, which were used to strengthen CSO and KVP engagement.⁶⁶

Also new in 2021 was that the GF instructions asked for a "List of CSO suggestions for inclusion in the C19RM FR" to be attached to full FRs. As the OIG report points out, the annex includes the list of CSOs' suggestions and recommendations to be considered as a part of the FR: "It was designed to be submitted with the other mandatory documents before the start of the C19RM 2021 FR review process. If it is not available, the FR should be considered incomplete for assessment until it is provided. Despite that, the OIG noted that the CSO annex was missing from the mandatory annexes in 7 out of 31 (23%) full FRs reviewed".⁶⁷

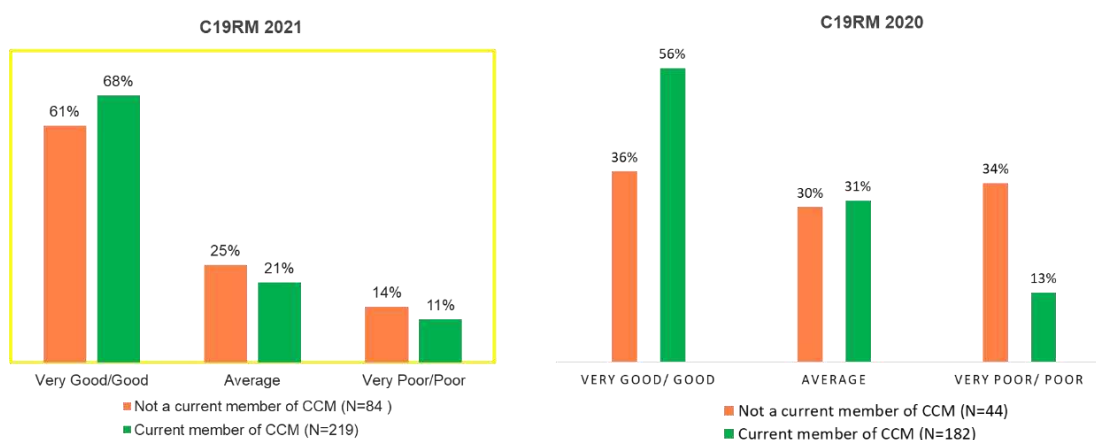
A second online survey performed by the GF CRG department, which mobilized financial support through the six community-led technical assistant platforms, shows an increase in the way respondents—and in particular those who are not CCM members- rate the GF efforts to engagement in the C19RM 2021 application process (Figure 8 below).

Figure 8. Rate of Global Fund support by community respondents, 2021 versus 2020

C19RM survey – results

Improved efforts to support engagement compared to C19RM 2020, with clear improvement with non-CCM members ("very good or good" for 61% in 2021 versus 36% in 2020)

How would you rate the Global Funds efforts to support your engagement in the C19RM 2021 application process?



Source: Global Fund. 2022. C19RM Community Engagement Dialogue. PPT file.

⁶⁶ The Global Fund. 2022. Audit of the COVID-19 Response Mechanism 2021. Office of the Inspector General.

⁶⁷ The Global Fund. 2022. Audit of the COVID-19 Response Mechanism 2021. Office of the Inspector General.

Feedback from the country cases and the Kis is mixed about how much the community consultation improved in 2021 compared to 2020. CCMs had more experience, but community members were not necessarily the same (hence, they had to learn from scratch) and some of the issues that hindered their participation (specifically, IT access and literacy) were not overcome. Additionally, countries were asked to engage COVID-affected communities, without the GF offering clear definition of who these were and how their representatives could be identified and engaged. This led to variation in practice, as shown in the country cases, with some (Angola, Malawi) ignoring the requirement while others (El Salvador, Rwanda) expanding the concept to include people with disabilities.

Even when community participation occurred, the inclusion of their requests in the 2020 grant applications was limited by the priorities set by the national health authorities and PRs and the instructions and eligibility criteria established by the GF Secretariat. Those criteria were not applied in the same way in each country. The data and the perceptions of Kis suggest that criteria were more flexible where budget allocations were higher or applications were submitted later. A good example relates to community demands to cover social protection measures such as food, housing, and transportation support in 2020 and in 2021. Some KIIs felt that social protection was beyond the GF mandate, that governments and other development partners have responsibility for these measures, and that in the pandemic required the GF to focus on COVID-19 containment and its impact on health services, and not on community systems and needs. Others thought that for disease prevention, testing, treatment, and care to be effective the social needs of KVPs should be central, consistent with the core value of the GF to protect communities affected by HTM. Those KIIs point to the decline of HIV and TB prevention and testing coverage, malaria outbreaks, and an increase in HIV and TB patients lost-to-follow-up as the consequences of ignoring the social impact of the COVID-19 pandemic among KVPs. At the end, only a few countries (from our sample, Rwanda) included a significant portion of their grant for social protection.

Chapter 9: Relationship Between ACT-A and C19RM

Introduction

Launched in April 2020, ACT-A is a global collaboration among pre-existing actors in global health, with the purpose of accelerating the development, production, and equitable access to COVID-19 “tools”—tests, treatments, and vaccines. It includes major organizations and philanthropists including the BMGF, CEPI, FIND, Gavi, GF, Unitaid, Wellcome, WHO, and the World Bank, governments, scientists, businesses, and civil society.⁶⁸

The ACT-A is organized into four pillars: diagnostics (co-convened by the GF and FIND), therapeutics (led by Unitaid and Wellcome), vaccines (convened by CEPI, Gavi, and WHO), and the Health Systems and Response Connector (co-convened by the GF, World Bank, and WHO, with UNICEF). The cross-cutting Access and Allocation workstream, led by WHO, develops the principles, framework, and mechanisms to ensure the fair and equitable allocation of technologies for the response to COVID-19. UNICEF and PAHO are delivery partners for COVID-19 Vaccines Global Access (COVAX), the vaccines pillar of ACT-A. Its modus operandi was intended to be informal and nimble, focused and time-limited.

Strategic Review of the ACT-Accelerator: An Interim Perspective

Twenty months after the ACT-A started, a strategic review of its work was published in October 2021.⁶⁹ It covered the scope and objectives, operating model, financing, and the broader ecosystem within which the ACT-A operated. The review found that ACT-A had played additive and important roles in accelerating the development and delivery of critical tools, and in responding to country needs. It noted that ACT-A had faced several external challenges, including the changing dynamics of the pandemic (with the emergence of variants of SARS-CoV-2), and the inhibitory effects of geopolitics and internally focused responses of higher-income countries on truly coordinated global actions. It also found that the following internal challenges had inhibited the efficacy of ACT-A as a mechanism for coordination and action: the scope of work, coordination, operations, representation, and participation. The latter highlighted insufficient and meaningful engagement of LMICs, regional bodies, CSOs, and community representatives.

The ACT-A Financial Commitment Tracker for the 2020-21 budget showed a total of US\$18.7 billion. Of the total amount, US\$458 million is attributed to the GF (including \$182 million for diagnostics and \$276 million for PPE). The ACT-A has published a Financing Framework to clarify sources of financing that could be used to fund its budget for October 2021 to September

⁶⁸ WHO. The Access to COVID-19 Tools (ACT) Accelerator. <https://www.who.int/initiatives/act-accelerator/>. Accessed on March 23, 2022.

⁶⁹ ACT-Accelerator Strategic Review. An independent report prepared by Dalberg. October 2021. <https://www.who.int/publications/m/item/act-accelerator-strategic-review>. Accessed on March 23, 2022.

2022.⁷⁰ It includes US\$ 16.8 billion in grant financing for ACT-A agencies (part of the total US\$ 23.4 billion ACT-A budget) and US\$ 6.8 billion to support countries to deliver COVID-19 tools locally.⁷¹ The latter is part of a larger investment need that goes beyond ACT-A agencies.

Relationship Between C19RM and ACT-A

II. What does ACT-A do for C19RM?

There is a mutually beneficial relationship between ACT-A and C19RM. ACT-A provided C19RM 2020 with access to technical expertise of relevance to COVID-19, which the GF, being a financing mechanism, does not possess. The GF sought that expertise:

*“They didn’t presume to know, that was important to note. Honest and open about that.”
—Interviewee at the global level.*

The range of expertise from which the C19RM 2020 benefited included specification of needs and types of diagnostics, therapeutics, and oxygen. For example, the use of Ag RDTs in the diagnosis of COVID-19 could be supported by GF grants when they are used as recommended in the WHO guidance.⁷² ACT-A also served as a broker at the interface between C19RM and experts working on technologies required for the response to COVID-19.

*“It was quite clear that the oxygen community had no prior experience engaging with the likes of the GF. They didn’t know what the requirements were, etc. So that connection piece between the two communities was really critical. It was also part of the reason why so small a part of first round funding went to oxygen.”
—Interviewee at the global level.*

Technical experts from ACT-A members, such as FIND, WHO, and Unitaid, shared their expertise with the GF. However, the collaboration did not necessarily result in a timely delivery of products to beneficiaries. The pathway from technical specifications to product delivery includes multiple steps, the execution of which often fell short of stakeholders’ expectations.

*“During the emergency, WHO did not move fast enough to make therapeutics available.”
—Interviewee at the regional level.*

⁷⁰ ACT-Accelerator. Consolidated Financing Framework for ACT-A Agency & In-Country Needs. 9 February 2022. <https://www.who.int/publications/m/item/consolidated-financing-framework-for-act-a-agency-in-country-needs>. Accessed on March 23, 2022.

⁷¹ ACT-Accelerator. At a glance: CONSOLIDATED FINANCING FRAMEWORK FOR ACT-ACCELERATOR AGENCY & IN-COUNTRY NEEDS. October 2021 to September 2022. A Facilitation Council Financial & Resource Mobilization Working Group Product.

⁷² The Global Fund. COVID-19 Response: Scaling-Up Testing with Antigen-Detection Diagnostics. <https://www.theglobalfund.org/en/sourcing-management/updates/2020-11-30-covid-19-response-scaling-up-testing-with-antigen-detection-diagnostics/>. Accessed on April 13, 2022.

The GF was a newcomer to tackling a fast-moving pandemic like COVID-19. ACT-A provided the GF, whose track record was in financing HIV/AIDS, TB, and malaria programs, with a fast track to institutional credibility in the response to COVID-19.

“ACT-A is increasingly seen as a crucial part of the global COVID-19 response. GF is known for HIV, TB, and malaria, but as part of ACT-A, it immediately gets credibility for COVID-19 response. There were two sides: financing and advocacy/ promotion. One key thing we do is consolidate the budgets and needs across the three product areas, raise awareness for it, especially big goals like equitable access.”

—Interviewee at the global level.

This sense of coordination (e.g., through meetings, aggregation of funding needs, sharing of plans for procurement, attempts to broker and allocate scarce commodities across countries – as happened with diagnostics in 2020 – was shared by the most immediate members of the ACT-A coalition. However, among large financiers outside the ACT-coalition, there was a perceived lack of coordination. The GF’s engagement with a segment of multilateral stakeholders was modest or absent, and it was perceived by some as doing its own thing.

“If you ask me what the GF has done, I don’t know. No engagement with the GF. No co-financing. We had some policy conversations and information sharing. Also, part of global mechanism discussing policy issues, situation analysis where GF was also a participant. In the future I would like to see more interaction with the GF.”

—Interviewee at the regional level.⁷³

II. What does C19RM do for the ACT-A?

The GF has been an asset to the ACT-A via the C19RM. As the core convener for two of ACT-A’s pillars—Health Systems and Diagnostics – the GF’s C19RM brought to ACT-A two important elements of the response to COVID-19: money and a pre-established platform for procurement. How well the combination worked was a matter of rich but divergent perspectives among respondents. The GF was perceived as successful in attracting resources, creative in generating the first billion dollars, and effective in getting additional funds for C19RM from the governments of the United States and Germany.

The C19RM was developed to swiftly respond to the pandemic. Several partners were keenly aware of the way it was formulated and implemented. They noted that it was still an evolving concept and that it was like building a ship while sailing it. They perceived the availability of information on COVID-19 dynamics as very low in many countries, making it difficult to fully define and prioritize C19RM programs.

⁷³ This statement may seem to contradict other interviews, but expresses an important viewpoint of a regional organization stakeholder.

“C19RM was chaotic at the start, no clarity on the criteria, deadlines, etc. GF was well set in the networks but forced links between COVID-19 and HIV and TB. Malaria is a clearer link to COVID-19 than for HIV or TB.”

—Interviewee at the regional level.

“There were no COVID-19 agencies at the beginning. So, we had to repurpose Global Health architecture into the COVID-19 response. Consider the counterfactual. If the GF didn’t exist, it would have been a much bigger challenge.”

—Interviewee at the global level.

The initial phase of C19RM (in 2020) was chaotic. Difficulties in moving from C19RM funds award to execution were attributed to lack of guidance from the GF. In other instances, difficulties were attributed to the fact that the GF was not an emergency response architecture.

Expert informants were convinced that COVID-19 negatively impacted TB notification. However, they were not convinced that C19RM mitigated the severity or duration of such disruptions.

“I don’t think C19RM at all helped prevent disruption to TB programs. On recovery, I don’t think we can say how much of it was natural recovery and how much was aided by additional funding from the GF. Would have to go country by country so you can talk about distribution, data, etc. Impossible to do without some kind of study or something more detailed.”

—Interviewee at the global level.

Furthermore, there are questions about the criteria for appropriateness of resources allocated to different types of interventions and commodities. For example:

“They spent only one quarter of their money on testing. Did you spend money the right way? If they appropriately prioritized testing, it would have helped. We don’t understand the pandemic in real time, and that is costing countries.”

—Interviewee at the global level.

Fitness for Purpose

The GF has made strong assertions about its suitability for responding to pandemics, as noted in Chapter 1 and in the current Investment Case: “Given our scale, inclusive operating model and focus on the biggest infectious diseases, plus our relentless focus on outcomes, the GF partnership is uniquely positioned to support countries in designing and implementing programs that simultaneously deliver immediate benefits in the fight against HTM and provide greater protection against future pathogens.”⁷⁴

⁷⁴ Source: *The Global Fund. Fight For What Counts. Investment Case. Seventh Replenishment 2022. Page 8.*
https://www.theglobalfund.org/media/11798/publication_seventh-replenishment-investment-case_report_en.pdf.

However, while partners acknowledge GF's C19RM as a contribution to the collective enterprise, the GF is not perceived as *primus inter pares* nor as uniquely positioned in preparing for or responding to pandemics like COVID-19. Respondents sounded several cautionary notes. The strongly held concerns fell into two categories. One category was about the suitability of the GF's pre-existing grant mechanisms for a fast-moving pandemic like COVID-19:

"GF is not equipped to handle emergencies beyond HIV, TB, and malaria. Mission creep is a concern. Speed and availability of resources were important, but unclear of their abilities to handle things beyond HIV, TB, and malaria. Is there a need for GF to have a competency in COVID? No. GF should stick to their strength—moving the money."

—Interviewee at the global level.

The other concern was about extrapolating from any positive effect of C19RM to concluding that C19RM was the model for responding to future pandemics:

"There is a danger in saying it's perfect, worked fine, and now we should use it for future pandemics. What we saw with C19RM was the GF doing what it normally does but faster. I think you should look to the future, this was not purpose-built for rapid deployment, push of critical tools. It was designed for another purpose."

—Interviewee at the global level.

"There are two issues with C19RM. The governance structure is the CCM, which is made up of HIV, TB, and malaria. This is not the same governance as the national COVID-19 response. There is also a structural issue of procurement in the GF. Utilization of money and the timeliness, being able to convert disbursement to response. The PR process takes a long time. Then select implementing partner, then procurement partner. Only the procurement partner can go to market to procure."

—Interviewee at the global level.

An important theme was that the GF was set up as a development model, but COVID-19 is an emergency.

"Credit to the GF, it moved fast by GF terms. The mechanism relied on CCM, which is not COVID-savvy. What the GF considered swift was not fast enough for COVID-19."

—Interviewee at the global level.

What Might Be Done Differently in Responding to a Future Pandemic?

In April 2022, ACT-A identified four near-term priorities and areas of focus: closing ACT-A's urgent financing gap, ensuring access to scarce tools, scaling up delivery and uptake in countries, and informing deliberations on the future global health security architecture.⁷⁵ The issue of what might be done differently generated animated responses during this study. The options suggested include: channeling money through existing global institutions; creating a new entity with the financing and organization; and creating a financing mechanism—essentially a bank account with a secretariat, then working through the details, like a financial

⁷⁵ World Health Organization. The ACT-Accelerator: Two Years of Impact. April 2022

intermediary fund; clarity of rules and regulations before going to the countries; more flexibility in the criteria for eligibility and more effort to understand the needs of countries; greater commitment by the GF's regional teams to support the process; more clarity in linking the work on HIV/AIDS, TB, and malaria to COVID-19; speedier availability of funds; and strengthening activities to have spillover for surveillance systems.

The discussions revealed complex inter-agency dynamics at play, regarding, *inter alia*: which agency should play lead roles in PPR; hosting or serving as the secretariat for a global-level pandemic financing mechanism; fundraising; procurement; and the relative emphasis between stakeholders at the global and regional levels.

"WHO should be providing technical expertise on what should be financed, what entities should be preparing those, and whether they are in line with priorities. World Bank and GF would both say they should be the secretariat. WHO would say no, they don't have the technical expertise. Who should perform the Secretariat function? If WHO does it, then WHO should not be a beneficiary. The beneficiaries could be CEPI, World Bank, GF, etc., but also national governments doing this work."

—Interviewee at the global level.

"Last big piece missing is you have to have a way to get financing. To go around with a paper cup is not enough. You need a \$10 billion war chest going into a pandemic. GF shouldn't hold that. A bank should hold that."

—Interviewee at the global level.

In matters of ownership and accountability, there was recognition that decision-making rests in few hands:

"It is important to recognize that the big countries with all the money, all the influence, call the shots."

—Interviewee at the global level.

Conclusions

The mutually beneficial relationship between ACT-A and C19RM has benefited the collective response to the COVID-19 pandemic. The C19RM contributed the GF's financing and procurement platform to the joint effort, while ACT-A conferred legitimacy on the GF's work on COVID-19 and provided technical support, especially on PPE, diagnostics, and oxygen. Multiple partners in ACT-A supplied the technical know-how that the GF does not have. There have been challenges in formulating and executing the C19RM. The collective response to the pandemic would have been worse off without the GF's engagement through the C19RM. However, in terms of fitness for purpose, it would be inappropriate to conclude that the GF's pre-COVID-19 mechanism and C19RM are optimal for preparing and effectively responding to pandemics like COVID-19.

PART C: KEY LESSONS AND RECOMMENDATIONS

Chapter 10: Lessons Learned

Based on this evaluation of C19RM 2020, a series of key lessons emerge that can be useful in making mid-course corrections to C19RM, improving future GF grants to countries to fight COVID-19, and building the GF's ability to assist countries in preparing for and responding to future pandemics (if the GF ends up moving in this latter direction). From a much longer list of possible lessons, we have selected 15 that we find most pertinent.

Monitoring and Evaluation

1. **While the context for C19RM 2020 (global crisis and emergency response, lack of understanding of the pandemic, global supply chain disruptions) helps to explain why the downstream implementation monitoring system for C19RM 2020 was rudimentary, the failure to have a robust monitoring set-up created a number of risks that are hard to correct retroactively.** The lack of visibility into non-PPM procurement; the difficulty in reconstructing C19RM spending patterns and calculating absorption levels, and of breaking down budgets and spending by disease and intervention area; the challenges of following service delivery disruptions and recovery in close to real time and assessing the impact of innovations, adaptations, and other mitigating measures; the limited ability to follow the implementation of health and community systems activities; and the lack of timely information to enable continuous reprogramming of funds in a fast changing emergency – occurred as a result of the weaknesses in monitoring and reporting on C19RM 2020. Many of these shortfalls are being corrected in 2021, but it is hard and/or would be costly to go back and fix them for 2020, leading to weaker accountability and a weakened ability to learn from the first year of the program.
2. **The absence of a Theory of Change for the first year of C19RM, and a framework for M&O in the second year that still falls short of a full ToC, makes it difficult for the GF and TERG, plus outside groups, to systematically evaluate C19RM.** The C19RM's M&E Framework has some valuable features but is not a substitute for a Theory of Change. Setting out a clear ToC that is endorsed by senior management and endorsed by the GF's board would have made it clear to everyone about the hypothesized relationship between C19RM and various downstream impacts and the expected intermediate causal chains involving investments, inputs, outputs, and outcomes would have made it easier to conduct future evaluations of C19RM. Having a clear and explicit ToC and monitoring system for collecting data on C19RM would also have had the additional benefit of encouraging the Secretariat to collect and archive data and documents on C19RM in a way that makes it easier for managers and evaluators to locate and use these materials, overcoming some of the barriers that we experienced in conducting the evaluation of this novel funding mechanism.

Global Fund and Country Governance and Processes

3. The GF's processes for C19RM 2020 Grantmaking drew heavily on existing practices for HTM grants plus some adaptations such as in-house technical review without the involvement of the TRP. **While these hybrid processes allowed for rapid approval of grants, it appears that they negatively affected the "quality at entry" of the C19RM 2020 projects and reduced visibility into what was happening in implementation, making it harder to take corrective actions.**
4. **The idea of having a different model of implementation management by the GF for C19RM using processes and rules for continuous adjustment and adaptation was allowed in the initial 2020 guidelines but does not appear to have been pursued in practice by the GF.** Grant top ups in 2020 allowed the GF to augment its scope and level of country support, but there is no evidence of additional reprogramming of C19RM 2020 grants in the face of a rapidly changing pandemic.
5. **The reliance on existing structures and practices at country, including sponsorship and priority-setting by the CCM, reduced the potential linkages to the larger pandemic response** (experts in overall disease surveillance, officials from the national COVID-19 emergency coordination centers). Where there was fortuitous overlap of HTM and COVID-19 leadership (e.g., Vietnam, Togo, and Malawi), the larger COVID-19 needs were introduced into C19RM planning, but in other countries this did not happen.

Mitigation

6. **The failure to coordinate systems for monitoring service disruption and impact of COVID-19 on HTM grants among agencies** (e.g., UNAIDS, WHO, GF) led to a situation in which a large amount of data was generated during 2020 on the issue of disruption and mitigation, but these data were incomplete and fragmented and fail to answer basic questions about what happened and why.
7. **The development an effort starting from day 1 of C19RM to monitor a carefully chosen sample of countries and health facilities in those countries and report/collect indicator data** would have enabled the GF to see more clearly whether its design was sufficiently robust to succeed, tailor its investment monitoring to emphasize areas at high risk of derailment, and pre-design an approach to determining whether the investments (by countries, the GF, and other financing partners) in mitigation were having an impact on service delivery levels for HTM.
8. **While not a substitute for rigorous and systematic analysis, the use of partial country data sets plus anecdotal evidence can help to describe and explain how mitigation actions** (PPE for frontline workers, extra outreach personnel) and program delivery innovations (e.g., telemedicine, self-testing, home delivery of bed nets and antiretrovirals (ARVs), etc.) may have contributed to protecting and restoring HTM services. **An enhanced ability by the GF**

and others to document these experiences and draw causal inferences could help to justify the C19RM mitigation investments and publish effective practices that countries could consider adopting.

Procurement/Direct COVID-19 Response

9. **The lack of a unified and integrated health products demand forecasting and planning management system, that covered both PPM and non-PPM PSM, reduced the GF's ability to access timely PSM data for decision making—particularly at the country level.**
10. While the GF did a commendable job on procuring COVID-19 tests and on volume commitments, **the lack of a stockpiles of PPE cost the GF and its client countries time** in completing in-country deliveries for urgently requested commodities.

Health and Community Systems

11. **Investments in health systems are important to build more resilient pandemic preparedness capacity in LMICs to prepare for future pandemics like COVID-19, but it is difficult in the midst of a large outbreak to plan and prioritize for these longer-term investments, especially under pressures to allocate scarce resources to immediate needs.** Hence, they tend to be forgotten or under-represented in FRs. Few countries made significant investments in health and pandemic systems strengthening in C19RM 2020. Countries that considered these longer-term issues and made systems investments, such as South Africa (additional outreach workers and testing/counseling staff), Ukraine (COVID-19 and infectious disease modeling), and Rwanda (national hospital infectious disease isolation unit) may end up reaping substantial benefits from these systems improvements.
12. **In the middle of a severe health crisis, it is also easy to neglect or under-invest in smart community responses to COVID-19 and other pandemics.** It takes longer for complex CSO structures to articulate their needs (e.g., in Ukraine or Peru). Direct COVID-19 measures and mitigation activities directed at KVPs may also have been hard to define at the start of the pandemic. Expecting the existing CCM structures to incorporate views from non-traditional communities most affected by COVID-19 (e.g., undocumented immigrants, minorities) is also not realistic without concerted efforts at redefining and realigning CCM membership.

Chapter 11: Recommendations

Our team generated a long list of potential recommendations to improve the effectiveness of C19RM and enhance the GF's ability to help countries prepare for and respond to future pandemics, building on the findings and lessons mentioned earlier in this report. From this longer list, we selected what we assessed to be 16 recommendations on the basis of their expected benefits to C19RM effectiveness and GF PPR capacities, the fact that they have not been highlighted in other C19RM reviews and audits and thus add more value, as well as feasibility, and balance across thematic areas of C19RM and the GF's PPR capabilities. Of these 16 recommendations, we selected 10 of these as being the highest priorities for the GF (First Priority Tier) and the other 6 as being important secondary recommendations (Second Priority Tier). All of these recommendations merit the full consideration of the GF for adoption, with special focus on the First Tier items. The recommendations are summarized in Table 12 at the end of this chapter, where we show the relevant finding, the related recommendation, and the degree of progress in implementing the recommended actions to date.

Monitoring and Evaluation

1. **Complete the implementation of C19RM M&O framework developed for 2021 (April 2021), with a focus on downstream implementation, impact, and quality**, being careful not to overload the data bases and dashboards to the point where country implementers, GF CTs, and Senior Managers are overwhelmed and potentially become demotivated by having too much data to interpret. Ensure that the input/output/outcome indicators chosen relate to all three components of C19RM (direct COVID-19 response, mitigation, and community and health systems), selecting appropriate, meaningful, and measurable indicators for each area. The findings and action points emerging therefrom should be relayed to CTs and CCMs for quick action. The findings should be put in the public domain with applicable caveats. (First Tier)
2. **Develop a basic turnkey M&O system (in collaboration with WHO and other large PPR funders) for any type of pandemic that the GF might be called upon to respond to in the future**, so that it can be rapidly activated without having to start from scratch. For each of the main classes of pathogens with pandemic potential, including respiratory, enteric, hemorrhagic and vector-borne, develop initial frameworks of outputs likely needed for control, budget templates, preliminary allocation criteria, and expenditure tracking categories. Plan ahead for guidance to countries, including recommendations to augment capacity with pathogen-specific experts. These components will have to be modified depending on the nature of the future pandemic but doing some of the initial planning ahead of time will increase the chances of a smoother and more effective response. This should also include easy-to-activate ways to measure the disruptions of future pathogens on HTM services (volume, coverage) and outcomes (new infections, deaths), improving on what was done for COVID-19 disruptions. (First Tier)
3. **Develop and publish a Theory of Change for C19RM retrospectively, as the main touchstone for all future monitoring and independent evaluations of the program.** This

would help the GF clarify its own thinking, specify the interconnected of different parts of the investment design, make explicit the key assumptions, and lay a verifiable basis for linking achievements with effort insofar as the evidence allows. (Second Tier)

Global Fund and Country Processes and Governance

4. **Design and disseminate tools and technical assistance for C19RM grant costing, priority setting, budgeting, and expenditure tracking and reporting.** Improvements in separate budgeting and expenditure tracking are already happening under 2021 but should be complemented with tools and processes for pandemic costing and priority-setting, VfM, and justification of proposed grant activities. There is a plethora of new technical guidance accompanying the grantmaking process for 2021, but very little in these suggested areas. (First Tier)
5. **Give PRs and CTs more tools and leeway to make more frequent adjustments to C19RM-financed activities and budgets, on a quarterly basis or more often if required.** The procedures for these adjustments should be light, leaving discretion to CTs for reprogramming up to a certain percentage of the C19RM grants (e.g., 10 or 20% of the grant award) without having to return to the IC, while still being subjected to random spot checks and other accountability measures. (First Tier)
6. **Adapt the current traditional model around grant implementation to include a new process for quality at entry, and policies and incentives for continuous adjustment and reprogramming.** Given the speed with which C19RM FRs are put together and approved (a strength), it is almost inevitable that there will be weaknesses in grant design that can be identified and solved during a “quality at entry” set of reviews and discussions of the kind that other multilateral agencies have been using for many years. Emphasis should be on readiness for implementation, to avoid situations in which grants are approved but implementation is delayed. (Second Tier)
7. **Reform CCM membership to align it better with national PPR knowledge and skills** and develop better tools and processes for coordinating GF investments with parallel investments by national governments and other key partners. (Second Tier)

Mitigation

8. **Create a stronger, more coherent, and coordinated system for monitoring HTM services and disruption/recovery, both within the GF and with countries and other leading agencies.** Right now, there is a plethora of fragmented and disparate data on this from multiple partners, unlike in 2020 when there was a relative paucity. Given the GF’s stated commitment to country-driven development and its interest in protecting HTM investments and programs in LMICs, it should play a leading role – working with others such as PEPFAR, UNAIDS, and WHO – to support country-designed and managed monitoring systems that generate the needed data that is primarily useful for in-country decision making (including but not limited to HTM) and concurrently meets the HTM-specific needs of the GF as a financier. (First Tier)

9. **Help to sponsor and establish a knowledge repository and learning hub for good practices in HTM innovation, adaptation, and mitigation to COVID-19.** Experiences – both positive and negative – and lessons learned need to be better collected, documented, vetted, published, taught, and discussed by countries as they design their mitigation measures. (First Tier)

Procurement/Direct COVID-19Response

10. **Invest in an integrated health product demand forecasting and planning management system** that provides close to routine and frequent data for both PPM and non-PPM procurement and enables timely, complete and useful access to and utilization of data for decision making on supplier diversity, product quality, product price, as well as supply chain performance from PO to delivery and utilization. The GF and other development partners should continue to invest in country supply chain system strengthening including LMIS that are inter-operable with a global demand forecasting and planning management system and incorporate on-shelf availability and service availability into standard and routine metrics. (First Tier)
11. **Use the HPMT as a key “source of truth” for PSM budgets and require timely, complete, and correct submission.** (Second Tier)
12. **Develop and implement agile instruments for pandemic procurement including stockpiles and hold limited buffer stocks in suitable LMIC hubs for health products that do not have short shelf lives.** Keep working on supply agreements used in C19RM 2020, including long-term agreements and volume commitments, as is appropriate for a given set of market conditions and health products. The use of catalytic Strategic Initiative funding for stockpiles and APCs for HTM health products under NFM3 has already been proposed, and this could be extended to pandemic health products. (First Tier)
13. **ACT-A partners, global health security key stakeholders, and agencies with emergency response mandates should develop clear decision rules for PSM roles in a pandemic/emergency context,** prioritizing agencies with proven, robust PSM capabilities versus setting up parallel structures that further fragment health product procurement. (First Tier)
14. **Continued and increased efforts are needed for regulatory harmonization at the country and regional levels across LMICs.** Without this, the introduction of new health products, including diagnostics and lifesaving therapeutics, will continue to be fraught with delays that will cost lives in times of urgent need. (Second Tier)
15. **Accessible ethical and standardized processes to report, address and close out quality incidents should be adopted** (Second Tier).

Health and Community Systems

16. **Given the importance of using C19RM to build long-term health systems resilience to pandemic threats and tap the knowledge and capabilities of civil society, consider a set-aside or earmark for each country for this purpose within future C19RM (and possible PPR) grants. Develop special incentives (for example, matching funds from strategic initiatives, additional time and technical assistance to develop and submit proposals) that encourage countries to submit HSS/CSS investment proposals.** This would help compensate for the natural bias in FRs to request funds during an emergency like COVID-19 for short-term commodity heavy needs for direct COVID-19 response and HTM mitigation. A modest earmark (e.g., 20% for HSS/CSS) could help to promote solid investments in these two areas which are hallmarks of the GF model. (First Tier)

Important progress has been achieved over the last year in some of the recommended areas, as C19RM 2020 transitioned to the second phase of the program. These and the remaining gaps are shown in the table below. By implementing the recommendations contained in this evaluation, the GF can strengthen the performance of C19RM as it completes its second year and continues into 2023 and possibly beyond. The improvements would yield large benefits both to LMICs curbing COVID-19 and to the GF's own capabilities in the response to the pandemic. Some recommendations, such as an enhanced C19RM M&O system and a more coordinated and complete analysis of HTM disruptions, mitigation, and service recovery, which are already under way, will simply require intensified efforts by the Secretariat. Others, such as a new C19RM learning hub, development of pandemic health products stockpiles and APCs, and measures to increase investments in health and community systems for C19RM, will require new initiatives by the GF, but the cost and effort involved are modest and within its reach. The GF, in responding to this evaluation and the earlier OIG audits, could create a small time-limited committee to agree on, commit to, and maintain focus on implementing these crucial recommendations.

The recommendations in this evaluation are also highly relevant to the GF's future role in financing PPR. Through C19RM, the GF has shown that it can adapt and, to a degree, leverage its existing capabilities to assist countries in fighting pandemics while protecting HTM gains. At the same time, the GF's model built over the past two decades to control and eliminate the three diseases contains inherent limitations that must be further addressed if it is to maximize its effectiveness in the PPR arena. With discussions now taking place among countries and multilateral agencies about global pandemic financing options, the recommendations in this report can help the GF enhance its processes and capabilities in the PPR domain and add greater value to the emerging global architecture for PPR.

Table 12. Evaluation findings and recommendations, by priority

Findings	Recommendation	Priority	Progress
Monitoring and Evaluation			
2020 monitoring system nascent, weak ability to systematically track inputs, outputs, outcomes and impact which affected implementation, budgeting and prioritization	1. Complete the implementation of C19RM M&O framework developed for 2021 (April 2021), with a focus on downstream implementation, impact, and quality	First	
Time to design and develop an M&O system is limited during a crisis and takes a backseat to rapid execution	2. Develop a basic turnkey M&O system for any type of pandemic that the GF might be called upon to respond to in the future	First	
Lack of a comprehensive Theory of Change is a major impediment to evaluation of C19RM and inhibits monitoring of pathways from inputs to outcomes and impacts	3. Develop and publish a Theory of Change for C19RM retrospectively as the main touchstone for all future monitoring and independent evaluations of the program	Second	
Global Fund and Country Processes Governance			
Limited toolkit for C19RM 2020 costing, budgeting, and priority setting among competing demands inhibited investment optimization and reduced downstream ability to assess efficiency of grants.	4. Develop and disseminate tools and technical assistance for C19RM grant costing, budgeting, optimization, and expenditure tracking and reporting.	First	
While C19RM 2020 guidance envisioned flexible reallocation of grants to respond agilely during an emergency, this option of continuous reprogramming was not used	5. Develop processes to allow for PRs and CTs to make more frequent adjustments to activities and budgets, on a quarterly basis or more often if required	First	
While the GF's adapted processes allowed for rapid approval of grants, they negatively affected the "quality at entry" of the C19RM 2020 projects and reduced visibility into implementation, making it harder to take corrective actions	6. Adapt the current traditional model around grant implementation to include a new process for quality at entry to mitigate implementation risks due to accelerated implementation	Second	
CCMs established for HTM did not have knowledge, skills, and membership needed to develop grants for an emerging pandemic or coordinate with national COVID-19 plans	7. Reform CCM membership to align it better with national PPR knowledge and skills.	Second	
Mitigation			
No clear evidence or ability to understand whether C19RM 2020 investments have had an impact on mitigation; Surveys and analysis fragmented among multiple agencies	8. Create a stronger, more coherent, and coordinated system for monitoring HTM services and disruption/recovery, both within the GF and with countries and other leading organizations	First	

Ecological evidence of investments in innovative service delivery suggests that some of innovations/adaptations may have contributed to mitigation, but there has been no systematic effort to capture learnings	9. Sponsor and establish a knowledge repository and learning hub for good practices in HTM innovation, adaptation, and mitigation in the face of COVID-19.	First	
Procurement/Direct COVID-19Response			
PQRs not required from PRs for COVID-19 products in C19RM 2020. Reports from country informants of limited stocks, price fluctuations, and inconsistent quality have not been documented. This compromised GF's ability to track non-PPM procurement.	10. Invest in an integrated health product demand forecasting and planning management system	First	
A C19RM Supplementary Template or List of Health Products was inconsistently populated, and budget information was, in some instances, inconsistent and misaligned with Notification Letters. Impacting the GF's ability to track country PSM expenditures.	11. Use the HPMT as a key "source of truth" for PSM budgets and require timely, complete, and correct submission.	Second	
While the GF did a commendable job on procuring COVID-19 tests and on volume commitments, the lack of stockpiles of PPE cost the GF and its client countries time in completing in-country deliveries for urgently requested commodities.	12. Develop and implement agile instruments for pandemic procurement including stockpiles and hold limited buffer stocks in suitable LMIC hubs for health products that do not have short shelf lives.	First	
The ACT-A consortium did not set up clear decision rules for PSM roles under COVID-19. Several actors established parallel structures rather than optimizing existing ones such as PPM. This fragmented health products procurement, caused confusion for countries and suppliers, and delayed efficient pooled procurement of PPE and oxygen equipment.	13. ACT-A partners, global health security key stakeholders, and agencies with emergency response mandates should develop clear decision rules for PSM roles in a pandemic/ emergency context	First	
While the WHO and SRAs accelerated regulatory approval pathways, non-harmonized country environments and COVID-19 testing policies were a barrier to faster introduction of novel health products	14. Continued and increased efforts are needed for regulatory harmonization at the country and regional levels across LMICs.	Second	
There appears to be no repository for country QA points of contact, or clear mechanism to address and close out QA reports/ events	15. Accessible ethical and standardized processes to report, address and close out quality incidents should be adopted	Second	
Health and Community Systems			
C19RM 2020 HSS/CSS investments were only 10% of total grant awards, in part because of bias in favor of short-term emergency actions plus unclear guidelines and more deliberate processes to design HSS activities and to fully engage KVPs and Civil Society	16. Consider a set-aside or earmark for HSS and CSS in future C19RM and PPR grants, including special incentives and separate timelines that encourage and enable countries to submit strong HSS/CSS proposals.	First	

ANNEXES

A. Theory of Change^a

C19RM Design Features			
Inputs^b (Commitments via reprogrammed HIV/AIDS, TB, and malaria (HTM) grants and new C19RM awards) →	Processes →	Outputs (Pillars are from WHO COVID-19 response plan framework, as included in the GFATM's C19RM of 2021) →	Outcomes and Impacts
Budgets for eligible investments in 3 broad categories: 1. COVID-19 control and containment interventions 2. COVID-19-related risk mitigation measures for programs to fight HTM 3. Expanded reinforcement of key aspects of health and community systems Via: • C19RM fund allocation • C19RM FRs, awards, and grant modification • C19RM fund disbursement	• Development of national COVID-19 plans • Expenditure on (procurement of) diagnostics by type and volume; PPE by type and volume; and therapeutics by type and volume • Expenditures for interventions and response pillars • Expenditures for community-led responses • Expenditures on health systems, including HMIS, surveillance, laboratory strengthening, facility-based health workers, community health workers (CHWs), etc. • M&O system to capture key performance metrics of C19RM and empower decision-makers to swiftly	• Stock availability of tracer commodities for HTM at facility level (Pillar 9) • Stock availability of COVID-19-19 commodities (Pillar 5, 6, 7) • Timeliness of supply deliveries by type • Status of delivery on approved funding for COVID-19 health products • % designated health facilities with PPE for health workers • % designated health facilities able to provide oxygen therapy • % designated health facilities able to provide SARS-CoV-2 testing services • People tested for COVID-19 (Pillar 3 and/or 5) • # confirmed cases hospitalized for COVID-19 (Pillar 3, 7) • # confirmed COVID-19 cases hospitalized, then discharged (Pillar 3, 7) • # people tested for HTM • Percentage of people who know their status who are on ART (all ages) • TB case notifications (total new and relapse)	OUTCOMES Country performance (to which C19RM plausibly contributes, but which must not be attributed to C19RM alone, given the multiple actors, pathways, and in the absence of credible and quantitative evidence of a causal link). Examples: • People living with HIV who have suppressed viral loads (%) • TB Treatment success rate and cohort size (New and relapse cases registered in prior year) • Number of malaria cases and deaths • COVID-19 case fatality among confirmed cases Established community response system (including CSOs, transport protocols, outreach services) for home-based care and support.

	act effectively at the country and global levels	- Percentage of pregnant women attending an antenatal care clinic at least once and receiving intermittent preventive treatment during pregnancy (IPTp) - Percentage of children sleeping under an ITN - Differences in the number of malaria tests performed across similar periods using data from selected health facilities. - Percentage of health care facilities experiencing different levels of disruptions to clinical services. - Installation of new COVID-19HMIS module - Number of additional PCR and genomic sequencing laboratories - Number of additional HRH employed to fight COVID-19 - Implementation of risk communications program - CSO COVID-19 monitoring activities - CSO advocacy regarding COVID-19	Increased institutional capacity (including laboratories, trained workers, audio-and video-based remote consultations, and protocols pre-tested via simulations) for: - disease surveillance - outbreak detection - outbreak response IMPACTS ON COVID-19 The following are potentially subject to modeling, but multiple assumptions (attribution, production function, etc.) could seriously limit their usefulness: - COVID-19 cases averted (attributable to C19RM) - COVID-19 deaths averted
Key Assumptions of C19RM Design Features			
Budgets are sufficient in quantity and appropriately timed for anticipated programs to be relevant	National plans have sufficient design validity to translate disbursement into desired outputs	- For purposes of contribution: C19RM-funding is one of several fungible sources. No claim of direct and isolated causal link from C19RM to observed changes. - For purposes of attribution: C19RM-funded processes are sufficient for changes in outputs and would not have happened without C19RM (no other funding source would have emerged).	- Defined outputs are necessary and sufficient for changes in outcome/ impact - Time since prior process is sufficient for maturation of programs

Plausible Counterfactual: Compared to what?			
Inputs	Process	Output	Outcome/ Impact
No incremental financing via C19RM mechanism by GF	No new C19RM customized processes; GF uses only existing grant processes to follow conventional HTM grants approved as part of NFM3 Country-specific reallocation only, for HTM program resilience: - From existing GF grant portfolio - Subject to GF approval	Best case scenario: - Approximates or modestly less than would have been accomplished in the absence of COVID-19 pandemic - Rapid recovery after initial disruption of HTM services caused by COVID-19 pandemic Worse-case scenario: - Reallocation quantitatively or qualitatively insufficient to mitigate disruptions by COVID-19 - HTM outputs markedly worse than initially planned - Persistent disruption of HTM services	Best case scenario: - Approximates or modestly less than would have been accomplished in the absence of COVID-19 pandemic Worse-case scenario - Reallocation quantitatively or qualitatively insufficient to mitigate disruptions by COVID-19 - HTM outcomes/ impacts markedly worse than initially planned

^a Developed retrospectively in the absence of a Theory of Change for C19RM. Informed by: The Global Fund. COVID-19 Response Mechanism Guidelines. 2021. M & E section. https://www.theglobalfund.org/media/10759/covid19_c19rm-guidelines_external_en.pdf

^b Inputs into the C19RM mechanism, not facility-level direct inputs into service delivery.

^c These are limited to country level outcomes of a proof of concept (not definitive impacts on mortality attributable to COVID-19).

B. Executive Summaries of the Country Case Studies⁷⁶

Angola: Executive Summary⁷⁷

Background and Context

Angola has recorded fewer than 100,000 total cases of COVID-19 and 2,000 deaths, placing it 40th out of 54 African countries in terms of COVID-19 morbidity and mortality. While official case counts are almost certainly serious underestimates due to shortages in diagnostic capacity, the lack of significant increases in unexplained pneumonia or excess deaths in Angola provides supportive evidence that COVID-19 has not affected Angola as seriously as other nations like South Africa or Egypt.

One theory is that the swift and sweeping early lockdowns imposed by Angola at the beginning of the pandemic helped to reduce the impact of COVID. A state of emergency was declared on March 25th, and, with technical support from the WHO, Angola rapidly closed all international borders to travel, mandated PCR testing for all air passengers, and severely restricted travel into or out of Luanda, its most populated province.

Approved Funding Requests for C19RM 2020

Month in 2020	Grant	Amount Approved in US\$
March	Grant Flexibilities (UNDP and World Vision)	1,581,988
June	C19RM 1 (World Vision)	2,110,980
July	C19RM top up (UNDP)	2,845,041
December	C19RM top up (World Vision)	1,254,014

Existing grant flexibilities and new grants from the GF contributed \$7,792,023 to Angola's COVID-19 response from March to December 2020. This has comprised a significant fraction of the country's total COVID-19 budget—the National Contingency Plan published in March 2020 indicated a total funding need of \$30 million. Moreover, GF funding was only a small component of all funds made available to Angola by international development organizations. The World Bank alone provided \$50 million in financing.

The 2020 C19RM grants tended to focus on reinforcing the national pandemic response and confronting COVID-19 itself, while the 2021 grant had more focus on protecting HTM programs from the effects of the pandemic.

Two PRs were responsible for the 2020 C19RM funding: the UNDP and World Vision International. The UNDP reports having used C19RM funds to procure PPE, antigen SARS-CoV-2 tests, GeneXpert cartridges, SARS-CoV-2 RT-PCR tests, and reagents and swabs. World Vision budgeted \$1.9 million to procure COVID-19 tests between May and December of 2020. However, World Vision reports having spent \$1.63 millions of those committed funds between May and October of 2020. The tests were intended to be distributed to health units defined by

⁷⁶ Comprehensive citations for the country case studies can be found in the full country case reports, expected to be published in June 2022.

⁷⁷ Not reviewed by the Angola CT.

MINSA, with no oversight role. World Vision's task ended with the delivery of the commodities at the health facilities. In addition, World Vision spent \$130,223 for PPE through grant flexibilities.

Overall, absorption was solid, with World Vision able to spend all \$4.49 million allocated to it through grant flexibilities and C19RM before June 2021.

The C19RM 2020 Grant Process

Angola developed its National Contingency Plan to control COVID-19 in March 2020, estimating that \$30M would be needed for strategic planning and coordination, communication, surveillance, border control, strengthening national laboratories, case management, and operational and logistical support for pandemic response. As part of implementation of the plan, a logistics subcommittee was commissioned with responsibility for procurement of essential commodities.

UNDP assumed the lead for coordinating the C19RM 2020 grant request proposal. According to interviews, there was significant confusion due to a perceived lack of guidance from the GF. CCM members were consulted, including the WHO and CSO members, but CSO input was not included in the final proposal. The CSOs mistakenly believed that two proposals would be submitted, one for CSOs and the other for UNDP to implement as the PR, and therefore CSOs were not included in the grant proposal. National lockdowns further reduced consultations.

Implementation Challenges

The lack of monitoring and a performance evaluation framework, common to all grants in the first year of C19RM, made it difficult to track absorption and outcomes. The LFA reported that implementation of C19RM was affected by several challenges:

- Evaluations of offers were based on total invoice amounts as opposed to product line-item cost comparisons
- Discrepancies with dates of the procurement process and a lack of adherence to stated deadlines
- End users (front-line health care workers) were not properly trained in the correct use/disposal of PPE nor in COVID-19 prevention steps
- There was no detailed budget or work plan prepared for C19RM 2020 expenditures

Many of the above challenges stemmed from the lack in Angola of a health system capable of providing primary services and of producing and tracking epidemiological data, compounded by the pressure to disburse funds rapidly for the first year of the program.

Disruptions to HTM Services

Mobility restrictions negatively impacted the delivery of community-based services for HTM with the largest negative effects on TB and malaria while HIV targets were relatively unaffected, according to the UNDP. Other sources paint a different picture, with key CSO informants indicating that COVID-19 had a significant impact on the ability of HIV patients, especially key

populations (KPs), to access ARVs. Less than 25% of grant targets were reached for the distribution of bed nets and IPTM for pregnant women in 2020, and TB case notifications and stockouts were similarly impeded. A lack of complete time series data on service delivery in 2019-21 makes it difficult to assess the disruptions or the degree to which C19RM 2020 investments helped to mitigate those disruptions. A thorough evaluation of the situation would be helpful.

Recommendations

Findings	Recommendations
The CCM reported to the Pharos team that they were largely left out of the planning process	The CCM should be brought to the center of the development of C19RM, beginning with a launch meeting.
Many informants were concerned that guidance from the GF was not forthcoming or was unclear, leading to reported confusion during the proposal writing process	Add seminars for national stakeholders to explain the guidelines, the amount of money available, and the eligibility criteria necessary to access the funds.
CSOs and others connected with the C19RM proposal development expressed that they were left out of the planning and implementation process	Set aside a percentage of the total grant for Civil Society to guarantee community engagement.
The lack of a monitoring system and grant performance targets led to implementation challenges and a lack of transparency and accountability for how the funds were used	Develop a national system to track C19RM 2020 procurement, budget, expenditures, and achievement of key programmatic targets. This can build on the new M&O framework for C19RM 2021. Results should be transparent and shared with all stakeholders including the CCM.
The absorption rate for UNDP between was low through December 2020	Give the CT more leeway to reprogram unspent funds where delays or new developments in the fight against COVID-19 might lead to new and evolving national priorities.

El Salvador: Executive Summary⁷⁸

Approach

This evaluation of El Salvador's C19RM 2020 grant was conducted between January and March 2022. A mixed-methods approach was used, and 19 semi-structured interviews were conducted along with review of all available internal documents, memos, and databases.

C19RM Funding At-a-Glance

Funding Streams		Amounts
Funding for COVID-19 mitigation through the Grant Flexibilities		US\$ 1,032,827
C19RM 2020		US\$ 892,860
Additional Funding Break-out	COVID-19 Impact	US\$ 756,800
	COVID-19 Diagnostic tests	US\$ 106,016
	Other	US\$ 30,044

Sources: MCP-ES, 2020; Tallada, 2021.

Main Findings

El Salvador managed COVID-19 well compared to others in the region. Compared to the rest of the Latin America region, El Salvador had one of the best performances in managing the COVID-19 pandemic, with one of the lowest excess mortality rates and highest vaccination coverage achieved.⁷⁹ Successful COVID-19 control was due in part to the strong national capacity to mobilize rapidly, plan an appropriate response, and coordinate quickly to implement lockdowns and other containment measures during the initial phase of the pandemic.

Service disruptions in HIV/TB programs occurred, mostly for case detection, but ongoing treatments were able to be maintained. As part of their initial response, El Salvador rapidly implemented lockdowns which were effective for COVID-19 control but detrimental to HIV/TB prevention efforts. Interventions requiring frequent contact between patients and healthcare workers were most affected, leading to significant service disruptions. HIV testing was markedly reduced, as was TB case detection. The diversion of GeneXpert machines from the TB program to COVID-19 testing also reduced case detection. On the brighter side, El Salvador was able to ensure maintenance of HIV patients on ARVs throughout the lockdowns by quickly implementing innovative solutions such as home delivery and multi-month prescriptions. Other NPIs such as masking were credited with reducing both COVID-19 and TB transmission in prisons.

The GF grants were a small but important contribution to the national COVID-19 response.

The GF C19RM 2020 grant amount of \$892k was a fraction compared to the \$65M in funding made available by Japan, the US and World Bank⁸⁰, but formed the basis for the larger subsequent 2021 grant of \$4.8M. The 2020 grant was used primarily for purchases of PPE, testing equipment, and providing support for SSR users.

⁷⁸ Reviewed by the El Salvador CT.

⁷⁹ Our World in Data, 2022. <https://ourworldindata.org/coronavirus/country/el-salvador>

⁸⁰ El Salvador Country Coordinating Mechanism Interviews

Procurement challenges and other obstacles reduced grant absorption. As of Dec 2021, only 16% of the grant had been used due to procurement challenges with Wambo, local procurement inefficiencies, and high shipping costs that reduced affordability. These procurement obstacles have been largely overcome with the 2021 grant.

Positive findings of El Salvador response include:

- Positive stakeholder viewpoint of added value of GF grants to national COVID-19 response
- Rapid capacity of CCM to mobilize and lead effective and inclusive grantmaking process aligned with national strategy
- Adoption of innovative methods such as using telemedicine to provide mental health support for KPs

Weaknesses of response include:

- Lockdown and containment measures did not respect human rights, according to reports.
- Extra workload not commensurate with grant size needed for C19RM 2020 grant
- Lack of coordination among donors
- Multiple procurement delays
- Lack of flexibility in grant to cover social needs of KPs affected by COVID-19

Recommendations

Finding	Recommendation
Rigid sourcing and procurement rules, when faced with the pressures of the pandemic environment, resulted in low procurement and absorption levels	• In emergencies, allow for flexible sourcing
HIV/TB programs were not prepared for the shock of the pandemic	• Define and update HIV/TB contingency plans for pandemic resilience
Health outcomes in other crucial sectors suffered during the pandemic, affecting both COVID-19 response as well as HTM efforts	• Allow staff outside of HTM to be able to be covered by a pandemic response grant
KPs often found themselves with little support in a challenging pandemic environment, leading to adverse health and well-being outcomes	• Increase social protection for vulnerable populations in grant design and implementation
CSOs felt left out of the grant proposal development and grant implementation processes, leading to lost value in community perspectives	• Increase community participation through active inclusion efforts

Malawi: Executive Summary⁸¹

Background and Context

Malawi has experienced four waves of COVID-19 including in June-September 2020 and January-March 2021, during the periods of C19RM planning and implementation. As of early April 2022, Malawi has had nearly 86,000 confirmed COVID-19 cases, of which 2,628 resulted in death.⁸² However, there is known to be widespread under-testing and under reporting of Malawi's true COVID-19 cases. Recent sero-surveillance indicates approximately 80 percent of Malawians had been infected with COVID-19 prior to the Omicron variant.⁸³ The national response has strong coordination at the central level through a cluster-response system organized by the Department of Disaster Management Affairs under management of the Office of the President, with support from a Presidential Task Force.^{84,85} Malawi has had little previous experience with emerging infectious disease outbreaks or epidemics like COVID-19 and thus very weak public health infrastructure equipped to detect and respond.⁸⁶ However, Malawi, with partner support, has mobilized a relatively effective response that has resulted in few reported deaths per capita.

C19RM 2020 Funding⁸⁷

Funding for COVID-19 response through Global Fund grant flexibilities	US\$740,370
Priority 1 funding (request fully funded)	US\$16,670,520
Priority 2 funding (partially funded of \$33,883,017 request)	US\$14,105,825
Total funded under C19RM	US\$31,516,715

GF support was a modest but important component of Malawi's COVID-19 response budget, which totaled \$212 million with \$58 million allocated for health. As of the end of June 2021, Malawi had spent \$26 million, or 82% of its C19RM 2020 funds.

Main Findings

The C19RM 2020 development process was rushed and the FR did not reflect a consultative process. Short submission windows led to insufficient involvement of donor partners and CSOs in the 2020 and 2021 FR development processes, although there were some improvements in 2021. If not a member of the CCM, partners were unlikely to be involved in the design processes. Input was collected from CSOs during a virtual national dialogue and is reflected in the FRs, but organizations felt there was not meaningful and effective engagement during the

⁸¹ Not reviewed by the Malawi CT.

⁸² Malawi Ministry of Health COVID-19 Dashboard, <https://covid19.health.gov.mw>.

⁸³ Nurith Aizenman, "Africa may have reached the pandemic's holy grail", NPR, January 28, 2022, <https://www.npr.org/sections/goatsandsoda/2022/01/28/1072591923/africa-may-have-reached-the-pandemics-holy-grail>.

⁸⁴ Declaration of State of Disaster by Malawi President Peter Mutharika, March 20, 2020, accessed 3 May 2021, <https://malawi.un.org/en/46778-declaration-state-disaster-malawi-president-peter-mutharika>.

⁸⁵ <https://www.ghsindex.org/>

⁸⁶ Joint External Evaluation (JEE) of IHR Core Capacities of the Republic of Malawi. Mission report: 11–15 February 2019, <https://apps.who.int/iris/bitstream/handle/10665/325321/WHO-WHE-CPI-2019.58-eng.pdf?sequence=1&isAllowed=y>.

⁸⁷ Malawi 2020 C19RM Funding Request

writing process. Coordination with development partners was particularly fraught, with some eventually writing letters to senior Malawian officials and the Geneva GF team to challenge technical aspects of the FR.

The C19RM 2020 FR was not based on evidence nor national experience, nor did it include adequate CSS. The C19RM 2020 nor 2021 funding cannot be classified as CSS. The national response has been focused on higher levels of the health system and mostly has not gone beyond the district or facility level. Most of the HSS support through C19RM 2020 went to infrastructure improvements and human resource support. While there was funding for hiring health surveillance assistants (HSAs), a critical community health cadre, the funding allotted was insufficient to train and fully equip them to fulfill their intended duties. Community support largely went to community dialogues, training, and local CSO capacity building; development and printing of education materials; and PPE for communities and CSOs. There was insufficient specific support for KPs.

Moreover, a lack of public health experience meant that the 2020 FR was not based on evidence, and there were issues with commodity forecasting and cost. The absence of full stakeholder engagement furthermore led to transparency issues and questions about the development process. The 2021 process was much more evidence-informed and robust compared to 2020. The 2021 FR came at a time when the needs of the country were clearer following two COVID-19 waves. Unlike how the development of the first FR was driven primarily by MOH program staff, in 2021, the Public Health Institute of Malawi, which has a co-mandate on COVID-19 within the MoH, participated actively.⁸⁸ The Ministry of Civil Education also was involved, and there were more active contributions from donor technical staff and civil society.

The C19RM 2020 funding was the first COVID-related funding received by Malawi and filled some, but not all, critical gaps in its detection and response capabilities. With limited established detection and response infrastructure, Malawi faced massive gaps in funding, human resource numbers and capacity in management of highly infectious respiratory agents, and health facility and laboratory capacity. Malawi's C19RM support built upon the foundation set by the NFM2 RSSH grant. Importantly, C19RM funding came early in Malawi's COVID-19 response, which enabled the country to target priority response areas and move more rapidly to respond and provide needed equipment, e.g., PPE. The C19RM 2020 allocation was adequate given Malawi's ability to absorb the funding. However, given continuing gaps, a larger allocation, with more direct support for procurement and implementation and focused health and CSS, should be considered in a future round of funding. Finally, while none of the specific items in the two submitted C19RM FRs were insignificant or unworthy, a significant portion of funds went to meetings and other convenings.

HIV services were the most disrupted by COVID-19, especially prevention services. Certain HIV services, including VMMC, PrEP, and routine viral load monitoring, were classified as non-

⁸⁸ PIU interview.

essential and were suspended through a series of government-issued circulars starting in April 2020.⁸⁹ Testing services were particularly affected. Following the first COVID-19 wave, there was a loosening of restrictions and new treatment initiation began to rebound.⁹⁰ At the same time, the MoH realized it needed to “up their game” in terms of advanced HIV disease management because those newly diagnosed with HIV during the first waves were those likely to get very sick or die from COVID.

HTM care providers explored novel ways of working in response to the conditions imposed by COVID, and even contributed to Malawi’s COVID-19 response itself via innovative strategies such as combining COVID-19 diagnostics with HTM diagnostics and/or care.

C19RM 2020 supported HTM mitigation, but attribution of specific contributions is difficult.

C19RM funding was essential to Malawi’s ability to mitigate disruption to and adapt its HTM services. The money helped keep the health system afloat by providing funds to hire health care workers, decongest facilities, transport patients, and support hard-to-reach communities.⁹¹ C19RM funds were complemented by the mitigation and adaptation pillars within the PEPFAR and other partner programs. However, it is difficult to attribute the C19RM contribution itself given that at least 50 percent of HTM funding comes from other donors. Further, regular services rebounded after the initial service suspensions in 2020.

Pooled procurement worked well, but local approval for procurement and implementation did not accelerate to meet the emergency nature of the response, resulting in massive delays.

Malawi has done well using PPM/Wambo for offshore procurement, but there are major obstacles with the approval process in-country which have hindered the ability to procure gas plants/oxygen. Local processes concerning release of funding also did not show flexibility considering the unprecedented circumstances imposed by COVID. The GF could help remedy this by allowing PPM procurement when there are local bottlenecks and adding requirements to future funding to address these issues.

The timing of procurements also has been a bit of a challenge. Several times, procurements initiated during one wave of the pandemic have arrived after the wave has ended and have been able to be used only during subsequent waves.

Delays in sharing final FRs and grant allocations has hindered transparency and accountability.

Final grants and funding allocations were not shared outside the MOH in a timely manner, leading to poor transparency and limited accountability, tracking, and independent verification that activities occurred as funded. Further, the absence of dates on many GF documents made it difficult to identify the sequence of events, figures, etc. Moreover, having C19RM funding co-mingled with the malaria grant has made it difficult to track, report

⁸⁹ Malawi People’s COP 21, <https://healthgap.org/wp-content/uploads/2021/03/Liu-Lathu-Mu-COP21-Malawi.pdf>.

⁹⁰ 7 May 2021 interview.

⁹¹ Dr. Rose Nyirenda, Director of the Department of HIV/AIDS and Viral Hepatitis, Malawi Ministry of Health, interview, 14 February 2022.

on, and place orders in Wambo. The Malawi CT engaged LFA teams to a limited extent to report on grant performance, primarily using “spot checks” of commodity inventories; however, the LFA did not review expenditures and thus has no direct knowledge how funds were spent.

While no GF funds have been identified in audits conducted over the last year, the National Audit Office and other evaluators have noted abuse in the channeling of COVID-19 response funds to allowances and per diems for meeting attendance and critical delays in expenditures of funds for their intended use.

Recommendations

Finding	Recommendation(s)
Community and partner organizations felt inadequately heard during the grant development process, and the lack of a comprehensive review framework hindered transparency and accountability.	• There is need not only for clear guidance and instructions to countries to ensure wide engagement but also for required transparency in the design and implementation processes. • The GF should move quickly to make funding allocations by budget line and progress indicators available on its public website.
C19RM 2020 featured an uneven mix of long- and short-term priorities.	• Separate C19RM and/or future PPR funding into separate grants or integrate them into the RSSH grant where there would be more alignment. • Differentiate between resources targeting low-hanging fruit and those targeting long-term planning.
C19RM 2020 showed little emphasis on developing community systems, and only strengthened Malawi’s health system at a national level.	• Any future C19RM funding or PPR funding should focus on building capacity at sub-national level, including support to local community groups and CSOs. Investments in Integrated Disease Surveillance and Response through HSAs would be an option to build local capacity and connect the district health offices with communities.
Communication and coordination between development and community partners was limited or sometimes even fraught.	• Hold a dissemination workshop with relevant stakeholders, especially communities, to share final funding allocations across budget categories and discuss de-duplication with partners. This should be done periodically outside of the CCM.
The C19RM 2020 FR was not based on evidence or national experience, which led to inefficiencies.	• Prioritization during planning should include depth, not just breadth; for example, inadequate funding for training and supplies for HSAs prevented full deployment and effective use of this critical human resource. Requests included in FRs should be sufficient to cover full implementation.

Peru: Executive Summary⁹²

Background and Context

Peru has been one of the countries most affected by COVID-19 since the beginning of the pandemic, with an infection rate starting at 200 per million people initially and rising as high as 1,500 cases per million during the recent omicron wave. Excess mortality was estimated to be 200% during the first wave between May and August 2020, and 250% between February and April 2021.⁹³ The reasons for Peru's poor COVID-19 management include health system weaknesses in primary health care and hospital capacity, severe staff shortages, oxygen shortages, and the fact that only one national lab has been able to perform molecular diagnostics. Moreover, during the pandemic, priority was given to shoring up intensive care capacity rather than to prevention.

C19RM 2020 Funding Overview

Funding for COVID-19 mitigation through the Grant Flexibilities	US\$ 1,176,222
Priority 1 – Initial Funding Request	US\$ 647,308
Priority 2 – Initial Funding Request	US\$ 168,188
Additional Funding Request	US\$ 995,859
Total of additional funding (except grant flexibilities)	US\$ 1,811,355

Main Findings

The development of the C19RM 2020 grant was rushed and community representatives felt left out of the process. The creation of the C19RM 2020 grant request had to be completed within a very tight timeframe: from June to 13 September 2020. Although all stakeholders that were requested to participate or at least endorse the proposal did so on paper, in real terms the perception among many key stakeholders is that the process was basically led by the PR (Socios en Salud) and MOH. The national state of emergency, as well as the state of shock among Peruvians, meant that was difficult for many to meaningfully engage in the design of the proposal; this was particularly true for the various KVP communities. Overall, however, stakeholders agree that the CCM responded well to the challenge, rapidly organizing the decision-making procedure, aggregating the mandatory data requested by the GF, and mobilizing CCM members to provide their endorsements.

The grant design process in 2021 improved due to several factors: experience acquired in managing the first year of COVID-19, support from the LAC Platform in engaging CSOs into C19RM planning, and technical assistance from Pharos Global Health Advisors to prioritize the country's needs. However, KIs unanimously agreed once again that the GF's instructions for C19RM 2021 were difficult to interpret, and that the responses from GF teams to clarifying questions changed over time.

The C19RM 2020 grant made a modest contribution relative to overall COVID-related aid but provided important support to fostering innovation. Overall financial flows, including

⁹² Reviewed by the Peru CT.

⁹³ Our World in Data, 2022. <https://ourworldindata.org/coronavirus/country/peru>

government contributions and development assistance contributions are unavailable; however, when compared to the impact of COVID-19, the additional GF investment of \$2M (plus an additional \$1.2M in grant flexibilities) relative to the overall need in Peru was modest. The C19RM 2020 grant had two main objectives, 1) prepare the health system for COVID-19 patients at the primary care level, and 2) support CSOs in adapting to COVID-19 their services for people living with HIV and TB.

Interventions under Priority 1 had a significant effect in the two regions in which they were implemented, Metropolitan Lima and San Martín. They were catalytic in supporting the proof of concept that switching the core response strategy from an intensive care, hospital-driven approach to one based at the primary care level was more effective, as well as in implementing a successful program to simultaneously screen for TB and COVID. Both of these initiatives were possible thanks to GF support for the design and development of “Puntos COVID”, health hubs where mild to moderate COVID-19 patients could be treated. GF grants started supporting 15 of those hubs and their peripheral health sites, and funding went toward HIV and TB services, medical and lab equipment, training activities and the hiring of health workers (1 doctor and 1 nurse for each post for 4 months). This successful model was then expanded to the rest of the country.

The GF also supported the provision of PPE for healthcare workers associated with the project as well as 30 staff members from each of 26 community organizations (16 HIV CSOs and 10 TB CSOs). CSOs also received training about COVID-19 prevention, infection control and other measures to deal with the impact of COVID-19 in their communities. Furthermore, informational and educational printed materials were made available to the Integrated Health Network Directorates of the regions in which Puntos COVID-19 were set up.

The grant also funded the hiring of two consultants who helped select the beneficiaries of cash bonuses for vulnerable people provided by a joint initiative from WFP and UNAIDS. A total of 635 people (80% migrants and 20% Peruvian) living with HIV and/or facing catastrophic expenditures were each given 760 soles – around US\$200.

By June 2021, all C19RM 2020 expenses were executed and 100% of performance targets had been achieved or even exceeded.

C19RM 2020 was not able to prevent service disruption for HIV and TB services. The grant did not prioritize addressing the gaps in access to HIV and TB services created by COVID-19 and the consequences thereof. The number of newly identified cases of PLHIV decreased by 50% in 2020 from 2019, and TB case detection decreased by 26%, due mainly to the halt of outreach activities. According to the figures available, the overall percentage of patients with HIV on treatment however did not decline, thanks to the implementation of adaptive safety measures, but patients lost-to-follow-up increased by 16% in 2020 compared to 2019⁹⁴. TB treatment

⁹⁴ This apparent contradiction is due to the fact that the number of PLHIV on ARV was increased by 2,759 in 2020, while the new diagnoses were 4,329.

success rates also declined, particularly for multidrug-resistant tuberculosis (MDR-TB) cases. Despite the PPE and protection training for healthcare and CHWs, KIs reported that critical and vulnerable populations, including patients with PLHIV or TB, were reluctant to access healthcare services for fear of COVID-19 contagion. C19RM 2021 now includes support for outreach and relinkage to care to mitigate these serious service disruptions for HIV and TB.

Ongoing health worker shortages, supply chain bottlenecks and turnover at the MOH affected the COVID-19 response. Another relevant bottleneck was the difficulties in hiring healthcare staff for the “Puntos COVID” financed by the grant. Healthcare workers were in great demand, and, as a consequence, salaries went up, exceeding the approved GF salary ceilings. Staff attrition was also high, with workers quitting “Puntos COVID” centers after acquiring valuable training and experience to seek better paying jobs elsewhere. The high staff turnover rate also required repeated training efforts for newcomers.

In 2020, like in most parts of the world, Peru had to overcome enormous PSM issues to locate, negotiate and acquire the health products that were included in the C19RM grant. GF instructions prioritized the use of Wambo, which offered very good catalogue prices. But when orders were processed, shipping costs were very high and made purchases unaffordable. Other market options explored were limited due to global shortages and/or difficulties in ensuring the quality of the items. As consequence, there were long procurement delays and some commodities such as pulse oximeters, digital thermometers and infra-red devices arrived as late as October 2021 despite being ordered in 2020.

Finally, public governance and stewardship of the COVID-19 pandemic has been hindered by the instability of political leadership at the MOH. Since early 2020, Peru has had 7 different Ministers of Health, undermining the capacity of the country to respond vigorously and in a coordinated manner to evolving challenges. The lack of political stability and of a formal space for donor coordination has meant that ACT-A members and other development partners, including bilateral agencies, were only engaged on an ad-hoc basis, and were not able to contribute strategically to a synergic and coordinated response.

Recommendations

Finding	Recommendation(s)
A challenging global procurement environment, combined with rigid rules for sourcing and acquisition, frustrated PSM efforts for key commodities	• Under emergency situations, adopt flexible grant-related procurement options • Regularly update the Wambo catalogue to reflect the full cost of delivery, including shipping costs
Key communities felt excluded from the development of the C19RM 2020 grant request	• Provide better guidance and support for the meaningful engagement of the community • Strengthen requirements for community engagement in grant development and implementation
A lack of reliable human resources was a major obstacle that held back the innovative and catalytic Puntos COVID	• Adapt human resource grant policies to exceptional circumstances

Rwanda: Executive Summary⁹⁵

Background and Context

Rwanda's COVID-19 statistics are on par with the average across the African continent, ranking 21st out of 54 nations in total cases per 1M population. Some of the country's success in containing the spread of SARS-CoV-19 can be attributed in part to the country's well-organized health system, rapid deployment of epidemic control procedures, trust in medical authorities, and strong community engagement through CHWs, CSOs, and other community groups. Rwanda has experienced 4 major COVID-19 surges and has recorded nearly 1,500 deaths during the pandemic. Notably, Rwanda has achieved one of the strongest vaccination efforts in the world, having administered enough vaccines for nearly 80% of its population to have received two doses.⁹⁶

Strict lockdowns implemented early during the pandemic have been credited with Rwanda's success in controlling COVID-19, but mobility restrictions also impacted access to and the delivery of health services, disrupted supply chains, and reduced the ability of technical partners to provide support through traditional channels.

Rwanda coped with these challenges by adopting a number of mitigation measures for HIV, including multi-month drug dispensing, moving ART services to locations closer to patients, and creating hotlines for PLHIV to access information about medication adherence. TB mitigation efforts also included multi-month drug dispensing, distribution of PPE to CHWs, and supporting directly observed therapy, but were less successful; TB notification rates decreased by a national average of 5% in 2020 and have not yet recovered to pre-pandemic levels. Malaria testing was also reduced and mobility restrictions prevented routine distribution of bed nets and IRS.

The GoR had mobilized budgetary spending totaling \$109M for COVID-19 response by July 2020, of which \$26M was budgeted for health-related spending, including the purchase of commodities and PPE, as well as the construction of quarantine centers. \$5.5 million in existing grant flexibilities and cost savings was approved by the GF in March 2020 ahead of the formal C19RM 2020 grant in June 2020, or 21% of the aforementioned total government budget for health. From 2020 until the end of 2021, a total of \$59.0M was approved through C19RM 2020 and 2021 along with grant flexibilities. The initial focus of GF funding was on COVID-19 response necessities such as PPE, medical supplies, and therapeutic equipment (e.g., ventilators). KIs had mixed opinions about this; some agreed with this prioritization while others argued that a lack of focus on maintaining continuity in HTM programs had a devastating impact. In mid-2020, this was addressed somewhat as the focus of GF grants shifted to the dual priorities of mitigating the impact of COVID-19 on HTM programs as well as the establishment of a prefabricated COVID-19 treatment center.

⁹⁵ Reviewed by the Rwanda CT.

⁹⁶ Reuters COVID-19 Tracker. <https://graphics.reuters.com/world-coronavirus-tracker-and-maps/countries-and-territories/rwanda/>

C19RM 2020 Funding

Initially, \$5.5M was immediately made available through grant flexibilities, followed by two additional requests for \$7.5M and \$3.8M for top-ups. The Global provided \$16.9M total in funding for Rwanda's COVID-19 response as shown in the table below.

2020-2022 allocation amount (or current grant allocation)	US\$ 190,161,352
Funding for COVID-19 mitigation through the Grant Flexibilities (NL date: March 2020)	US\$ 5,510,002
<i>C19RM 2020-First part (NL date: 5th June 2020)</i>	<i>US\$ 7,556,242</i>
<i>C19RM 2020-Second part: Additional funding for reinforcing national COVID-19 response (NL date: 7th August 2020)</i>	<i>US\$ 3,860,275</i>
Total of C19RM 2020 (excluding Grant Flexibilities)	US\$ 11,416,517
Total of C19RM 2020 (including Grant Flexibilities)	US\$ 16,926,519
C19RM 2021: Fast Track (NL date: 9 th June 2021)	US\$ 11,329,802
C19RM 2021: Full Funding Request (NL date: 11 th August 2021)	US\$ 36,210,536
<i>C19RM total award to date (excluding Grant Flexibilities):</i>	US\$ 58,956,855

Most C19RM 2020 funding was budgeted towards reinforcing the national COVID-19 response (68%), followed by actions to mitigate the impact of COVID-19 on HTM programs (20%), and improving health and community systems (12%). Procurement of goods, mostly local, constituted the majority of spending, with the largest budgeted items including the provision of nutritional support for PLHIV, TB, and KPs (9%), procurement of essential health commodities (29%), and construction of a COVID-19 isolation center (23%). Compared to other countries studied for this evaluation, Rwanda was relatively unique in prioritizing social support interventions such as nutrition for vulnerable patient populations, and CSO support for community education and awareness. Interviewees reported that C19RM funding helped to ensure that key messages on COVID-19 prevention and treatment could be rapidly disseminated at the community level and were helpful in engaging village and other local leaders to encourage community participation in COVID-19 infection and control measures.

Main Findings

Grant development, design, and alignment with national plans. The Rwanda Biomedical Center developed the list of commodities for funding through the initial application for grant flexibilities, and the CCM was not involved or consulted. Regarding the first grant application for C19RM 2020, several interviewees reported that technical guidance from the GF was unclear, particularly the requirement for community consultations that were not possible given the total lockdown and movement restrictions that were in place. The CCM secretariat began the grant development process through virtual meetings with the MOH and Rwanda Biomedical Center. CSO and CCM members gave input through email exchanges. CCM members and TB/HIV representatives did not feel that their needs were well-considered given the speed required for response. Most engagement was done through email, and some CCM members missed the opportunity to respond if their emails did not match those on record.

Interviewees reported that the process for 2021 was much improved, with better procedures in place for prioritization and consultation.

C19RM 2020 was not well aligned with the national response because the national response was still being developed as the 2020 request was submitted. C19RM 2021 was much better aligned.

59% of C19RM 2020 was absorbed by June 30th, 2021. Absorption rates were lowest for supply-chain dependent items, such as ready-to-use therapeutic food for PLHIV and malnourished TB patients (0% of \$353k), strengthening of chest x-ray readings for TB patients (0% of \$983k), and procuring motorcycles for the resupply of medical commodities (0% of \$986k). The unspent funds were rolled over into 2021. National lockdowns and other pandemic measures also impacted the ability of the PR and grant sub-recipients to provide services and thus spend allocated funding.

Implementation challenges:

- C19RM 2020 was not able to be fully spent during the 9-month implementation period given numerous supply chain and system challenges. Additionally, Rwanda is relatively unique in that GF grants are incorporated within overall health sector support and are thus subject to national planning, budgeting, and spending cycles, which did not allow for total absorption within 9 months.
- The lack of M&E frameworks, including the lack of targets and a performance evaluation framework has made it impossible to track progress on grant implementation and effectiveness. This has been mitigated somewhat by the improved results framework in C19RM 2021.
- High and volatile shipping costs associated with Wambo made ordering very difficult, and not cost-effective compared with local procurement options. Rwanda adapted by modifying regulatory processes and working with the WHO to use the WHO Supply Portal that was able to negotiate directly with suppliers and secure volume.
- Coordination between central and district level for planning and implementation, beyond representation on the CCM, was weak. It was unclear whether central priorities were appropriate for district-level needs, particularly concerning community engagement, and mobility restrictions made implementation of some centrally planned activities like supplying health centers impossible. Moreover, the planned decentralization of Rwanda's COVID-19response in mid-2020 presented some obstacles for grant implementation, although the availability of grant funds was able to smooth this transition somewhat.

Although difficult to directly assess, KIs report that C19RM 2020 was effective in helping Rwanda respond to COVID-19and mitigate some of its impacts on HTM services. The majority of KIs agree that funding from the GF, although modest in scale relative to total need and total budget, allowed for important aspects of the country's COVID-19response as well as played a large role in supporting continuity in HIV and TB programs. The lack of a performance evaluation framework or key targets makes direct evaluation of the grant impossible; however, budgetary support for key commodities like PPE for CHWs, adaptations in service delivery

modalities, and support for laboratory strengthening likely made a positive difference in reducing some of the worst effects of otherwise unchecked pandemic spread. Time will also tell whether Rwanda's prioritization of C19RM grants towards responding to the COVID-19 pandemic, including investments in laboratory capacity, surveillance, and health workers will pay dividends beyond simply COVID-19 control. In investing in laboratory capacities, Rwanda has planned for upgraded equipment and laboratories to be used for other diseases in addition to COVID-19 and the post-COVID-19 world.

Recommendations

Finding	Recommendation(s)
Wambo was difficult to use and not always cost-effective once high and volatile shipping prices were taken into account	• The GF should allow for flexible, simultaneous, and multiple procurement options during emergency situations
The lack of a performance evaluation framework has made evaluating and troubleshooting implementation challenges very difficult	• The GF should incorporate a performance framework with inputs, processes, output, and outcome indicators to guide grant activities and to facilitate M&E • The GF should ensure that interventions well-outlined in HTM mitigation strategies, such as PLHIV maintained on ARV treatments, HIV testing etc. are included in future C19RM FRs
The challenges faced by HTM programs have provided a wealth of lessons learned and opportunities for improvement, which should be thoroughly reviewed	• There is a need to implement an overall assessment of the lessons learned regarding the impact of COVID-19 on HTM services in Rwanda. Based on its conclusions, incorporate, and regularly update contingent plans for HTM services in the wake of any eventual future new emergencies
The grant development phase was too rushed, and CSOs and communities were left out of the consultative process	• Even in emergency situations, the GF should allow sufficient time for community consultation in grant development • Prioritize inclusion of communities and CSOs in early planning stages and involve them particularly with budget prioritization activities
C19RM process was able to bring together effective partnerships	• Continue to build upon and reinforce strength of CCM to promote effective stakeholder engagement

South Africa: Executive Summary⁹⁷

Background and Context

South Africa was one of the countries most affected by COVID-19. There have been nearly 4M confirmed cases since the start of the pandemic over four main waves including the most recent Omicron and BA.2-driven surges⁹⁸. South Africa responded initially to the first COVID-19 wave by instituting broad lockdowns starting with a five-week lockdown on March 27, 2020, and since then has implemented varying sets of restrictions including curfews, alcohol bans, limitations on religious and social gatherings, and mandatory mask use. Overall, vaccination coverage remains low mainly due to low demand, with only 29.06% of the population being fully vaccinated as of 9 March 2022.⁹⁹

C19RM Funding Overview

The C19RM 2020 response mechanism comprised a small portion of the total overall COVID-response budget, but played an important role for PPE, diagnostics, and HR support. \$64.5M was allocated for South Africa's COVID-19 response through C19RM 2020 (inclusive of grant flexibilities), or approximately 4.5% of the total amount of funding mobilized by South Africa for COVID-19 in the 2020/21 financial year. C19RM 2021 has allocated \$161M to South Africa, a substantial increase from 2020. 14.2% of the total funding across both rounds of C19RM were classified as being for mitigating COVID-19 impact on HTM programs, but our analysis suggests that some health and community systems investments also helped to reduce HTM service disruptions.

C19RM 2020 Funding Overview

Grant Flexibilities	US\$ 12,342,510
C19RM 1	US\$ 36,059,867
C19RM 1 top-up	US\$ 16,102,999
C19RM 2	US\$ 161,029,989

Main Findings

The 2020 grant development process was rushed, and not all stakeholders were consulted. Inclusiveness improved with 2021. The South African CCM, the South African National AIDS Council and the Institute for Health Programs and Services developed the initial C19RM 2020 proposal together. Various interviewees recalled that they found the guidance from the GF to be lacking or unclear, beyond indicating the broad areas that the GF was willing to support.

Given the compressed timeframe for proposal submission, several key stakeholders including the National Treasury were not adequately engaged in the development process (beyond their existing role on the CCM) and it is unclear the level of involvement of KP groups. All CCM members did approve the final proposal before submission, and most interviewees agreed that

⁹⁷ Not reviewed by the South Africa CT.

⁹⁸ Our World in Data, 2022. <https://ourworldindata.org/coronavirus/country/south-africa>

⁹⁹ Our World in Data. (2022, February 16). Share of people vaccinated against COVID-19, Feb 16, 2022 (in South Africa). https://ourworldindata.org/covid-vaccinations?country=OWID_WRL

the grant focus on direct COVID-19 response was appropriate and aligned with the also-nascent National COVID-19 Response strategy.

For 2021, a greater understanding of the dynamics of the pandemic, as well as improved technical guidelines and templates from the GF and more realistic timelines have led to a better overall grant application process. Interviewees expressed that C19RM 2021 achieved more inclusive grant design, better aligned with national priorities.

By June 2021, 78% of the C19RM 2020 grant had been absorbed.

C19RM 1 budget allocation	Budget allocation	Expenditure by 30 June (including commitments)	Absorption rate
Aids Foundation of South Africa	\$5,878,423	\$3,620,961	62%
Beyond Zero	\$4,090,335	\$2,794,858	68%
Networking HIV & AIDS Community of Southern Africa	\$4,040,744	\$2,166,457	54%
National Department of Health (NDOH)	\$38,153,364	\$31,874,973	84%
Total	\$52,162,866	\$40,457,249	78%
<i>Source: The Global Fund. (2021, April 1). Global Fund COVID-19 Response Mechanism (C19RM) Funding Request Form. South Africa. The Global Fund.</i>			

Absorption was very slow between April-September 2020 and increased rapidly in subsequent periods. Some of the initial challenges included the lack of global supply for key commodities like PPE and diagnostics, recruiting delays for staff, and program startup delays. The first round of underspending was reallocated from areas like human resources to more PPE, and still unspent grant dollars were then rolled over from C19RM 2020 to 2021 and used to back pay salaries and for other activities in the gaps between grants. Overall, while it took PRs time to ramp up activities, they were able to record high absorption rates for C19RM 2020 interventions although activities extended into the first quarter of C19RM 2021 (30 September 2021). PRs performed well by adapting and (almost) fully expending their budgets.

The only occurrence of a low overall absorption rate is for activities related to risk mitigation for disease programs implemented by Beyond Zero, which received only a small budget allocation (\$435k) to begin with. For this specific intervention, the PR achieved an absorption rate of 13.0% by September 2021, and comments in the PU/DRs indicated that underspending was due to delays in SRs recruiting staff, signaling a chronic problem. In the end, underspending on this intervention was spent on procuring PPEs. By the end of September 2021, the PR had fully expended its C19RM budget.

M&E systems were nascent, and weak financial monitoring and performance framework (generally for C19RM 2020) made retrospective evaluation in South Africa difficult. Because COVID-19 became an urgent and rapid-moving crisis, the GF did not set C19RM-specific

performance targets due to the lack of a predictable relationship between financial inputs, service outputs and disease-related outcomes. The direct impact on COVID-19 was not estimated. Existing HTM program targets were used to measure mitigation of service disruption. The monitoring system in the first year had a limited ability to track financial performance, though notably the PRs in South Africa were able to report their C19RM spending.

Financial tracking has been complicated by the fact that C19RM 2020 was mixed with NFM2, with tracking by cost dimension and implementer for budgets and expenditures comingled. While NFM2 has grant-specific HTM indicators, there are no COVID-related indicators, making performance-related monitoring challenging. Maintaining HTM indicator targets was seen to be an indication of C19RM grant effectiveness. Regular procurement surveys by the LFAs have now also been merged and expanded into more comprehensive pulse and spot checks which are part of the 2021 M&O system.

The lack of a robust 2020 M&O system resulted in implementation challenges and the inability to quantify implementation effectiveness.

Multiple implementation challenges occurred. The absence of performance targets resulted in the lack of objective guidance or oversight of funded activities. As a result, there was sometimes misalignment between activities conducted and what was initially agreed to in the grant. Global supply chain shortages caused continuous price fluctuations and inconsistent quality of available products. Overall supply shortages and limited numbers of suppliers plus insufficient procurement guidance from the GF resulted in PRs initially paying different prices for similar products and procuring and distributing commodities of varied quality. There was also difficulty using Wambo because ordered products needed to wait for lengthy approvals from national regulatory agencies, and also met resistance from government departments that were otherwise required to purchase locally. Staffing challenges occurred due to non-competitive salaries offered for COVID-related activities relative to government salaries, as well as shortages due to COVID-19 infections in staff. The unintentional break between 2020 and 2021 grants also resulted in a loss of momentum, resignation of key staff during the unpaid period, and inefficiencies introduced by the need to rehire and retrain staff for 2021. Coordination between GF-supported and non-GF-supported districts was also reported to be poor.

Despite the numerous implementation challenges, the majority of KIs considered the grants to be effective, particularly for PPE procurement. C19RM 2020 met the needs of increased HR for outreach, contact tracing and transportation helped to mitigate service disruption for HIV and TB patients. COVID-19 teams were reported to be particularly helpful for maintaining HIV-related and AGYW services to KPs who could no longer access services at health facilities or in schools. GF HR-related support also allowed for COVID-related staff to be seconded to the NDOH to assist with HIV and TB related services, as well as data capture and analysis which improved real-time planning and decision-making. Many respondents also noted that PPE procurement, as well as efforts to mobilize community leaders and training of traditional

healers to use masks and distancing as part of COVID-19 protocols, would have been difficult if not impossible without C19RM 2020 funding.

C19RM 2020 funding catalyzed innovative approaches. HIV and TB-related services needed to be adjusted and modified to cope with frequent mobility restrictions and shortages of facility staff. COVID-19 testing and screening was integrated with HIV/TB screening, and door-to-door COVID-19 testing services also offered HIV and TB testing too. Innovations like multi-month dispensing, telemedicine, self-testing kits, and even Uber deliveries of medicines were rapidly adopted with GF support. Community health systems were also strengthened by training CSOs to disseminate COVID-19 prevention information and conduct contact tracing and screening. Informants noted that many of these innovations arose from the flexibility offered by the GF.

Recommendations

Finding	Recommendation(s)
The speed of proposal development during a crisis prevented an inclusive process	• Even in an emergency, the GF should allow sufficient time for more consultation to improve grant development and reduce implementation delays • Local stakeholders, especially Treasury, NDOH and South African National Aids Council need to improve coordination and collaboration during crisis grant planning to ensure effective allocations to necessary response areas • Include provincial and district-level council involvement to facilitate a coordinated implementation response
Global supply shortages resulted in excessively high and volatile prices paid for necessities	• SRs conducting pooled procurement for the NDOH should actively monitor the prices paid through Wambo and compare these to local reference prices to ensure VfM.
The absence of performance framework linked to a detailed budget is of concern	• The GF should incorporate in all grants a performance framework with output and outcome indicators to guide grant activities and to facilitate M&E.
The flexibility of C19RM 2020 allowed for discovery of new innovations	• Continue to maintain grant architecture to support an emergency response that includes a 'flexible' component which allows implementers to innovate at will and evolve interventions as situations evolve.

Ukraine: Executive Summary¹⁰⁰

Background and Context

Ukraine has been heavily affected by the COVID-19 pandemic, similarly to other Central and Eastern European states. Before Russia's invasion in February 2022, Ukraine ranked among the 30 countries with the highest death rates from COVID-19. COVID-19 exposed challenges in the country's health system; however, in general terms, Ukraine responded proactively with emergency preparations and procedures, including establishing a new coordination body at the President level and activating existing emergency structures, developing preparedness and response plans, implementing control measures in transportation hubs, relying on blanket (initially) and later on adaptive lockdown approaches, and allocating significant domestic funding for COVID.

Nevertheless, Ukraine has still suffered four main COVID-19 surges. The country's test positivity rates reached as high as 49% during the recent Omicron wave despite increased national testing capacity. Moreover, non-government-controlled areas (NGCAs) in eastern Ukraine have been difficult for public health interventions to reach for years, with pre-pandemic HIV/TB programs as well as pandemic-era COVID-19 response efforts dependent on humanitarian support. COVID-19 vaccination rates in Ukraine remained low, plateauing at 36% despite sufficient supply due to widespread vaccine hesitancy.

\$12.6M was allocated to Ukraine for C19RM 2020 (including flexibilities), 93% for commodities

The total amount of 2020 C19RM funding, including \$1.7M in grant flexibilities, \$7.1M for C19RM 2020, and \$3.7M in top-up grant from C19RM 2020, is broken down in the table below. C19RM 2021 directed \$35.8M to Ukraine, a major increase over the previous amount. In 2020, GF support represented only around 1% of the country's COVID-19 response budget.

Month / Year of approval	Grant	Amount (US\$)	Implementation period
April, June & August 2020	Grant flexibilities	1,744,599*	Until 31/12/2020
October 2020	C19RM 2020	7,141,026	Until 30/06/2021**
December 2020	C19RM 2020 top-up	3,697,299	Until 30/06/2021**
August 2021	C19RM 2021	35,843,480**	Until 31/12/2023
Approved in 2020		12,582,924	
Total approved 2020-2023		46,681,805	
*Grant flexibilities were not fully spent			
**US\$2,402,449 of C19RM 2020 grants was unspent as of June 2021 and were integrated in C19RM 2021 grants. The amount above reflects only the additional award in 2021.			

Main Findings

Ukraine was among the first countries to use grant flexibilities for HIV and TB programming and small synergistic funding for direct COVID-19 response. \$1.7M in grant flexibilities was rapidly approved from existing HIV/TB grants and was the main source of C19RM 2020 spending in 2020 until the main bulk of grants was approved later that year. 53% of grant flexibilities were spent on PPE and disinfectants. GF grants were critical for getting PPE and

¹⁰⁰ Reviewed by the Ukraine CT.

other essential commodities to NGOs working with KPs who were otherwise left out of government PPE provision plans, but also to government HIV and TB services in the times of deficit and rationing of basic protection means and for supporting adaptations. 44% of grant flexibilities were spent on diagnostic tests and reagents. The remaining 3% was spent on programmatic costs for reinforcing the national COVID-19 response in the first 4-6 months of the global pandemic. This included reimbursing travel for staff of the only lab with diagnostic capacity at the time during lockdown, translation of COVID-19 guidance and evidence, securing skilled professionals for the MOH COVID-19 hotline, and initiating epidemic and response modeling work which served as the basis for establishing adaptive lockdowns. These programmatic efforts in particular have been highly catalytic and timely.

Use of main HIV/TB grants for early service adaptations. In addition to grant flexibilities, the existing HIV and TB grants supported COVID-related adaptations in services and monitoring. However, the exact amounts are hard to extract. These main grants contributed to the early guidance for adaptations and wider use of existing good practices including to allow dispensing for longer periods, changing client/patient pathways when health facilities were reprofiled, and use of online tools. In March 2020, the MOH recommended reducing daily visits and use of observed intake of opioid agonist therapy, increasing the share of clients benefiting from take-home medicines from 56% in March 2020 to more than 80% by the end of 2020. Similarly, the share of people receiving TB treatment with the video observed therapy nearly doubled over one year, reaching more than half of all under treatment in 2021.

Ukraine submitted \$9.9M for the C19RM 2020 FR of which \$7.1M was approved. An additional top-up grant of \$3.7M was awarded. Of the \$10.8M in C19RM 2020 and top-up grants, 93% of the funding was spent on PPE, COVID-19 tests and reagents, and COVID-related equipment. Oxygen concentrators, ventilators and oxygen masks were delivered to the 22 phthiopulmonology facilities in 21 administrative units (out of 25 that were under the government control). The PPE and COVID-19 diagnostic supplies reached HIV and TB service providers in the government health system, community sector and the penitentiary health system, also for testing at the crossing of the intersection line with the NGCAs. Oxygen supply stations were supplied for military hospitals that, like penitentiary system, are outside the MOH mandate. The remaining 7% was spent on mitigation of the impact of COVID-19 on HIV and TB programs and strengthening the COVID-19 response, including home deliveries of ARVs, mobile HIV-related support, technical assistance on oxygen station procurement, and COVID-19 testing training at the intersection line with the NGCAs.

C19RM grant development in 2020 was swift but did not include key donor partners or civil society outside the PRs and had a smaller government leadership. This situation improved under C19RM 2021 in 2021. Initially, grant flexibility spending was largely driven by the PRs in agreement with the GF. PRs reported not having a joint process for coordinating flexibility spending initially until the CT and the LFA stepped forward to play the coordination role. One PR reached out to the Deputy Minister of Health and U.S. CDC partners to discuss the programmatic needs for the COVID-19 response as early as mid-March 2020.

Similarly, the C19RM 2020 and top-up FRs in 2020 were developed rapidly over 2-3 weeks and approved unanimously by the CCM. Due to the speed of development and relatively small available amounts for awards, several respondents reported country consultations being limited, and did not include technical partners like the WHO, UNAIDS or USAID in their design. The two PRs are large CSOs with staff from people living with HIV and KPs and one being led by people living with HIV, therefore their participation includes voices of affected individuals and civil society. However, unlike in the extensive consultations for the HIV/TB FR in spring 2020 and for C19RM 2021, in the case of C19RM 2020 the broader and vibrant ecosystem of HIV and TB community and other CSOs were left out.

National COVID-19 coordination bodies other than the MOH and PHC were not included (and generally were busy with setting up the COVID-19 response in the first year), and the national plan on which C19RM 2020 needed to build contained many gaps. Admirably in March 2020, UKR and OCHA developed the Emergency Response Plan for the COVID-19 Pandemic. This points to the strengths that there were already plans in place from UKR and OCHA, as well national and regional governments. However, KIs including a high official in the government explained that the March 2020 plans were generic. The Pharos team confirmed this finding in reading the actual plans. Given the time constraints, the country did quite well, but there were still large gaps that remained to be filled.

Significant improvements in the C19RM 2021 process. In 2021, the C19RM 2021 request development process was much more consultative, transparent and intensive, with an open process of submitting suggestions from HIV and TB KPs, civil society, technical partners and government institutions. CRG and UNAIDS technical assistance was mobilized for community consultations. The process was not without its difficulties, including in-country stakeholders missing additional guidance for prioritization and for evidence-based community-led solutions despite support from WHO/UN and GF guidance.

72% of the initial C19RM 2020 FR was approved. Funding for the seroprevalence study, COVID-19 hotline, analysis on impact of COVID-19 on KPs and people living with HIV, and creation of an epidemic emergency interagency response mechanism was not approved by the GF, which instead prioritized pandemic mitigation efforts in HIV and TB programming.

The GF recommended more funding towards NGCAs, where the GF is the sole donor of ART and MDR-TB treatments that are not included in Ukraine state co-financing.

78% of the C19RM 2020 funding was absorbed by July 2021, well above the global average and despite Ukraine only having 6-7 months for their implementation. \$2.4M remained unspent and was rolled over into C19RM 2021. The unspent funds were budgeted for rapid tests, PCR- testing reagents, and installation of oxygen generating systems, which faced extra time needed for defining specifications of new products procured, long delivery and port clearance times and global supply shortages.

Long delivery of Wambo orders and unrealistic international reference prices. The Wambo platform was used for easing access to quality assured COVID-19 diagnostic tests, lab reagents and oxygen stations. However, the SARS CoV-2 antigen tests ordered through Wambo using the original 2020 grant flexibilities only arrived in March 2021. Some orders dated from February and March 2021 were planned to be delivered by December 2021. PPEs, oxygen concentrators, ventilators, oxygen masks were sourced locally and, after the volatile 2020 market situation, in 2021 had more predictable, shorter delivery times and costs for distribution. GF reference prices for key commodities were not aligned with the market prices that Ukraine was able to obtain. Even in C19RM 2021 negotiations, for certain expensive non-HIV/TB/COVID-19 specific products like patient monitors with EKG/ECG, blood gas analyzers, portable ultrasound, the reference prices were up to 10x lower than local market or actual Wambo prices, leading to replanning activities within the grants in order to accommodate higher prices for essential commodities.

C19RM 2020 monitoring and oversight in Ukraine was weak, as in other countries, due to the lack of a monitoring framework and of integrated data collection instruments. There was also limited focus on oversight of the C19RM awards and mitigation of COVID-19 impact, with no special meetings convened by the National Council on TB and HIV/AIDS (CCM) to discuss results, and (as in other countries) the dashboard of HIV/TB grant implementation did not include COVID-19 related indicators. Improved multi-stakeholder learning from COVID-19 mitigation efforts is seen as a critical area for C19RM 2021 grants which are larger in size, programmatic work and innovations.

C19RM 2020 led to a significant increase in management operations, without an increase in budgets for management (as in other countries). With commodity-heavy awards, procurement took significant efforts, especially in the first year of the pandemic when the market was particularly volatile. Key interviewees reported that despite the additional C19RM funding being integrated with existing NFM2 and NFM3 grants, the GF required the PRs to open separate accounts for additional C19RM funding, therefore sub-recipient and outreach worker contracting also had to be done separately instead of updating existing contracts. This was an issue across all countries.

GF support was essential for sustaining political and programmatic attention on HIV and TB during the pandemic and helped support innovations. It allowed for the adoption and/or scale-up of innovations like home-based treatment delivery of ARVs, take-home opioid agonist therapy provision and video-observed TB treatment. In the words of a KI: “COVID-19 gave us a perestroika.” KPs also benefited from receiving PPE and other essential commodities that they otherwise would not have had access to since they were not covered by government programs.

C19RM was more effective in mitigating the effects of COVID-19 on HIV than on TB, following a pattern observed globally. HIV services were generally better-protected, with ART coverage improving and viral load monitoring being sustained through home deliveries and mobile units. Prevention services among most KPs increased in scale. Despite the general 22% reduction in HIV testing in 2020, compared to 2019, KPs saw relatively smaller disruption. For example, 79%

more people who inject drugs were diagnosed with HIV in 2020 than in 2019. PrEP scaleup increased during the pandemic, though coverage remains limited.

In contrast, TB case and MDR-TB notifications were reduced by 31% and 47% in 2020, compared to 2019, as well as treatment coverage and survival. Similar trends are recorded in other Eastern European and Central Asia countries. However, the regional average reduction of TB case notification was slightly lower in Europe and central Asia (with the EU) at –24.1% in 2020. The TB service disruptions in Ukraine were due in part to mobility restrictions, low access to primary care which is the first line in TB diagnostic, transportation interruptions for samples and patients, and repurposing of TB resources to COVID-19 response. The National TB Program reports observing more complex TB patients (who were the focus of C19RM 2020 support in the TB area). Integrated testing for TB and COVID-19 was only introduced in 2021.

Both HIV and TB were affected by mismanagement in state procurements – until extra procurement was organized with the GF support, there were insufficient numbers of ARVs to issue multi-month refills, while in some locations there was a shortage of MDR-TB medicines delaying the initiation of treatment.

Conclusions and Recommendations

As the result of the GF C19RM and other support, the HIV and TB programs were less disrupted than other disease areas in Ukraine. The emergency mode created early and innovative adaptations in C19RM and other GF grants. Ukraine developed many of its own plans, not relying on the slower global guidelines from the large international donors involved in the country. However, the tight timeline for C19RM 2020 also created fragmented and vertical approaches, including limited linking of HIV and TB community system responses with the COVID-19 response in health system or existing mental health and ehealth tools. Fortunately, a number of the gaps created by the tight timeline in 2020 were rectified in 2021 through C19RM 2021.

Going forward, the experience of C19RM 2020 and lessons learned should be used to address shortcomings in areas including state procurement planning and management, the involvement of civil society and affected communities, and the promotion of services in settings outside public health systems such as community systems, penitentiary, and conflict areas. Ukraine's national stakeholders should plan ways to maximize the integration of C19RM supported work in its regular TB/HIV and RSSH grants under NFM3, including possible investments in PPR after 2023.

Vietnam: Executive Summary¹⁰¹

Background and Context

At the beginning of the pandemic, Vietnam was hailed as one of the few non-Island success stories that had controlled COVID-19 despite dense urban populations and LMIC status. There were fewer than 100 cases being reported daily through the first 15 months of the pandemic before the alpha, delta and omicron surges occurred during the last half of 2021. There have since been 10m estimated cases with 43,000 COVID-related deaths in the country which has a population of 97m.

Much of Vietnam's early success has been attributed to its command-and-control approach to managing the virus with lockdowns swiftly implemented. Vietnam was also able to leverage its previous experience with the SARS epidemic in 2003 and avian influenza outbreaks in 2004 and 2010 to take early action by imposing targeted lockdowns, instituting travel bans, closing businesses, imposing mass quarantines, and conducting widespread testing. PCR test kits were developed by Hanoi University, the Vietnam Academy of Science and Technology, and the Military Medical University and widely distributed. Cluster testing and contact tracing was also swiftly mobilized.

C19RM Funding Overview

C19RM 2020 disbursed a total of \$8.5m to Vietnam, \$4.1m (48%) of which was integrated into the NFM2 budget. The remainder was integrated into the NFM3 budget (52%). Additionally, each of these two budgets received half the amount diverted from existing GF grants under grant flexibilities, which amounted to roughly \$1m each. \$1.5m was reallocated from the HTM grant budget for COVID-related adaptations such as home-based services for TB and malaria. C19RM 2020 was a small contribution to Vietnam's overall COVID-19 response, but interviewees agreed it played an important role.

The grant development process was rushed but well-run. Some respondents reported that the C19RM templates provided as part of the grant development process were cumbersome and challenging to use, but there was general agreement that the activities available for C19RM funding were appropriate for the pandemic. Community groups were consulted and included in the brainstorming process. Inter-agency collaboration could have been improved, although respondents said that leadership by the Chairperson of the National Malaria Control and Elimination Program played an important role in organizing proposal development, prioritizing activities, and engaging CCM members.

Most respondents reported favorably that the grant was designed appropriately to help meet needs. It was also noted by national program officers and by donors in-country that malaria-related activities under C19RM were well-aligned with the malaria strategic plan and existing GF grants. Moreover, C19RM also generally complemented existing GF-related and national malaria response plans including capacity-building of staff to adapt malaria services to COVID, as well as funding for pandemic and communication materials.

¹⁰¹ Reviewed by the Vietnam CT.

COVID-related service disruption was severe for HIV and TB programs, less so for malaria.

Supply chain disruptions have reduced the availability of ARVs, no doubt negatively affecting HIV treatment continuity. Vietnam's TB program has also been significantly affected by COVID-19 with notification rates 26% lower in 2020 as compared to 2019, and alarmingly 23% lower in 2021 compared with 2020, indicating that TB program strength has not recovered. Malaria detection declined during COVID-19 as well, due in part to restrictions on movement for forest-goers during lockdown periods, and perhaps due to reduced testing. In the case of all three services, people have been reluctant to seek care at health centers due to fear of COVID-19 transmission, and there have been staff shortages as many workers left HIV and TB-related positions to focus on COVID-19 care.

Community mobilization was particularly important for Vietnam's early success in COVID-19 control. Vietnam was an early leader in contact tracing and rapidly educating and mobilizing the community to engage in COVID-19 control and prevention. Volunteer forces were quickly recruited to provide food, and distribute masks and oxygen cylinders. Perhaps recalling the country's previous experience with SARS and Avian influenza, the Vietnamese people were much more willing than those of some other countries to pull together collectively against COVID, and government communication was effective in educating people on what they should do to stay safer.

C19RM funding played an important role in PPE acquisition, ventilator purchases, and HTM service disruption mitigation. For example, C19RM was beneficial to the TB program in strengthening staff capacity, supporting communication activities, and procuring equipment for TB and drug resistance diagnostics such as GeneXpert molecular diagnostic testing systems, PPE, and medical equipment that benefited both COVID-19 and TB interventions. For malaria, C19RM was focused on complementing ongoing malaria activities under GF and the overall national response. Capacity-building activities included support for quality delivery of malaria services (including case management, vector control, and surveillance) in the context of the pandemic and communication materials for public awareness of malaria. Home-based service delivery for HTM services also helped mitigate disruption.

Recommendations

Finding	Recommendation(s)
Acute health worker shortages hampered Vietnam's COVID-19 response	Institute programs to better professionalize and prepare volunteers as part of pandemic preparedness activities
The GF grant process missed key opportunities to add value	The GF should do more to strengthen interagency collaboration, lengthen the time available to prepare emergency grant requests, reduce requirements for evidence-based planning during a pandemic when evidence is scarce, and provide clear guidance at the outset
C19RM 2020 and the GF helped Vietnam procure critical commodities quickly	- Recognize the crucial role that the GF can play in sourcing supplies such as GeneXpert machines, ventilators, oxygen cylinders, masks, PPE and therapeutics - Prioritize sourcing as an area where GF support can be particularly impactful and actively assist grant recipients with supply needs

C. Technical Supplement on Monitoring and Data Challenges

Figure C-1. Example procurement order summary and delay dashboard



		To find month required for order placement, first select products and the date required in country																				
		2021		2022										2023								
Conservative Indicative lead-time planning guide		November	December	January	February	March	April	May	June	July	August	September	October	November	December	January	February	March	April			
COVID-19	Note that there may be some variations within the category - please consult the subsequent product level detail for more specific guidance																					
	COVID Dx (PCR & Rapid Test) - by Air	emergency order			Order Urgently	Nov-21	Dec-21		Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22			
	PPE - by Air	emergency order			Order Urgently	Nov-21	Dec-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22			
	PPE - by Ocean			Late/emergency order				Order Urgently	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22			
HIV	Optimal high volume ARVs			Late/emergency order						Nov-21	Dec-21	Nov-21	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22			
	Specialist or limited use ARVs			Late/emergency order						Nov-21	Dec-21	Nov-21	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22			
	Other medicines			Late/emergency order						Nov-21	Dec-21	Nov-21	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22			
	HIV Rapid tests, including self-tests			Late/emergency order						Nov-21	Dec-21	Nov-21	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22			
	Condoms & lubricants			Late/emergency order						Nov-21	Dec-21	Nov-21	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22			
	HIV Viral Load / Early Infant Diagnosis**			Late/emergency order						Nov-21	Dec-21	Nov-21	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22			
	CD4 / Chemistry / Hematology**			Product availability is dependent on manufacturer production schedule at time of order confirmation.																		
	ALU-dispensible and non-dispensible) ASAG			Late/emergency order						Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22			
	Artisanate Injection			Late/emergency order						Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22			
					Late/emergency order						Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22		
Malaria	Seasonal malaria chemoprevention (AQ+SP)			Late/emergency order						Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22			
	Other ACTs and antimalarial medicines**			Late/emergency order						Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22			
	Malaria Rapid tests			Late/emergency order						Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22			
	Malaria Rapid tests - POCT			Late/emergency order						Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22			
	LLINs (pyrethroid)			Late/emergency order						Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22			
	LLINs - PBO			Late/emergency order										Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
	IRS			Late/emergency order										Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
General Laboratory equipment, consumables & supplies*				Late/emergency order						Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22			
Non-health				For non-health products lead-time significantly varies, for more details please refer to specific product lead-times below																		

Figure C-2. Example consolidated bi-weekly country monitoring survey

Angola

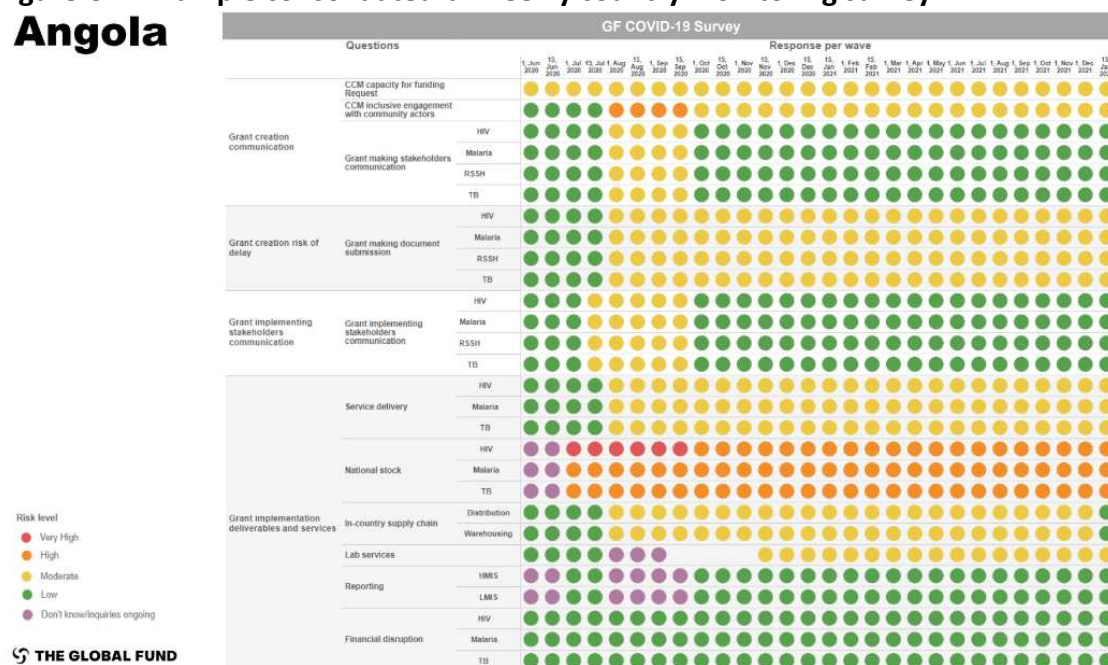


Figure C-3. Example graph of coverage for an indicator from 2020-2021

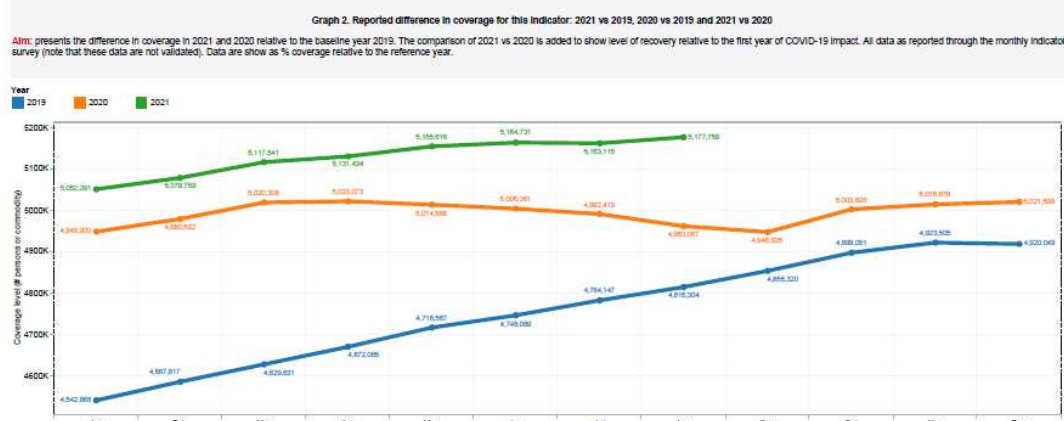


Figure C-4. Example spot check survey

[illegible]

Table C-1. Overview of C19RM 2020 M&O components

Component	Contents	Frequency
Order summary dashboard	Lead times for key HTM and COVID-19-related commodities	TBD
Country monitoring survey	28 traffic light indicators on aspects of grant creation and implementation for HTM and RSSH	Bi-weekly
Grant indicator survey	Selected HTM coverage indicator trends for the country	Monthly
Facility spot checks	27 questions on facility-level management and service delivery of COVID-19-related commodities	Quarterly

Table C-2. Granularity of C19RM 2020 M&O tools

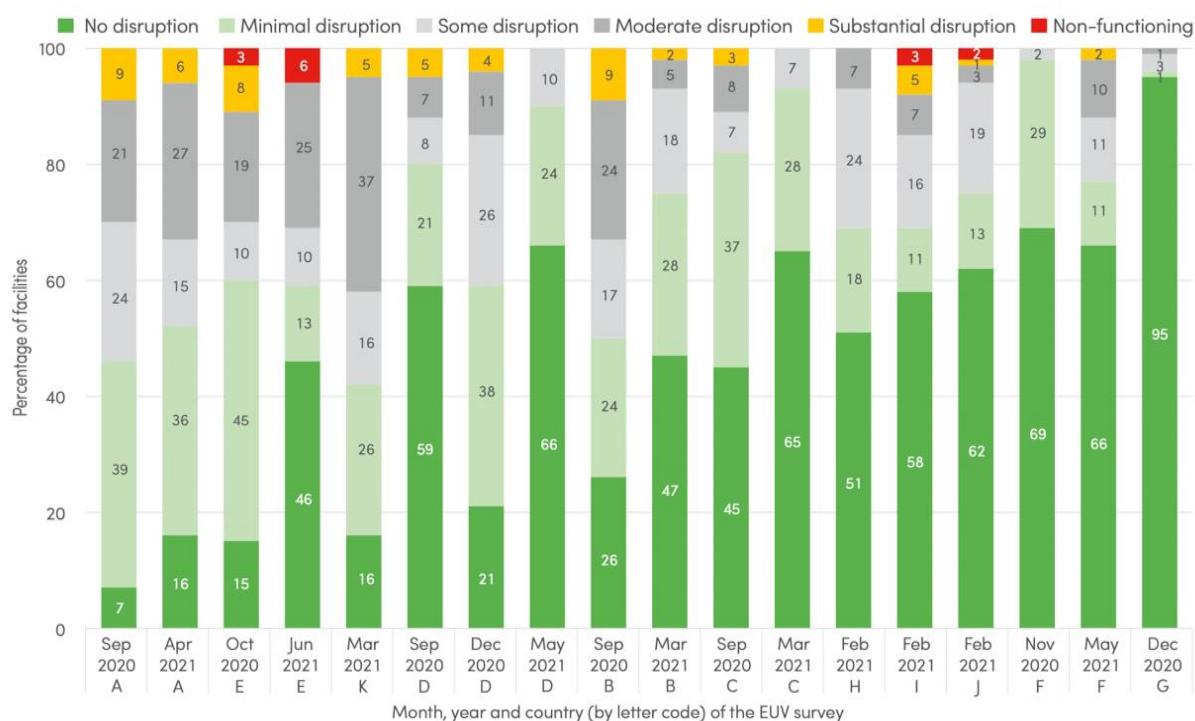
	Grant-level	Facility-level	Country-level	HTM indicators	COVID-19 indicators
Order summary dashboard	✗	✗	✓	✓	✓
Country monitoring survey	✓	✗	✓	✓	✗
Grant indicator survey	✓	✗	✓	✓	✗
Facility spot checks	✓	✓	✗	✓	✓/✗

Table C-3. Overview of C19RM 2021 M&O components

Component	Contents	Who collected	Who received / Primary Audience?	Frequency
Pulse checks	• Financial • Implementation progress on COVID-19, HTM, RSSH • Disruption • Coverage indicators	PRs	HQ – internal analyses, reporting, grant reviews, IC updates	Quarterly
HSSC	• Country level descriptors • Supply chain • Service provision/disruption (2019-2021 trend analysis by essential health services for HTM, and service utilization including COVID-19) • Health system indicators (HRH, facility financing, labs, COVID-19 case management, vaccine readiness)	Palladium, IQVIA	Awaited confirmation from Secretariat, never received	Quarterly

D. Technical Supplement on HTM Disruption and Mitigation

Figure D-1. Percentage of facilities experiencing different levels of disruptions to clinical services.



EUV: end-use verification; PMI: United States President's Malaria Initiative.

Source: PMI EUV surveys. In WHO: World Malaria Report 2021. Page 17. [Note: In 2020, EUV surveys were expanded to include a module on continuity of care in the context of COVID-19. Eighteen surveys in 11 countries (Angola, Benin, Burkina Faso, Ethiopia, Ghana, Guinea, Liberia, Mali, the Niger, Nigeria, and Zimbabwe) were implemented with the new module from September 2020 through to the end of July 2021. Data were obtained from a total of 1578 service delivery points across the 11 countries. Respondents at service points were asked whether there were disruptions. Those who responded that they had experienced disruptions were then asked to rank them on a scale of 1 to 5 (where 1=minimal, 2=some, 3=moderate, 4=substantial and 5=nonfunctioning). In most countries, less than 30% of service delivery points experienced moderate to substantial disruptions (Fig. D-1 above).]

Table D-1. HIV burden and coverage with antiretrovirals.

Country	People living with HIV (all ages) (thousands) ^a			New HIV infections (all ages) (thousands) ^b			Percentage of people who know their status who are on ART (all ages) ^c		
	2018	2019	2020	2018	2019	2020	2018	2019	2020
Angola	330	340	340	25	23	22	59	56	61
El Salvador	25	25	25	1	<1	<1	63	69	72
Malawi	990	990	990	26	22	21	93	93	94
Peru	83	87	91	4.3	4.6	4.1	79	86	80
Rwanda	220	220	220	4.9	4.4	4.2	97	>98	>98
South Africa	7,500	7,700	7,800	260	250	230	72	75	72
Ukraine	240	250	260	10	9.8	9.3	72	80	83
Vietnam	240	250	250	7.3	6.7	6.1	Data not available.	Data not available.	68

^{a,b,c} Sources:

UNAIDS. AIDSinfo. Global data on HIV epidemic and response. <https://aidsinfo.unaids.org>.

UNAIDS Data Book, 2021. https://www.unaids.org/sites/default/files/media_asset/JC3032_AIDS_Data_book_2021_En.pdf.

Table D-2. TB incidence, case notification, and treatment success rate.

Country	Estimated TB incidence— number (thousands) [rate per 100,000 population]			TB case notifications— total of new and relapse cases and cases with unknown previous TB treatment history (thousands)			TB treatment success rate and cohort size for new and relapse cases registered in the prior year— cohort size (thousands) [% success]		
	2018	2019	2020	2018	2019	2020	2018	2019	2020
Angola	109 [355]	112 [351]	115 [350]	66.2	74.1	63.1	57.9 [25%]	66.2 [50%]	66.0 [69%]
El Salvador	4.5 [70]	3.8 [58]	3.6 [55]	3.6	3.0	2.0	3.7 [90%]	3.6 [91%]	3.0 [90%]
Malawi	28 [153]	27 [146]	27 [141]	15.6	16.9	15.1	16.3 [86%]	15.4 [88%]	16.8 [88%]
Peru	38 [119]	39 [119]	38 [116]	31.4	31.8	23.8	26.1 [86%]	28.6 [83%]	28.9 [83%]
Rwanda	7.3 [59]	7.2 [57]	7.5 [58]	5.8	5.8	5.5	5.5 [86%]	5.8 [86%]	5.6 [87%]
South Africa	391 [677]	360 [615]	328 [554]	228.0	209.5	191.0	240.3 [77%]	228.0 [71%]	216.7 [79%]
Ukraine	36 [80]	34 [77]	32 [73]	26.5	25.4	17.5	21.2 [76%]	20.2 [77%]	19.4 [79%]
Vietnam	174 [182]	170 [176]	172 [176]	99.7	102.5	99.9	102.2 [92%]	99.6 [91%]	102.4 [91%]

Source: WHO global TB database as of 28 March 2022. <https://www.who.int/teams/global-tuberculosis-programme/data>.

Table D-3. Malaria burden and coverage with selected preventive measures.

Country	Reported malaria cases (presumed and confirmed) ^a			Percent of population with access to an ITN (modelled) ^b			Number of malaria cases treated with ACTs (thousands) ^b		
	2018	2019	2020	2018	2019	2020	2018	2019	2020
Angola	5,928,260	7,530,788	7,156,110	52.5	27.2	14.1	NA	NA	5,800
El Salvador ^{1,2}	2 [^]	3	0	NA	NA	NA	NA	NA	NA
Malawi	5,865,476	5,205,920	7,169,642	73.1	71.5	42.3	NA	NA	6,100
Peru ²	45,619 [^]	24,324	15,847 ⁺	NA	NA	NA	NA	NA	3.2
Rwanda	4,231,883	3,612,822	2,043,392	53.7	36.9	59.3	NA	NA	1,000
South Africa ²	10,789	13,833	8,126 [^]	NA	NA	NA	NA	NA	16
Ukraine	Not applicable.			NA	NA	NA	NA	NA	NA
Vietnam ²	6,870 [^]	5,987 [^]	1,733 [^]	NA	NA	NA	NA	NA	818

¹ Certified malaria free countries are included in this listing for historical purposes.

² Cases include imported and/or introduced cases.

[^] Confirmed cases are corrected for double counting of microscopy and RDTs.7.2

⁺ Incomplete laboratory data. Confirmed cases reported by the country exceed microscopy positive + RDT positive.

^a Source: World Malaria Report 2021. Annex 5-H (Reported Malaria Cases by Method of Confirmation, 2010–2020).

^b Source: WHO Malaria Toolkit Mobile App, Version 2.9. Data as of April 12, 2022. <https://apps.apple.com/us/app/who-malaria-toolkit/id1300199731>.

Table D-4. Coverage of selected HIV prevention and treatment indicators, 2018-2020.

	Angola			El Salvador			Malawi			Peru			Rwanda			South Africa			Ukraine			Vietnam		
	2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020
Pregnant women who know their HIV status	NA	NA	NA	NA	NA	NA	647,635	643,569	619,697	NA	NA	NA	NA	NA	NA	NA	NA	NA	6,795	NA	NA	NA	NA	NA
People receiving Opioid Substitution Therapy	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	29	72	77	12,486	12,867	15,712	NA	45,179	45,163
Sex workers reached with HIV prevention programs	12,487	10,024	5,651	9,720	7,765	4,614	3,217	11,119	9,515	NA	NA	NA	NA	NA	NA	85,812	30,452	38,274	30,660	33,985	42,651	44,101	45,482	39,682
People of ART with suppressed viral load at 12 months (<1,000 copies/ml)	NA	NA	NA	625	664	254	859,581	1,527,287	1,607,102	NA	NA	NA	1,461	506	500	13,545	12,801	NA	NA	NA	NA	77,776	92,430	40,202
People on ART for HIV	85,236	91,164	108,897	10,564	13,193	13,155	805,232	831,729	863,075	56,381	66,292	71,557	189,362	196,310	201,629	4,354,123	4,855,841	4,948,925	122,697	136,105	146,488	135,029	144,664	155,978

Source: The Global Fund. Results Report 2021 Data Explorer. <https://data.theglobalfund.org/results>.

Table D-5. Coverage of selected TB prevention and treatment indicators, 2018-2020.

	Angola			El Salvador			Malawi			Peru			Rwanda			South Africa			Ukraine			Vietnam		
	2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020
People with TB treated	67,954	72,632	29,352	3,615	1,328	983	15,578	16,836	15,113	31,120	15,465	23,485	NA	NA	NA	NA	209,545	191,074	26,560	27,574	18,798	99,465	101,749	99,535
Percentage of TB patients with drug-susceptibility testing result for at least Rifampicin	NA	NA	NA	NA	2,450	1,618	2,960	4,435	5,368	NA	NA	NA	3,717	3,998	1,993	NA	NA	NA	NA	NA	NA	NA	NA	NA
Rifampicin- and/or MDR-TB cases notified	564	1,345	427	NA	NA	NA	120	102	116	NA	548	1,384	NA	NA	NA	NA	2,859	5,043	6,271	6,489	4,595	3,270	3,434	3,486
Rifampicin- and/ or MDR-TB cases that began second-line treatment	564	640	NA	7	21	37	106	104	114	1,656	2,709	1,587	NA	NA	NA	10,084	8,634	6,051	7,421	7,517	5,321	3,110	3,243	3,294
TB patients with documented HIV status	31,776	55,298	19,637	NA	NA	NA	15,377	16,706	15,030	NA	NA	NA	NA	NA	NA	NA	20,993	71,711	25,949	25,005	17,282	84,816	87,423	83,319

Source: The Global Fund. Results Report 2021 Data Explorer. <https://data.theglobalfund.org/results>.

Table D-6: Coverage of selected malaria prevention and treatment indicators, 2018-2020.

	Angola			El Salvador			Malawi			Peru			Rwanda			South Africa			Ukraine			Vietnam		
	2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020	2018	2019	2020
Mosquito nets distributed	3,614,745	4,106,500	220,226	NA	NA	NA	11,581,832	886,255	935,483	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	134,084	181,186
Cases of malaria treated	6,092,332	5,028,415	2,854,716	NA	NA	NA	7,043,006	5,089,716	6,100,758	NA	NA	NA	1,610	1,057,098	1,045,546	NA	NA	NA	NA	NA	NA	4,525	4,665	1,456
Suspected malaria cases that received a parasitological test	14,556,370	12,861,554	6,495,758	NA	NA	NA	12,946,379	11,208,133	11,464,767	NA	NA	NA	10,326,447	8,784,690	3,554,617	NA	NA	NA	NA	NA	NA	1,159,107	1,745,135	1,810,398
Pregnant women attending antenatal clinics who received IPTp for malaria	140,909	332,619	108,479	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Source: The Global Fund. Results Report 2021 Data Explorer. <https://data.theglobalfund.org/results>.

E. Global COVID-19 Aid Landscape

The global COVID-19 response has been a monumental effort, and one which has required the timely, decisive action of international organizations, governments, civil society, and ordinary citizens alike. However, there is not a single, unified, worldwide COVID-19 response of which to speak; diverse actors have faced the pandemic in diverse ways, some more effectively than others, with the specific response of each shaped primarily by the local incentives and constraints by which each is governed. Therefore, pandemic responses spearheaded by different organizations have often been designed and implemented independently, sometimes out of sync with or competition with one another, and amidst contradictory policies of member governments. For example, bans on exports of PPE in the early stage of the pandemic restricted the ability of some states to procure the vital goods.

Recognizing the risks of independent national-level COVID-19 responses as well as the potential benefits of international collaboration, numerous multilateral organizations have operated their own pandemic response initiatives. Organizations with all different areas of focus have redirected part or all of their focus to alleviating the effects of the pandemic, and this section seeks to characterize the ecosystem of aid that has resulted therefrom, examining especially the efforts of the WBG, Gavi, WHO, the AfDB, the Asian Development Bank (AsDB), and PEPFAR. An accurate sense of this broader ecosystem is foundational for understanding the context within which the GF acted, and, consequently, for evaluating its endeavors and achievements.

Mandates and Goals

The mandates and goals of multilateral organizations' COVID-19 responses varied: some focused mainly on shielding ongoing operations from the effects of the pandemic, while others pivoted resources and energy to fighting COVID-19 itself. PEPFAR, for example, describes its priorities as follows: "continuity for both prevention and treatment services and the provision of services in a way that is safe for both providers and recipients of services."¹⁰² Gavi's mission covers three pillars¹⁰³:

Respond and protect: With COVID-19 now reported in almost all Gavi-eligible countries, the Vaccine Alliance is providing immediate funding to health systems, enabling countries to protect health care workers, perform vital surveillance and training, and purchase diagnostic tests.

Maintain, restore and strengthen: Gavi will support countries to adapt and restart immunization services, rebuild community trust and catch up those who have been missed both before and during the pandemic, while also investing in strengthening immunization systems to be more resilient and responsive to the communities they serve.

¹⁰² "2021 Annual Report to Congress." *The United States President's Emergency Plan for AIDS Relief*, U.S. Department of State, 8 Feb. 2021, <https://www.state.gov/wp-content/uploads/2021/02/PEPFAR2021AnnualReporttoCongress.pdf>.

¹⁰³ "Responding to COVID-19." *Gavi, the Vaccine Alliance*, 27 Apr. 2021, <https://www.gavi.org/covid19#>.

Ensure global equitable access: Gavi is co-leading COVAX, the global effort to securing a global response to COVID-19 that is effective and fair, using its unique expertise to help identify and rapidly accelerate development, production and delivery of COVID-19 vaccines so that anyone that needs them, gets them.

Other organizations have not published COVID-19 specific mission statements; leading efforts to counter a global pandemic already falls under the WHO's purview, and the AfDB and AsDB already help to finance public health interventions, although their attention toward this specific development area has likely been greatly increased by the pandemic. Moreover, the level of focus specifically directed at LMICs varies between organizations.

Funding Committed

The amount of funding committed by each case-study organization in its COVID-19 response varies, since the definition of "funding" is inconsistent. Multilateral development banks (whose funding primarily takes the forms of loans and concessional credits, with some grants) have committed exceptionally large amounts across sectors, including \$204 billion by the WBG^{104,105} and \$31.1 billion¹⁰⁶ by the AsDB. On the other hand, the total health-specific funding committed by grant-based organizations has been more modest. Table E-1 shows the amount of development assistance for health committed to COVID-19 in 2020 via different channels.

¹⁰⁴ World Bank Group's Operational Response to COVID-19 (coronavirus) – Projects List. April 1, 2022
<https://www.worldbank.org/en/about/what-we-do/brief/world-bank-group-operational-response-covid-19-coronavirus-projects-list>

¹⁰⁵ "The World Bank Group Responding to the COVID-19 Pandemic." *The World Bank*,
<https://thedocs.worldbank.org/en/doc/bb1b191f6b1bd1f932d0ddc5492987ec-0090012021/original/WBG-Responding-to-the-COVID-19-Pandemic-and-Rebuilding-Better.pdf>.

¹⁰⁶ "COVID-19 (Coronavirus): ADB's Response." *Asian Development Bank*, 11 Apr. 2022,
<https://www.adb.org/what-we-do/covid19-coronavirus>.

Table E-1: Development assistance for health specific to COVID-19 in 2020, by channel of assistance (2020, US\$ millions).

Institution/ Financier	Total	New funds	Repurposed funds
African Development Bank	566.3	566.3	-
Asian Development Bank	1,817.0	1,817.0	-
Bilateral Development Agencies	2,775.5	2,493.4	282.0
Bill & Melinda Gates Foundation	313.3	313.3	-
Coalition for Epidemic Preparedness Innovations	278.7	278.7	-
European Commission	605.6	565.9	39.6
Gavi, the Vaccine Alliance	1,903.3	1,827.2	76.1
The Global Fund	977.9	720.7	257.3
Inter-American Development Bank	363.9	363.9	-
Non-governmental organization	280.6	267.5	13.1
Pan American Health Organization	218.7	218.7	-
UNAIDS	9.0	0.6	8.4
United Nations Population Fund	96.9	56.5	40.4
UNICEF	614.2	506.3	107.9
Unitaid	17.7	-	17.7
USA Foundations	93.7	93.7	-
World Bank (International Bank for Reconstruction and Development)	913.1	873.1	40.0
World Bank (International Development Association)	528.5	519	9.4
WHO	1,295.5	1,295.5	-
Total	13,669.4	12,777.3	891.9

Source: Extracted from Global Burden of Disease 2020 Health Financing Collaborator Network*. 2021. Tracking development assistance for health and for COVID-19: a review of development assistance, government, out-of-pocket, and other private spending on health for 204 countries and territories, 1990–2050.

<https://www.thelancet.com/action/showPdf?pii=S0140-6736%2821%2901258-7>. Data for The Global Fund checked and corrected to ensure “New” and “Repurposed” funds in the correct columns.

Areas of Focus

The organizations reviewed have had diverse areas of focus in their COVID-19 responses. The WHO, as the leading global public health authority, has taken a bird’s-eye view and worked chiefly to coordinate international efforts to combat COVID-19. This has included liaising with national health departments, publishing timely updates on the development of the pandemic, providing guidance to national and local authorities, and spearheading the ACT-A initiative. Gavi leads the vaccination pillar of ACT-A, COVAX, which aims to ensure equity in the global vaccine rollout. Financial institutions such as the WBG, the AfDB, and the AsDB, have worked to provide crucial financing for their member states’ COVID-19 related spending. These institutions have financed emergency cash transfers for at-risk migrant workers affected by the pandemic¹⁰⁷, investments in clean water infrastructure to enhance sustainability and slow the spread of

¹⁰⁷ “The World Bank Group Responding to the COVID-19 Pandemic.” *The World Bank*, <https://thedocs.worldbank.org/en/doc/bb1b191f6b1bd1f932d0ddc5492987ec-0090012021/original/WBG-Responding-to-the-COVID-19-Pandemic-and-Rebuilding-Better.pdf>.

COVID-19¹⁰⁸, and skilling and vocational programs to boost economic recovery¹⁰⁹. Finally, in addition to its efforts to preserve progress made in addressing HIV/AIDS around the world, PEPFAR has also shifted some of its attention to combatting COVID-19 itself, for example by offering COVID-19 vaccinations at PEPFAR-supported clinics¹¹⁰.

Geographies

WHO has a global mandate, regardless of country income classification. The efforts of the WBG and regional development banks have reached virtually all countries in which they are mandated to operate, those being the LMICs. Around 50-60 countries, all lower income, are eligible for regular support from Gavi and PEPFAR, and these countries have continued to receive aid from the two organizations for the duration of the COVID-19 pandemic so far. The Gavi-led COVAX program is open to 92 LMICs, some of which are not typically eligible for Gavi vaccines.

Key Partners

The organizations examined often counted one another as key partners; in particular, Gavi leads the vaccination pillar of ACT-Accelerator (ACT-A), whose Facilitation Council is co-hosted by the European Commission and WHO. The WBG collaborates with the AfDB and the AsDB. Many of these organizations have also partnered with other multilateral organizations, national governments, and NGOs.

Evaluations

Of the reviewed organizations, none published a comprehensive internal or external evaluation of their COVID-19 response, although some others have published approach papers, indicating that such an evaluation may be occurring on a similar time frame as that of the GF. The WBG has published a study¹¹¹ of the “relevance” (as defined statistically) of WBG COVID-19 related interventions, while PEPFAR has discussed the effects of COVID-19 at length in its most recent

¹⁰⁸ African Development Bank. “Nordic Development Fund Extends Grant of \$8.8 Million to African Water Facility for COVID-19 Recovery in the Sahel and Horn of Africa Regions.” *African Development Bank*, 12 Dec. 2020, <https://www.afdb.org/en/news-and-events/press-releases/nordic-development-fund-extends-grant-88-million-african-water-facility-covid-19-recovery-sahel-and-horn-africa-regions-39891>.

¹⁰⁹ Asian Development Bank. “53277-002: Assam Skill University Project.” *Asian Development Bank*, Asian Development Bank, 18 Apr. 2022, <https://www.adb.org/projects/53277-002/main>.

¹¹⁰ “2021 Annual Report to Congress.” *The United States President’s Emergency Plan for AIDS Relief*, U.S. Department of State, 8 Feb. 2021, <https://www.state.gov/wp-content/uploads/2021/02/PEPFAR2021AnnualReporttoCongress.pdf>.

¹¹¹ Naeher, Dominik, Raghavan Narayanan, and Virginia Ziulu. “Relevance of the World Bank Group’s Early Response to COVID-19.” (2022).

annual report¹¹² to US Congress and country operational guidance paper¹¹³. These documents share a great deal about the outcomes and impacts of these two organization's COVID-19 responses—these insights will be discussed in further detail in the next section. The WBG¹¹⁴, along with Gavi¹¹⁵, the WHO¹¹⁶, the AfDB¹¹⁷, and the AsDB¹¹⁸, have published approach papers detailing their proposed evaluation methods. The AsDB evaluation was planned to be conducted in real-time and to inform the bank's evolving COVID-19 response, with a final formative report to be published in September 2021; however, this final report is still not yet publicly available. The AfDB has published a Request for Expression of Interest, which initiated an independent evaluation of its COVID-19 response.¹¹⁹

Efficiency, Impact, and Challenges

Public communications tend to highlight an organization's successes in the form of brief anecdotes, which may or may not be representative of the whole of the organization's endeavors. Given the scarcity of formal internal or external evaluations among the six organizations examined, most conclusions about the overall impact of these organization's COVID-19 responses are what can be inferred or triangulated from other sources. However, evaluative reports which are available shed insight into the factors which enhanced or impeded COVID-19 relief efforts. In the case of the WBG, it was determined statistically that while financial support was more likely to go to the group of countries pre-defined as low-income than to the group pre-defined as high-income, within the low-income group, the support was

¹¹² "2021 Annual Report to Congress." *The United States President's Emergency Plan for AIDS Relief*, U.S. Department of State, 8 Feb. 2021, <https://www.state.gov/wp-content/uploads/2021/02/PEPFAR2021AnnualReporttoCongress.pdf>.

¹¹³ "PEPFAR 2022 Country and Regional Operational Plan (COP/ROP) Guidance for All PEPFAR-Supported Countries." *The United States President's Emergency Plan for AIDS Relief*, U.S. Department of State, https://www.state.gov/wp-content/uploads/2022/02/COP22-Guidance-Final_508-Compliant-3.pdf.

¹¹⁴ "Approach Paper Report on Evaluation of the World Bank Group's Early Response in Addressing the Economic Implications of COVID-19." *World Bank Group*, 22 Oct. 2021, https://ieg.worldbankgroup.org/sites/default/files/Data/reports/ap_covid19economicimplications.pdf.

¹¹⁵ "Evaluability Assessment and Evaluation Design Phase Report: COVAX Facility and AMC Evaluability, Evaluation Design and Formative Review/Baseline Study." *Gavi, the Vaccine Alliance*, <https://www.gavi.org/sites/default/files/evaluations/COVAX-Facility-COVAX-AMC-Evaluability-and-Evaluation-Design-Final-Report.pdf>.

¹¹⁶ World Health Organization. *COVID-19 strategic preparedness and response plan: monitoring and evaluation framework*, 11 May 2021. No. WHO/WHE/20220207. World Health Organization, 2021.

¹¹⁷ "Evaluation of the Bank Group's Crisis Response Support to RMCs in the Face of COVID-19: Approach Paper." *African Development Bank*, <https://idev.afdb.org/sites/default/files/documents/files/Approach%20Paper%20AfDB%20COVID-19%20Response%20Evaluation%20.pdf>.

¹¹⁸ "Evaluation Approach Paper: Real-Time Evaluation: ADB's Response to the COVID-19 Pandemic." *Asian Development Bank*, Nov. 2020, <https://www.adb.org/sites/default/files/evaluation-document/652326/files/eap-rte-adb-response-covid-19-pandemic.pdf>.

¹¹⁹ African Development Bank. 2021. Request for Expression of Interest African Development Bank Group (AfDB). Independent Development Evaluation department (IDEV) Consultancy services: Evaluation of the Africa Development Bank Group's COVID-19 Response. https://www.afdb.org/sites/default/files/reoi_covid-19_response_evaluation_27th_oct_2021_003.pdf. Accessed on April 5, 2022.

not necessarily targeted toward those with the greatest need. That is, while more help went to the vulnerable, the most vulnerable did not necessarily receive support commensurate with their level of risk¹²⁰. Moreover, WBG financing was not always relevant to countries' needs, which spanned sectors including education, agriculture, services, etc. This suggests that WBG funding may have been allocated more based on the WBG's own comparative advantages or sectors of expertise, rather than based on differential needs between sectors within a recipient state.

PEPFAR's 2021 annual report to US Congress acknowledge many of the ways that their mission has been made more difficult by COVID-19, as well as some successes and weaknesses of their COVID-19 strategy. Although the pandemic disrupted—either precluded or made substantially more difficult—many critical services, PEPFAR also found that it was the impetus needed to innovate and implement a number of novel approaches which it hopes to maintain even post-pandemic¹²¹. These include new, more efficient, decentralized drug delivery systems as well as a separation of clinical care from drug delivery, so that healthier patients may have to come into the clinic as little as once a year. Despite these advancements, PEPFAR noted the heightened risk posed by the pandemic, which had the potential to wipe out nearly 20 years of progress in combating the global HIV/AIDS epidemic.

Outlook

The six organizations reviewed in this section all incorporated COVID-19 relief efforts as part of their broader fundamental vision. The WBG, the AfDB, and the AsDB are focused on economic, social, and political development in their respective geographies. In particular, developing resilience is one of the four key tenets of the WBG's COVID-19 response mission statement¹²², and it, along with the AfDB and the AsDB have invested billions into projects with long-term public health benefits, perhaps signaling momentum that will persist past the age of COVID-19.

The WHO aims to promote global public health as a whole and Gavi and PEPFAR work to enhance specific aspects of global public health. The WHO and Gavi are key players in ACT-A, the first international collaboration of its kind, and are undoubtedly gaining precious experience from their roles. Similarly, PEPFAR has already identified specific pandemic-era care practices that it wants to make permanent going forward.

The COVID-19 response of each of these organizations has not only focused on alleviating immediate suffering and loss of life due to illness, but also on strengthening systems, infrastructure, and practices to better prepare LMICs for future pandemics, among other risks. Each still has plans to continue providing aid at a rate and in a form similar to how it has done

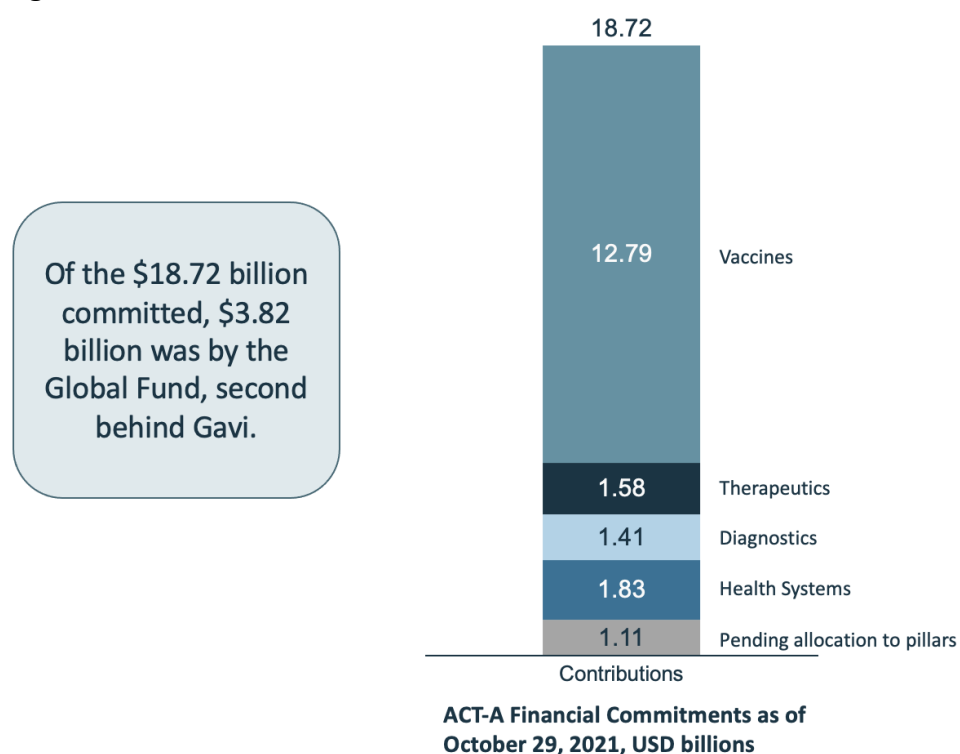
¹²⁰ Naeher, Dominik, Raghavan Narayanan, and Virginia Ziulu. "Relevance of the World Bank Group's Early Response to COVID-19." (2022).

¹²¹ "2021 Annual Report to Congress." *The United States President's Emergency Plan for AIDS Relief*, U.S. Department of State, 8 Feb. 2021, <https://www.state.gov/wp-content/uploads/2021/02/PEPFAR2021AnnualReporttoCongress.pdf>.

¹²² "The World Bank Group Responding to the COVID-19 Pandemic." *The World Bank*, <https://thedocs.worldbank.org/en/doc/bb1b191f6b1bd1f932d0ddc5492987ec-0090012021/original/WBG-Responding-to-the-COVID-19-Pandemic-and-Rebuilding-Better.pdf>.

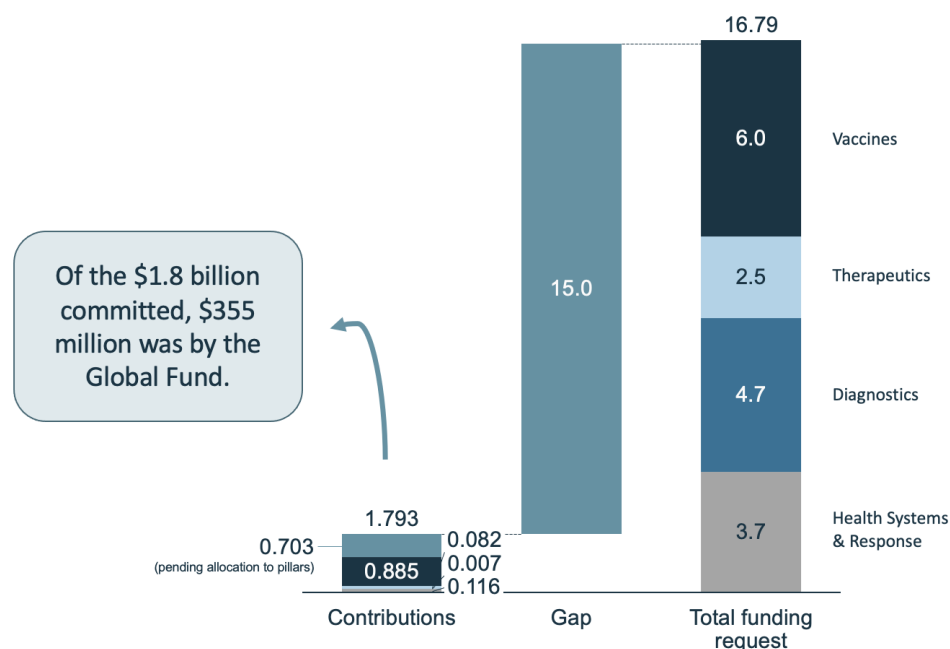
so thus far, presumably indefinitely as long as COVID-19 continues to touch billions around the world. Even when the pandemic is declared over, however, the aid delivered, and new ways of working conceived during the pandemic era will have their effects felt for decades to come.

Figure E-1. ACT-A financial commitments as of October 29, 2021.



Source: <https://www.who.int/publications/m/item/access-to-covid-19-tools-tracker>

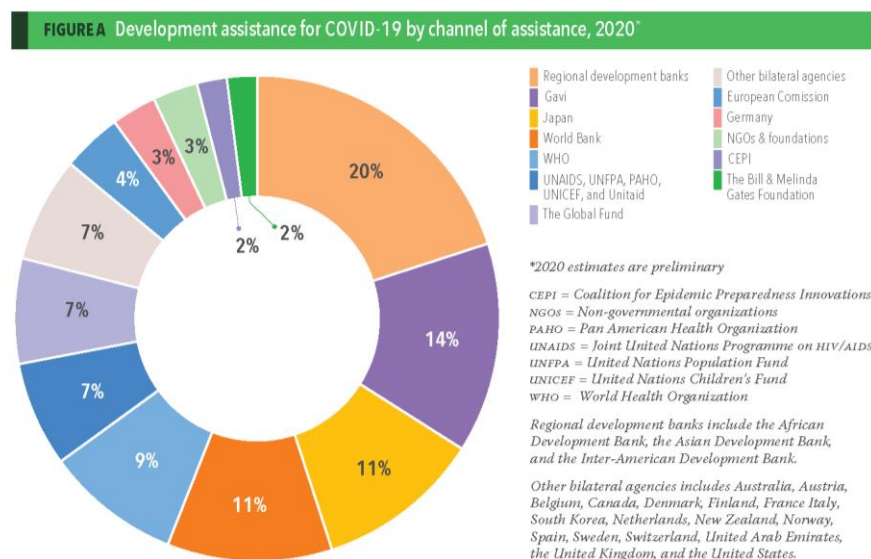
Figure E-2. ACT-A funding snapshot as of April 7, 2022.



ACT-A funding snapshot as of April 7, 2022, USD billions

Source: <https://www.who.int/publications/m/item/access-to-covid-19-tools-tracker>

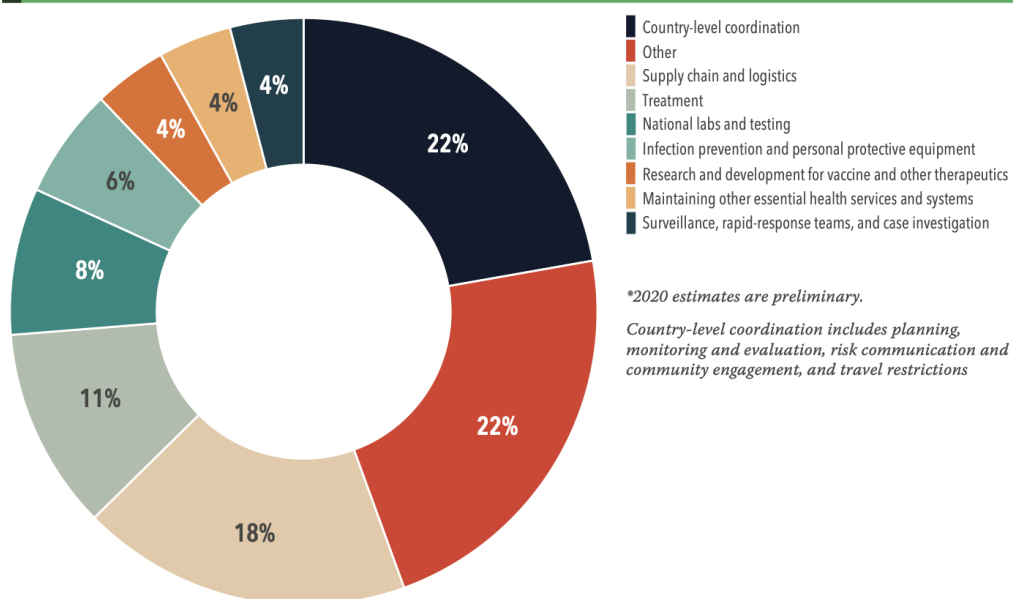
Figure E-3. GF contributed only 7% of total DAH for COVID-19 in 2020.



FINANCING GLOBAL HEALTH 2020 | COVID-19 PROFILE

Source: IHME, Financing Global Health: 2020, 22 September 2021.

Figure E-4. Globally 18% of funds went to PSM and 6% to infection prevention and PPE; these are areas where GF had large impact.

FIGURE B Development assistance for COVID-19 by program area, 2020*

Source: IHME, Financing Global Health: 2020, 22 September 2021.

F. Lists of Key Informants

Global – Global Fund Secretariat

Role	Organization	Subject of interview
Head of Human Resources	GF	ACT-A/Coordination
Head of Strategic Information	GF	ACT-A/Coordination
Head of Strategy and Policy	GF	ACT-A/Coordination
Medical Laboratory Specialists	GF	RSSH/Labs
Chief Risk Officer	GF	Risk management
Senior Advisor, TB	GF	HTM
Head of Malaria	GF	HTM
C19RM Specialists	GF	M&O/C19RM management
LAC Regional Manager	GF	Global
Department Head of Asia, Europe, and LAC Department Head of High Impact Africa I Head of Grant Portfolio Solutions and Support	GF	Global
Head of Africa and Middle East	GF	Global
Head of High Impact Asia	GF	Global
Head of High Impact Africa II	GF	Global
Head of Technical Advice & Partnerships	GF	RSSH
Senior Specialists, Impact and Evaluation	GF	M&O/HMIS
Officer, High Impact Africa II Officer, Analytics and Transformation	GF	OIG
Chief Financial Officer	GF	Finance
Senior Advisor, Health Security, Technical Advice and Partnerships	GF	RSSH
Senior Specialist, Community Health Worker Programming	GF	RSSH/HRH
Officer	GF	M&O
Specialists, Knowledge Management, Program Finance	GF	Finance
Specialist, COVID-19 monitoring	GF	M&O
Senior Disease Advisor	GF	HTM
Senior Advisor, Health Security, Technical Advice and Partnerships Specialist, C19RM and Pandemic Preparedness Specialist, M&O	GF	RSSH
Head of Grant Finance	GF	Finance
CCM Hub Manager	GF	Governance

Global – External

Role	Organization	Subject of interview
Professor, Director of Center for Global Health Science and Security	Georgetown University	Global
Director of Division of Global Health Protection	USG - CDC	Global
Senior Vice President of Prevent Epidemics	Resolve to Save Lives	Global

Deputy Manager, Global Fund Partnership	UNDP	Global
Senior Health Advisor, U.S. Representative to the Global Fund	USG - PEPFAR/DOS	HTM
Deputy Administrator, Bureau of Global Health Operational Research Coordinator, Bureau of Global Health	USAID - PMI	HTM
Director, Regional Support Team for Eastern Europe and Central Asia	UNAIDS	HTM
Senior Advisor to the Director-General Technical Officer, Transformation Implementation and Change	WHO	ACT-A/Coordination
Executive Secretary, Salud Mesoamerica	Inter-American Development Bank	ACT-A/Coordination
Director, Health Emergencies Partnerships and Planning Officer	WHO	ACT-A/Coordination
Director of Programmes and ACT-A Co-Chair Senior Technical Manager, Malaria Technical Officer, Strategy	Unitaid	ACT-A/Coordination
Director	Asian Development Bank	ACT-A/Coordination
Program Director, Health Nutrition and Population Team Leader, COVID-19 Fast Track Facility	World Bank	ACT-A/Coordination
Country Programme Officer Chief Governance Officer Manager, Public Health, Security, and Nutrition Division	African Development Bank	ACT-A/Coordination
Regional Advisor, Asia and the Pacific Deputy Executive Director	Stop TB	ACT-A/Coordination
Regional Emerging Threats Advisor	USAID	ACT-A/Coordination
Public Health Specialists, Global TB Programme	WHO	ACT-A/Coordination

Procurement and Supply Management (PSM)

Role	Organization
Head of Supply Operations	GF
Head of Supply Chain	GF
Senior Manager, Principal Recipient Services Coordinator, COVID-19 Response Mechanism Head of Strategic Sourcing	GF
Chief Global Supply Chain Division	UNICEF
Group Lead, Supply and Access to Medicines	WHO
Chief, Supply Chain	PEPFAR
Senior Program Officers, Supply Chain	BMGF
Contracts Manager, Supply Division	UNICEF
Quality Assurance Specialist	GF
Senior Advisor, Global Fund Partnership	UNDP
Global Malaria and Health Partnerships Advisor Chief, Health Technology Centre Chief, Medicines and Nutrition Centre, Supply Division	UNICEF
Manager, Supply Operations	GF

Procurement expert	BMGF
Senior Health Advisor, Global Health Programme	UNICEF
Deputy Manager, Global Fund Partnership Manager, Global Fund Partnership, Health Implementation Support Team	UNDP
TERG member	GF

Community Engagement

Organization	Role
GF	CRG Department
GF	CRG Department
GF	Fund Portfolio Manager, Multicountry Grant, Caribbean
GF	Fund Portfolio Manager, Multicountry Grant, Middle East MER
GF	Civil Society Constituency, GAC-CTAG
GF	Civil Society Constituency, GAC-CTAG
Caribbean Community (CARICOM)	Project Manager, PR CARICOM, Multicountry Grant, Caribbean
CARICOM	M&E Officer, PR CARICOM, Multicountry Grant, Caribbean

Angola

Role/Organization
CCM Adviser
CCM President
CCM Executive Secretariat
UNDP, Representante Residente Adjunta de Programa & Operações
UNDP, GF PMU Deputy Coordinator/C19RM
UNDP, GF Project Coordinator
UNDP Consultant
Consultant for the National Institute to Fight AIDS
MINSA, Secretary of State for Health
MINSA, National Director of Public Health
World Vision, Chief of Party for GF grant
Senior Officer for Partnerships & Community Development Officer
LFA, Price Water House Coopers, Assurance Services
Instituto Nacional de Investigação em Saúde
WHO, Disease Prevention and Control Officer
UNDP, Senior M&E Specialist*
UNDP, Senior Specialist for Purchasing and Procurement Management*
Directora Nacional dos Hospitais*
ANASO President*

**Providers of information, non-interviewed*

El Salvador

Role	Organization
Vice Minister, Health Development & Management	MOH

Head, STI/HIV Program Unit	MOH
Coordinator, External Funds Unit	MOH
Country Director	ONUSIDA
Head, TB & Respiratory Diseases Program Unit	MOH
Planning Specialist	Inter-American Development Bank
C19RM regional grant IREM coordinator	Inter-American Development Bank
Financing Coordinator. GF Grant.	Plan Internacional
LFA programmatic monitoring	Jacobs Group
LFA Team Leader, financing monitoring	LFA
Consultant C19RM	CCM
Coordinator, STI/HIV Unit Laboratory	MOH
Acquisitions officer – STI/HIV Unit	MOH
Project Manager, Health	World Bank
Executive Director	Colectivo Alejandría
Community Representative	CONAVIH
Community Representative	CCM, M&E Committee
Portfolio Manager – El Salvador	GF
Former Portfolio Manager – El Salvador	GF

Malawi

Organization	Role
Office of the President	National COVID-19 Coordinator
MOH	GF PIU, PR
MOH	GF PIU, PSM Specialist
MOH	Department of HIV/AIDS & Viral Hepatitis
MOH	Community Health
Malawi CCM	-
Kamuzu University for Health Sciences	Professor, member of the COVID-19 Experts committee
Kamuzu University for Health Sciences	Professor, lead for the 2020 GF TB-HIV concept note development process, former CCM member
Luke International Norway	MOH Public Health Institute of Malawi technical advisor
Clinton Health Access Initiative	Country Director
Action Aid (GF TB-HIV PR)	PR on previous TB-HIV grant
PEPFAR Malawi	PEPFAR Senior Multilateral Advisor, USAID Supply Chain and Commodities Branch Chief
Paradiso TB Patients Trust, AVAC/COMPASS, Women Living with HIV/AIDS	CSOs representing the affecting communities
PwC	LFA
GF	Current and former CT
GF	Former CDC Country Director

Peru

Role/Organization
Directorate, TB Prevention & Control, MOH

Directorate, TB Prevention & Control, MOH
Directorate, HIV Prevention & Control, MOH
Directorate, HIV Prevention & Control, MOH
NGO Representative, HIV, CCM
Trans population representative, CCM
Gay population representative, CCM
Female Sex Workers representative, CCM
Former Pharos Consultant
Fund Portfolio Manager, Peru, GF
People affected by TB, Representative, CCM
PLHIV, Representative, CCM
PLHIV, Representative, CCM
PLHIV, Representative, CCM
UNAIDS Office, Peru
HIV PR, CARE
TB & C19RM PR, Socios en Salud Sucursal Perú
TB & C19RM PR, Socios en Salud Sucursal Perú
World Bank, Responsible, Peru Projects
World Bank, Responsible, Peru Technical Assistance

Rwanda

Role/Organization
HoD planning, health financing and M&E, MOH; Chair CCM during C19RM 2020
Coordinator Single Project Implementation Unit (SPIU), MOH
Co-chair CCM secretariat, MINECOFIN
Head of Institute of HIV/AIDS Disease Prevention and Control (IHDPC), RBC
Coordinator SPIU, RBC
Division Manager Malaria and other parasitic diseases, RBC
Division Manager HIV/AIDS and other STI Diseases, RBC
Division Manager Public health surveillance, disease preparedness and response, RBC
Permanent secretary/Administrative focal point, CCM Secretariat
Senior Fund Portfolio Manager, GF
Senior Finance specialist, GF
Program Officer Program Officer, GF
LFA, PwC
Procurement and Supplies Management expert, LFA, PwC
Programmatic M&E, LFA, PwC
WHO representative
WHO representative
Health program coordinator, Private Sector Federation
Representative/People living with HI/AIDS (ANSP+), CSO

South Africa

Role	Organization
Principal Recipient	Networking HIV & AIDS Community of Southern Africa (NACOSA)
C19RM Technical Lead	Department of Basic Education (formerly SANAC)
CCM Secretariat	South African National Aids Council (SANAC)
CCM Secretariat	South African National Aids Council (SANAC)
CCM Secretariat	South African National Aids Council (SANAC)
Principal Recipient	Beyond Zero
Principal Recipient	Beyond Zero
Principal Recipient	Beyond Zero
Principal Recipient	National Department of Health (NDOH)
Principal Recipient	National Department of Health (NDOH)
Principal Recipient	National Department of Health (NDOH)
Principal Recipient	National Department of Health (NDOH)
Principal Recipient	National Department of Health (NDOH)
Principal Recipient	National Department of Health (NDOH)
Principal Recipient	Aids Foundation Of South Africa (AFSA)
Principal Recipient	Aids Foundation Of South Africa (AFSA)
Principal Recipient	Aids Foundation Of South Africa (AFSA)
Principal Recipient	Aids Foundation Of South Africa (AFSA)
Proposal developer / Sub-recipient	Institute of Health Programs and Systems (IHPS)
C19RM budget specialist	Avante Advisory Services
CCM Oversight Committee	CCM Oversight Committee
LFA	KPMG
TERG focal point	Independent
Broader COVID-19 financing	National Treasury

Ukraine

Role/Organization
Deputy Minister of Health, Chief Sanitary Doctor (during the C19RM 2020 Deputy and Acting Director General of Public Health Center); NC
Deputy Director, Public Health Center (PR); NC
Head of HIV Department, Public Health Center (PR); NC
Head of the TB Department, Public Health Center (PR); NC
Chief Accountant, Public Health Center (PR)*
Associated Director: HIV Prevention, Alliance for Public Health (PR)
Director: Treatment, Procurement and Supply Management, Alliance for Public Health (PR)
Finance Director, Alliance for Public Health (PR)*
Program Director (until March 2022), 100% LIFE (PR)
Program Director (from March 2020, previously Deputy Program Director), 100% LIFE (PR)
Human Rights and Community Development, 100% LIFE (PR)
Grant Management Department, 100% LIFE (PR)

Finance Director, 100% LIFE (PR)*
Free Zone, representative of people in prisons; NC
UNAIDS Country Director
UNAIDS Country Office
Senior Advisor on TB, HIV, and Viral Hepatitis, WHO Country Office
Deputy Director of Health, USAID Ukraine, Belarus, Moldova; NC
USAID
USAID
U.S. CDC Deputy Director
Lead Modelling Expert, Kyiv School of Economics*
Consultant on Sustainability (member of technical working groups on sustainability)*

**no full interviews, clarifications in writing and over phone*

Vietnam*

**No interviews. This is a list of questionnaire respondents.*

Role/Organization
Coordinator, GF funded project on HIV/AIDS, Vietnam Authority of HIV/AIDS Control
Project Manager, GF supported project on HIV/AIDS, Viet Nam Union of Science and Technology Associations (VUSTA) Project Management Office
Technical Deputy Director, VUSTA
Deputy Director, National Lung Hospital
1 st Project Officer, GFATM Project for TB Control in Vietnam
Vice Chair CCM + Civil Society Signatory + WHO country representative
CCM Member, Representative of TB Patients
Chair of National Malaria Control Program (NMCP)
Deputy Director, NMCP
Deputy Head of Epidemiology Dept. of NIMPE
WHO focal point for TB
WHO focal point for Malaria
Strategic Information Advisor, UNAIDS
WHO focal point for Malaria
Chair CCM, Vietnam

G. Interview Guides

Country interview guide

1. **Can you please *describe your involvement* in C19RM in this country? What were your roles in the design and implementation phases of C19RM in 2020? In 2021?**
 [Probe: National Strategic Planning for COVID-19 Response; National HTM Mitigation/Adaptation Planning; Program oversight or implementation; CCM membership/leadership functions; Principal Recipient functions; LFA functions; Donor/partner support and coordination. *Ask for specific examples.*]
 [Probe: Specificity of the roles]
2. **For Principal Recipients: Could you describe the process and elements of the GF's support in relation to the COVID-19 pandemic, starting from early 2020 grant flexibilities, additional funding through C19RM in 2020 and 2021?**
3. **How *relevant* is the C19RM portfolio to this country's responses to COVID-19? In 2020? In 2021? Were important aspects of the COVID-19 response overlooked?**
 [Probe: Adapting and mitigating actions to minimize negative effects of COVID-19 on HTM services? Directly fighting COVID-19 to prevent infections, save lives, etc.? Building more resilient community and health system responses? *Ask for specific examples.*]
4. **How well *designed* do you think the C19RM 2020 grants have been regarding this country's needs?** [*Can be asked together with question 3*]
 [Probe: What strengths and weaknesses have you observed? What explains these strengths and weaknesses?]
5. **How *effective* have the grants been in achieving their objectives?** [Ask to restate these objectives, and probe for specific examples.] **How well are the C19RM grants working in this country?**
 [Probe: Speed of implementation? Efficiency? Quality? Impact, if discernible? Tangible services and benefits for the population? Community mobilization? *Ask for specific examples.*]
6. **How well have *inter-agency partnerships* (e.g., with WHO, Gavi, US CDC/USAID, World Bank, etc.) helped or hindered the C19RM in this country?**
 [Probe: Added value? Scale? Scope? Pros and cons of the country-specific partnerships regarding C19RM? How has C19RM influenced the inter-agency partnerships within the country? *Ask for specific examples.*]
7. **What are the strengths and weaknesses of the *coordination, M&E* of C19RM grants in this country?**
 [Probe for specificity.]
8. **What would have happened to this country's COVID-19 response without the C19RM? (the *counterfactual*)**
 [Probe: No difference? Important differences, whether positive or negative?]
9. **What are the *lessons to be learned* from the C19RM experience, and what key actions would you *recommend to improve C19RM* going forward? Did the 2021 grants improve as a result of learning from 2020 (if so, how exactly)?**
 [Probe: The 2020 phase? The 2021 grant? *Ask for specific examples.*]

[Probe: To improve ongoing C19RM activities? For any additional funds in the future? For future Fund support to pandemic preparedness? For the GF's grants in general? Should C19RM grants be integrated in HTM/RSSH grants after 2024?]

[Probe: In your position, what would you do differently if C19RM had another phase?]

Request for relevant documents:

- Reports of C19RM grants, including good practice descriptions, outcomes and impacts.
- Documents describing the process of the country development of its C19RM requests

PSM-specific questions for country evaluators:

1. Document requests for the HPM specialist, LFA, and PR in your country:
 - Did your country complete a PSM diagnostic assessment pre-COVID-19 or during COVID? If so, please share this
 - Please share any reports that cover PSM aspects (spot checks, on-shelf availability assessments, PU/DRs, etc.) for C19RM 2020 and 2021
 - C19RM-specific PSM guidance and tools

These questions may be answered best by a combination of PR, HPM specialist and LFA:

2. What procurement mechanism/s (PPM/ Wambo, local procurement, other) were used for each product category, and what was the rationale? Please specify this for 2020 and 2021.
 - PPE
 - Diagnostics
 - Therapeutics
 - Oxygen
3. Please share details of **locally-sourced commodities under C19RM**, along with key lessons learned. In particular, please share:
 - Did you have cash on hand from TGF?
 - Time from funds disbursement to initiation of procurement. If there were delays, what were the reasons for this?
 - Incoterms
 - How quality assurance was done
 - Lead time and reasons
 - Warehousing and transportation aspects
 - Any other information that is relevant to the procurement context
4. What **key performance indicators for sourcing and product delivery** did you use? What were the results? (Please collect data)
 - How were these captured? Is there an electronic LMIS in your country? Please describe it.
 - What key delivery opportunities and challenges did you encounter?
 - Please specify specific supply chain metrics: OTIF, on shelf availability, LMIS data quality, etc. and how these were measured
5. What key PSM challenges did you face? Did you communicate these to TGF? If so, to which team or teams? How were they addressed?

6. Looking back at 2020, what worked? What would you have done differently? What could TGF have done differently?
7. Looking forward, are there any PSM-related recommendations or insights you would like to share?

General global interview guide

1. Can you please describe your involvement in the design and implementation of C19RM in 2020? What were your roles and responsibilities? How has this carried over into the C19RM 2021 grantmaking process of the past six months?
2. How relevant do you think the 2020 C19RM portfolio has been to global and country needs to respond to COVID-19? Mount adaptive and mitigating actions to minimize negative effects of COVID-19 on HTM services? Build more resilient community and health systems responses? Concrete examples...
3. How well designed do you think the C19RM 2020 grants have been to country needs? What are some design strengths and weaknesses that you have observed? What helps to explain these strengths and weaknesses?
4. How effective do you think the C19RM grants have been in achieving their objectives? Cite specific examples if possible.
5. Please comment on the monitoring and measurement of C19RM grants and their implementation, and of M&E of related processes. How strong are the systems for M&E? Why?
6. How well have the processes for country and global design and implementation of C19RM been developed and proven fit for purpose? What new or adapted processes were put in place for the work you have performed on C19RM for 2020? What were their strengths and weaknesses?
7. Are there other important organizational, staff, and procedural changes in the GF secretariat that emerged through C19RM 2020? How successful have these changes been?
8. What are the lessons to be learned from the C19RM 2020 experience?
9. Have these lessons been applied to the C19RM 2021 portfolio which has recently been designed and approved for most countries? Where has C19RM 2021 gone better than in the previous year?
10. What key actions would you recommend to further improve C19RM for the 2021 implementation roll out and for any additional funds that might be programmed for C19RM in 2022?

Procurement and Supply Management (PSM) interview guide

1. What are the key **external and upstream supply chain factors** that have enabled or adversely impacted delivery and utilization of in-scope COVID-19 supplies across the value chain? How and at what frequency is the GF tracking them, and what execution and **risk mitigation** actions are being taken/ by whom?
2. How has the evolution of the **ACT-Accelerator's** PSM-related funding, functions and processes shaped the GF's C19RM PSM activities? What are the pain points, areas of duplication of effort, or areas for ongoing or increased collaboration?

3. What **GF Supply Operations** fund disbursement, strategic and technical assistance approaches, capabilities, processes, tools, technologies, data, partnerships and other internal and external resources have been deployed and what outputs and outcomes have been achieved? How has this been coordinated with other GF structures and teams?
4. How have **CCMs, implementing partners and other regional and country partners** engaged with the C19RM to procure COVID-19 commodities?
5. Key areas to explore for select country case studies include:
 - a. What key design and execution considerations were considered?
 - b. What metrics are used to track PSM performance (e.g., number of qualified suppliers, lead time, freight and logistics capacity, data quality, on time/ in full delivery, on-shelf availability, inventory turns, inventory and forecast accuracy, stock levels, expiries, etc.) and what data are available?
 - c. What are the root causes of deviations from desired performance? How might these be addressed and by whom?
 - d. How do C19RM PSM efforts link to HTM commodity supply? Are there any areas of duplication of effort and cost or opportunities to leverage each other?
 - e. What innovations have emerged? Are they being replicated/ scaled where appropriate?

H. Data and Documents Availability

Quickly provided to or acquired by team		
Outcomes Dashboards	2020	Provided quickly
COVID-19 Approved Funding Dashboards	2020, 2021	Provided quickly
C19RM Guidance and Procedure Notes	2020, 2021	Provided quickly
C19RM Monthly Updates to the Board	2020, 2021	Provided quickly
C19RM Outcomes Dashboards	2020, 2021	Provided quickly
C19RM Allocations	2020, 2021	Provided quickly
OIG Audits (global reports)	2020, 2021	Provided quickly
GF Guidance Notes on Civil Society, Communities	2020, 2021	Provided quickly
Rain or Shine II Webinar and Files	2021	Provided quickly
C-TAG-related information	2021	Provided quickly
DAC, Gavi, IHME Global Spending Reports	2020	Acquired quickly
World Malaria Reports	2019, 2020, 2021	Acquired quickly
Global TB Reports	2019, 2020, 2021	Acquired quickly
Global Fund Results Reports	2019, 2020, 2021	Acquired quickly
Global Monitoring Efforts	2020, 2021	Acquired quickly
Global Fund Mitigation and Adaptation	2020, 2021	Acquired quickly
ACT-A Quarterly Updates	2020, 2021	Acquired quickly
ACT-Accelerator Strategic Review (Dalberg)	2020, 2021	Acquired quickly
WHO press releases, speeches, reports	2020, 2021	Acquired quickly
World Bank press releases, speeches, reports	2020, 2021	Acquired quickly
Global Fund Strategy Reports (external)	2019, 2020, 2021	Acquired quickly
WHO Global Response Survey	2021	Acquired quickly
COVID-19 Information Note: Considerations for Global Fund Support for RSSH	2020	Acquired quickly
C19RM 2020 Funding Request, GF Review, Grant Revision, and Notification Letter	2020	Provided quickly for all 8 countries
Funding Landscape Table submitted with 2020 application	2020	Provided quickly for 6 of 8 countries
C19RM 2021 Funding Request, GF Review, Grant Revision, and Notification Letter	2021	Provided quickly for all 8 countries
Funding Landscape Table submitted with 2021 application	2021	Provided quickly for all 8 countries
Global Fund reports and guidance notes on PSM	2019-2021	Acquired quickly
Essential Data Table	2021	Provided quickly for all 8 countries
Investment Committee Meetings and Decisions	2020, 2021	Provided quickly for 7 countries

Eventually provided to or acquired by team		
Monthly / Quarterly Indicator Reporting	2019, 2020, 2021	Requested November 2021 Provided March 2022
In-country supply operations assessment reports	2019, 2020, 2021	Requested January 2021 Provided January-March 2022
Lab Systems Investments Slides for C19RM	2021	Requested January 2022 Provided Q2 2022
OIG Audits for C19RM (country studies)	2020, 2021	Requested November 2021 Provided Q1-Q2 2022
Global Fund Strategy Reports (internal)	2019, 2020, 2021	Requested November 2021 Provided December 2021-March 2022

C19RM Performance and Accountability Metrics	2021	Requested early January 2022 Provided mid-February 2022
C19RM Financial Database	2021	Requested November 2021 Provided on 24 January 2022
C19RM Disbursements	2021	Requested November 2021 Provided on 24 March 2022
C19RM Monitoring & Evaluation Framework	2021	Requested November 2021 Provided in Q1 2022
PU/DRs	2020, 2021	Requested Q4 2021 Provided for 7 of 8 countries December 2021-April 2022
HPMTs and user guides	2021	Requested January 2022 Provided January-March 2022
Pulse Checks	2021	Requested December 2021 Provided for 6 applicable countries March 2022
Secretariat Lessons Learned	2020	Began search in January 2022 Acquired in February 2022
AfDB Reports and Presentations	2021, 2022	Began search in December 2021 Acquired in March 2022
Civil Society and Community Engagement for C19RM	2020	Began search in February 2022 Acquired in April 2022
COVID-19 Global Spending	2020	Began search in November 2021 Acquired in March 2022
UNAIDS TSM Support of C19RM	2020, 2021	Began search in November 2021 Acquired in March 2022

Not in existence or not shared		
Allocation of mitigation across the three diseases	2020, 2021	Not in existence
C19RM Performance and Accountability Metrics	2020	Not in existence
Financial database for C19RM 2020 spending after June 30, 2021	2020	Not in existence
C19RM Disbursements	2020	Not in existence
C19RM Monitoring & Evaluation Framework	2020	Not in existence
COVID-19 Global Spending	2021	Not in existence
Spot Checks: Health Sector	2021	Unclear if in existence or not provided for 2 countries
Country-specific disruption data	2020, 2021	Not in existence for all 8 countries
OIG country documents	2020, 2021	Not in existence for most countries
Local procurement data	2020	Not in existence
Quality Assurance/Quality Control Reports	2020	Not in existence
Grant Rating Files, Budgets for PRs	2020, 2021	Unclear if in existence or not provided for most countries
Performance Letters	2020, 2021	Unclear if in existence or not provided for most countries
Contingency/catch up plans, procurement reviews, and LFA service disruption surveys	2020, 2021	Unclear if in existence or not provided for most countries
Spot Checks: LFA	2020	Unclear if in existence or not provided for most countries

I. Other Supplemental Tables and Figures

Table I-1. Recent economic outlook and COVID-19 impacts in case study countries.

Country	Economic and Health Overview
Angola	Angola is in its fifth year of an economic recession only exacerbated by the pandemic due to lower oil prices and production levels. The country's real GDP contracted around 5.4 percent in 2020, meaning a total GDP decline of 10.8 percent in the past five years. The World Bank reports that Angola is expected to end the long recessionary cycle in 2021, aided by higher oil prices, stabilization of oil production, and a recovery of the non-oil sector supported by lifting of COVID-19 related restrictions and the lagged impact of macroeconomic reforms. Real GDP growth is estimated at 0.4 percent, with non-oil sector growth offsetting a renewed contraction of the oil sector. The pandemic has not been as drastic in Angola in terms of real numbers and in per capita. As of March 2022, Angola reported a total of 98,698 cases and 1,899 deaths (1.9% fatality rate) due to COVID-19 over four major waves throughout the pandemic. While low testing could partially explain the numbers, there has not been a surge in unexplained pneumonias or deaths, suggesting that other factors have turned out to be protective such as Angola's young population (median age of 16.7 years), adherence to social distancing and mask mandates, limitations in international and domestic travel among other protective measures taken Sources: https://www.worldbank.org/en/country/angola/overview#1 https://graphics.reuters.com/world-coronavirus-tracker-and-maps/countries-and-territories/angola/ National Contingency Plan
El Salvador	El Salvador has experienced modest economic growth in recent decades, but the COVID-19 pandemic has had a significant negative impact on the economy, with a 7.9% contraction of GDP in 2020. In 2021, growth is showing signs of recovery, supported by remittance-fueled consumption and exports. El Salvador has been one the countries least affected by COVID-19 in the Central American region. The country instituted very aggressive lockdown policies (e.g., home quarantines, mobility restrictions, and intense police control). As the pandemic evolved, El Salvador showed a comparatively better epidemiological behavior compared to its neighbors. The peak of registered confirmed cases in 2020 was around 10 August, with 66 cases per million, while in 2021 it was 10 November, with 90 cases per million. Cases peaked again January to March 2022 due to the Omicron variant. Each of the associated lockdown policies have had negative shocks on the economy. Sources: https://www.worldbank.org/en/country/elsalvador/overview#1 Our World in Data
Malawi	Malawi's economy continues to be heavily affected by the COVID-19 pandemic. The economy was severely hit by the second wave of the COVID-19 pandemic which largely subsided by March 2021, but a third wave led to a jump in case numbers from June to August. As a result, the government increased social distancing policies which impacted the services and industry sectors, although these policies were then lifted in August as conditions improved. The economy was expected to grow at 2.4 percent in 2021. Domestic debt continues to increase and has pushed Malawi into high overall risk of debt distress, and it is budgeted to continue rising sharply. This is being compounded by recent external non-concessional borrowing. This increasingly reducing fiscal space for development spending and risks crowding out private sector investment. Source: https://www.worldbank.org/en/country/malawi/overview#1

Peru	The COVID-19 pandemic has had a devastating impact on the country. A strict and prolonged quarantine led to a decline in GDP of 11% in 2020, and a rebound in 2021 of 13.1% of GDP though remains below the pre-pandemic trend. Peru recorded one of the highest death rates globally. Daily new confirmed cases rapidly reached 200 per million people, fluctuating down and up after that, reaching peaks in August 2020 and the first half of 2021, and skyrocketing to almost 1,500 cases per million in early 2022 due to the omicron variant (Our World in Data, 2022). Excess mortality reached almost 200% between May and August 2020, declining after that to rebound to around 250% between February and April 2021. However, the acceleration of vaccine program in the second half of 2021 led to a significant drop of COVID-19 deaths, both confirmed and as estimated excess mortality (Our World in Data, 2022). Sources: https://www.imf.org/en/News/Articles/2022/03/07/mcs030722-peru-staff-concluding-statement-of-the-2022-article-iv-mission https://www.worldbank.org/en/country/peru/overview#1
Rwanda	Rwanda was in the middle of an economic boom before the pandemic. The real GDP growth in 2020 was -3.4%, the first negative economic growth in more than a quarter-century. The International Monetary Fund (IMF) projects a 10.2% growth in 2021, outperforming earlier estimates. Compared to other countries in the region, Rwanda has been credited with managing the COVID-19 pandemic by implementing extensive policies aimed at containing the virus: restricting and limiting movement, introducing curfews, and encouraging social distancing. The two worst outbreaks occurred in June – September 2021 and December 2021 – January 2022. As of March 2022, nearly 100,000 people were infected with COVID-19 and over 1,459 people died of COVID-19 in Rwanda. Sources: https://www.worldbank.org/en/country/rwanda/overview#1 https://www.imf.org/en/Publications/CR/Issues/2022/01/13/Rwanda-2021-Article-IV-Consultation-and-Fifth-Review-Under-the-Policy-Coordination-511923 https://www.trade.gov/country-commercial-guides/rwanda-market-overview Rwanda Biomedical Center
South Africa	South Africa was in a period of low positive economic growth when the pandemic hit and led to a 6.4% decline in real GDP in 2020. Economic growth is expected to rebound to 4.0% in 2021, so still significantly below pre-pandemic levels. South Africa has faced four waves of infection, with the number of confirmed cases at 3.7 million and an incidence rate of 6,186 per 100,000 persons (as of 9 March 2022). March 2020, President Ramaphosa announced a National State of Disaster and instituted the National COVID-19 Command Council (NCCC). Since a strict five-week lockdown in March 2020, the government implemented varying degrees of lockdown restrictions coupled with a comprehensive public health response including curfews, alcohol bans, restrictions on religious and social gathering, and mandating non-pharmaceutical interventions. The vaccine rollout began in mid-February 2021, but uptake has been slow with only 29.06% of the population being fully vaccinated as of 9 March 2022. Sources: https://www.worldbank.org/en/country/southafrica/overview#1 https://www.nicd.ac.za/diseases-a-z-index/disease-index-covid-19/surveillance-reports/national-covid-19-daily-report/ https://ourworldindata.org/covid-vaccinations?country=OWID_WRL
Ukraine	Ukraine has experienced acute political, security, and economic challenges during the past seven years, especially in the first quarter of 2022 with the Russian invasion of the country. Prior the

	pandemic, Ukraine's GDP switched between strongly negative GDP growth and modest positive GDP growth. The IMF records a -4.0% GDP growth in 2020 and projects 3.5% growth in 2021. Although the economic impact of the pandemic has been less severe than expected, Ukraine remains among the countries in Europe most severely affected by the COVID-19 pandemic in health terms. Ukraine experienced major waves in late 2020 and early 2021, and a significantly higher third wave in autumn 2021 and the largest fourth wave in early 2022, peaking with 860 cases registered per million people in February 2022. Sources: https://www.worldbank.org/en/country/ukraine/overview#1 https://www.imf.org/en/Countries/UKR#countrydata
Vietnam	Vietnam was one of only a few countries in the world to record positive GDP growth in 2020 when the pandemic hit. However, the COVID-19 Delta variant has dealt a shock to Vietnam and GDP is estimated to grow between 2 and 2.5 percent in 2021, about 4 percentage points lower than the world average. The pandemic largely spared the country until Q2-3 of 2021, and then a major uptick during the omicron variant in Q1 2022. Cases per capita peaked at near 5,000 confirmed new cases per million people per day on 12 March 2022. Sources: https://www.worldbank.org/en/country/vietnam/overview#1 Our World in Data, Vietnam

Table I-2. Total C19RM funding approved in 2021 for case countries and globally, US\$

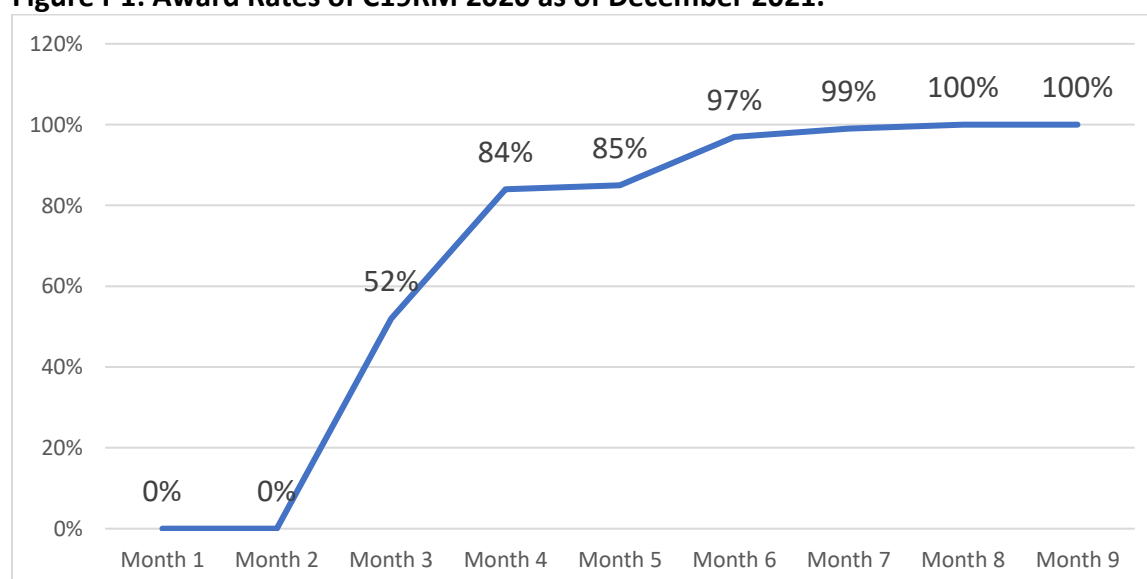
Country / Multicountry	Mitigating COVID-19 impact on HIV, TB and malaria programs		Reinforcing national COVID-19 response		Urgent improvements in health and community systems				Total immediate funding for 2021
					CRG		RSSH		
Angola	2,173,149	11%	18,338,111	89%	56,941	0.3%	81,884	0.4%	20,650,086
El Salvador	242,500	5%	2,533,708	53%	232,206	5%	1,798,828	37%	4,807,242
Malawi	12,245,244	12%	78,931,018	77%	7,374,580	7%	4,004,762	4%	102,555,604
Nepal	4,088,194	14%	21,126,834	73%	601,511	2%	3,201,524	11%	29,018,064
Peru	4,778,261	32%	8,454,225	57%	1,067,567	7%	637,831	4%	14,937,883
Rwanda	675,652	1%	40,741,175	86%	657,113	1%	5,466,397	11%	47,540,337
South Africa	16,993,036	11%	128,280,370	80%	3,504,616	2%	12,251,967	8%	161,029,989
Togo	3,714,606	14%	20,656,672	76%	1,340,810	5%	1,546,546	6%	27,258,634
Ukraine	12,413,279	35%	17,485,466	49%	4,146,496	12%	1,798,239	5%	35,843,480
Viet Nam	5,605,146	16%	27,594,184	80%	507,190	1%	924,527	3%	34,631,047
10 country subtotal	62,929,067	13%	364,141,763	76%	19,489,030	4%	31,712,505	7%	478,272,366
Global total	341.666.305	11%	2.396.054.187	75%	121.974.654	3.8%	334.070.244	10%	3.193.765.397

Source: Funding Approved for the COVID-19 Response, as of 12 April 2022. <https://www.theglobalfund.org/en/our-covid-19-response/>.

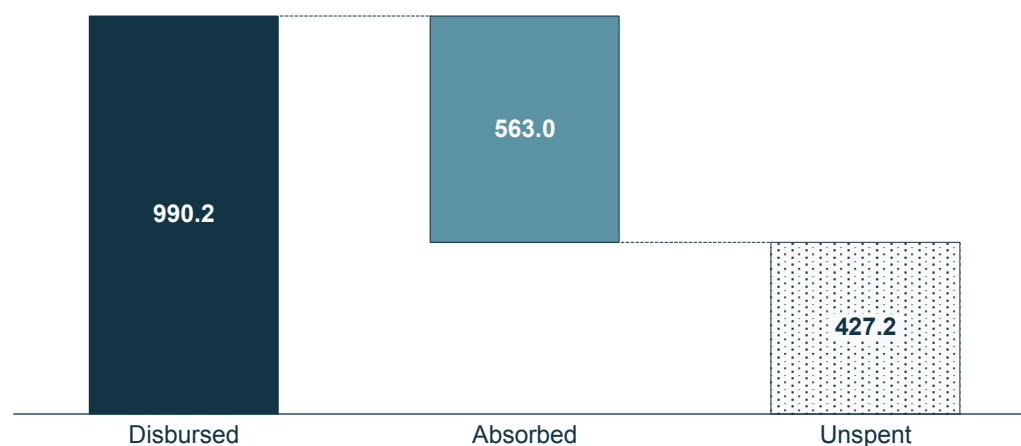
Table I-3. C19RM 2021 disbursement as of 18 March 2022.

Country	Disbursement of C19RM 2021 (as of 18 March 2022) (US\$ millions)	Disbursement of C19RM 2021 as % (as of 18 March 2022)
Angola	13.63	66%
El Salvador	0.999	21%
Malawi	14.65	14%
Peru	4.83	32%
Rwanda	25.66	54%
South Africa	56.88	35%
Ukraine	5.32	15%
Vietnam	120209	32%
Global Totals	0.877	27%

Sources: C19RM 2021 disbursement data as of 18 March 2022.

Figure I-1: Award Rates of C19RM 2020 as of December 2021.

Source: OIG Audit of the COVID-19 Response Mechanism, 29 March 2022.

Figure I-2. Absorption of C19RM 2020 as of 30 June 2021, US\$ millions

Source: C19RM expenditure as of 30 June 2021, data pulled on 30 April 2022.