



EURO HEALTH GROUP

Thematic Review of the Global Fund in Fragile States

Team leader:

Nigel Pearson

Other consultants:

Egbert Sondorp

Clare Dickinson

Veronica Walford

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Acronyms

ADB	Asian Development Bank
AfDB	African Development Bank
ART	Antiretroviral Therapy
ASP	Additional Safeguards Policy
CAR	Central African Republic
CCM	Country Coordinating Mechanism
CDD	Community Driven Development
COE	Challenging operating environments
CPIA	Country Policy and Institutional Assessment
CS	Civil Society
CT	Country Team
DAC	Development Assistance Committee
DRC	Democratic Republic of Congo
EHG	Euro Health Group
EPA	Eligibility and Performance Assessment
EPHS	Essential Package of Health Services
FA	Fiduciary or Fiscal Agent
FCAS	Fragile and Conflict-Affected States or Situations
FM	Financial Management
FPM	Fund Programme Manager
FSI	Failed States Index
g7+	The g7+ is a self-selected group of 19 states experiencing fragility
Global Fund	The Global Fund to fight AIDS, Tuberculosis and Malaria
GMS	Grant Management Solutions
GOU	Grant Oversight Unit
HIV	Human Immunodeficiency Virus
HPF	Health Pooled Fund
HSS	Health Systems Strengthening
HRITF	Health Results Innovation Trust Fund
ICRC	International Committee of the Red Cross
IDB	Inter-American Development Bank
IDP	Internally Displaced Person
IFRC	International Federation of the Red Cross
INCAF	International Network on Conflict and Fragility
INGO	International Non-Governmental Organisation
IOM	International Organisation for Migration
KAPs	Key Affected Populations (formerly known as MARPs, see this)
LFA	Local Fund Agent
LMIC	Lower Middle Income Country
MA	Management Agent
MARPs	Most At Risk Populations
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MDTF	Multi-Donor Trust Fund
MOH	Ministry of Health
MOSS	Minimum Operating Security Standards
MSF	Médecins San Frontières
NFM	New Funding Model
NGO	Non-Governmental Organisation
NSP	National Strategic Plan
ODA	Official Development Assistance
OECD	Organization of Economic Cooperation and Development
OFDA	Office of Foreign Disaster Assistance
OIG	Office of Inspector General
OSDV	On Site Data Verification
PEPFAR	US Presidents Emergency Plan for AIDS Relief
PBF	Performance Based Funding
PFM	Public Financial Management

PIU	Project Implementation Unit
PLWH	People Living with HIV
PMU	Project Management Unit
PO	Project Officer
PR	Principal Recipient
PS	Private Sector
PSM	Procurement and Supply Management
QUART	Qualitative Risk Assessment, Action Planning and Tracking Approach
RMO	Risk Management Office
RMU	Risk Management Unit
SRC	Somali Red Cross
SR	Sub Recipient
TB	Tuberculosis
TERG	Technical Evaluation Reference Group
TOR	Terms of Reference
TRP	Technical Review Panel
UNDSS	United Nations Department of Safety and Security
VPP	Voluntary Pooled Procurement

Abstract

This report presents the findings of a thematic review of the Global Fund's support to fragile states commissioned by the Global Fund's Technical Evaluation Reference Group (TERG).

The aim of the review is to develop recommendations and options to improve Global Fund processes in fragile states, identifying how these can be tailored to different contexts to increase impact and better manage risk.

Similar to other organizations, challenges remain for the Global Fund in countries considered 'fragile' by normative definitions of weak and fragile states. Despite successful progress in many 'non-fragile' countries towards HIV and AIDS, TB and malaria service coverage, certain key obstacles remain in fragile states to achieve similar levels of improvement.

Some of the changes introduced by the New Funding Model and the Operational Risk Management Approach already provide greater flexibility in grant design and management and there are examples of very positive innovations made by country teams and partners. But performance and coverage will not be improved unless more radical measures are taken, in addition to these recent initiatives.

Large populations, including some of the poorest and most vulnerable continue to be out of reach. A limited group of countries with extreme fragility present further challenges to operations and access as well as exceptionally low coverage with key services. Working in fragile states is, in its nature, unpredictable, time consuming and difficult. There are no universal simple solutions that can be applied, yet there are an important set of country by country actions to support impact in these contexts.

This review proposes a series of innovative options for each level of Global Fund grant design and implementation. Innovative options are presented for: CCMs; PRs and SRs; LFAs and FAs; Health System Delivery and Performance-based Funding; promoting strategic partnerships; and for impacting on human rights, equity and coverage. The review makes 8 key recommendations, introduced here and explained in more detail in the Executive Summary and the review.

1. *Identify* a group of countries and possibly regions that merit special attention and a special approach. This review suggests a new name for them: *Challenging Operating Environments (COEs)*.
2. *Adopt* a country-by-country approach focusing on the most complex and challenging settings to deliver programmes and achieve results.
3. *Capitalize on* the current approach and the New Funding Model to flexibly tailor support and management arrangements to the local country context.
4. *Select* the most appropriate approach for each country and grant, depending on the assessment of context and partnerships in that environment.
5. *Invest* in staff working in Challenging Operating Environments. Undertake measures to improve security and access to those countries.
6. *Learn from* past Global Fund and partner experiences of what works well.
7. *Improve* Monitoring and Evaluation guidance on target setting in COE countries, including how to measure performance and how to include capacity strengthening and state building measures.
8. *Consider involvement* in acute emergencies on a case-by-case basis in support of humanitarian relief agencies.

Successful interventions in fragile states remain extremely important to the Global Fund that by its very nature seeks to impact the three core diseases worldwide, regardless of local circumstances. Reducing the high burden of disease in fragile states increasingly emerges as a key Global Fund target, as emphasized in all global declarations on aid effectiveness.

1. Executive Summary

1.1 Key Findings

1.1.1 Data Analysis of Global Fund Grant Performance in Fragile States

Research carried out by the Global Fund in 2010 showed that grant performance was slightly worse in a group of 41 states considered 'fragile' at the time. Data analysed for this review of the same countries (until 2013) showed that performance in terms of grant ratings¹ has worsened in recent years.

In 2013, average grant performance is consistently poorer for the most fragile 35 countries (using the Failed States Index, 2013, Very High & High Alert, and Alert countries) compared to other countries receiving Global Fund grants (Fund for Peace 2013).

Comparing performance of the three disease grants in fragile states, show reduced performance for all three diseases. Malaria grants perform particularly poorly, TB grants less so. Preliminary analysis of health service coverage rates also tend to worsen with increasing fragility as indicated by the various FSI categories.

It is important to emphasize that all health interventions for all partners in countries considered fragile or conflict-affected face extraordinary challenges, in particular the lack of capacity or willingness of governments to respond to the basic needs of their populations. The Global Fund trend for core diseases (see 1.1.6), revealing a coverage gap between 'fragile' and 'non-fragile' states is representative of trends of other health indicators by intervening organizations. For example, in 2014, the World Health Organization assessed global vaccination coverage for the proportion of the world's children who receive recommended vaccines. The WHO points out that despite improvements in global vaccine coverage, particular efforts are needed to reach populations in fragile states and conflict-afflicted countries and regions (World Health Organization 2014).

One of the Global Fund's strategies to improve impact in fragile states has been to use Principal Recipients (PRs) from outside the government. Multilateral organisations, primarily UNDP, regularly function as PRs in fragile states compared to other recipient countries. Analysis indicates that PR performance for multilaterals is substantially better than that of government and civil society/private sector organisations, with multilateral agencies showing grant performance ratings in the most fragile states comparable to other recipient countries.

Donor evaluations have indicated consistently lower or below average results for their programmes. A World Bank evaluation recorded consistently lower results of country assistance programmes in Fragile and Conflict-Affected States or Situations (FCAS) as measured by its CPIA (World Bank 2013). Also, the Africa Development Bank's (AfDB) review of the decade 1999 to 2010 found that their projects in fragile states showed below-average performance (AfDB 2012). However there are indications showing this might be changing. An independent evaluation of World Bank operations in fragile states indicate that some individual projects (all sectors) perform better, partly explained by the Bank's increased investment in administrative budgets² and international staff in fragile states (World Bank 2014). Some of the new management arrangements introduced by the Global Fund (e.g. NFM, wide choice of partners, ability to attract technical assistant, funding capacity building of partners and investing in M&E, enhanced risk management, etc.) provide more flexibility to face challenges in fragile contexts. However constraints associated with the Global Fund model exist and include the limited contextual analysis and ability to monitor for results in areas affected by conflict, the lack of country-based staff and limited travel of staff in conflict-affected countries, the heavy requirements

¹ The analysis uses grant disbursement ratings, which are not fully objective measures as the composition of ratings has changed with time and scores will depend in part on how challenging the grant targets were. However, it gives an initial indication that there is a need to consider the performance of fragile states further.

² In real terms, preparation and supervision expenditures per project have increased since fiscal year 2007 in fragile and conflict affected states. Projects in these countries have received 9 percent more on average in real terms for project preparation and 19 percent more for supervision than projects in International Development Association countries that were never fragile and conflict affected states (World Bank 2014).

for CCMs and liability to particular interests within CCMs, and the limited adaptability of existing grants to changing circumstances.

While the review's data analysis shows a clear correlation between grant performance and country fragility, this does not provide comprehensive explanation as to the reasons for the poorer performance in more fragile countries. Other factors need to be considered as well to understand grant performance. First, grant performance correlates with successful completion of second year evaluation. This determines whether a grant will continue to receive funding from the Global Fund and the conditions for continued funding. Second, reduction or termination of funding due to country failure to address Global Fund recommendations and/or poor performance in relation to the targets set. Third, grant performance increases with time. In other words, sustained continuity remains crucial for successful grant performance, which may partially explain why Global Fund grant performance has been shown to be less successful in countries with political instability (Katz et al 2010). Moreover, a recent survey found, inter alia, that the current Global Fund rating system might not reflect performance (Wafula et al 2014). To remedy this, the study recommends finding performance assessment methods that are not limited to measuring numbers. At the very outset, this includes looking at the ability of countries to set their own context relevant targets, including the choice of indicators. Yet, the very factors that lead to a state being classified as fragile may be the same factors that impede grant performance, e.g., weak governance and institutions, on-going lack of genuine political settlement, access problems due to conflict and insecurity and so on. While the Global Fund, within the realm of specific disease programmes, cannot influence the causes of fragility, it may be possible to identify and address issues that can be overcome through flexible and tailored responses.

1.1.2 Methodology for Identifying Countries Needing Special Measures

Following an analysis of the different definitions and indices of fragile states in use, the review proposes a new terminology that is less politically-driven and more operationally useful to the Global Fund: **Challenging Operating Environments** (COEs). COEs embrace countries that have poorer grant performance, present greater operational challenges and risks and warrant more flexible measures.

The term COEs may be considered for countries as a whole, but can also be used for unstable parts or regions of countries, or for countries with less fragility that present a deteriorating operating environment.

To identify a group of countries that are *Challenging Operating Environments*, the review proposes that countries are taken from the first two sub-groups of the Fragile States Index i.e. the 'Very High Alert' and 'High Alert' countries. As of August 2013 these two categories included 16 countries. Three additional countries are suggested that represent countries "in" or "coming out of" acute instability. With discretion, the Grant Management Division could also include an FSI 'Alert' country if it had become particularly challenging to work in. Together these 19 countries are COEs. In line with other agency approaches e.g. GAVI, the country identification process should be reviewed and updated on an annual basis.

The review suggests that these 19 COEs can be sub-categorised to help tailor responses more appropriately to different country contexts and capacity levels.

Countries selected as Challenging Operating Environments (COE) by group	
1. Chronic instability with weak systems	Afghanistan, Central African Republic, Chad, Democratic Republic of the Congo, Guinea, Guinea Bissau, Haiti, Somalia, South Sudan
2. Chronic instability with stronger systems	Côte d'Ivoire, Iraq, Nigeria, Pakistan, Sudan, Yemen, Zimbabwe
3. Acute instability	Egypt, Mali, Syria

Each COE demonstrates two or more of the following characteristics

- Weak governance (typically including state failure, weak institutions, low capacity, low will and high corruption, violations and uneven protection of human rights)
- Poor access to health services and weak health systems
- Higher than average portfolio burden of disease

- Complex emergency³ (conflict)
- Humanitarian crisis⁴ (acute or chronic)

1.1.3 Current Challenges and Risks of Working in Challenging Operating Environments

The review was asked to identify key challenges and risks experienced by the Global Fund when operating in COEs. Whilst the challenges vary between countries, they can be summarised as:

Governance and oversight

Donors and local stakeholders: Non-alignment of interests for the three diseases

Local Fund Agents (LFAs): Their ability to function is affected by security constraints (with limited access for field verification and unreliable data to verify) and limited national capacity (physical presence but also availability of expertise at the national level e.g. programmatic, public health and procurement).

Country Coordinating Mechanisms (CCMs): Weak governance including corruption, inadequate programmatic oversight, poor ability to demonstrate transparent and democratic selection of PRs, conflicts of interest and dominance by government representatives are commonly reported problems.

Principal Recipients (PRs): Weak technical, managerial and organisational capacity to implement programmes effectively (domestic, multilateral and international NGOs have all experienced capacity issues, to some degree, in fragile states).

Sub-Recipients (SRs): Grant portfolios with large numbers of sub-recipients have added to the complexity of implementation with many SRs having struggled to meet capacity standards.

Financial management and fiduciary controls

Financial management and fiduciary controls are often an issue in COEs, given the weak governance and accountability capacity that characterises these states and the disruption to normal systems when there is a crisis. Financial Management (FM) systems have not demonstrated short to medium-term capacity to plan, spend, and justify grant funds.

Access to health care and health systems

Health systems: Chronically underfunded with ineffective governance, dilapidated and poorly functioning health service infrastructure, limited human resources.

Ministries of Health (MOHs): Weak in many COEs, and may lack the will and capacity to take up a proper stewardship role. In post-conflict countries, good intentions to strengthen governance and health systems may be restricted by limited human resource capacities and the challenges of coordinating many stakeholders, including multiple donors, in the health sector.

Access to health care: Often poor, and equity and human rights not sufficiently mainstreamed. The needs of refugees and internally displaced people (IDPs) are not usually planned for within grants.

Procurement and Supply Management (PSM): Inefficient systems lead to delays, interruptions and stock outs.

Monitoring and Evaluation: M&E systems are usually weak presenting difficulties in establishing baselines, projecting coverage targets and reporting results. Where there is instability or conflict, reduced access to parts of the country reduces programme coverage and the ability to monitor activities.

Coordination: The fact that multiple agencies respond simultaneously may affect efficient monitoring of activities more than the mere ability to report into health management information system (HMIS). Coordination among numerous intervening organizations remains a key challenge.

³ **Complex emergency:** “A humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single agency and/or the ongoing United Nations country programme” (OCHA 1999).

⁴ **Humanitarian crisis:** “An event or series of events which represents a critical threat to the health, safety, security or wellbeing of a community or other large group of people, usually over a wide area. Armed conflicts, epidemics, famine, natural disasters and other major emergencies may all involve or lead to a humanitarian crisis that extends beyond the mandate or capacity of any single agency. Humanitarian crises can be grouped under the following headings: 1. Natural Disasters (earthquakes, floods, storms and volcanic eruptions), 2. Man-made Disasters (conflicts, plane and train crashes, fires and industrial accidents) and 3. Complex Emergencies (when the effects of a series of events or factors prevent a community from accessing their basic needs, such as water, food, shelter, security or health care)” (Humanitarian Coalition 2014).

Partnerships

The case studies demonstrated how capacity constraints, conflict, political upheaval and weak governance limit the Global Fund's engagement with partners and choice of PRs. Increased Secretariat resources available for High Impact Countries have however enabled stronger communication and relationship building with partners at national level.

The Global Fund funding mechanisms

Current challenges for the New Funding Model in COEs primarily include how to identify and address such contextual challenges and subsequently how to design flexible programmes and operational arrangements. Those challenging operating environments with exceptionally poor data and outdated national strategic plans present critical challenges for the Global Fund, when collecting key material as the basis of funding allocations, concept notes and performance measures. Some of these countries have few partners to support the New Funding Model process, in combination with a poorly functioning Country Coordinating Mechanism and limited administrative staff capacity to support this process. In countries, with acute emergency situations that are evolving rapidly, such as Syria, the New Funding Model is not viable and such situations are likely to need a different response.

Aid effectiveness

The idea of *aid effectiveness* concerns how to effectively turn development aid into tangible results in terms of economic and human development through the concept of improving results through adherence to a set of Aid Effectiveness principles emphasising country ownership, use of country systems, etc. The Global Fund has prioritised country ownership and supports the Organization of Economic Cooperation and Development (OECD) engagement principles in fragile states. The OECD supports state building as the *"purposeful action to develop the capacity, institutions and legitimacy of the state in relation to an effective political process for negotiating the mutual demands between state and societal groups"* (OECD 2008). This requires a combination of local domestic action and responsive international assistance. Such state building exemplifies a positive outcome of effective aid, certainly also in fragile and conflict afflicted states. However, the Global Fund has not carried out a formal examination of the effect of its programmes on state building processes. Yet, the review suggests both positive and negative effects on state building and varying levels of adherence to the Paris Declaration Principles. Concerning country ownership, using country systems is a core principle of aid effectiveness as well as the New Deal. There is consensus among OECD donors and country governments that use of country systems should be nuanced to take into consideration country contexts. In tailoring responses, the use of country systems is not an *'all or nothing approach'* but can be increased gradually in coordination with partner countries. Sequential planning is required in fragile states – this can allow for greater use of country systems even while substituting for these systems in the short term in order to comply with GF requirements and standards (a 'dual' track approach).

Support for emergencies

The Global Fund has limited experience of participating in global humanitarian forums or in-country Humanitarian Cluster coordination mechanisms. The Global Fund model was not set up to respond to acute emergency situations with cross border migration (such as Syria and the refugee influx in Jordan, Iraq, Turkey and Lebanon – yet it has some key partners in, for example, ICRC and UNDP).

1.1.4 Current Approaches Implemented by the Global Fund in COEs

In addition to identifying the challenges, this review analysed existing Global Fund approaches, selected examples of which are detailed below.

Governance and oversight

Short Term Technical Assistance (TA) to CCMs: This has produced revised guidelines for CCM eligibility that allows CCMs to identify their own challenges and define actions how to improve. Some countries have adapted the CCM to better fit the country context e.g. Myanmar, where the CCM has and expanded, health sector coordination role.

Longer Term 'embedded' TA to CCMs: the Global Fund collaborates with USAID. The Global Fund also works in close collaboration with partners to support CCM Eligibility and Performance Assessments and to improve Governance and Oversight.

Technical assistance to Principal Recipients (PRs): this strengthens *management* and oversight capacity and mechanisms. Initiatives include changing the PR and streamlining of *Sub Recipients (SR)* including changing the nature and number of SR contracts (to be more service and performance-oriented e.g. Chad).

Procurement and Supply Management (PSM): Due to the inability of local PRs to adhere to the Global Fund quality assurance policy and ensuring value for money while maintaining consistent availability of health products of the right quality, Global Fund initiatives include the use of procurement agents and/or its pooled procurement mechanisms.

Operational risk management: this has become more nuanced and has improved within the Secretariat. The Qualitative Risk Assessment, Action Planning and Tracking Tool (QUART) analysis is a useful tool, giving a clear picture of the levels of risk as well as a systematic approach to plan actions. It has been helpful in broadening the focus of risk to include fiduciary, programmatic, governance and health service risk. Two particularly valuable operational risk outputs of a comprehensive grant and country risk assessment are the *heat map* and the *implementation mapping* to visualize the risk within the portfolio. Yet, risk management is also an issue of investing more staff time in COEs, which is not fully captured by high impact teams.

Facilitated Eligibility, Performance Assessment, Minimum Standards and Short term TA to support Oversight and Governance process.

Financial management and fiduciary controls

In particular cases, the Global Fund apply the Additional Safeguard Policy (ASP) to impose strict risk mitigation measures and reduce risk. This primarily included the introduction of Fiscal or Fiduciary Agents (FAs) in some ASP countries, particularly COEs, to verify expenditures, a zero cash policy to Sub-Recipients, advice on accounting systems and build PR capacity. This has been a useful tool for managing high-risk settings and allowing grants to progress, reducing risk of fraud and improving financial reporting.

Access and health systems

The current investment strategy and NFM are providing opportunities to advocate for human rights and equity and to develop innovative partnerships to improve access to services by Key Affected Populations (KAPs) – *formerly termed Most-At-Risk-Populations (MARPs)* – across the three diseases. Although COEs have been slow to respond to potential opportunities of health system strengthening grants, there are examples of grants enhancing the quality and integration of health services.

The Global Fund grants have included measures to enhance the reliability of supplies, such as establishing separate supply chains for HIV and AIDS, TB or malaria products and using procurement agents or pooled procurement mechanisms. The use of the Global Fund Pooled Procurement Mechanism (PPM) has been helpful in ensuring reliable supplies of quality drugs and to more effectively meet procurement challenges. Actions have been taken to ensure that:

- Future cases of stock outs are limited
- Procurement and supply management functions are strengthened
- Disruptions to essential services in challenging operating environments are minimized

The Global Fund is investing in M&E frameworks and systems. These frameworks include the *Health Management Information Systems (HMIS)* in challenging operating environments, supported by Global Fund grants, including the *Special Initiative* fund. Country examples of this include Zimbabwe, the Democratic Republic of Congo, Myanmar and Nigeria. The roll out of national monitoring and evaluation software is being supported in DRC.

Global Fund funding mechanisms

The NFM provides a good opportunity and basis for assessing the COE context in more depth and adapting grants to suit the conditions. During implementation there is scope to adjust grants to take account of progress on programme outcomes and impact, assessed annually. This seems appropriate and helpful for COEs with a more stable and predictable context.

Support for emergencies

Global Fund financed stocks of key commodities are often available in-country when a crisis hits, but there has been resistance to re-allocating stocks in response to an acute crisis. However there have been some examples of more flexibility in emergencies – reprogramming to better meet needs (post crisis in Côte d'Ivoire; post flooding in Pakistan) and emergency procurement of Antiretrovirals (ARVs) to avert stock outs during the crisis in Côte d'Ivoire.

1.1.5 Partner Approaches and Lessons Learned from Operating in Fragile States

The international community has increased its focus on fragile states, justifying this interest on both development and security grounds. This recognition required a *tailored* approach to make aid *effective* in these situations, as emphasized in this review. The OECD has helped steer the development of aid effectiveness policies and promote principles for better engagement in fragile states. State building is the current diction that frames donor investment. The 'New Deal' concluded between g7+ countries, development partners and international organisations sets out peace and state building goals as the foundation to achieve Millennium Development Goals (MDGs) and development in these states. In particular, the post-2015 agendas for sustainable development stipulate fragile states at the centre of attention, specifically highlighting the need to position health as a cross-cutting issue, including equity and human rights considerations.

The importance of tailoring to context, political-economy assessment, and flexibly designed and implemented country programmes

Multiple recent donor evaluations of investments in fragile states (World Bank 2013, ADB 2012, AfDB 2012, and DFID 2012) and OECD policy guidance (2011a) all emphasise the importance of doing things differently in fragile states in order to achieve greater impact. This review includes lessons learned from the evaluations/guidance and other donor approaches (including USAID and GAVI).

Governance and oversight

Development partners are using aid to try to strengthen strategic state functions essential for poverty reduction and to make progress on essential public reforms. The major institutions recognise the importance of strengthening institutional capacity and governance arrangements. As the central objective for engagement in fragile states, investment in governance continues to be framed around state building.

Financial management and fiduciary controls

Where Government systems are weak, some donors have outsourced financial management to private consultants or accountants, or used fiduciary agents to monitor payments.

Contracting programme management remains a common approach in COEs, including third party financial/fund management, typically an NGO, a UN agency or a private contractor. Pooled funds or Multi Donor Trust Funds (MDTFs) are used to support service delivery in some of the most fragile states, allowing for shared financial and risk management and shared fiduciary controls (as well as shared implementation and reporting mechanisms).

Access and health systems

In the fragile states with substantial donor support and multiple donors, a common approach to providing international assistance has included coordinated support for country-wide delivery of an Essential Package of Health Services (EPHS) e.g. in South Sudan, Liberia, Somalia. Donors also often adopt measures to strengthen stewardship functions of the public sector alongside support for service delivery. In certain contexts, it may not make sense for the Global Fund to bring in additional agencies to act as PRs to deliver separate disease programmes, and a more integrated and complementary delivery mechanism would be more cost-efficient and effective.

Supply and demand-side processes need to work together for quick gains in access. Gap-filling in commodity supply is a feature of many DFID and USAID-supported programmes (and increasingly GAVI in fragile states). On the other hand, underinvestment by even the key global players characterizes the situation in challenging operating environments. Here, supply chain networks are often not prioritized.

Programme implementation and performance

Results-Based Funding (RBF) approaches are being tested under the Health Results Innovation Trust Fund (HRITF) managed by the World Bank. Early results, including from some COEs (Nigeria, Afghanistan, and DRC) suggest that the approach can help to improve efficiency in service delivery, equity and accountability. The Global Fund already provides performance-based funding at the level of grants and some performance based incentives for PRs linked to grant ratings. There could be scope for performance-based payments to providers or users of services, drawing on lessons from the HRITF, although this would be less suitable in COEs with basic monitoring challenges.

Staff and ways of working

Many donors (including SIDA, DFID, GIZ⁵ and the World Bank) are reforming and investing more in their Human Resources (HR) to focus on fragile states. The changes include: additional resources for and recruitment of staff dedicated to working on fragile states; reviews of staff requirements, composition and competency frameworks; security and language training; financial and career incentives; increased travel budgets, pre-identified staff able to be deployed quickly for short term visits, and security training – training on health programming in fragile states. The GAVI Alliance, which, like the Global Fund has no country presence, has scaled-up its Secretariat staff in order to deal with the extra demands of implementing its new policy on tailored approaches.

Support for emergency situations

Many donors (DFID, USAID, and EC) have a separate humanitarian arm. Within the Humanitarian Cluster Approach, WHO leads the Global Health Cluster and is typically the cluster lead for health in coordinating the response with MOHs and international agencies in specific countries experiencing crises. If the Global Fund were to play a more proactive role in providing support to (acute) crisis areas in countries where they have on-going programmes, engaging in the Health Cluster would facilitate coordination, identification of needs and priorities.

1.1.6 Correlation between State Fragility and Health Service Coverage

A different approach of looking at fragile states and Global Fund relevant health service data (which does not rely on the Global Fund's own performance rating scores) is shown in the table below. For each of the three diseases, the average coverage of one relevant global indicator in WHO's World Health Statistics report 2013 for each disease area has been determined, for various subcategories of the FSI list.

Health service coverage by degree of state fragility					
FSI	ART Coverage	FSI	TB detection rate	FSI	Child <5 under bed net
FSI 1 (14)	30%	FSI 1 (16)	54%	FSI 1 (10)	14%
FSI 2 (16)	40%	FSI 2 (19)	60%	FSI 2 (11)	31%
FSI 3 (27)	48%	FSI 3 (30)	63%	FSI 3 (16)	32%
FSI 4 (39)	56%	FSI 4 (46)	78%	FSI 4 (7)	22%

FSI columns indicate FSI category and number of countries with available data in the World Health Statistics report 2013

FSI categories: FSI 1=very high and high alert (16); FSI 2=alert (19); FSI 3=Very high warning (35); FSI 4=others (47)

Source: (Fund for Peace 2013)

These aggregate data show clear correlation between state fragility and health service coverage, most clear-cut for Antiretroviral Treatment (ART) and TB detection. Some care is needed when looking at these data, since within each category there is a lot of variation with both high and very low coverage. Also, these are averages based on country indicators, so population size is not taken into account. Nevertheless, figures do show that needs are higher in the more fragile countries.

1.1.7 State Building and Aid Effectiveness

The Global Fund has not carried out a formal examination of the effect of its programmes on state building processes. With its emphasis on delivering results for coverage of the three diseases, a focus on state building may seem remote from Global Fund priorities, but when state building is understood (as per the OECD emphasis on this principle) to include *poverty reduction, addressing human rights, civil society engagement, mobilising revenue, and supporting an enabling environment for service delivery*, then Global Fund grants can have a substantial impact in these domains. The Global Fund has al-

⁵ GTZ was renamed GIZ in 2012

ways prioritised country ownership and supports, to some extent, some of the OECD engagement principles in fragile states, e.g.

- Working in many countries that are ‘aid orphans’ – i.e. the Global Fund has supported and invested more in specific COEs like CAR and Sudan than other donors and bilateral organizations
- Committing to the longer term with reasonably predictable funding (even if not ‘fast acting’)
- Promoting non-discrimination
- Agreeing on practical coordination mechanisms (e.g. in Myanmar).

The case studies suggest both positive and negative effects on state building and varying levels of adherence to the Paris Declaration Principles. A number of observations made from the case studies and broader Global Fund documentation are included in the review.

1.2 Recommended Approach for the Global Fund Operating in COEs

1.2.1 A country-by-country approach to operating in COEs with chronic instability

This review recommends the Global Fund to adopt a flexible, country-by-country approach to operating in COEs. This follows international consensus (OECD/INCAF) and partner experience (World Bank, ADB, AfDB, USAID, GAVI, DFID) on the importance of developing context-specific responses in fragile states and undertaking assessments, regular reviews and learning from implementation strategies.

Overview of proposed approach for dealing with COEs with chronic fragility

An essential first step would be a **country-specific assessment** that goes beyond disease and programme issues to consider the wider political economy including fragility-relates issues, social context, and operating conditions. The assessment **would be in addition to reviews** envisaged in the Grant Management Assurance Framework and would help mitigate against politically-driven or self-interested allocation and implementer selection, and the exclusion of KAPs where there could be high impact. The assessment **will feed into country dialogue** processes and help inform decisions regarding resource allocation, the selection of implementing agencies and the selection of strategies and risk management options appropriate to that setting.

The aim is **not to have a lengthy assessment** just for the Global Fund. In line with international guidance and practice, it is strongly advised that the Global Fund links with donors and country partners to access existing **political economy assessments, joint Risk Assessments, joint Fragility Assessments, Public Financial Management (PFM) assessments** (e.g. those being carried out in New Deal countries, between INCAF members, relevant country assessments undertaken by Risk Management Offices (RMOs) where appropriate) and/or commission an assessment with other donors, or a component of an assessment (e.g. look at more Global Fund specific issues such as the political economy of the representation and effectiveness of CCMs).

1.2.2 A country-by-country approach to operating in countries with acute emergencies

A country-by-country approach to operating in countries experiencing acute instability is also recommended and is in line with other partners’ approaches such as GAVI and humanitarian partners. However, the country-specific assessment, as outlined for chronically unstable countries would not be applied for acute crises. Instead, it is recommended that the Global Fund links with Humanitarian Cluster mechanisms to benefit from any acute health assessments that are being carried out by emergency agencies. Via the Global Health Cluster, the Global Fund could collaborate around a common agenda and usefully input commodities and diagnostics during the acute phase, and support health systems development post-emergency (see [Appendix 1](#)).

1.3 Options and Recommendations for Operating in COEs

This review proposes a series of innovative options for each level of Global Fund grant design and implementation. Innovative options are presented for: CCMs; PRs and SRs; LFAs and FAs; Health System Delivery and Performance-based Funding; promoting strategic partnerships; and for impacting on human rights, equity and coverage.

The options put forward by this review include current practices and also new measures that could be explored and adopted in different settings. The options are not a ‘shopping list’. They have been assessed against the current Global Fund five year strategy, the Global Fund founding principles, the OECD

principles of engagement in fragile states, and the Busan Partnership for Effective Development Co-operation/Paris Declaration on Aid Effectiveness. Moreover, the options are grounded in analysis and lessons learned from international and partners' experiences of operating in fragile states.

It is important to recall that working in fragile states is, in its nature, unpredictable and difficult. International experience has demonstrated that there is no magic bullet or universal solution that can be rolled out and expected to work the same way in each fragile state. Testing and adapting multiple existing and new approaches that deviate from past practices is necessary.

Summaries of strategic options with preferred option recommendations

[Appendix 2: CCMs](#)

[Appendix 3: PRs and SRs](#)

[Appendix 4: LFA and FA; Human Rights, Equity and Coverage](#)

[Appendix 5: HSS and Maximising Synergies](#)

[Appendix 6: Strategic Partnership and Performance Based Funding](#)

[Appendix 7: Emergencies](#)

1.3.1 Global Fund Additional Funding Considerations for COEs

COEs face additional costs of more extensive country assessments, risk mitigation, technical assistance, surveys and verification of use of funds, quality of services provided and performance. The review suggests how the Global Fund can allocate additional funding for COEs within the grant allocation formula to partially compensate for these costs. This is a follow-up to the Global Fund March 2014 pilot initiatives, in which risk factor elements were applied and decided for fragile states as part of country allocation to cover for increased costs. The review also suggests reserving a modest amount for commodities in emergencies.

1.3.2 Secretariat Role and Resourcing

In line with other donor strategies to invest in staff working with fragile states, the review proposes synergistic recommendations that concern Secretariat staff being selected/recruited for these contexts, trained in security management and better enabled to conduct missions in COEs. More focused resources will give staff greater opportunities to travel, understand the context, develop faster solutions to implementation problems and monitor tailored approaches. Creation of a special function within the Policy Hub specialised on fragile states should be considered, which will monitor and update fragile states list on an annual basis, provide guidance to Country Teams managing grant portfolios in COEs, document best practices and share learning experiences, monitor and report key risks, build partnerships at global level and facilitate partnerships at country-level.

1.4 Summary of Key Recommendations for the Global Fund

Over the last few years, the Global Fund has introduced a risk management framework, differentiated management processes for specific situations, and is evolving its funding model which is designed to enable more flexible, focussed investments to achieve impact. Many of these changes will benefit the countries highlighted in this review. However, to date, there has not been a *specific differentiated policy* for working in COEs. Approaches have developed on a more ad-hoc basis, often dependent on the pro-activeness of individuals and country teams within the Secretariat and at country level (Global Fund Framing Document, 2013). A more systematic and flexible approach is now needed to ensure new processes and systems can be operationalized in COEs and tailor-made responses can improve the effectiveness of Global Fund financing in COEs. The review makes the following recommendations:

1. The Global Fund should identify a group of countries and possibly regions that merit special attention and a special approach due to the difficult working environment. The review provides the criteria and initial selection of such countries, suggestively termed *Challenging Operating Environments (COEs)*. The objective is to improve the impact and sustainability of Global Fund support in these countries.
2. In line with international practice and the approaches of other agencies to fragile states, there should not be a standardised approach applied to all grants in these settings. The Global Fund should adopt a country-by-country approach. This requires understanding the fragility-related,

political, economic, social and governance contexts of each COE, designing and implementing tailored responses which are frequently monitored, adapted and developed further.

It is recommended that the Global Fund should focus on the most complex and challenging settings to enhance programme delivery and achieve results. Accordingly, the recommended approach for the identification of COEs should be based on the Failed States Index Very High and High Alert categories, and additional countries and regions facing particularly difficult situations or acute emergencies. At the time of writing this report, 19 countries were identified as COEs.

3. The Global Fund should build on the strengths of its current approach and the New Funding Model, which include considerable flexibility to tailor support and management arrangements to the country context. It should allow further flexibility and tailoring of the engagements in COEs.
4. The country teams working in COEs should select the most appropriate approach for each country and grant, depending on the assessment of context and partnerships in that environment. In line with the experience of other agencies, including GAVI, arrangements will need to be developed in conjunction with country partners. The options will need to be explored further, tested, adapted and developed.
5. Following on-going reforms within other donor agencies including GAVI, and the additional costs of tailoring approaches, it is recommended that the Global Fund invests in staff working on COEs and undertakes measures to improve security and access to those countries. This would include (among others) prioritising country teams for *all* COEs in a similar way to the prioritisation of staff in High Impact Countries; having an enhanced security management framework in place; tailoring recruitment and skills for staff to work on COEs; providing specialist security training and in-country back up to reassure staff when travelling.
6. Working in COEs is in its nature unpredictable and difficult and there are no universal simple solutions. As other agencies have found, working in fragile states is a process that needs continual adaption to changing contexts. It is recommended that the Global Fund systematically learn from its own experience and from others of what works well and less well in order to improve its practice in these contexts and communicate lessons learnt and experiences with Country Teams managing portfolios in COEs and other relevant stakeholders.
7. Improve Monitoring and Evaluation guidance on target setting in COE countries, including how to measure performance and how to include capacity strengthening and state building measures.
8. For acute emergencies it is recommended that the Global Fund should consider involvement in acute emergencies on a case by case basis in support of humanitarian relief agencies. The Global Fund should assess each emergency and decide a) whether or not to get involved b) whether to provide access to commodities in areas affected by emergency and/or c) whether grants need to be adapted because they are disrupted by the emergency. Some additional budget for emergencies would facilitate this approach.

The international community emphasises the importance of state building in fragile states; accordingly, the Global Fund could apply a stronger state-building lens when considering the impact of its grants. The first step would be to commission research and formulate a policy outlining how grants in COEs can potentially contribute to aspects of state building. This could be supported by state building/institutional capacity building indicators in its QUART tool, Concept Notes, and grant agreements.

2. Introduction

The Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) invests significantly in almost all countries that are identified as ‘fragile’ based on various state fragility/stability indices. The Global Fund is the third largest of the multilateral development funding sources to 47 countries categorised as fragile, totally US\$ 1.4 billion in 2010⁶ (OECD 2013).

The Global Fund uses different approaches within countries and grants to address the challenges of working in fragile states but is faced with the reality common to all donors that it is much harder to achieve impact in countries affected by conflict, insecurity and very weak governance.

2.1 Defining fragility

Various terms have been used to label a group of countries that are considered ‘fragile’ including: ‘failed states’; ‘low-income countries under stress’; and ‘difficult partnerships’. While still not very satisfactory, the international community tends to use the terms ‘fragile states’ or ‘fragile and conflict-affected states or situations (FCAS)’.

While definitions vary, most consider poor governance, insecurity, poverty and weak institutional capacity as core elements of fragility, resulting in a lack of inclusive, pro-poor policies and poor service delivery. In these situations, elites may dominate politics and control resources, show little interest in equity or the rights of minorities and may actively suppress some groups. Armed conflict can be the cause or the result of state fragility.

Box 1: The OECD (2013) definition of Fragile States

“A fragile region or state has weak capacity to carry out basic governance functions, and lacks the ability to develop mutually constructive relations with society. Fragile states are also more vulnerable to internal or external shocks such as economic crises or natural disasters. More resilient states exhibit the capacity and legitimacy of governing a population and its territory. They can manage and adapt to changing social needs and expectations, shifts in elite and other political agreements, and growing institutional complexity. Fragility and resilience should be seen as shifting points along a spectrum.”

Emphasis varies between agencies. The Asian Development Bank (ADB) identifies fragile or conflict-affected countries as “those of its developing member countries with weak governance, ineffective public administration and rule of law, and civil unrest” (ADB 2012). The World Bank identifies ‘fragile situations’ by weak performance on the Bank’s own Country Policy and Institutional Assessment (CPIA) or the presence of a UN or peace-keeping mission (World Bank 2013). DFID defines FCAS as not being able to meet the needs of their populations because they lack will and capacity. In not meeting these needs, governments fail to gain legitimacy. FCAS countries are examined through a political economy lens to understand the vested interests that maintain conflict, the large flows of money that by-pass the central state and the potential drivers of change that could affect the status quo. USAID distinguishes between fragile states that are vulnerable from those that are already in crisis, with vulnerable referring to those states that are unable or unwilling to assure the provision of security and basic services, and where the legitimacy of the government is in question. *Crisis* is used in countries usually in conflict, where the government does not exert control over its own territory or provide services and where legitimacy is very weak (USAID 2005). USAID have developed fragility indicators around political, security, economic and social domains that help to establish a confidential *instability* list. The measure of fragility recognises the relationship between state and society and the extent to which outcomes are legitimate and effective.

It should be recognised that countries can be more or less fragile, and in different ways, and that sub-national areas can be fragile despite being in stable countries. The lists of states defined as fragile varies depending on the definitions and criteria used. The 2013 OECD list, for example, combines the harmonised World Bank, African and Asian Development Banks’ list for 2012 and the Failed States Index (FSI) for 2011 to come up with a list of 47 countries. The list excludes fragile areas within stable states.

⁶ Define EU institutions as multilateral

The OECD notes the changing composition of fragile countries and their link to poverty. Over the last decade an increased proportion of fragile states in OECD's list are classified as middle-income countries (18 lower middle-income and 3 upper middle-income), in part because some formerly low-income states have reached middle-income status (OECD 2013). The fragile states include an increasing proportion of the world's poor people (estimated at 40% in 2010, up from 20% in 2005) with 50% of the world's poor expected to be found in fragile states by 2015 (OECD 2013).

2.2 Approaches to countries experiencing fragility

Despite progress made in many countries towards meeting the Millennium Development Goals (MDGs), progress in fragile states is lagging (OECD 2013). Fragile states have increasingly become the focus for strengthened engagement by different donor agencies. The quality of aid in these states has been markedly poorer (OECD 2011) and donors have searched for ideas and programming tools that bring better results. Section 8 discusses approaches and experience of agencies and service delivery organisations in more detail.

While there is no blueprint approach to working in fragile states, there is convergence on a number of issues and principles for operating in fragile states including recognition that the unique character of every situation of fragility requires a tailored response to the country context. *State building* has become a central theme. This is summed up by a recent statement of the g7+ countries (a group that define themselves as fragile states)⁷ *"The goal is to stop conflict, build nations and eradicate poverty through innovative development strategies, harmonized to the country context, aligned to the national agenda and led by the State and its People"* (g7+ 2014).

The more recent New Deal for Engagement in Fragile States⁸, which has state building at its heart, builds on the Development Assistance Committee (DAC) Engagement Principles, as well as the Paris Declaration on Aid Effectiveness. It includes fragility assessments to diagnose the causes of fragility and existing mechanisms that can be supported to strengthen capacity. The World Bank outlined how it was making a 'paradigm shift' in approaches to fragile and conflict-affected states in the 2011 World Development Report 2011: Conflict, Security and Development, calling for longer term institutional strengthening approaches.

2.3 Acute crises

Countries experiencing fragility are also at risk of acute crises caused by civil war, political upheaval or natural hazards that may cause national and regional humanitarian emergencies. These may be accompanied by disease outbreaks and the large-scale displacement of people within borders as Internally Displaced Persons (IDPs) or across borders as refugees. Fragile states may have greater difficulty in dealing with humanitarian crises and a major humanitarian crisis may exacerbate fragility. The civil war in Syria is a good example of a previously stable country that has imploded, creating a regional crisis and mass displacement.

2.4 The Global Fund's experience in fragile states

An internal study carried out in 2010 of Global Fund performance in fragile states (Bornemisza et al 2010)⁹ found that 34% of countries with Global Fund grants had experienced a humanitarian crisis in the preceding five years or featured on the 'alerts' groups of the FSI 2009¹⁰. The Global Fund had disbursed US\$ 5 billion in these countries by mid-2010. These countries had scored lower grant performance ratings than their "non-fragile" comparisons (79% compared with 85% in "non-fragile" countries on the latest disbursement). Performance ratings for monitoring and evaluation (M&E) systems

⁷ The 18 members of g7+ are: Haiti, Guinea, Guinea-Bissau, Sierra Leone, Liberia, Cote d'Ivoire, Togo, Chad, Central African Republic, Democratic Republic of the Congo, Afghanistan, Somalia, Comoros, South Sudan, Burundi, Timor-Leste, Papua New Guinea and Solomon Islands (g7+ 2014).

⁸ The New Deal is an agreement between the g7+ countries, development partners and international organisations, including the United Kingdom, the United States, several EU member states, the African Development Bank, the African Development Bank, the Asian Development Bank, the European Union, the IMF, the World Bank and the United Nations.

⁹ Countries included in the Bornemisza study: the 28 countries that have experienced humanitarian crises in the last five years, as documented by ReliefWeb in April 2010. These crises included, for example, national or regional conflicts or natural disasters such as earthquakes and floods. These 28 countries were then supplemented with the 13 additional countries which feature as "alerts" on the Failed States Index 2009 compiled by the Fund for Peace (Bornemisza et al 2010).

¹⁰ And that only 4 countries with humanitarian crises in the five preceding years did not appear as "alerts" on the FSI.

were considerably lower (47% A or B1 rating among fragile states compared with 67% for “non-fragile” states). The study recommended that in these countries, aid disbursement should be accelerated, grants should be more responsive and opportunistic to changing contexts and crises, and that more should be done to build health system capacity and strengthen health governance (Bornemisza et al 2010).

Since then, the Global Fund is introducing a more flexible and contextual approach to grant making with the New Funding Model (NFM) and has put in place enhanced risk management and differentiated management approaches. The Global Fund also developed a strategy (2012-2016), which supports wider reforms and aims to better target investments to the epidemics. These developments allow better tailoring of approaches to country conditions but have not explicitly made allowances for countries with extreme fragility or crises.¹¹

2.5 Purpose of this thematic review

The Global Fund’s Technical Evaluation Reference Group (TERG) commissioned this thematic review to assess how the Global Fund could engage more effectively in fragile states as part of its work plan for 2013-2014. The aim of this review, as outlined in the framing document (Global Fund 2013 Thematic Review) is to develop recommendations and options on how to improve the effectiveness of Global Fund financing and processes in fragile states in order to increase impact and better manage risk. The Terms of Reference (TOR) for the review can be found in Annex 1.

Euro Health Group (EHG) A/S in collaboration with the Tropical Institute of Amsterdam (KIT) was contracted by the Global Fund to conduct this review. Four consultants carried out the review: Dr Nigel Pearson (Team Leader); Dr Egbert Sondorp (KIT); Veronica Walford and Clare Dickinson (independent consultants). The review was carried out from June to September 2013. The draft report was presented in September, and finalised in March 2014.

This report is structured as follows:

- Section 3: Outlines the **methodology** used for the review
- Section 4: Discusses the key findings from the **data analysis** of Global Fund grant performance and coverage with key interventions in fragile states
- Section 5: Outlines the rationale and **typology** of countries deserving special attention: fragile states and countries fitting the new definition of Challenging Operating Environments, COEs
- Section 6: Analyses **current challenges and risks** for the Global Fund of working in challenging operating environments (COEs)
- Section 7: Looks at the **current approaches** implemented by the Global Fund in COEs and lessons learnt; it highlights country and desk case study findings and discusses Global Fund grant implementation experience
- Section 8: Provides a short overview of **current international thinking and donor approaches** to working in fragile states
- Section 9: Proposes the **Global Fund approach to Challenging Operating Environments**
- Section 10: Presents **options and recommendations** for the Global Fund for operating in COEs.

¹¹ For NFM funding allocation in early 2014, a risk factor was also used in the formula, which led to additional funding for some COEs to cover for the additional costs of required risk mitigation measures such as Fiduciary Agent, etc.

3. Methodology

The methodology for the review included the following:

- **Document review and analysis of specific Global Fund policies and operations:** Extensive documents were provided by the Global Fund Secretariat and other donors, in addition to the team's own document search, review and analysis.
- **Data analysis and typology of fragile states:** analysis of Global Fund grant performance undertaken by Egbert Sondorp and the research team at KIT; a typology was developed for fragility and for crises based on results of the research and the team's interpretation of analysis from the case studies. New terminology is proposed of relevance to the Global Fund.
- **Briefing sessions, focus group discussions & semi structured interviews:** Interviews were conducted with the Global Fund staff during 3 visits to the Secretariat (2-6 June all consultants and CEO of EHG); 17-19 June (one consultant); 24-27 June (3 consultants); 5 July (with Syria CT and CCM); 18-19 July (1 consultant, interviews and participation in thematic reviews workshop). The list of all interviewees can be found at Annex 2.
- **Country case studies** were conducted in Democratic Republic Congo (DRC), Chad and South Sudan during the period 7-24 July jointly with Global Fund Country Team (CT) members. The visit to DRC included Kinshasa and Goma. In Chad, N'djamena and Massakory district. In South Sudan, Juba and Nimule (Eastern Equatoria state).
- **Desk case studies for Global Fund programmes** were undertaken by the consultants for Côte D'Ivoire, Myanmar, Pakistan and Yemen and included a limited number of interviews with country stakeholders. Fund Portfolio Managers (FPM) undertook light case studies for Central African Republic (CAR) and Syria.
- **Participation in July meeting of Organisation of Economic Co-operation and Development (OECD) International Network on Conflict and Fragility (INCAF)** on use of country systems by consultant Clare Dickinson
- **Analysis of findings workshop** held in Oxford 29-30 July with all 4 consultants. Strategic options elaborated.
- **Interviews with fragile states experts** in a range of agencies with relevant experience of working in similar fragile state contexts as the Global Fund including WHO, GAVI and UNHCR, DFID, OECD, USAID, ICRC and PEPFAR.

4. Data analysis on Global Fund grant performance in fragile states

The review commenced with a data analysis to gain a better understanding of Global Fund grant performance in fragile states. The only performance data available across all countries that could be compared systematically was ratings of grant performance. Data looking at other aspects such as the impact on disease targets, and morbidity and mortality from the three diseases is not consistently available across countries, with fragile states producing poorer quality, less reliable data to compare.

The 2010 paper 'Health Aid Governance in Fragile States: The Global Fund Experience', researched and published by Global Fund staff (Bornemisza et al 2010), called for further investigation of the relation between grant performance and fragile states. The 2010 study found that overall, grants were performing well but performance in fragile states was lower than in other recipient states. Grant performance of 41 fragile states was compared to 81 other countries against six different variables. All variables showed a similar finding in that fragile states were doing somewhat less well than other countries. For instance, active grants in fragile states achieved, on average, 83% of their agreed targets for main programme indicators compared to 88% for the other recipient countries.

This review re-examined the previous research on grant performance and updated it for the years 2010 to 2013. This sought to determine the robustness of the relationship between state fragility and grant performance, and whether there was a 'cut off' point, which would help identify a typology of countries experiencing fragility that could be of use to the Global Fund. This data analysis does not provide a complete picture of Global Fund operations in fragile states. A series of case studies (see Annex Volume II and Section 7) provides a descriptive overview of the challenges and solutions to grant performance in nine countries.

Results are shown based on what proves to be the most available, valuable and useful indicator, the Global Fund grants disbursement ratings. The first part of the analysis was based on the same 41 fragile states as in the 2010 study. This original list of 41 states consisted of 28 states that had experienced humanitarian crises in the last five years, prior to 2010, supplemented by 13 countries that appeared as ‘alerts’ on the 2009 Failed States Index (FSI). The FSI is compiled annually by the Fund for Peace and is based on a composite score of 12 indicators¹². With Somalia having the highest score (113.9 in 2013) and Finland the lowest (18), scores above 90 are labelled as ‘alerts’, between 60 and 90 as ‘Warning’, while others are labelled as stable and sustainable. Within the alerts, scores over 110 are very high alerts and scores of 100-110 are called high alerts.

The Global Fund Secretariat regularly assesses grant ratings for each grant, using a rating system of A1 or A2 (exceeded or met expectations), B1 (performed adequately), B2 (potential demonstrated), and C (unacceptable). For the purpose of analysis, these ratings are grouped into good performance (A1, A2, and B1) and poor performance (B2, C). The following table shows performance of active grants in the 41 fragile states¹³ as identified in 2010 compared to other recipient countries, with data from the 2010 Bornemisza study and data from the complete data set 2002-2013.

The grant performance rating has some drawbacks as a measure of performance: the way it is calculated has changed over the period, including increasing emphasis on outcome indicators; it is a composite measure based in part on judgements, and it relies in part on how tough the indicators were that were set at the start of each grant. Comparisons of grant performance rating results over time should be seen in this light, recognising that some of the change in performance may be due to changes in the rating process, and the results seen as indicative of changes in performance.

Table 1: Grant performance in fragile states vs. other recipient countries

	Fragile States - 41 countries*	Other recipient countries¹⁴ - 81 countries
	<i>Good performance grants (%)</i>	<i>Good performance grants (%)</i>
2010 Bornemisza study (active grants)	79%	85%
Active grants as of June 2013	63%	86%
All (active + closed) grants 2002-2013	70%	86%

*based on list in 2010 study

The 2010 study showed that grants in fragile states, on average, were performing less well than in other recipient countries. However, when the same analysis on the same countries is applied to the current portfolio of grants, the percentage of grants in fragile states performing well has dropped from 79% to 63%, with performance in other countries remaining the same. A comparison of performance of all Global Fund grants, both active and closed, between fragile states and other countries shows a gap in performance from 70% and 86%, respectively. A caveat towards avoiding hasty conclusions emphasizes that it remains unclear if this gap relates to fragility, grant performance or timely coincidence with the introduction of a standardized and consistent grant rating methodology.

Earlier studies referred to in the 2010 Bornemisza study showed similar results for fragile states and other countries in the early days of the Global Fund grants. The 2010 study identifies a difference, but of mild proportion and is still quite optimistic about Global Fund operations in less stable states. However, these new data – despite the above reservation – show a worrisome trend with a substantial reduction in good grant performance in fragile states in recent years. Even taking into account the shortcomings of the grant rating as a measure, this finding alone seems to justify special attention to fragile states and examination of special measures that could be taken to reverse this trend of increasing poor performance in fragile states.

¹² The FSI is based on twelve key political, social and economic indicators (which in turn include over 100 sub-indicators). The twelve indicators are: Demographic Pressures, Displacement, Group Grievance, Human Flight, Uneven Economic Development, Poverty/Economic Decline, State Legitimacy, Public Services, Human Rights and Rule of Law, Security Apparatus, Factionalised Elites, and External Intervention.

¹³ The 2010 list of 41 countries included all the 37 ‘alerts’ of the FSI for 2009 plus Mauritania, Rwanda, the Solomon Islands and Togo.

¹⁴ In all tables, ‘Other recipient countries’ are all countries that receive a Global Fund grant, but are not considered ‘fragile’.

To test the hypothesis that the difference in performance between fragile states and other countries could be caused by one of the regions with relatively many fragile states doing badly, irrespective of fragility, compared to other regions, the review looked at the performance between fragile states and other countries in each region (Table 2).

Table 2: Grant performance in fragile states vs. other recipients by region

	Fragile States - 41 countries*		Other recipient countries - 81 countries	
	<i>Good performance grants (%)</i>		<i>Good performance grants (%)</i>	
	Active grants	All grants	Active grants	All grants
Africa region	58%	65%	78%	76%
Asia	65%	76%	91%	94%
Eastern Europe/Central Asia	78%	93%	93%	96%
Middle East / North Africa	71%	72%	79%	82%

* based on list in 2010 study

The results in Table 2 show a similar pattern: grants in fragile states in all regions perform less well compared to other countries in the same region. So, while grants in Africa generally perform less well than in other regions, states labelled 'fragile' within Africa perform substantially less well than other countries in Africa. The decline in the proportion of grants with good performance ratings among active grants in fragile states compared to 'all grants' confirms the downward trend in recent years and seems to be a phenomenon in all regions, except the Middle East and North Africa region.

Grant performance was also analysed by disease, for all currently active grants (Table 3). While all grants for the three diseases, on average, perform less well in fragile states, there are clear differences between the three disease programmes, with malaria grants performing considerably less well and tuberculosis grants much better.


Table 3: Grant performance in fragile states vs. other recipients by type of disease

	Fragile States - 41 countries,	Other recipient countries - 81 countries
	<i>Good performance grants (%)</i>	<i>Good performance grants (%)</i>
HIV and AIDS grants	67%	83%
Malaria grants	45%	81%
Tuberculosis grants	82%	93%

* based on list in 2010 study

The results of the analysis, based on the initial list of 41 fragile states, seem to clearly indicate that there is an issue with grant implementation and that special measures may be warranted. The analysis in the next paragraphs uses the 2013 edition of the FSI (Fund for Peace 2013) with the dual purpose of repeating the initial analysis with an updated list of fragile states and to examine whether the FSI might be a useful tool to identify a group of (fragile) states that warrant special attention for Global Fund. The first 89 (out of 178) countries in the 2013 FSI are shown in Figure 1.

Figure 1: Failed States Index 2013: country ratings classified by alert and warning status

Rank	Score (out of 120)				
Very High Alert					
1.		Somalia	113.9		
2.		Congo (D. R.)	111.9		
3.		Sudan	111.0		
4.		South Sudan	110.6		
High Alert					
5.		Chad	109.0		
6.		Yemen	107.0		
7.		Afghanistan	106.7		
8.		Haiti	105.8		
9.		Central African Republic	105.3		
10.		Zimbabwe	105.2		
11.		Iraq	103.9		
12.		Côte d'Ivoire	103.5		
13.		Pakistan	102.9		
14.		Guinea	101.3		
15.		Guinea Bissau	101.1		
16.		Nigeria	100.7		
Alert					
17.		Kenya	99.6		
18.		Niger	99.0		
19.		Ethiopia	98.9		
20.		Burundi	97.6		
21.		Syria	97.4		
22.		Uganda	96.6		
23.		Liberia	95.1		
24.		North Korea	95.1		
25.		Eritrea	95.0		
26.		Myanmar	94.6		
27.		Cameroon	93.5		
28.		Sri Lanka	92.9		
29.		Bangladesh	92.5		
30.		Nepal	91.8		
31.		Mauritania	91.7		
32.		Timor-Leste	91.5		
33.		Sierra Leone	91.2		
34.		Egypt	90.6		
35.		Burkina Faso	90.2		
Very High Warning					
36.		Congo, Republic	90.0		
37.		Iran	89.7		
38.		Mali	89.3		
39.		Rwanda	89.3		
40.		Malawi	89.2		
41.		Cambodia	88.0		
42.		Togo	87.8		
43.		Angola	87.1		
44.		Uzbekistan	86.9		
45.		Zambia	86.6		
46.		Lebanon	86.3		
47.		Equatorial Guinea	86.1		
48.		Kyrgyz Republic	85.7		
49.		Swaziland	85.6		
50.		Djibouti	85.5		
51.		Solomon Islands	85.2		
52.		Tajikistan	85.2		
53.		Papua New Guinea	84.9		
54.		Libya	84.5		
55.		Georgia	84.2		
56.		Comoros	84.0		
57.		Colombia	83.8		
58.		Laos	83.7		
59.		Mozambique	82.8		
60.		Philippines	82.8		
61.		Madagascar	82.7		
62.		Bhutan	81.8		
63.		Gambia	81.8		
64.		Senegal	81.4		
65.		Tanzania	81.1		
66.		China	80.9		
67.		Bolivia	80.8		
68.		Fiji	80.8		
69.		Israel	80.8		
70.		Guatemala	80.7		
High Warning					
71.		Lesotho	79.4		
72.		Nicaragua	79.2		
73.		Algeria	78.7		
74.		Ecuador	78.6		
75.		Honduras	78.3		
76.		Azerbaijan	78.2		
77.		Indonesia	78.2		
78.		Benin	77.9		
79.		India	77.5		
80.		Russia	77.1		
81.		Belarus	76.7		
82.		Turkmenistan	76.7		
83.		Bosnia	76.5		
84.		Moldova	76.5		
85.		Tunisia	76.5		
86.		Turkey	75.9		
87.		Jordan	75.7		
88.		Maldives	75.4		
89.		Venezuela	75.3		

First, the three ‘alert’ categories were compared to the other countries on the FSI that receive Global Fund grants. Results using the ‘alert’ countries of the FSI as a proxy for fragile states are remarkably similar in terms of grant performance to the earlier analysis using the initial list of fragile states from the 2010 study.

Table 4: Grant performance in FSI ‘Alert’ states vs. other recipients

	Fragile States / FSI ‘Alert’ countries (based on ‘alert status’ 2013 FSI)	Other recipient countries
Number of grants (all) ¹⁵	352 (35 countries)	636 (90 countries)
% of all grants with good performance	67%	86%
Number of grants (active)	146 (35 countries)	271 (78 countries)
% of active grants with good performance	62%	85%

Comparing the 41 fragile states from the initial study in 2010 with the first 41 countries on the 2013 FSI, it shows that Togo, Uzbekistan, Tajikistan, Solomon Islands and Georgia are no longer among the first 41 countries, while Cambodia, Mali, Egypt, Syria, and South Sudan have appeared on the list.

To examine if the FSI could be a useful tool as a first filter for countries where Global Fund grants tend to perform less well, various groups of countries were compared. The two ‘alert’ groups in Table 5 perform remarkably less well than the ‘very high warning’ groups. While there are countries in the ‘alert’ groups that perform well, as well as countries in the ‘very high warning’ group that do not perform well (see analysis later on), the cut off for poor performance is between countries numbered 40 and 45.

Table 5: Grant performance in various 2013 FSI groups

	FSI category		Average for all countries with grants	
	<i>Good performance grants (%)</i>		<i>Good performance grants (%)</i>	
	Active grants	All grants	Active grants	All grants
FSI ‘Very High & High Alert’ (1-16)	62%	65%	77%	79%
FSI ‘Alert’ (17-35)	63%	68%	77%	79%
FSI ‘Very High Warning’ (36-70)	79%	82%	77%	79%
Other FSI countries with Global Fund grant	89%	89%	77%	79%

While overall good performance in the two ‘alert’ fragile states categories is 62%, poor performance may be disproportionately caused by inclusion of smaller grants. Table 6 shows that this assumption is partly true.

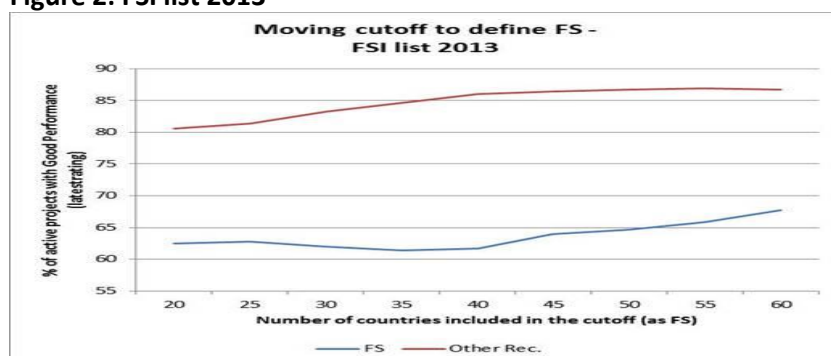
Table 6: Grant performance in FSI ‘Alert’ states and grant size

	Fragile States / FSI ‘Alert’ countries (2013 FSI)	
Grant size in monetary terms	Less than US\$ 10million	Over US\$ 10million
Number of grants (active)	38	107
% of active grants with good performance	53%	66%

Smaller grants, defined here as those with signed budgets of less than US\$ 10million, are indeed more frequently poorly performing than larger size grants. The allocation of small grants may already take the risk of poor performance into account. A similar pattern is found for the ‘Very high warning group’, where the overall good performance rate is 79% for active grants, with 68% for small grants below US\$ 10million and 81% for larger grants.

The top 40 to 45 countries on the FSI 2013 are at risk of poor performance as a group. This does not mean that all countries in this group show poor performance. For instance, Ethiopia, Haiti, Iraq, Mauritania, South Sudan and Zimbabwe do not have a single grant at the moment with a poor performance rating.

¹⁵Excluding grants in Kosovo, Zanzibar, West bank and Gaza, and Multi-country grants, that are not listed on FSI

Figure 2: FSI list 2013

On the other hand, there are several countries outside the FSI 'Alert' group that show signs of poor performance. Table 7 shows countries outside the FSI 'Alert' group with multiple poor performance ratings during 2012.

Table 7: Countries with multiple poor grant ratings in 2012

Not in the top 35 "Alert" countries of the FSI 2013 list

Countries with poor grant ratings - at least two different grants		Countries with poor grant ratings - at least 3 different grants
Angola	Madagascar	Angola
Benin	Mozambique	Benin
Congo	Nicaragua	Congo
Cape Verde	Papua New Guinea	Cape Verde
Djibouti	South Africa	Djibouti
Ecuador	Senegal	Ecuador
Ghana	Swaziland	Ghana
India	Zambia	Lesotho
Lesotho		Madagascar
		Zambia

One of the assumptions of this review is that improvement in performance in fragile states may need more attention from the Secretariat. Initially, it must be kept in mind that performance depends on Global Fund target setting. This target setting is supposed to be in line with national targets and the absorptive capacity of the country and its principal grant recipients, as determined during grant negotiation. This process reveals new challenges, in particular high variation in grants, some with overambitious national targets, others with rather low unambitious targets. Yet, a proxy measure to look at this assumption may be to compare performance in fragile states among the 'high impact countries' with other fragile states. 'High impact countries', including the fragile states amongst them, receive more resources including staff time. As can be seen in Table 8, 'High Impact' fragile states do indeed seem to perform better than those in other regions, with the regions with fragile states in Central and Western African showing poorest performance.

Table 8: Grant performance in fragile states by "Region"

Region (as defined within Global Fund Secretariat)	Active grants
	Fragile States (FSI alert)
	Good performance grants (%)
All High Impact fragile states (Africa 1 + 2 and Asia)	71%
All 'non-high impact' fragile states (Central + Western Africa, Mena, SE Asia, LA)	56%
High Impact Africa (1+2)	66%
Central and Western Africa	45%
Central and Western Africa plus Sub-Saharan countries from MENA (Somalia, South Sudan, CAR, Mauritania)	55%
Central and Western Africa plus all MENA (Middle East & N. Africa)	57%

One of the strategies for mitigating risks in fragile states has been to use Principal Recipients (PRs) from outside government. The following table shows how often this is the case for the fragile states based on the FSI alerts and the relation between type of PR and performance.

Table 9: Type of PR in fragile states and other recipient countries

Type of PR	All grants (2002-2013)		Active grants	
	Fragile states (FSI alerts)	Other recipient countries	Fragile states	Other recipient countries
Civil Society / Private Sector	83 (24%)	191 (28%)	42 (29%)	100 (35%)
Government	178 (50%)	383 (57%)	73 (50%)	144 (50%)
Multilateral Organisations	91 (26%)	100 (15%)	31 (21%)	45 (15%)

Multilateral organisations, primarily UNDP, do more often play a role as PR in fragile states compared to other recipient countries. However, at least in the active grants, there is a reduced role for civil society/private sector (CS/PS) in fragile states, with the role of government as PR remaining the same.

Table 10: Performance of PR in fragile states and other recipient countries

Type of PR	Fragile States (FSI alert)		Other recipient countries	
	Good performance grants (%)		Good performance grants (%)	
	Active grants	All grants	Active grants	All grants
Civil Society / Private Sector	63%	59%	89%	88%
Government	58%	69%	83%	85%
Multilateral Organisations	80%	74%	82%	89%

Grant performance in fragile states is reduced for both CS/PS and Government, with multilateral agencies keeping up performance compared to other recipient countries.

Table 11: Type of PR and performance in most fragile states (top 16 of 2013 FSI)

Type of PR	Active grants	Active grants
	PR in most fragile states	Good performance grants (%)
Civil Society / Private Sector	19 (29%)	58%
Government	24 (37%)	48%
Multilateral Organisations	22 (34%)	86%

In the most fragile states (high and very high alerts) the role of government as PR is further reduced, from being PR for 50% of grants in the larger group of fragile states to 37% in the most fragile states, with increased shares of CS/PS and in particular multilaterals. Compared to Table 9, performance goes down for both Government PRs (from 58% to 48% for the active grants) and CS/PS PRs (from 63% to 58%), while multilateral PRs show improved performance (from 80% to 86%).

A different way of looking at fragile states and Global Fund relevant health service data (which does not rely on the Global Fund's own performance rating scores) is shown in Table 12. For each of the three diseases, the average coverage of one relevant global indicator in WHO's World Health Statistics report 2013 for each disease area has been determined, for various subcategories of the FSI list.

Table 12 Health service coverage by degree of state fragility

FSI	ART Coverage	FSI	TB detection rate	FSI	Child <5 under bed net
FSI 1 (14)	30%	FSI 1 (16)	54%	FSI 1 (10)	14%
FSI 2 (16)	40%	FSI 2 (19)	60%	FSI 2 (11)	31%
FSI 3 (27)	48%	FSI 3 (30)	63%	FSI 3 (16)	32%
FSI 4 (39)	56%	FSI 4 (46)	78%	FSI 4 (7)	22%

FSI columns indicate FSI category and number of countries for which data are available in the World Health Statistics report 2013. *FSI categories:* FSI 1=very high and high alert (16); FSI 2=alert (19); FSI 3=Very high warning (35); FSI 4=others (47)

With these aggregate data a clear correlation between state fragility and health service coverage is shown, most clear-cut for Antiretroviral Treatment (ART) and Tuberculosis (TB) detection. Some care is needed when looking at these data, since within each category there is a lot of variation with both high and very low coverage. Also, these are averages based on country indicators, so population size is not taken into account. Nevertheless, figures do show that needs are higher in the more fragile countries.

The data on grant performance (measured by grant ratings) and coverage indicates that fragility as measured by the FSI is correlated with less good performance at the country level.

Additional analyses on available data have been performed with the similar aim of determining a relationship between grant performance and fragility of states. This included analyses of performance

indicators, absorption capacity and cash balances, as well as some data on On-Site Data Verification (OSDV). However, because these other indicators are not independent from the more composite indicator that the grant disbursement rating represents, they are not included. The preliminary conclusion from the other analyses showed very similar trends as the analysis based on grant ratings, with fragile states doing less well than other recipient countries. Good performance of countries that have applied the Additional Safeguards Policy (ASP)¹⁶ is 68% compared with 79% for all other countries.

Box 2: Summary of key findings from the data analysis

- Global Fund grants in fragile states perform less well compared to other recipient countries
- The gap in performance seems to have widened over recent years
- The FSI lists all countries in the world in order of fragility, and defines a number of categories in which countries are being grouped
- There seems to be a clear correlation between these categories and performance: the more 'fragile' the less favourable performance and vice versa, although there are some exceptions
- All regions show a gap in performance between fragile states in the region and other countries
- All three diseases show reduced performance in fragile states – most prominently for malaria grants, least for TB grants
- In fragile states, multilateral organisations, in particular UNDP, more often take on a PR role. Performance for multilaterals in fragile states is reported to be substantially better than that of governments and CS/PS as PR.
- Preliminary analysis of service coverage data for ART, TB detection and malaria nets indicates poorer coverage in the most fragile countries of the FSI.

The data analysis suggests that the Global Fund faces similar challenges in programme performance as other donors; the World Bank for example recorded consistently lower results of country assistance programmes in FCAS as measured by its CPIA (World Bank 2013). The Africa Development Bank's (AfDB) review of the decade 1999 to 2010 found that their projects in fragile states showed below-average performance (AfDB 2012).

However, some preliminary, and yet insufficiently analysed and explained data¹⁷ seem to indicate that individual projects (all sectors) in fragile states are beginning to perform better than those in non-fragile environments (World Bank 2014). A recent independent evaluation of World Bank operations in low-income fragile states claims that performance has improved at the level of individual programmes with better results for larger size programmes in fragile states, especially 2009-2012 (ibid.).

While the review's data analysis shows a clear correlation between grant performance and country fragility, this does not provide comprehensive explanation as to the reasons for the poorer performance in more fragile countries. Other factors need to be considered as well to understand grant performance. First, grant performance correlates with successful completion of second year evaluation. This determines whether a grant will continue to receive funding from the Global Fund and the conditions for continued funding. Second, reduction or termination of funding due to country failure to address Global Fund recommendations and/or poor performance in relation to the targets set. Third, grant performance increases with time. In other words, sustained continuity remains crucial for successful grant performance, which may partially explain why Global Fund grant performance has been shown to be less successful in countries with political instability (Katz et al 2010). Moreover, a recent survey found, inter alia, that the current Global Fund rating system might not reflect performance. To remedy this, the study recommends finding performance assessment methods that are not limited to measuring numbers (Wafula et al 2014). Yet, the very factors that lead to a state being classified as fragile may be the same factors that impede grant performance, e.g., weak governance and institutions, ongoing lack of genuine political settlement, access problems due to conflict and insecurity and so on. While the Global Fund, within the realm of specific disease programmes, cannot

¹⁶ The calculations have been done with the following ASP countries: Chad, Côte d'Ivoire, DRC, Djibouti, Guinea-Bissau, Haiti, Iran, Iraq, Mali, Mauritania, Myanmar, Niger, North Korea, Papua New Guinea, Sudan, Syria, West-Bank and Zimbabwe. From the 19 COEs, the following are not in this list: Somalia, South Sudan, Yemen, Afghanistan, CAR, Pakistan, Guinea, Nigeria and Egypt.

¹⁷ More on possible explanations in Section 8

influence the causes of fragility, it may be possible to identify and address issues that can be overcome through flexible and tailored responses.

5. Typology to identify states needing particular consideration

International experience of engaging in fragile states suggests that a ‘one size fits all’ response is inappropriate and responses need to be tailored, taking into consideration the politics, economics, partners, history and capacity of systems in those countries. For the purposes of the Global Fund, a tool is needed to identify which countries merit special consideration (based on assessing fragility-related issues e.g. conflict and access, politics, corruption, equity etc.) and decide how to maximise impact on HIV/AIDS, TB and Malaria.

5.1 Choice of Indices

The review considered and assessed several fragile states indices but concluded these were not appropriate for use by the Global Fund (see analysis of different indices in Table 13).

The review team analysed the **Failed States Index** produced by the Fund for Peace and concluded that **this index is more appropriate for the Global Fund and recommends its use** to identify a group of fragile states that are at risk of poorer grant performance and require special attention. The rationale for the choice of this index, despite some limitations includes:

- It is the most comprehensive, researched, referenced, transparent and objective index available; no other index remotely compares to the quality of research and scope of analysis;
- The index is updated annually;
- The index includes an extensive triangulation process between quantitative analysis and qualitative inputs;
- The strength and relevance of the index lies in its incorporation of displacement, of uneven development and poverty, the inclusion of measures of human rights and public service provision, and the degree of international intervention/assistance; there are also indicators of natural disasters, malnutrition and disease;
- It is widely accepted and used as a basis for the OECD fragile states list, by GAVI and many other donors; and
- The Fund for Peace is a non-profit, independent, non-partisan research institute.

The option of defining an entirely independent approach to identifying fragility for the Global Fund (rather than relying on an existing index or list) was rejected. It would not be feasible for the Global Fund to create its own index, and the credibility of the selected index would be questioned. The Global Fund does not have its own database of governance, health systems, conflict/ humanitarian indicators or other independent variables, and there would be the temptation to assume that poor grant performance is due to fragility. In addition, the Global Fund would not want to be perceived as making “value judgements” of countries where it works, especially of a political, security or governance nature.

There are a few limitations of the FSI e.g. Israel/ Palestine still cited as one country (Israel). The name of the index is not helpful when in dialogue with countries. The language of failure brushes over the complexities underlying instability. Such a hierarchical ranking assumes that countries can be easily compared on a numerical scoring. But despite the drawbacks¹⁸, and in the absence of any other useable index, the 2013 index of 178 countries includes almost all countries in which the Global Fund works. South Sudan is included in the 2013 index separately from Sudan.

The international humanitarian community uses the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) list of emergency appeals addressed via three pooled funds. The reach of the CERF is larger to cover all countries affected by a common emergency, whereas the CHF and the ERF are country-specific¹⁹. These appeals are not specific to fragile states but can be launched in any country experiencing an emergency that requests significant external assistance. Of interest to the Global Fund is to be aware of what emergencies are being officially acknowledged by the international humanitarian community. The exact list of countries with humanitarian appeals is of less concern–

¹⁸ One voice would confine the FSI to the “policy dustbin” (Leigh 2012)

¹⁹ Central Emergency Response Fund (CERF), Common Humanitarian Funds (CHF), and Emergency Response Funds (ERF).

the relevant questions being whether and how an emergency will impact on three diseases programming. The Global Fund might want to consider revising its approach in a country if there is an emergency (see Sections 9 and 10) – whether OCHA has launched appeals or not.

Table 13: Different fragile states indices in use and pros and cons for use by the Global Fund		
Name of index	Positive aspects	Reason why not appropriate for Global Fund
World Bank Country Policy and Institutional Assessment (CPIA) ²⁰	Covers in detail state public sector and economic management and includes policies on social inclusion and equity	Doesn't measure conflict & displacement, doesn't include development indicators or measurement of poverty, and doesn't show the extent of intervention by international actors. In some ways the CPIA index is used as a tool for picking winners, rather than pointing out how to make better investments in poorer performing countries.
OECD list of fragile states	Uses several indices (WB CPIA, AfDB & ADB and FSI). A composite list based on other indices without a 'ranking'.	Not updated sufficiently quickly (current list uses FSI 2011 index). ADB 'over-estimates' fragility compared with the African context. The ranking doesn't reflect the reality of fragility in countries (e.g. Eritrea is scored next to Somalia; Zimbabwe next to South Sudan; Malawi next to CAR - countries that have very different capacities in their health sectors).
Carleton University's Global Fragility Ranking	Global Fragility Ranking of 197 countries. The ranking is based on a maximum fragility rating score of 10. A useful, more independent and broad assessment.	Uses 2010 data for the most recent index, so too old to be useful.
State fragility index & Matrix 2012 Compiled by M. Marshall & B. Cole, Polity IV project, Centre for Systemic Peace, George Mason University. Linked to the US government's Polity Instability Task Force	Uses 2011 data for 167 countries with populations over 500,000 in the Global Report. Rating scores of 25 to 0, 25 most fragile. Indicators of effectiveness and legitimacy for security, governance, economic and social dimensions of state performance. The "Polity Score" captures this regime authority spectrum on a 21-point scale ranging from -10 (hereditary monarchy) to +10 (consolidated democracy).	It has a strongly political and subjective theoretical bias, examining qualities of democratic and autocratic authority in governing institutions with a 3-part regime categorisation of "autocracies", "anocracies" and "democracies". The fact that in the 2011 SFI, North Korea, China, Turkey and Vietnam had the same score questions the applicability of this index. Israel is listed but as of 2011 the West Bank and Gaza are not listed. There are also eccentric criteria, for example comparing oil production and consumption and whether the population has a majority Muslim population or is in Africa.
GAVI 2012 Eligibility for country tailored approach	Inclusion criteria for 'tailor-made' approaches. Not ranked, but rather a subset of countries that are in 'protracted fragility situations' and those experiencing short-term emergency situations. The inclusion criteria include: humanitarian emergencies as defined by OCHA, countries in the top 2 levels of the FSI, countries with 'complete devolution of MOH from central to regional levels and 4 immunisation-related criteria.	Too few countries included, and GAVI immunisation programme performance not necessarily relevant to Global Fund programming. The MOH devolution criteria would be hard to measure and do not necessarily reflect health system performance. Country by country approach for tailoring responses, developing criteria for identification of countries, reviewing the choice of countries on an annual basis and distinguishing between countries with chronic fragility from those of acute crisis is useful for the Global Fund.
Transparency International Corruption Perception Index	Measures perceptions of corruption.	A subjective rather than objective measure that only looks at one aspect of governance.
African Governance Index	A comprehensive and impartial index of state governance performance.	Only looks at African countries
Revenue Watch	Assess governance and corruption in countries with large mining sectors	Doesn't measure performance of social sectors, and only looks at countries with large extractive industries.
CRISE Network – Centre for Research on Inequality, Human Security and Ethnicity (DFID-funded 2003-2010, Oxford University based)	Proposed a classification based on failure in authority, service delivery and legitimacy, but used data from other indices. A useful attempt to highlight poverty and poor service delivery and reduce some of the political bias of other indices.	Not updated annually.
g7+ states involved in the New Deal	Helps to redefine fragility in more positive terms, with strong country determination to drive country towards greater stability	A self-selecting list of countries, not based on criteria. Only two of the country self-assessments have been conducted to date, so there is no comparative body of indicators to draw from.

²⁰The World Bank's recent independent evaluation on fragile states operations recommends developing a new, more suitable and accurate classification approach, since the current CPIA results in 'considerable errors of exclusion and inclusion' (World Bank 2014). World Bank aims to develop a new classification, which could be of possible relevance to Global Fund in future.

There will be other scenarios in which a country with a humanitarian appeal will not need the GF to significantly adapt its approach (e.g. for example appeals launched by OCHA in 2012 in Columbia and Indonesia would not necessarily have required a change of approach from the Global Fund).

5.2 Terminology

A more neutral term, other than ‘fragile states,’ is proposed for use by the Global Fund which relates to the difficulties of achieving successful programming for which a unique set of solutions is needed. Severe difficulties with programming may be experienced in a province of a country rather than the whole country, or may prevail in a region of two or three countries (such as drought in part of the Horn of Africa). For this reason, the term “environment” is used instead of “state”. The proposed terminology is **Challenging Operating Environments (COEs)**. Use of this term will be more widely accepted, also in the affected countries, and less politically loaded than ‘fragile states’. The term may also apply to sub-national areas within a country or, across borders, to a region. The term ‘COEs’ is used from now on in this report when referring to the group of countries identified as in need of special attention within Global Fund’s portfolio²¹.

5.3 Proposed Global Fund methodology for identifying COEs

To enhance performance in fragile states, the Global Fund needs to identify which countries would be eligible for special measures.

The use of two filters is proposed:

1. The ‘Very High Alert’ and ‘High Alert’ categories of the FSI as a first filter to identify a group of fragile states that are very challenging to work in, at risk of poor performance, and that need special attention and scrutiny regarding Global Fund operations; and
2. Add to this any countries, in acute and extreme crisis, in which normal programming becomes impossible, as determined by the Grant Management Division in the Global Fund. This filter is flexible in that countries can be added at any time to activate a series of measures. This includes three countries in acute crisis as of August 2013 (Syria, Mali and Egypt).

The review team proposes starting with the Very High and High Alert countries in the FSI as they are much more fragile and more difficult to work in than the Alert countries. The focus on the top two FSI groups rather than all the Alert countries is also partly a pragmatic suggestion to limit the number of countries for which special consideration is applied. It will provide the Global Fund with some experience in adapting its processes and working arrangements for the most challenging states. The experience from adopting this approach in the most fragile scenarios could then be extended to countries with lower fragility ratings in the future.

This approach is recommended despite the finding that Global Fund grant performance is similar in the next tranche of Alert countries, which in part reflects remedial measures such as using multi-laterals as PRs which help bring up grant performance ratings in the most fragile countries. But in most of these other Alert countries the challenges to operating are not as severe as in the first two Very High and High Alert countries.

The case for focussing on the highest alert categories is strengthened by an independent analysis of risks of operating in these countries. The Global Fund uses the company, Control Risk, to conduct independent risk analysis of working in countries. Control Risk’s Country Risk Forecast looks at operational, travel, political, security and terrorism risks. Comparing their risk analysis for the Very High Alert and High Alert FSI countries (2013) with the Alert FSI countries, the risks of working in these categories of countries are considerably higher – as shown by the difference in colour coding in the two tables that follow.

²¹ The terms fragile states or fragile and conflict affected states (FCAS), may still be used when referring to terminology adopted by other donors, in reference to a broader group of countries.

Figure 3: Comparison of risk analysis by Control Risk of the COE countries

COUNTRY	POLITICAL	OPERATIONAL	SECURITY	TERRORISM	TRAVEL
COE countries (FSI 2013 countries 1 to 16 and acute instability)					
Somalia	Extreme	Extreme	Extreme	High	Extreme
Congo (DRC)	High	High	High	Low	High
Sudan	High	High	Medium	Medium	Medium
South Sudan	High	Extreme	High	Low	High
Chad	High	High	Medium	Low	High
Yemen	High	High	High	High	High
Afghanistan	High	Extreme	Extreme	High	Extreme
Haiti	High	High	High	Low	High
CAR	High	High	High	Low	High
Zimbabwe	High	High	High	Insignificant	Medium
Iraq	High	High	Extreme	Extreme	Extreme
Côte d'Ivoire	High	High	High	Low	High
Pakistan	Medium	High	High	High	High
Guinea	High	High	Medium	Low	Medium
Guinea-Bissau	High	High	Medium	Low	High
Nigeria	Medium	Medium	High	Medium	High
Syria	Extreme	Extreme	Extreme	High	Extreme
Egypt	High	Medium	Medium	Medium	Medium
Mali	High	High	Medium	High	Medium

Risk analysis of the next 30 countries on FSI list**FSI 2013 countries 17 to 30**

Kenya	Medium	Medium	Medium	Medium	Medium
Niger	High	High	Medium	Medium	Medium
Ethiopia	Medium	Medium	Medium	Medium	Medium
Burundi	Medium	High	Medium	Low	Medium
Uganda	Medium	Medium	Low	Medium	Medium
Liberia	Medium	High	Medium	Low	Medium
North Korea	High	Extreme	Low	Insignificant	Medium
Eritrea	High	High	Medium	Medium	Medium
Myanmar	High	High	Medium	Low	Medium
Cameroon	Medium	High	Medium	Low	Medium
Sri Lanka	Medium	Medium	Medium	Medium	Medium
Bangladesh	Medium	High	Medium	Medium	Medium
Nepal	High	High	Medium	Low	Medium

FSI 2013 countries 31 to 40

Mauritania	High	High	Medium	Medium	Medium
East Timor	Medium	Medium	Medium	Low	Medium
Sierra Leone	Medium	High	Medium	Low	Medium
Burkina Faso	Medium	Medium	Medium	Low	Medium
Congo	Medium	Medium	Medium	Insignificant	Medium
Iran	High	High	Low	Low	Low
Rwanda	Medium	Low	Low	Low	Low
Malawi	Medium	Medium	Low	Insignificant	Low

FSI 2013 countries 41 to 50

Cambodia	Medium	Medium	Medium	Medium	Medium
Togo	Medium	Medium	Medium	Low	Medium
Angola	Medium	High	Medium	Low	Medium
Uzbekistan	High	High	Medium	Medium	Low
Zambia	Medium	Medium	Medium	Insignificant	Low
Lebanon	Medium	Medium	Medium	Medium	Medium
Equatorial Guinea	High	High	Medium	Low	Low
Kyrgyzstan	High	High	High	Medium	Medium
Swaziland	Medium	Medium	Medium	Insignificant	Medium
Djibouti	Medium	Medium	Medium	Medium	Medium

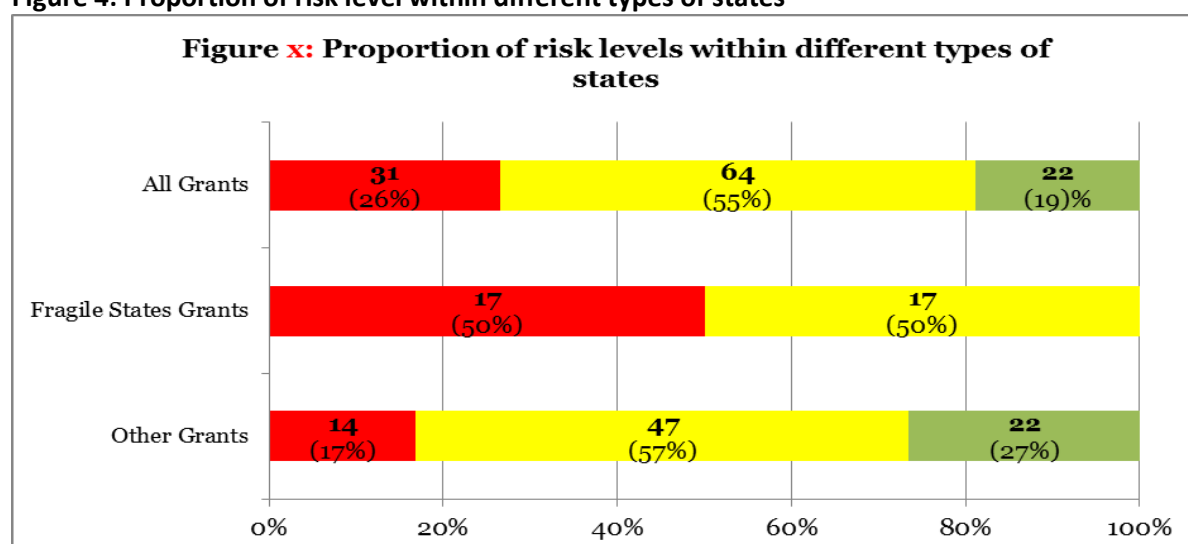
Source: Global Fund, Control Risk, August 2013

17 of the 19 countries (89%) suggested as COEs (16 Very High and High Alert plus three crisis countries) are rated as Extreme or High operational risk, compared with half of the next 30 countries. For travel risk, 14 of the 19 countries are rated Extreme or High, and 5 Medium risk. Of the next 31 countries, none are rated Extreme or High, and are either Medium or Low risk. This backs the supposition (from the FSI Index) that the Very High Alert, High Alert and acute crisis countries do pose significantly more risk to operating and travel.

The Global Fund's own tool for analysis of operational risk to grants – the Qualitative Risk Assessment, Action Planning and Tracking Tool (QUART) – also finds higher risk in the countries identified. The QUART tool has so far only been applied in the High Impact Countries and a few other cases. The Global Fund Secretariat has analysed the first round of QUART findings in High Impact Countries, covering 117 grants that make up 55% of the total grant portfolio by value (Global Fund, The Grant Risk Report, September, 2013).

Six of the nineteen high impact countries are COEs based on the definition proposed above (Cote d'Ivoire, DRC, Nigeria, Pakistan, Sudan and Zimbabwe). The QUART findings indicate substantially higher risk in grants for these countries, with 50% of the COE high impact country grants rated as high risk, compared to 17% of grants in other high impact countries, and no low risk grants among the COEs (see Figure 4).

Figure 4: Proportion of risk level within different types of states



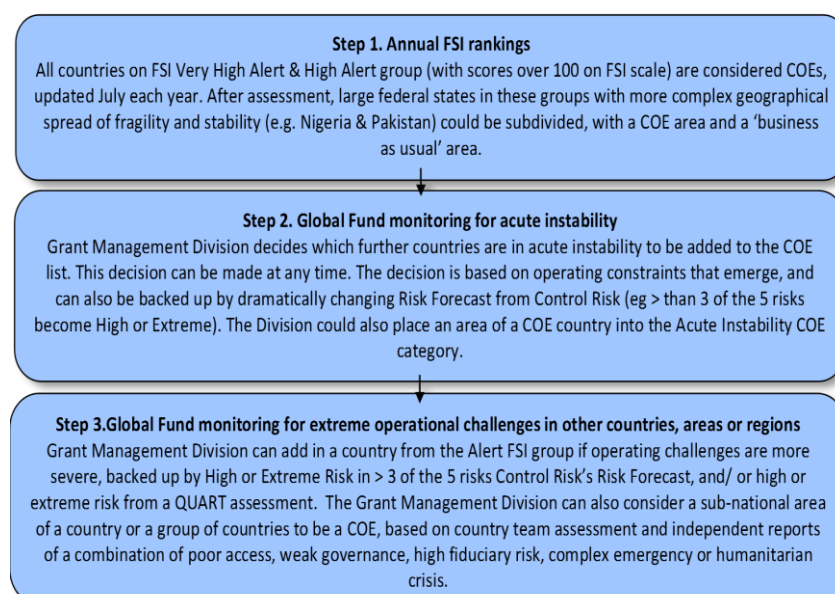
Source: (GFATM 2013e). Notes: red indicates high risk; yellow is medium risk and green is the low risk range. Figures are for High Impact countries only.

Additional countries, sub-national areas or regions of countries for consideration as COEs

With discretion, the Grant Management Division could also include an FSI Alert country if it had become particularly challenging to work in (for example increasing risk as assessed on the Control Risk forecast). Some areas of FSI 2013 Alert countries, or parts of Alert countries, that are particularly fragile could be considered as COEs. The following are some examples:

- Semi-arid parts of **Kenya** and the very insecure North Eastern Province (with a refugee camp with more than half a million Somali refugees);
- Marginalised peripheral lowlands of **Ethiopia**; **Karamoja** and the northern and western districts of Uganda;
- Areas of **Niger** bordering Mali and Nigeria;
- Border areas of **Myanmar** that have experienced decades of conflict; and
- Very inaccessible mountain areas of **Nepal**.

These areas of countries would then be assessed like other COEs. Parts of countries receiving huge influxes of refugees might fall in the COE category to allow flexible reprogramming and additional funds, for example, for the Syrian refugees in Jordan, or countries receiving Syrians could be taken together as a COE (e.g. Jordan, Iraq and Lebanon considered for a regional COE approach). A summary of the method proposed for deciding which countries are COEs is outlined in Figure 5.

Figure 5: Summary of proposed steps for identification of COEs by the Global Fund

It is at the discretion of the Grant Management Division to decide at what moment a country or region is no longer considered as a COE. This would be based on a changed FSI score, changing Risk Forecast but above all experience of the country team (CT).

5.4 Countries currently identified as COEs

If the criteria above were applied, the following countries (as of August 2013) would fall into the category of COEs (Table 13). These countries are experiencing extreme fragility and present significant risk to travel and operations, based on the FSI index and supported by Control Risk's Country Risk Forecast analysis. We propose that each of these countries would need to be further assessed by the Global Fund to identify the specific challenges to operations (see Section 9). In some contexts, a sub-national (instead of whole country) COE approach may be useful, and could focus on some states of large federal countries such as Nigeria and Pakistan. For example northern parts of Nigeria with a state of emergency²² because of the insurgency by Boko Haram and the Federally Administered Tribal Areas of Pakistan (FATA) were evaluated as Extreme for all five risk categories on the Control Risk forecast.

Table 14: Countries identified as COEs in August 2013

Top 16 'Very High & High Alert' countries plus countries in, or coming out of, acute crisis

Very High Alert Countries (FSI 2013)	High Alert Countries (FSI 2013)		Countries in or coming out of extreme acute crisis
Somalia	Chad	Iraq	Mali
DR Congo	Yemen	Côte d'Ivoire	Syria
Sudan	Afghanistan	Pakistan	Egypt
South Sudan	Haiti	Guinea	
	CAR	Guinea Bissau	
	Zimbabwe	Nigeria	

Each COE has two or more of the following features:

- Weak governance (typically including state failure, weak institutions, low capacity, low will and high corruption, violations and uneven protection of human rights)
- High fiduciary risk
- Complex emergency (conflict)
- Humanitarian crisis (acute, chronic; natural or human-made disaster)
- Poor access to health services
- Overall weak health systems

²²Borno, Adamawa, Kaduna, Bauchi, Yobe and Kano in August 2013

5.5 Sub-categorisation of COEs

Findings from this review suggest three sub-categories of COEs can be identified in relation to the strength and capacity of their health systems, and by implication, their ability to deliver services and achieve impact in HIV/AIDS, TB and malaria (see Table 15 below). The review team, based on the case study findings and personal knowledge of the countries, has developed the sub-categorisation of COEs. Note there is no hierarchy or scoring of COEs on this list but the sub-categorisation should help define the kind of responses needed (see Section 10).

The division of countries is intended to be an aid for designing the Global Fund response rather than a formal and rigorous categorisation. COEs with stronger financial management, M&E, and health systems are likely to need different approaches to those with weaker systems that may require significant health system inputs. Countries undergoing acute instability are likely to require a different set of measures both for the short term and transitional period back to 'normalcy'. It is possible that the strength and performance of health systems within a sub-category may also vary.

Table 15: Sub-categories of COEs

1. Chronic instability with weak systems	Afghanistan, Central African Republic, Chad, Democratic Republic of the Congo, Guinea, Guinea Bissau, Haiti, Somalia, South Sudan
2. Chronic instability with stronger systems	Côte d'Ivoire, Iraq, Nigeria, Pakistan, Sudan, Yemen, Zimbabwe
3. Acute instability	Egypt, Mali, Syria

Features of each group:

Group 1 countries have very poor health infrastructure and poorly functioning services, weak financial management, limited human resource capacity, poor access and low coverage for large parts of the population. Disease prevalence and incidence data is typically insufficient for planning. In most cases there are few partners available to work with, and it has been difficult to find effective Principal Recipients (PRs). In some cases (South Sudan, Afghanistan) there is an extensive donor response and the challenge is to complement what is already being provided and share systems that are being developed, in order to make efficient use of resources, improve synergies and maximise impact.

Group 2 countries tend to have stronger health systems in place, better financial management capacity, some human resource capacity (although this is often weaker at sub-national levels), and tend to have better service coverage than Group 1 countries. Instability and access issues remain a significant problem, particularly in some areas of the country e.g. in certain states or provinces of Nigeria and Pakistan. There is more overall capacity but large gaps in coverage, high fiduciary risk and challenges to governance, coordination, oversight and PR performance remain.

Group 3 countries (acute crisis) are more varied and may have had strong systems that are temporarily incapacitated (e.g. Syria) or weak to moderate systems (e.g. Mali). During and following the emergency, health facilities may be destroyed and services disrupted. Countries need flexible and immediate responses, with a variable combination of a 'humanitarian' and systems approach. As an example there have been cases where resources procured by the Global Fund programmes located in warehouses in a country experiencing acute instability could have saved lives in the emergency, but were not released for emergency use.

6. Current challenges and risks of working in COEs

The challenges and risks that the Global Fund has encountered in operating in COEs affect programme implementation and performance. This section considers the findings from the case studies and interviews.

6.1 Governance and oversight

6.1.1 Inadequate CCM governance, compliance and oversight

Findings from the case studies indicate challenges with CCMs in some COEs. Weak governance, inadequate programmatic oversight, poor ability to demonstrate transparent and democratic selection of PRs, conflicts of interest and dominance by government representatives are commonly reported problems.

The case studies identified considerable disconnects between eligibility compliance and *actual* CCM performance. While Myanmar's CCM is considered 'exceptional', many CCMs (e.g. Pakistan, Chad, Cote D'Ivoire, Yemen, CAR, South Sudan) have been plagued with problems and are struggling in varying degrees to work more effectively, evidenced through numerous technical support requests, and attempts to restructure and reform (see Box 3).

Box 3: Reforming and restructuring CCMs: country case study findings

Yemen: Restructured in 2002, 2006 and 2007. Technical assistance (TA) in 2010 started a process to strengthen CCM governance and oversight but was cancelled as a result of insecurity. Prior to cancellation, the TA consultants tried, with great difficulty and marginal results, to determine the status of the CCM and continue the CCM reform agenda.

Pakistan: Grant Management Solutions (GMS) technical assistance to strengthen CCM oversight in 2009. The CCM was recently restructured following the resignation of the CCM Secretary due to identification of financial irregularities in an independent audit. History of problems rooted in part from Pakistan's political instability (e.g. changing Chairs due to turnover of civil servants) but also due to flaws in CCM leadership, structure and organisation. Informant reported that first ever oversight visit took place earlier in 2013.

CAR: Received eight capacity building visits from GMS and two from the French 5% Initiative, yet remains underperforming, lacking transparency, oversight, and unable to resolve conflicts of interest in its membership.

Chad: The CCM has restructured itself relatively recently. Faced with a potential conflict of interest in the selection of PRs and SRs, the committee did not choose a Chair or Vice-Chair from the MOH but instead have elected a representative from the Ministry of Education as Chair. It remains to be seen how the MOH will step up its performance to be electable in the future, and whether the relationship between the CCM and the MOH will be workable. The CCM did not provide effective oversight during early rounds but is increasing its interlocutor role, and from 2007 had experts in M&E and financial management.

South Sudan: The recent appointment of a new CCM Chair by the MOH sparked off a prolonged debate about roles, knowledge of procedures and functioning of the CCM. Earlier GMS-led training for the CCM had not led to much improvement in practice. New TA is now envisioned to strengthen the CCM's own functioning and also that of the CCM Secretariat that has just been renewed and lacks experience in Global Fund work and procedures. Relations between the CCM and PRs are sub-optimal with elements of mutual distrust, not conducive in finding solutions for working in the difficult environment South Sudan poses.

The Global Fund is open to non-CCM applications from countries without a legitimate government, countries in conflict, facing natural disasters or in complex emergency situations, or countries that suppress or have not established partnerships with civil society and non-governmental organizations. A number of the countries in the top two categories of the FSI would probably qualify for non-CCM applications. Currently, the only examples of non-CCM countries are Somalia and the Palestine. The experience of the Somali non-CCM is briefly outlined below.

Box 4: Operating in Somalia without a CCM

Coordination for the 3 Somali political zones – With the three semi-autonomous Somali political zones, and three ministries of health (MOH), it was not possible to set up a CCM. Some CCM functions have been delegated to the Somalia Health Sector Coordination (HSC), based in Nairobi. This should, in theory, contribute to a more harmonised and integrated approach (Eldon J, 2013).

Somalia's health sector coordination mechanism: The HSC mechanism and its role with regard to the Global Fund business is weak. It originally devised and submitted proposals and is now tasked with overseeing the Global Fund grant implementation but only informally; there is confusion over what this means in practice and how to do it. The Global Fund business model is not well integrated into HSC mechanisms and this complicates lines of accountability and reporting to the HSC by PRs. PRs essentially report to the Global Fund CT in Geneva; PRs don't really report data with the HSC, rather, info on process. Additionally, to avoid conflicts of interest (e.g. UNICEF is a PR but also a member of the HSC) separate meetings with different participants are scheduled, potentially limiting synergies and integration with broader sector priorities and issues).

Possible solutions: These issues suggest that the real Fund Manager for Somali grants is the Country Team in Geneva, not the HSC. Possible solutions include increased and more flexible travel for the Country Team, more verification by LFA, closing the loop on communications between the Country Team, PR and LFA. PRs could be supported to be more business-like with a stronger results-orientation and could assume the role of an in-country 'Fund Manager' that contracts SRs using results-oriented frameworks; and manages all contracts, rather than disease-specific grants (for more detail see Sections 9 and 10).

Sources: Eldon J, 2013; Review team (NP, ES) experience

There is currently very little Global Fund guidance that discusses options or alternative arrangements for non-CCMs (and/or CCM ‘blending’ e.g. with national or sub-national sector coordination arrangements) in COEs, despite the fact that non-CCMs may be more appropriate in some COEs.

The Global Fund has recently revised its CCM minimum standards and eligibility requirements (October and December 2013). Under the NFM, the process for reviewing CCM eligibility has changed. Some criteria of eligibility will be assessed during the Concept Note preparation phase, other criteria will be assessed through an annual performance assessment process, for which technical assistance is recommended, though not obligatory. It is not clear the extent to which local consultants will be available to undertake the assessments with the CCMs. However, many of the suppliers are international and use international consultants, raising questions over the feasibility of undertaking annual performance assessments in COEs where instability and upheaval frequently prevent travel and access to the country and key partners. With exception to the reference to non-CCMs, the updated guidelines are still geared towards a ‘standardised’ CCM model that applies globally.

6.1.2 Variable Principal Recipient governance, capacity and compliance

PRs are an essential element of the Global Fund’s architecture at country level, directly responsible for receiving the Global Fund money and managing the implementation of programmes, or recruiting other organisations as SRs for implementation. For this reason, they represent an important intervention point for efforts to improve the Global Fund’s performance. In line with the Global Fund’s policy of using dual track PRs, a key strength of Global Fund operations in COEs is the range of different PRs that can be used to manage the implementation of programmes. These include government ministries or departments, INGO/NGOs and multilateral bodies such as the UN.

The Global Fund has introduced Minimum Standards for Principal Recipients, M&E and PSM systems proposed for program implementation applicable to grant signing of NFM grants (and included in the NFM Concept Note). Emphasis has been put to incentivize countries to select strong PRs and capable implementers while investing in building national capacity. Important capacity weaknesses of PRs and selected key implementers will have to be adequately addressed before grant signing and start of implementation.

PR capacity and performance

As discussed in Section 4, data on PR type and performance in COEs at an aggregate level demonstrates that multilaterals, especially UNDP, UNICEF and UNOPS, play a greater role as PRs in COEs compared to other recipient countries, and their grant performance keeps up with that of non-COE (86% of multilateral PR grants in COEs rated as good performance).

Government PRs play a smaller role in COEs than in other countries, with 37% of active grants in the COEs compared to 50% in other countries. The proportion of Civil Society/ Private Sector (CS/PS) and government managed grants rated as performing well is substantially lower in COEs than in other countries (58% of CS/PS and 48% of government PR active grants).

Examples of grant performance from the case studies indicate a variable pattern:

- Government of Pakistan as PR for TB and malaria grants performs well – four grants, all scoring A1 or A2; Pakistan CS/PS grants perform less well for the same diseases – three grants scoring B1 or B2;
- Myanmar, with a grant portfolio comprising only UN/INGO PRs performs relatively well for all three diseases with grants scoring B1+, UNOPS scores particularly well (A2+);
- Government of Yemen as PR for TB and malaria grants scores reasonably well – two grants with B1 ratings;
- South Sudan’s grant performance has recently improved and now all grants receive good ratings, with UNDP (TB, HIV, HSS) and PSI (Malaria) as PRs; and
- DRC’s picture is more mixed with government PRs performing poorly with two grants scoring B2 and C (for HSS). DRC’s previous grants also show a mixed picture, with UNDP scoring C for two HIV grants.

Some of the main challenges facing PRs operating in COEs are outlined in Box 5.

Box 5: Key challenges to PR performance: case study examples

- Limited choice of PR available in-country due to conflict, instability, political upheaval which reduces and/or determines choice of PR partners (e.g. in **Yemen, Chad, CAR**)
- Weak understanding and adherence to complex grant requirements and procedures leading to delays in reporting and disbursements (e.g. in **Yemen, Chad**)
- Inadequate capacity and expertise in PSM (e.g. **DRC, Cote D'Ivoire, Myanmar, CAR, Yemen**), financial management (e.g. **DRC, Yemen, Chad**) and M&E (**Chad, CAR, Yemen**)
- Delays in PR and SR early recruitment, staff turnover during life of the grant causing implementation delays (e.g. **Pakistan, DRC, Yemen, Myanmar**)
- Inadequate monitoring and supervision of SRs by PR (e.g. **DRC**)
- SR weak experience of performance-based implementation and poor capacity and resources for programme implementation (e.g. national disease programmes as SRs in **Chad**)
- Poor support, communication and coordination between the PR and other actors, which can lead to disbursement delays and poor performance (e.g. **DRC, Yemen**). A confusion over reporting roles particularly in **Somalia**, where there is no CCM, and lines of accountability are blurred.
- Challenges in compliance with Global Fund procedures and Secretariat staff turnover delays grant implementation (e.g. **Chad, Myanmar, Somalia**)
- The quality of PRs and SRs in **CAR** has been so low that the basic management capacity of these agencies had to be strengthened first before being able to have an impact on the country's health system.

UNDP as PR of 'last resort'

The Global Fund has from its early days used the option of multilaterals (usually UNDP) to manage grants in difficult contexts. UN agencies, principally UNDP (the 'PR of last resort') but also UNICEF and UNOPS, act as interim PRs in countries facing exceptional development challenges and/or complex emergencies, including ASP countries. As of June 2013, UNDP served as a PR in twenty-five countries (approximately 12% of the Global Fund portfolio), including ten ASP countries.

UNDP grants perform well at an aggregate level; their contribution to successful grants in COEs needs to be recognized. However, findings from the country case studies also highlight problems and variable performance of UNDP as a PR in DRC, Chad, Yemen, and South Sudan (see Box 5). In DRC, UNDP pulled out of its PR role due in part to the difficulties of working with the government but also due to UNDP's weak national office which impacted on grant management, oversight and performance.

6.1.3 Inadequate Secretariat and LFA management

Successful programming in COEs requires contextualised knowledge of the environment, the political economy, the health system and of successful, innovative programmes that achieve impact in each setting. This knowledge cannot be gained from Geneva alone. The Global Fund has at times been risk-averse to country team (CT) travel to insecure countries, including to some more stable capital cities in countries like Mali and Guinea-Bissau. Many of the problems in grant implementation have arisen due to communication problems between Ministry of Health (MOH), citizens and community groups, CCMs, PRs, SRs, LFAs and the CTs, that perhaps could have been resolved more swiftly with greater CT presence. The Global Fund's model does not have in-country presence. However, evidence from other partner operations in fragile states and some (not all) country informants for this review, suggests that achieving greater impact in COEs requires more time spent in-country. As one donor partner pointed out, *"if you want operations to succeed you have to be on the ground"*.

Rapid turnover of CT staff especially the Fund Portfolio Manager (FPM) has been a regular occurrence for a few fragile states and is not conducive for contextual understanding and developing lasting relationships and trust. One reason for rapid turnover could be the fragility of a country and the difficulties of travelling and security, which may make these posts less attractive for staff.

Whilst the Local Fund Agent (LFA) provides the Secretariat with a flexible and locally based resource to review grant performance and verify programmatic results and use of funds, the review findings demonstrate challenges for LFAs in fragile states including:

- In emergency conditions (e.g. the extremely poor security outside the capital in CAR) the LFA is also affected and may be unable to carry out its verification roles. In some cases (such as the fighting in Cote d'Ivoire) their staff may leave the country;
- Some LFAs are permanently based outside the country (e.g. South Sudan) and face similar problems to Global Fund in gaining access during emergencies;
- In countries with very weak capacity and limited human resources, it can be a challenge to assure the quality of LFA staff, even when they are better paid than the public sector; and
- Communication between LFAs, PRs, CCMs and external auditors was identified as an issue by the High Level Panel (HLP, 2011) and continues to be an issue, for example in Chad the CCM felt left out of the loop – that if they were made aware of LFA findings they could help bring about improvements in the government PR and SRs. In Yemen, PRs seemed more accountable to the LFA than the Secretariat, which prevented the CT from understanding the PRs problems with reporting, and limited the CT's ability to give guidance.

6.2 Financial management and fiduciary controls

Financial management (FM) and fiduciary controls present challenging issues in COEs, given the weak governance and accountability capacity that characterises these states and the disruption to normal systems when there is a crisis (see Box 6). This is reflected in poor scores for corruption (for example on the Transparency International Corruption Perceptions Index, 2013). The Global Fund has devoted considerable resources to identifying and addressing financial and fiduciary issues (see Section 7). The box below draws out some examples identified in the case studies.

Box 6: FM difficulties faced in COEs: examples from case studies

- **CAR:** financial management systems demonstrated inadequate controls, late reporting, poor cash flow, as well as cases of fraud and inadequately supported expenditures
- **Chad:** weaknesses in financial management including irregularities in net distribution; failure to account for funds led to suspension of support to the blood bank
- **Cote d'Ivoire:** during the political crisis and fighting, there was concern over access to funds and the banking system shut down at one point
- **Yemen:** Weak understanding of Global Fund requirements and processes among national PRs, and lack of enforcement of financial management and audit procedures, with insufficient supervision of PR project management unit staff
- **Myanmar:** ASP country with 'Zero Cash' policy in place. PRs have developed a 'managed cash' system with finance officers visits to Global Fund activity sites and reimbursing participants, or advances being paid and PR reimbursing participants through the banking system. The immature banking system meant reimbursements could take a year to be paid, deterring participants from Global Fund activities
- **Pakistan:** Incidence of 'cash out' and acute shortages of drugs due to inadequate/slow LFA capacity to analyse and forecast funding requirements

6.3 Access to Health Care and Health Service Delivery

6.3.1 Governance and oversight

At the heart of many poorly functioning health systems is ineffective governance of the health sector. MOHs in many COEs are weak, and may lack the will and capacity to take up a proper stewardship role, develop and implement policies, design and enforce regulation and provide leadership to develop the health system. In post-conflict countries, good intentions to strengthen governance and the health system may be restricted by limited human resource (HR) capacities, competing priorities, and the challenges of coordinating the many stakeholders, including multiple donors, in the health sector. For example, South Sudan is a new country with limited functional administration. The MOH faces the challenge of having to develop a health system with very limited HR, while dealing with a relatively strong international community that, despite efforts, is not fully aligned or harmonised.

Weak governance as a result of institutional weakness and poor human resource capacities does not only apply to central MOHs, but will take its toll throughout the whole system, including provincial and district level authorities as well as the leadership of individual health facilities. It takes much more effort and time to include these lower levels in capacity strengthening support. This may be of greater

importance in post-conflict countries, which place more emphasis on decentralisation as part of broader processes of inclusion and increased accountability.

Most fragile states suffer from – often extreme – shortages of human resources for health, in particular after periods of prolonged conflict. This affects the whole health system as well as specific disease programmes and is not easy to remedy in the short term.

6.3.2 Inadequate access and lack of equity and human rights

HIV/AIDS, TB and malaria prevention and treatment coverage in COEs can be very low in large areas of the country, and some Most At-Risk Populations (MARPs) are not being reached. Anecdotal evidence from the country visits confirmed the picture that large affected groups are not accessing prevention or treatment. These include the very poor, in particular women, girls and young children, and displaced populations in sub-Saharan Africa COEs. While grants may be designed to reach these groups, the realities of poor grant performance and poor programme geographical reach, particularly in insecure areas, brings a risk that core target groups remain untouched. An example from DRC's North Kivu province highlights this issue.

Box 7: Limited access to HIV services: North Kivu Province, DRC

North Kivu province in eastern DRC has a population of approximately 7 million people, and has suffered from extensive violence, disruption and abuse of human rights over the last 17 years. An estimated 960,000 people, 14% of the province's population, were displaced in July 2013. Just over a quarter of displaced people are living in 31 IDP camps, while some 73% of them are thought to stay with host families outside the camps.

Data on HIV prevalence in North Kivu is limited and incomplete. Sentinel surveillance in 2011 was carried out at only four antenatal sites in each of two health zones. HIV prevalence in pregnant women was 1.2% in Katwa and 2.2% in Goma but higher in the IDP camps, with one survey showing HIV prevalence of 3.2% among IDPs aged 18 to 35 year olds, with more women testing positive than men.

Antiretrovirals (ARVs) are only available in 2 urban centres in this huge, largely rural province, and paediatric ARVs are only available at one hospital in Goma. There are currently 4,415 people on ARVs in North Kivu, while the national HIV programme estimates the eligible population for ARV in the province at 17,500. The National AIDS Council's coverage figures for North Kivu are very low: Prevention of Mother To Child Transmission (PMTCT) coverage for the province is estimated at 23%, voluntary counselling and testing coverage at only 8%, and behavioural change communication at 4%. Furthermore, 42% of newly diagnosed cases of HIV present already in WHO stage III, and 27% of people living with HIV (PLWH) admitted to hospitals die there. This implies late presentation, late diagnosis of HIV and high mortality rates after diagnosis. Most funding for Community-Based Organization (CBO) outreach programmes was cut with the restructuring of the GF portfolio, partly because of the difficulty in showing impact with many small projects.

In the IDP camps, the humanitarian clusters support services. Neither the Global Fund nor the PR for HIV had been involved in humanitarian health cluster discussions in DRC. The Global Fund was not supporting HIV/AIDS, TB and malaria services in these camps. UN partners in Goma reported that the Global Fund's PR for HIV had not, to date, offered any flexibility in access to Global Fund-supported HIV funds.

The North Kivu figures suggest that for HIV in DRC: 1) the need is still considerably underestimated; 2) the disease and complications are being detected very late; 3) the coverage of treatment and PMTCT is low; 4) a high percentage of PLWH living outside large urban centres, and those living in IDP camps, lack access to HIV services; and 5) at-risk populations include the displaced, women and babies born to untreated HIV positive mothers.

In most of the case studies there are large areas, which are not served by quality health facilities. These include conflict-affected areas where facilities were destroyed (Côte d'Ivoire, CAR, DRC) but also large, very poor, isolated areas that never had good facilities (South Sudan). In Myanmar there has been an extension of HIV/AIDS, tuberculosis and malaria services into conflict areas; the treatment needs of marginalised populations living in these border areas that have seen conflict for decades is presumed to be very high.

Refugees and IDPs

COEs tend to be characterised by high numbers of refugees and displaced people. Comparing the COE list against UNHCR data for numbers of displaced people in 2012 (UNHCR 2013), 11 COEs are hosting

more than 500,000 ‘persons of concern to UNHCR’²³. For many of these countries, these involve large numbers of internally displaced people. This compares with only 3 of the next 30 countries on the FSI 2013 index. COEs are both countries of origin and countries of asylum for large numbers of refugees, and some COEs have more than a million people displaced internally in the country, representing a significant proportion of the population.

Research by UNHCR showed that 57% of HIV national strategic plans (NSPs) did not mention IDPs and 48% of NSPs did not mention refugees. For malaria NSPs, the figures were 44% for IDPs and 47% for refugees. Only a minority (21% to 29% of HIV and malaria NSPs) referenced and included activities for refugees and IDPs. Furthermore, between 61% to 83% of countries with more than 10,000 refugees and IDPs did not include these groups in their approved Global Fund grant proposals for malaria and HIV. TB treatment is generally more available as refugees and IDPs do tend to have access to government TB programmes (Spiegel et al 2010).

One factor in this may be that refugees and IDPs are not systematically represented in CCMs. It may be more practical to include them in provincial or local coordination mechanisms closer to where they are currently living, either way, they should not be forgotten. CCMs should consider all groups of people living in the country.

6.3.3 Poor quality of health services and lack of integration

The quality of health services in COEs is likely to be compromised due to insufficient numbers or inadequate distribution of qualified health workers providing services; under-resourced, absent or damaged infrastructure; lack of adequate training in international protocols and treatment guidelines; absence of referral mechanisms or integrated services; and sub-optimal services and care due to ill-equipped health centres, stock outs, inadequate availability of drugs and reagents. Findings from the case studies endorse many of these points, as can be seen below.

Box 8: Poor health service quality and its impact on disease outcomes: examples from case studies

- No dissemination of new treatment guidelines, no training of health workers e.g. **CAR**
- Limited health staff capacity at all levels e.g. **Chad, South Sudan, Yemen, Pakistan** and **Myanmar** at sub-national/provincial levels. Need for retraining a familiar issue, including post-conflict e.g. Cote D’Ivoire
- Inadequate numbers of health workers including due to flight of health workers during upheavals, disrupting services e.g. **Syria, Cote D’Ivoire**. In **Yemen**, supervision of health service quality and M&E verification visits to the Global Fund grant sites cancelled due to insecurity. In **Syria**, limited supervisory visits outside Damascus for the past two years
- Lack of infrastructure, basic services and difficulties accessing health facilities throughout the country e.g. **South Sudan**; decrepit infrastructure and equipment and poor quality of care are major issues for health in **Myanmar**; limited number of functioning health centres in **Syria** due to conflict; damaged and looted infrastructure in **Cote D’Ivoire** limits services and standards
- Reports of the Global Fund programmes attracting resources and staff away from other important (and related) health services, potentially impacting on synergies and delivery of sustainable services in the future e.g. in **Myanmar**. Use of parallel PSM, M&E, FM, Project Management Units (PMU) systems and use of incentives for health workers for the Global Fund programmes (e.g. **DRC**) limits integration of Global Fund programmes in the short term.

6.3.4 Disruptions to services due to health system and Global Fund management problems

Disruptions in the supply of core health products for prevention (malaria bed nets, insecticides, condoms, diagnostics) and treatment (e.g. pharmaceuticals such as ARVs) due to weaknesses in PSM, increase the risk of negative health outcomes for beneficiaries. In addition, lack of adequate storage, weak planning and distribution systems can result in sub-standard products reaching the population, or use of expired products, causing service disruptions and representing considerable wasted cost. PSM issues are apparent in the COEs in this review, particularly in situations of conflict.

²³ Persons of concern (PoCs) to UNHCR include refugees, asylum seekers, internally displaced persons, stateless and other people of concern.

While disruption features prominently as an end result of poor PSM systems for health products, poor quality of service is also a huge risk factor. Issues that impact PSM negatively, and ultimately lead to disruption of services and poor quality of service, include:

- 1) Lack of *reliable transport systems* and well mapped, efficient *distribution networks* to ensure timely resupply of commodities
- 2) Lack of *trained personnel* to monitor supplies and ensure constant availability of products through good supply chain management practices.
- 3) Lack of focus on *pharmaceutical care for patients* to ensure positive clinical outcomes.
- 4) Lack of *capacity to forecast demand* and ensure *timely procurement* and *continuous flow of commodities*, while at the same time planning for resources ahead of time to avoid funding gaps and supply disruption in the long run.

Box 9: Disruptions of service due to PSM issues: examples from case studies

- Weak country capacity in PSM to prepare, order, secure, control stock, or deliver drugs and health products to consistently meet need, has led to stock-outs, expired drugs and disrupted services. Weak data on consumption hinders PSM processes e.g. in **CAR, Chad, Pakistan**. In **Chad**, government purchased ARVs with short shelf life, leading to loss of \$400,000 worth of drugs.
- Unrest and insecurity leading to theft and looting of commodities further disrupting services e.g. **CAR, Cote D'Ivoire, Yemen**.
- In **Yemen**, sporadic outbreaks of violence led to the temporary closure of the premises of the MOH, National AIDS Program (NAP) and National Population Council (NPC). Due to a blockade in the Al-Hassaba area, ARVs procured under the Round 3 HIV grant valued at over US\$ 50,000 could not be stored in the central warehouses and were distributed to ART sites on the basis of the PR's estimates, not necessarily supported by actual demand from the sites. Medical equipment procured for the regional branches of the National Blood Transfusion and Research Center valued at around US\$ 2.5 million could not be transported to their sites and the PR had to rent a warehouse for a period of six months.
- Unrest and insecurity hampers import of commodities potentially disrupting services, experienced in acute crisis e.g. **Cote D'Ivoire** problems with importation of commodities during the crisis due to closure of ports and the airport. In **Syria**, lengthy importation procedures for medication and equipment, particularly since Damascus airport is not functioning, continue to undermine the efficiency of operations.
- **Cote D'Ivoire** experienced challenges in storing and distributing commodities using the national pharmaceutical system due to insufficient space, unreliable transport and damage to some storage and health facilities.
- Very practical supply chain inefficiencies in all grants have hugely delayed programme outputs and treatment coverage in **DRC**, e.g. catastrophic delays in transportation of TB drugs and lab reagents. In the national supply chain there is very weak provincial and zonal infrastructure with little capacity for supplying and transporting drugs to zones. There are overlaps in ARV supply in Province Oriental since PEPFAR started supplying ARVs, while half of the country remains without ARVs.
- Within PRs, there have been delays in procurement, capacity building efforts and staff recruitment leading to gaps in supplies e.g. UNOPS, in **Myanmar**; MoH, Caritas and Cordaid in **DRC**.

6.3.5 Inadequate M&E, country data systems and poor quality data

Weak Monitoring and Evaluation (M&E) systems and poor data quality risks grant results (impact, outcome and output results) being misreported, the grant not achieving its targets, and national programmes being under- or misinformed on the state and progress of addressing an epidemic. M&E weaknesses feature prominently in the COEs under review, particularly weak skills and capacity of M&E staff, and inadequate planning, data collection and reporting. Fragility and upheaval limit access to the Global Fund programme sites, making monitoring, verification and oversight more difficult. Despite efforts to improve the M&E systems, there has sometimes been poor progress made on agreed M&E systems strengthening activities.

Particular issues arising in insecure contexts include:

- Access to perform M&E activities is not possible (national scale surveys: MICS, DHS, MIS, etc.)
- Surveys are delayed or not implemented (cost increase, security, etc.)
- HMIS may no longer function or has never functioned
- Lack of coordination: Donors set up parallel systems
- Poor data collection: Use of vertical data instead of data collected across the health system
- Poor reporting by countries

Box 10: Inadequate data and M&E systems: examples from case studies

- In **South Sudan**, where the health system is starting from a very low base, data availability, the quality of data, and reporting is poor and fragmented from district to central level.
- In **Cote D'Ivoire**, unrest led to delays in planned surveys, disrupting the ability to report on performance. A Malaria Indicator Survey (MIS) and a Knowledge Attitudes and Practices (KAP) survey planned for 2011 were both cancelled. One consequence of the weak HIS and lack of coverage data is that PRs were unable to report on some key indicators on time. This contributed to low grant scoring for TB and malaria.
- Weak national M&E data in **Myanmar**: data is often out of date and has major gaps particularly from border areas which are comprised of states known to have high numbers of key affected populations. Under-reporting is a major limitation with key sectors (e.g. malaria cases found in the private sector) not reporting into the national database and NGO reporting (including that of the Global Fund SRs) only started in 2012. Mapping tools are not in use so identifying and prioritizing 'hot spots' for interventions is problematic. Data is reported up through the system, but there is little feedback, analysis and use of data for planning at township level.
- National M&E systems and programme evaluation capacities remain weak with scanty M&E expertise in **Yemen**. The TB programme has relatively good quality data collection, management and reporting systems but this is not consistent across the three diseases. Although a national M&E strategy for the HIV response was developed, there is still a need to build a comprehensive M&E system for the response, including reporting forms, tools and training. There is also a need to strengthen national M&E systems, supervision and monitoring, as well as the capacity of programme partners. Challenges remain in ensuring M&E capacity is strengthened at sub-national levels and the current vertical systems of reporting on HIV/AIDS, TB and malaria are embedded within the health system.
- Because of the need for data for the Performance Based Funding for the Global Fund, Principal Recipients remain reluctant to rely on systems that should be strengthened (HMIS). For this reason, collaboration with partners has been weak. This ends up with vertical systems that duplicate or 'bypass' existing systems.

6.4 Country level partnerships

The case studies demonstrate how capacity constraints, conflict and post conflict situations, political upheaval and weak governance limits the Global Fund's engagement with partners, and choice of PR, including UNDP as PR of last resort. In COEs such as Yemen, and some of the smaller West and Central African countries including Chad, CAR, and Cote D'Ivoire there are few remaining partners to work with and/or viable options for organizations to serve as PRs who meet the Global Fund Minimum Standards. Yemen has selected government PRs due to their constant presence and potential reach (compared to UNDP, where staff have been evacuated and the office operates with a skeleton staffing). In CAR, the International Federation of the Red Cross (IFRC) is establishing itself specifically to serve as PR. In Chad, the Ministry of Planning's PMU to support population activities (FOSAP) has been retained as sole PR despite its B2 performance rating, but under Conditions Precedent and management actions. In Myanmar, where a zero cash policy exists, PR implementation is undertaken by UNOPS and INGOs, although a transition to government PRs is likely from 2016.

Some COEs are shifting away from using UNDP as a default PR and are diversifying to use of INGOs and stronger national NGOs, if available, as PRs – e.g. in Mali and DRC where three INGOs and two national NGOs have been selected as PRs, respectively. Increasing the use of alternative UN agencies has been suggested by review informants and may offer greater potential to develop synergistic activities e.g. in PMTCT and malaria prevention and treatment.

Innovative approaches to overcome challenges of operating in COEs have been adopted by the Global Fund (e.g. in CAR, where the French military are used to protect warehouses storing Global Fund commodities, and in Myanmar where talks with Save the Children in China are helping open up services in border areas). In addition, PEPFAR and the Global Fund are strengthening synergies and dividing tasks in a number of countries, including use of same supply chain systems and coordinated capacity strengthening of national systems. To this end, PEPFAR encourages their country coordinators to participate in CCMs. USAID/PEPFAR has also started funding long term, more 'embedded' TA (Global Fund Liaison Officers) to CCMs. This is happening in a range of different countries and regions (Central America, Central Asia, West and East Africa) including COEs such as Myanmar, DRC, Haiti, South Sudan, and Zimbabwe. The roles are tailor-made but typically include PSM and M&E support, coordination, data analysis/presentation and troubleshooting functions.

Findings from country case studies indicate that the increased Secretariat staffing available for High Impact Countries have enabled stronger communication and relationship building with partners at the national level through more regular visits, phone calls and emails (e.g. in Cote d'Ivoire, Myanmar and Pakistan).

This review highlights the need for the Global Fund to work with different partners, such as humanitarian organizations, *in addition* to traditional Global Fund partners and bilateral donors in relation to the three diseases.

6.5 Global Fund funding mechanisms

6.5.1 Challenges to implementing Performance Based Funding (PBF)

The analysis of grant data indicates that grants in COEs are more likely to have poorer performance ratings compared to other recipient countries, which in turn, is likely to lead to lower levels of grant funding. Difficulties for COEs with the PBF systems include:

- Lack of or delayed data due to M&E weaknesses or disrupted reporting systems. Absence of data has led to lower grant ratings. This may not reflect poor performance as much as poor reporting (e.g. Cote d'Ivoire)
- Delays in start-up and implementation due to weak PRs, grant freezes and additional safeguards, leading to lower results than targeted, again reflected in low grant ratings. This can reflect poor management performance and difficulty in meeting Global Fund standards for expenditure and reporting, but not necessarily poor grant performance in terms of the services delivered by implementers.

6.5.2 Challenges to implementing the New Funding Model in fragile states

The NFM represents a potentially more flexible funding, grant design and implementation approach to the previous rounds-based approach but case study findings also highlight the challenges of implementing the NFM in COEs, including countries experiencing acute crisis (see Box 11).

Box 11: Potential challenges in implementing the NFM in COEs: examples from case studies

- Agreeing the disease funding split may be difficult, especially willingness to allocate funds to cross cutting HSS activities, with disease programmes reluctant to reallocate what they see as theirs (although not necessarily a problem exclusive to COEs). However in **Cote d'Ivoire**, this was not considered a concern as there is widespread agreement on the need to strengthen basic systems
- Time taken and information requirements to develop an indicative request and a full expression of demand. This was confusing in **Myanmar** and may be not viable in other weaker COEs
- Weak or poorly-functioning CCMs will need to be carefully managed by the CT and technical partners to influence grant design

"Bringing together all partners from different backgrounds will be something for Yemen and will take us to a new level of sitting together and coming to consensus...but it could take a long time and it will be hard to control country dialogue" (Yemen informant)

- Secretariat capacity may not be sufficient for NFM processes in COEs especially those not graded as High Impact where fewer CT resources are allocated, yet they are equally or more complex COEs, often with few other partners present. Even in High Impact countries, the CT is already stretched (OIG survey findings, in May 2013 report). If CTs are to encourage a more differentiated approach, for example working at province level where provinces are COEs, this would increase the workload.
- Lack of quality data or outdated NSPs in COEs to form the basis of funding allocations, Concept Notes, performance measures etc., thus potentially compromising the case for strategic investment. In **Chad**, for example, there is no current national health plan, nor NSPs. However this is not universal – NSPs are being developed and updated e.g. in **Cote d'Ivoire**.
- In the emergency context of Syria, many aspects of the NFM would be impossible (such as a country dialogue, CCM request, National Strategic Plans). In such settings, the Global Fund Secretariat needs to collaborate with the humanitarian cluster partners to consider how best to maintain key services to affected populations, reviewing and updating needs regularly.

Whilst **counterpart financing** can be planned and included in programme budgets, problems are more likely to arise in COEs in delivering the planned funding. This may be due to political or economic

disruptions to which they are prone, for example unrest leading to a fall in revenue collection, or a substantial exchange rate decline. Inability to spend may also relate to service disruption or inability to make or record payments such as salaries during unrest or a crisis. In the case of large scale acute crisis, planned budgets are likely to be changed due to the need to respond to that crisis (although there may be some contexts where emergency planning averts the need for such reallocations, for example where floods are expected and planned for, as in Pakistan). In CAR, disruption meant counterpart funding commitments were not met. The Global Fund recognised this was unrealistic under the circumstances and has allowed a temporary inability to pay. This sort of flexibility is necessary in a crisis context and is consistent with other partner approaches (e.g. the GAVI Alliance).

6.6 State building and aid effectiveness

The Global Fund has not carried out a formal examination of the effect of its programmes on state building processes. With its emphasis on delivering results for coverage of the three diseases, a focus on state building may seem remote from Global Fund priorities, but when state building is understood (as per the OECD emphasis on this principle) to include poverty reduction, addressing human rights, civil society engagement, mobilising revenue, and supporting an enabling environment for service delivery, then Global Fund grants can have a huge impact in these domains. The Global Fund has always prioritised country ownership and supports, to some extent, some of the OECD engagement principles in fragile states, e.g. working in many countries that are ‘aid orphans’; committing to the longer term with reasonably predictable funding (even if not ‘fast acting’); promoting non-discrimination; agreeing on practical coordination mechanisms (e.g. in Myanmar).

The case studies suggest both positive and negative effects on state building and varying levels of adherence to the Paris Declaration Principles. A number of observations can be made from the case studies and broader Global Fund documentation (see Box 12).

Box 12: The Global Fund impact on state building and aid effectiveness

- In general, key Global Fund documentation (e.g. proposals, Concept Notes, grant performance score-cards) provide limited opportunity for analysis of the role and contribution of the Global Fund to aid effectiveness or state building in any countries including COEs
- The Global Fund model has always involved trade-offs, for example, between using country systems – a key principle of state building and aid effectiveness – and the achievement of short term rapid programme results, and this comes through as a strong finding in the case studies. The Global Fund scores well on alignment (with national strategic plans, ‘on plan’, and supporting country programmes) but in the case study countries the grants are still largely managed and implemented through earmarked, vertical budgets and structures, with dedicated PMUs and with controls and measurements that are largely independent of country systems (e.g. use of INGOs or UN as PRs, independent audits, use of Voluntary Pooled Procurement (VPP) or third party procurement, separate M&E reporting arrangements for HIV/AIDS, tuberculosis and malaria)
- The **CAR case study** points out that Global Fund programmes have not enhanced state building. Weak national management systems resulted in the Global Fund tightening its risk management (use of Conditions Precedent and safeguard measures) which may have caused reductions in service delivery
- In some COEs, where there are institutions, systems and capacity for policy making and service delivery, the Global Fund is doing more to strengthen and use country systems e.g. transitional plans from federal to provincial PRs in **Pakistan**, in line with the 18th Constitutional amendment on decentralisation; in **Cote D’Ivoire**, where the Global Fund and other donors are strengthening the pharmaceutical supply system as a basis for greater use of national systems in the future
- While other donors play a more visible role in **South Sudan’s** health sector, and including more health system strengthening activities at county, state and national level, their role in state building is potentially easier to assess than the Global Fund’s role
- In **DRC** the PMU that manages grants had an initial negative impact on service delivery (in terms of outcomes and impact) as the PMU’s management capacity was initially so weak. The lesson learned being that investments in PMUs should be planned over the medium term and that grants should either be accorded in progressive amounts to PMUs as their grant management capacity is demonstrated or that a parallel PR/agent is in place that initially manages and then transfers functions
- In **Myanmar**, a donor reported on the enormous transaction costs (and opportunity costs) involved for government working with the Global Fund, stating the government had been ‘Global Fund writing mode’

for the last six months and there was an urgent need to make the Global Fund processes ‘routine’ – by aligning and supporting one national health strategy, one M&E plan etc., rather than disease specific plans and systems

- There is nothing inherently wrong with PMUs if they are integrated into the core systems of MOH. The Global Fund salary differentials operated through PMUs can make this more difficult however, and potentially undermine the sustainability of programmes and systems, with staff only wanting to work on Global Fund programmes. The **Pakistan** CT is aware of the large salary differential in government PMUs and work is planned to bring PMU salaries in line with the market. It is also often reported that the Global Fund programmes function on the front line largely because health workers are receiving Global Fund incentives e.g. in **DRC**, but widely reported elsewhere.

6.7 Limited Flexibility in Emergency Situations

The Global Fund has rarely participated in either international humanitarian forums or in-country humanitarian cluster coordination mechanisms. For example, CT staff members have not participated in the health clusters in DRC or Syria. Another example reveals a problem of access, not the lack of participation: In Mali, the M&E team asked the Local Fund Agent to be a health cluster observer, but the activities happened in remote inaccessible places outside the capital. The question then arises, whether the Principal Recipient should be the health cluster observer.

It is common for commodities funded by the Global Fund to be available (in stock) in a country when an acute emergency arises. There have been cases (e.g. in Togo and DRC) where country partners have wanted to use Global Fund commodities (such as bed nets, malaria treatment, ARVs) for displaced people, or ARVs for refugees fleeing a country (Syria) but the Secretariat or PRs did not have the flexibility to do this.

In Jordan, UNHCR gave a significant grant of other donor money to the International Organisation for Migration (IOM) to screen, diagnose and treat Syrian refugees for TB and only later were able to access some of the Global Fund Jordan TB grant (8 months after the TB programme for refugees had been running). This points to a crucial point: the Jordan example shows that reprogramming happens, but it is the very predicament of an emergency that prevents from responding to acute needs. Inside Syria the PR (UNDP) has only been able to conduct supervisory visits in the Damascus governorate, and has not hired NGOs to get around the country, despite the fact that organisations like the Syrian Arab Red Crescent has been able to support health programmes across the country. Many aspects of the NFM would be impossible at the moment (such as a country dialogue, CCM request, revising National Strategic Plans).

7. Current approaches implemented by the Global Fund in COEs

This section draws heavily from the findings of the case studies and Secretariat interviews to discuss the experience of the Global Fund programme implementation and oversight in COEs. As far as possible, it follows the same structure as the previous section.

7.1 Governance and oversight

7.1.1 Enhancing CCM governance, compliance and oversight

CCMs have provided a structured platform for various sectors to work together, in many cases for the first time. The ability to bring government, charitable groups, the private sector, donors, UN agencies, and affected populations to the same table has changed the nature of public discourse in many countries, including in some COEs.

“The idea that civil society groups can sit equally around a table with government, and openly challenge their decisions is ground breaking” (informant, Yemen)

The Secretariat is trying to address problems of CCM eligibility and effectiveness through recently revised guidelines for CCMs. Starting in 2014, CCMs will be required to conduct an annual self-assessment to allow the CCM to determine its degree of compliance and how well it is functioning. A key area for annual assessment is programme oversight. CCMs that are fully compliant will be able to submit a Concept Note without having to go through the CCM

Eligibility Screening (3 to 6). For non-compliant CCMs, providers will support the CCM to elaborate a milestone-driven improvement plan. Non-adherence to the improvement plan will have an impact on current and future funding.

Box 13: Critical success factors of the M-HSCC, Myanmar

Historically, a small donor community existed in Myanmar, which enabled coordination to function well. Global Fund withdrawal galvanised DPs to support to HIV/AIDS, TB and malaria through the Three Diseases Fund (3DF), which became the main sector coordinating body. Donors have since been supporting the government to do the right things, including development of a well-functioning CCM, to attract the Global Fund to return.

The Minister of Health is the lead for the CCM, a politician and a paediatrician with extensive understanding of “on the ground” issues and the importance of the Global Fund funds in addressing health needs. There are strong incentives to prove to the outside that Myanmar can successfully lead and implement the Global Fund grants and a strong desire on the part of the Minister of Health to have coordinated programmes; *“I don’t want a project based ministry”*.

The CCM has a strong Secretariat (UNAIDS) which worked with DFID to revamp the CCM. Two key individuals in UNAIDS and DFID helped drive the coordination process and the smooth functioning of the CCM/M-HSCC. USAID is funding two positions to support the CCM work on a daily basis, based in the MOH, in the capital city. Their remit is to ensure the success of Global Fund implementation and donor coordination through mentoring and supervision, data analysis, policy dialogue etc. In time, these positions will transfer to the MOH.

Donors have set up a division of labour for representation on the CCM/M-HSCC. An appropriate working culture and structure supports decision making, a governance manual with controls to avoid conflicts of interest, clear terms of reference for working groups, and a relatively transparent website exists.

7.1.2 Enhancing Principal Recipient governance, capacity and compliance

Weak PRs in COEs affecting Global Fund performance and impact have been identified as a key problem throughout this review. The ability of PRs to implement programmes effectively appears to be influenced more by technical, managerial and organisational capacity factors than factors directly relating to instability. The Global Fund and PRs are implementing innovative strategies to overcome some of these issues (see Box 14).

Box 14: Strategies put in place to overcome challenges of PR/SR performance

- QUART tool being used to assess risk in all grants, in some cases jointly with country partners, to increase understanding of risk and ownership of risk mitigation and management strategies
- Regular planned/undertaken OIG audits/reviews in COEs (e.g. **Myanmar, Pakistan and DRC**)
- Technical assistance for developing PSM plans or mechanisms (e.g. **Cote D’Ivoire**); requested CCM to establish a PSM working group which can provide support to PR (e.g. **Myanmar**)
- Change of PR e.g. to UNDP from government programme in Yemen and from UNDP to NGOs in **DRC**
- Portfolio restructuring/consolidation where there are signs of poor performance and/or where greater efficiencies can be sought e.g. **Chad**, reducing eight PRs to two, and 34 SRs to four; **Benin**, where streamlining of SRs saved US\$ 2million which is being reprogrammed
- Planned or recruited fiscal agents (FAs, see below) in 11 countries with FAs sitting with PR/SRs verifying expenditures and in some cases advising on improved or new accounting systems and building capacity within PRs.

Specific strategies put in place in CAR to improve programming

- Procurement agents and FA have been contracted to improve performance
- Management processes have been simplified for PRs
- Parallel delivery systems have been used where government systems did not exist
- The Additional Safeguard Policy (ASP) has been invoked
- The PR has been changed
- A QUART has been conducted to provide a comprehensive risk management strategy
- The CT has spent 25% of its time in-country

7.1.3 Enhancing Secretariat and LFA management

Country informants positively noted the greater engagement by CTs with their country portfolio (including more visits). The High Impact Country approach has been particularly effective, making a very positive contribution e.g. in Myanmar, and larger federal states like Pakistan and DRC, where dedicated CTs with time and resources for more visits (25% of their time) are making significant improvements in engaging with other partners, overcoming grant implementation problems and strengthening grant management and oversight. Greater country engagement and presence appears to be empowering CTs to make swifter and more flexible decisions, which is welcomed by implementing partners. The same approach could be applied to non-High Impact COEs which suffer from problems that make grant design, implementation and oversight very labour-intensive, but have fewer Secretariat staff resources to deal with them. Note that OECD policy guidance for improving operations in fragile states supports more focused staff deployment.

Risk management for staff has become more nuanced and has improved within the Secretariat with the current security team (who are housed in Administration but not yet on permanent contracts, thus potentially limiting their influence, and not linked to Risk Management). Good security information is purchased from *Control Risk* and also accessed from UNDSS, and updates provided to CTs with alerts. A 10 day working rule is followed (travel approved 10 days in advance, then security clearance procedure followed and briefing before departure and option of UNDSS briefing in-country). If *Control Risk* states “essential travel only” travel can be approved if measures are put in place for the trip according to Minimum Operating Security Standards (MOSS) standards. Insurance and evacuation are contracted from the company SOS. But CTs do not have standardised in-country security personnel they can consult routinely but do use ISOS, and UNDSS often provide advice on a good-will basis (but this varies between countries) and the CTs can contract local security firms.

The country case study for DRC involved a first time visit for CT staff to Goma, North Kivu province, (July 2013) and this enabled a first meeting between the Global Fund representatives and the UN humanitarian team and enabled the PR (CORDAID) to relatively easily include IDPs in their disease programming (20% of the population of North Kivu are currently IDPs). By being present, by finding out what is going on, creative solutions to complex problems can be more easily found.

Aside from the LFA which is supposed to be the ‘eyes and ears’ of the Global Fund in a recipient country, other bilateral partners have been used to play this role e.g. the DFID Health Adviser in Mozambique, though examples of this approach and experience and lessons learned are poorly documented. Contracting or developing Memorandums of Understanding with existing or new partners in COEs is an area that merits further exploration.

Local Fund Agents (LFAs)

LFAs are an important component of risk management in the Global Fund structure, contracted by the Global Fund to provide independent assessment, verification, advice and recommendations to GF on implementation arrangements and grant performance. As the Grant Management Assurance Framework (Global Fund, 2013, p.21) states:

“Local Fund Agents permit the Global Fund to balance three core principles that are at the heart of the organization: foregoing direct country presence, remaining a lean, flexible organization, and ensuring robust and systematic Assurance. To this end, the founders of the Global Fund intentionally did not limit the Local Fund Agents’ scope to financial statements or audit-type verifications. The broad range of Local Fund Agent services enables country teams to identify and address major risks.”

LFAs provide services during the entire grant life cycle

- *Before grant signing:* assessment of proposed implementation arrangements, implementers’ capacity, internal controls and systems. Review of detailed budget, work plans, and other grant related documents.
- *During grant implementation:* review of progress in achieving targets and appropriate use of funds. Verifying financial information and programmatic data and results.
- *When grant reaches the end of its life cycle or is terminated:* review of activities relating to the closing of the grant and advice to Global Fund on issues and risks related to grant closure.

Following the HLP recommendations and evolving risk management practice in the Global Fund, the differentiated approach to risk management is reflected in the allocation of resources for LFAs. The amount of funding for LFAs and hence 'level of effort' that they are commissioned to deliver is expected to be higher for high-risk contexts. With a higher level of effort, resources can be used for sampling more transactions and for spot checks and extra verification exercises. This differentiated approach is a useful tool for tailoring responses in the COEs.

A recent analysis of risk assessment and management (for the High Impact Countries only) indicates that COE countries do not necessarily have higher LFA costs per grant, with LFA cost per grant in 2013 ranging from \$92,000 in Pakistan to \$220,000 in DRC and \$231,000 in Nigeria. This partly reflects large-scale grants, as LFA costs as a % of disbursements expected in 2013 are relatively low for Nigeria (1.03% of disbursements) and DRC (1.65%), and in Zimbabwe (0.48%).

7.1.4 Strengthening risk management in grant operations

The Qualitative Risk Assessment, Action Planning and Tracking Tool (QUART) has been introduced as part of the operational risk management approach of the Global Fund, based on recommendations of the HLP. The approach is intended to make the process of risk assessment and management more effective, standardised and comprehensive. The QUART is conducted alongside an Implementation Mapping Analysis of the key entities involved in implementation of Global Fund funded programs and geographic coverage of programmes vs disease hot spots and coverage of key affected populations. The process provides an assessment of risks and identifies actions to mitigate and manage the risks identified.

The QUART has been applied during 2013 in all the High Impact Countries (except China where the programme is ending) and in a few other high risk countries including CAR, with the aim to cover 80% of grants by early 2014. The QUART will be extended to cover all grants in 2014 and assessments will be updated annually. The CT leads on preparing the QUART and as required involves other partners including the LFAs. In some cases (including DRC and Cote d'Ivoire) the risk assessment and action planning to adequately mitigate and manage risks has been concluded with the involvement of in-country stakeholders (CCM, PRs and partners) via a risk management workshop at country level and subsequent risk assessment and management plans developed by the CCM and PRs (strategic and cross-cutting risks per disease program for CCM oversight and grant specific risks per PR).

The QUART tool has four main types of risk:

1. Programmatic and performance risks, including sustainability risk;
2. Financial and fiduciary risks;
3. Health services and product risks, including Access and Human Rights risk; and
4. Governance, oversight and management risks (applicable to CCM, PR, Global Fund/LFA)

The grants are assessed in terms of 19 operational risks under these headings, and for each risk there are 6 to 11 contributing factors to be assessed that may contribute to the risk.

The highest risks identified across *all* the High Impact Country grants in the first round of QUARTs are: risk 3.1: Risk of treatment disruption, due to weaknesses in procurement and supply management leading to stock outs of supplies (in 94% of grants); and risk 3.3: Poor quality of health services (in 89% of grants).

For the COEs among the High Impact Countries, the top two risks are 3.3: Poor quality of health services and risk 1.4: Not achieving programme outcome and impact. Risk of treatment disruption was the third highest risk, while 1.5: Poor aid effectiveness and sustainability was also higher up the list than for the non-COE High Impact Countries.

The QUART analysis seems to be a useful tool, giving a clear picture of the levels of risk as well as a systematic approach to plan actions. The QUART assessment enables both a grant risk view as well as a strategic risk view of the disease and country portfolio and has been used to better tailor management of grant portfolios, optimize existing investments and design strong NFM proposals. It shows fair correlation between COEs and high-risk assessments, as might be expected (as shown in Section 4). FPMs interviewed reported that it has been helpful in broadening the focus on risk from a narrow fiduciary focus to look more broadly at programmatic risk of failing to reach beneficiaries. The heat

map provides a concise sense of areas of risk and its review by senior management in the Operational Risk Committee ensures due attention and opportunities for the FPM and CT to suggest creative solutions and flexible responses. Over time the Global Fund will define its appetite for risk or risk tolerance – recognising that risks are typically higher in COEs, the point is to be informed about risks and manage them, and to learn from experience. E.g. in Myanmar the ORC approved a first expansion of GF engagement to conflict zones to reach so far unserved vulnerable population.

QUART compared to OECD's framework for risk assessment

In order to consider the suitability of QUART to assess risks related to COEs, the QUART can be compared with the OECD DAC framework which identifies three different types of risk in providing aid to fragile and conflict affected states (OECD 2011c):

- **Contextual risk** – risks of state failure; return to conflict; development failure; humanitarian crisis. These risks are due to the country situation, and generally outside the control of the international aid agency.
- **Programmatic risk** – risk of failure to meet the objectives of the programme or risk of doing harm in the wider environment, for example by aid fuelling conflict, unintended political bias in aid distribution, or negative impact on macro-economic stability.
- **Institutional risk** – risk to the aid provider such as reputational damage, financial and fiduciary risk or security risks to staff and partners.

Looking at how the QUART addresses the issues raised in the OECD framework for risk analysis in fragile and conflict affected states, the QUART mostly focuses on programmatic risk in terms of inability to meet the objectives, and on institutional risk in terms of financial and fiduciary risks. In doing so it allows for some (albeit limited) contextual risks as contributing factors:

- Under the risk of failing to achieve targets (risks 1.3 and 1.4), there is a contributing factor “inadequate stability of country and enabling environment, in terms of significant political changes or social unrest, on-going conflicts, poor physical infrastructure, natural disasters, humanitarian crises”.
- Contextual risks also feature in the risk of fraud (2.3) with a contributing factor of: “recent or imminent events that may potentially weaken normal control mechanisms and/or increase pressure for fraud, theft or corruption, including natural disasters, civil or military unrest, political change or elections”.
- Risk 2.5 includes factors related to exchange rate changes and inflation.
- Country political, social and legal environment feature as contributing factors to risk 3.4 on equity and human rights.

Thus there is limited attention to the broader country context in the QUART, while the issue of ‘doing no harm’ in the design and implementation of programmes does not feature explicitly in the QUART approach. This raises the question, whether the Global Fund should bring more political and economic contextual analysis into the QUART or rely on an initial country assessment. International consensus on the need for more contextual analysis for COEs is discussed in Section 9 and 10 in this report.

The 2011 OECD report reviews risk assessment arrangements of different agencies and identifies that few have a separate risk assessment process or tools for fragile states. Efforts to pilot joint risk assessments in fragile states have proved difficult and the June 2013 INCAF meeting proposed to promote good practice on sharing risk assessments. The Global Fund could engage with these processes and benefit from the broader political and economic risk assessments by other agencies.

7.2 Financial management and fiduciary controls

The Global Fund introduced the ASP in response to problems experienced in some countries especially around financial management and misuse of funds. The ASP involves more intervention and controls over financial resources and typically includes a range of measures, including requiring use of international pooled procurement mechanisms or contracting procurement agents.

One measure commonly used under ASP is introduction of zero-cash policies so that funds are not transferred to implementers in advance of implementation. Whilst this contributes to the security of funding, the case studies indicated that it can also cause delays in implementation. In Myanmar for

example, delays in reimbursements of up to a year led to reluctance among participants to attend the Global Fund supported activities, until the system for reimbursement was improved in 2012.

Fiduciary or Fiscal Agents (FAs)

Fiduciary or Fiscal Agents (FAs) have been introduced in the last year in some ASP countries as a measure to reduce risk of misuse of funds and inadequate financial procedures. They are used in the face of an emergency or detection of financial irregularities, particularly in COEs. FAs were introduced in Niger, DRC, CAR and Guinea Bissau, and previously in Myanmar. An FA-type arrangement is being established in Cote d'Ivoire. The role of the FA in Niger is outlined in Box 15.

Box 15: Use of Fiscal Agent (FA) in Niger

- A FA was appointed in Niger in 2013 as one of the risk management measures under the ASP. The FA has one staff member sitting in the office of each PR, plus an international team leader (part time, based outside the country) and national deputy team leader. The FA approves and co-signs any expenditure under the grant
- The FA is to cover all the PRs with active grants – with two government PRs and two INGOs expected by the end of 2013. A new INGO PR (IFRC) will be supported by the FA in the early stages of the grant, with the expectation that this will not need to continue. The intention is to phase out the FA once financial management procedures improve
- The budget is Euro 72,000 per quarter per grant – so EUR 1.15million per year for four grants. The costs are funded out of the grants
- The introduction of the FA has allowed expenditure to restart and is reported to be working well. The FA is expected to build the PRs and SRs capacity to justify expenditure and follow Global Fund requirements
- In the case of the HIV grant with the National AIDS Council as the PR, the GF grant supports 4 regions, in coordination with the World Bank which supports another 4 regions. The FA only deals with expenditures from Global Fund grants, while the local World Bank office oversees expenditure from its funding.

Source: Interview with Niger FPM

The case studies indicate the introduction of FAs has broadly been a useful tool for managing high risk settings and allowing grants to progress, with reduced risk of fraud and improved financial reporting. However the use of Fiduciary or Fiscal Agents, FAs, can and has presented its own problems:

- In **DRC**, the LFA picked up weaknesses that the FA did not identify. A recent OIG consultation recommended that the FA be required to take immediate actions to address weaknesses
- In **CAR**, the first FA, who reported to the PR, was replaced after implication in fraud. The second FA has been hampered by the PR in fulfilling its key control function. The FA is now contracted directly by the Global Fund
- In **Chad**, grant implementation was delayed by one year under a government PR as it took that long to appoint an FA.

The FA is a new and evolving measure whose scope can be adapted to country contexts. For example, in Cote d'Ivoire, the FA has an explicit remit to review control systems and build capacity of the MOH systems, as well as supporting financial management of grants. The drawback of the FA is their lack of programmatic skills and remit, leaving the Global Fund Secretariat involved in approving expenditure. This level of micro-management is resource intensive for a stretched CT and it changes the role of the Secretariat, to be more involved in management and oversight than the Global Fund model envisages. The FA remains a useful risk management option for fragile states, with its focus on financial risks, but there may be contexts where it would be preferable to have more programmatic support.

The Global Fund has taken other measures to strengthen financial management in the case study countries, including changing PRs and requesting some PRs to strengthen their financial management by taking on additional finance staff. Measures to reduce the numbers of PRs and SRs (discussed above) also help to simplify the scale of the financial management task and risk facing the PRs and their oversight requirements.

Financial management and fiduciary issues remain a concern in COEs and this is reflected in the QUART assessments of High Impact Countries, as noted above. The QUART assessment indicated that

the COEs are more likely to have poor ratings for financial and fiduciary risks (29% of current COE grants had a red rating compared to 16% of non-COE grants in this category of risks). This is the assessment after the existing risk management measures have been applied. The QUART process also identifies risk mitigation measures for the risks, and on the financial management and fiduciary side these include the measures described above (including requiring use of pooled procurement, fiduciary agents, enhanced LFA and country team capacity, and zero cash policies).

7.3 Access and Health Systems

7.3.1 Improving access and promotion of equity and human rights

The Global Fund's 2013 HIV and Human Rights Policy document raises the profile of women and girls as MARPs as well as encouraging the identification and targeting of MARPs for HIV. It may take time for these requirements to feed through into results on the ground, and to achieve the scale of operation required to raise coverage among underserved groups including the under-fives, women, inaccessible and displaced populations who are affected by the three diseases. It will be important to ensure these large affected groups are also targeted as MARPs, and to monitor service coverage of these groups.

The current investment approach and NFM are providing opportunities to advocate for human rights and equity and to develop innovative partnerships to improve access to services by MARPs. This has already happened in Myanmar where the CT visited China to negotiate with the Kachin, the Myanmar MOH and the Chinese, on how to operate in the restricted border areas. It has been agreed that Save the Children (SCI) based in China (currently working in Kachin from across the border) would act as SR, and would report to the Kachin authorities and SCI, Myanmar.

7.3.2 Enhancing quality of health services and promoting integration

Strengthening effectiveness of the integrated service delivery platform remains a key challenge. Countries are encouraged to identify weaknesses in health systems performance and to design cross-cutting HSS interventions that can be either included in a disease grant or funded as a separate HSS grant. They are encouraged to focus on the most efficient way to increase impact, which, in many contexts, has meant interventions to overcome short term obstacles to achieving the programme targets (e.g. in-service training of health workers in specific areas of HIV) rather than investments in systemic health system weaknesses (such as pre-service training and long term supply of staff).

Yet, the Global Fund places much focus on *sustainable* impact. Many *Health System Strengthening* interventions are designed with this in mind. In the number of sampled countries for this review, the team found a higher proportion of HSS interventions, which aimed at producing *immediate* results, as exemplified above. This is understandable in the context of fragile states. But this does not warrant the general recommendation that countries should focus on short-term obstacles, when *sustainable* impact remains the key policy goal.

However, countries with poor health governance or particularly weak health systems that might benefit from HSS grants have often not taken up the opportunities offered by funding from the Global Fund to address system weaknesses. The Global Fund does currently have the flexibility to make large inputs into strengthening systems. The grant that supports DHIS implementation in DRC, harmonised with contributions from other donors, is a case in point. But in other COEs, where the need for system strengthening is a prerequisite to getting effective programmes and results, the CCM has not taken advantage of the flexibilities built into the country allocation (for example in Chad, which has very weak systems, where the CCM has never requested an HSS grant). CTs working on COEs should make systems grants a high priority in COEs with weak systems. It could become a prescribed policy that COEs with weak systems would have systems-strengthening grants.

There are limited opportunities within proposal documents (including the new Concept Notes) to discuss how HIV/AIDS, TB and Malaria interventions piggy back and build on service delivery platforms in ways that have positive impacts for increasing coverage with key interventions for the three diseases (and other services). The HSS Information Note provides guidance on integrated service delivery, but there is no explicit instruction to provide details on synergies except for HIV/TB, or to consider scope for increasing efficiency by delivering alongside other services, where this is appropriate.

Examples from the case studies do exist of Global Fund actions enhancing the quality of health services and facilitating greater integration of services.

- In **Chad**, doctors have been trained
- In **Yemen**, the malaria programme has supported HR development and collaboration with IMCI
- In **South Sudan**, Global Fund HSS grants have focused on infrastructure improvements
- In **DRC**, an HSS grant is perceived to support horizontal processes such as supervision of all activities.

Other examples of Global Fund programmes making the most of opportunities to work in an integrated way with other services and systems include (see Box 16).

Box 16: The Global Fund programming and health systems: examples from case studies

- In **Côte d'Ivoire** most HIV/AIDS, TB and Malaria interventions are delivered in an integrated way with other health services. This includes the provision of one million nets to pregnant women and children at routine services between 2007 and 2011 and nets were also distributed alongside a measles campaign in 2008. The forthcoming net campaign is considering ways to build on immunisation campaigns, vitamin A distribution and other services to increase reach and efficiency. There is high attendance at ante-natal care (91% of women see a health provider during pregnancy, according to the 2011/12 DHS) so there is scope for increasing coverage of presumptive treatment for malaria (IPTp) as well as providing nets, and the HIV programme has planned for expanding provision of PMTCT by links with ante-natal care
- In **Myanmar** TB and HIV services are increasingly being integrated via a “one-stop” service, particularly targeting intravenous and other drug users. There is also convergence of HIV/AIDS, TB and Malaria planning via a consolidated Concept Note. The malaria programme is well integrated into the general health service under state, regional and township medical offices. Village Health Committees initiated under Round 9 Malaria are in charge of vector control and now function independently of the Global Fund funded programme
- In **Pakistan**, Provincial CCMs have been set up for provincial health disease planning (with more credible, inclusive plans). In addition, specific HSS components of proposals (e.g. Malaria Round 10) are reported to have: increased coverage of health services at all levels of facility (e.g. including tertiary care hospitals to undertake DOTS care); trained health workers; improved PSM of essential medicines and health products; improved laboratory and warehousing infrastructure; improved surveillance capacity; strengthened planning and management capacity of Federal and Provincial programmes; increased private sector engagement and service delivery; and ensured the institutionalization of national health accounts. TB and malaria services are reported to be fully integrated with primary health care services
- Greater engagement by the CT in broader health sector coordination is welcomed by development partners e.g. in **South Sudan** where so much needs doing in health systems that no single partner can work alone. The CCM will take a lead role in outlining responsibilities for key partners and the CCM.

7.3.3 Enhancing reliability of supplies and quality of health products

Global Fund grants have included measures to enhance the reliability of supplies, such as establishing separate supply chains for HIV/AIDS, TB or malaria products and using procurement agents or pooled procurement mechanisms. In many COE contexts, national PSM systems may be embryonic or un-useable for the large scale commodity supply and distribution needs of the Global Fund.

Substantial investments are being made to try to stimulate and strengthen the capacity of national PSM systems in some COEs e.g. Chad, Myanmar, and Cote D'Ivoire. In Cote D'Ivoire, the move to a comprehensive plan for PSM and information systems with other partners is a positive development. Slow implementation so far in these systems and in restoring infrastructure suggest that technical capacity may be needed, and monitoring of the implementation of such system strengthening will be important.

At the same time there is a need to find alternatives of “what works” in each context by using (as the Global Fund does) local initiatives such as the private regional pharmacy ASRAMES in eastern Congo that provides commodities to many provinces. This was set up by a group of community based organisations and international agencies as a successful not-for-profit but efficient pharmaceutical depot and supply system.

The Global Fund and its partners have taken innovative actions to ensure stock outs are limited, PSM functions are strengthened and disruptions to essential services in COEs are minimised. Examples are included in Box 17.

Box 17: Innovative actions to minimise disruptions to essential services

- Use of a French military warehouse for safe storage of commodities in **CAR**
- Use of an INGO for procurement and supply of drugs as short term measure in **Myanmar**
- Investment in third party procurement e.g. UNICEF for **Chad**, procuring drugs and vehicles; VPP and/or independent procurement agents in **Pakistan**. Inventory management and distribution goes through Pakistan's national systems including to private providers. **Yemen** procurement through third party but distributes through national systems
- Importing to neighbouring countries while waiting for ports to reopen e.g. **Cote D'Ivoire**'s use of PEPFAR store in Ghana; shipping medicines to Beirut and onward to Damascus, **Syria** via road transport
- **Cote D'Ivoire**'s close collaboration with PEPFAR to ensure adequate ARVs were available during the crisis. The Global Fund was unable to release funds for use in country so agreed to reprogramme funds to procure ARVs, while PEPFAR was able to continue disbursements for service delivery on the ground
- Extra insurance taken out by an INGO PR against civil disruption (funded from the Global Fund grant), hence some reimbursement on losses of nets in **Cote D'Ivoire**
- Partnerships to develop consolidated system-wide PSM national strengthening plans in **Cote D'Ivoire** with PEPFAR. In **Myanmar**, the CT has requested CCM to establish a PSM working group with CCM and non-CCM members to provide assistance to the PR and including oversight and monitoring
- Strengthened procurement arrangements including comprehensive PR PSM manual in place; additional recruitment of logisticians at provincial level; and GMS technical support to PSM for the national malaria programme in **Pakistan**

7.3.4 Strengthening M&E, country data systems and data quality

The Global Fund is investing in M&E systems in COEs. Partners generally see this as positive and a niche area for the Global Fund, as well as investment that can yield broader health system benefits. Several initiatives have been taken:

- The **Global Fund** joined partnership with WFP and UNMISS and other humanitarian entities to airlift supplies to points of need during conflict and flooding.
- **HSS programming** can be used to strengthen the M&E system of the country, for example to foster creative solutions within emergencies for data collection.
- **Coordination** with emergency health partners and donors remains a key challenge.
- The UN Refugee Agency's own health management information system could be an appropriate system for data collection within an emergency.
- The **District Health Information System 2 (DHIS2)** is being implemented in several COE countries

Box 18: Strengthening M&E systems

- In **DRC**, under the High Impact Country policy shift, Global Fund investments are being made to support the roll out of national M&E software. The shared donor support to the national roll out of DHIS2 will potentially improve the M&E of grant outcomes and has positive systems-wide benefits. The Global Fund is financing US\$ 2.3million out of US\$ 16million invested by donors. The harmonisation of the indicator list within DHIS2 should contribute substantially to creating a national health data base and impact national planning
- In **Cote D'Ivoire**, a consolidated plan for HMIS is under development, as a basis for support by several partners to strengthen the system, rather than separate HMIS components under each grant
- Piloting electronic TB surveillance in districts and conducting surveys, results of which are used for planning in **Yemen**
- In **Myanmar**, the Global Fund appears to have relatively weak influence on gaps and performance of national M&E and data quality. CT trying to ensure that in Global Fund expansion to conflict zones, SRs, at least informally, report to MOH Myanmar. PRs (e.g. for Malaria) are advocating to MOH for standardised, integrated reporting systems. Strengthening measures are in place to improve the PRs M&E capacity including development of PR M&E plans, monitored by the CT.
- In **Zimbabwe** the DHIS roll-out has been catalysed by special initiative funds.

7.4 Global Fund funding mechanisms

7.4.1 Facilitating PBF and modifying the current funding model

Funding has been linked to performance in several ways in the previous rounds-based funding model, primarily through the grant rating and subsequent adjustment of funding levels and disbursements, especially at the Phase 2 or grant renewal stage. The grant rating was linked to performance on input and activity indicators and increasingly linked to outcomes (such as coverage), and adjusted for grant management performance/risk.

The case studies indicate that there has been some flexibility in applying PBF to compensate for specific challenges faced (e.g. in CAR, where a Phase 2 malaria grant was allocated more funding despite its 'C' rating).

In the NFM it is likely that the level of disbursement within the grant will be less directly linked to grant ratings, with more focus on programme outcomes and impact at annual reviews. This disbursement approach seems appropriate and helpful for COEs, which by their nature tend to be less stable and therefore in more need of adaptation to grant design and targets.

In line with the increased focus on strategic impact, the formula for country allocations in future rounds may take past grant performance into account (based on past grant ratings and progress on impact). This raises the question of whether COEs will be able to provide the evidence to judge impact, given the common weaknesses in their information systems and monitoring capacity. If the data is not available, will they be penalised for this or will the Global Fund and partners address this by allocating extra resources for M&E systems and verification of results? Will there be allowance for problems of data quality due to disruption or conflict?

If COEs continue to have lower grant performance, this will lower their access to funds over time. This may be the Global Fund's intention, i.e. to allocate more funds to programmes and countries that are having more impact on the three diseases, which necessarily means less for those with lower performance and impact.

7.4.2 Mechanisms to support roll-out of the NFM in COEs

The NFM is a radical change in the Global Fund process for awarding grants. It provides an excellent opportunity to adapt the Global Fund support to the contexts of COEs. This section looks at the process, opportunities and challenges of applying the NFM in the COEs (see Box 19 and Box 20).

Findings on the NFM from the case studies

Myanmar is the only country studied which was an early applicant to the NFM across all three diseases. Positive experiences are reported in recent documents on the NFM process (as seen below).

Box 19: Positive NFM experiences: case study examples

Myanmar: The M-HSCC, now a policy advice and partner coordination mechanism for the entire health sector, helped facilitate country dialogue. The NFM was widely perceived as a break with the past, with a strong sense of team work between Global Fund Secretariat, TRP and country partners. Country dialogue also took place with ethnic minorities

Cote d'Ivoire: NSPs have been developed; with relatively few development partners in each disease program, the Global Fund has a key role in supporting strategic investments. In the case of HIV/AIDS, Global Fund is already working closely with the major funder, PEPFAR, and both are targeting high risk groups/MARPs. For malaria, transitional funding has been defined. There is widespread recognition of the need to strengthen basic systems for drug supply management and information systems, and the NFM process should provide a good basis for agreeing which partners will take the lead in providing and harmonising support for each area, and their respective roles

Pakistan: The highly decentralised nature of the health system (with plans and service delivery by provincial governments and diverse disease conditions and micro-epidemics) calls for close working with provinces in grant development in order to ensure grants are more strategic and targeted to have most impact. As a High Impact Country, there is a full time CT which is enabling closer engagement with PRs and partners in country, but participating in country dialogue and assessment of risks at provincial level would be stretching

Yemen: Poor functioning of the CCM is a risk for getting good outcomes in terms of agreeing the allocation of funds and converting Concept Notes to grants ready for implementation. This will need active engagement by

the Global Fund and partners, but is hindered by difficulties in access and limited technical support available in country. The formats and requirements may be unnecessarily complex and demanding for the grants envisaged

South Sudan: Similar issues as for Yemen may be the case. However, provided good TA to assist in the process, and sufficient time allocation, the development of NSPs may get a boost from the NFM process with wider implications

Syria: In the current civil war context of Syria, the NFM would not be an appropriate mechanism to define how best to allocate the Global Fund resources and implement the Global Fund-funded programs. The context is not conducive for 3 year planning as the response needs to react and adjust as the situation evolves, and full country dialogue is not feasible

CAR: The assessment of risks (QUART) and the concept of a disbursement ready grant with possibility of differentiation based on context, capacity or risk will help to anticipate issues and should allow risk and capacity challenges to be addressed before grants start. The country dialogue process with the CT allows for shared responsibility for achieving a quality grant. Adequate Secretariat staff resources are required to avoid delays in implementation of the NFM

DRC: Past grant suspension was devastating for coverage of vital disease services (for example there was a significant decrease in TB treatment coverage in 2010 – 2011 following grant suspension). The NFM should help to largely avoid grant suspension by making grant design more responsive, by pre-empting problems and by identifying weaknesses much earlier.

Box 20: Opportunities and challenges of implementing the NFM in COEs

Overall, the NFM should **benefit** COEs by:

Strengthened focus on critical issues in disease epidemiology. Greater partner involvement in the design of grants should help target Global Fund support where it can have most impact on the diseases and improve coordination with other funders.

Greater engagement by the CT in-country and with partners should help deepen knowledge of the political and social context, including human rights issues, enhancing grant design, selection of implementers, and ensuring grants “do no harm” – a critical factor identified for agencies working in fragile states.

Early engagement in Concept Note development and early country risk assessment for COEs (as per the NFM) should help to identify areas for strengthening, helping to pre-empt problems and identify weaknesses and solutions. This should enable more appropriate and responsive grant designs.

Engagement with partners in the broader sector wide dialogue at appropriate levels (including province level in the case of a federalised country) should help identify ways to build on existing services that work well and appropriate design of HSS activities.

The case study findings suggest that the NFM processes offer advantages over past Global Fund practice in some respects, but may need to be adapted to address the issues that arise in chronic COEs, including the legitimacy of the CCM in representing different interests. Acute emergencies are also likely to need a different response, which is can ensure appropriate and “rapid” support to countries.

7.5 Support in Emergency Situations

In many countries, the Global Fund is the major or at least a significant supplier of commodities for the three diseases, so there may be few other options available for HIV/AIDS, tuberculosis and malaria commodities in the short term. In acute crises, where country partners (usually the CCM and PRs) identify an urgent need to deploy resources, particularly commodities, the Global Fund should be able to respond to this need. In some cases this reallocation will mean fewer resources for planned activities, because supplies have gone to different areas or populations than originally envisaged (or possibly because stocks have been destroyed in the crisis). Currently, extra commodities have to be supplied from domestic resources, from other humanitarian sources or by amending grant targets and PSM plans. During acute crisis, country systems have at times to be by-passed.

8. Partner approaches and lessons learned from operating in fragile states and their applicability for the Global Fund

8.1 Broad approaches and lessons from the international community

The international community has increased its focus on fragile states, justifying this interest on both development and security grounds. Policy debates and activities typically focus on two main issues:

1. How to expand delivery of services in these countries despite the fragility
2. How to address the underlying causes of fragility and enhance stability and economic growth

There are many prescriptions of how to ‘fix’ failing states and how to drive successful transitions (Ghani & Lockhart 2008). The World Bank recognises that to break cycles of violence requires the strengthening of legitimate institutions and governance, thereby providing citizen security, justice and jobs (World Bank 2013).

Based on donor experiences, the OECD has helped steer the development of aid effectiveness policies (e.g. promoting ownership, harmonisation, alignment, results, mutual accountability) and international engagement in fragile states (see Box 21). Aspects of the Global Fund’s work align with some of these principles e.g. the important of context, of promoting non-discrimination and of aligning with local priorities, avoiding pockets of exclusion.

Box 21: OECD DAC Principles for Engagement in Fragile States

1. Take context as a starting point.
2. Do no harm.
3. Focus on state building as the central objective.
4. Prioritise prevention.
5. Recognise the links between political, security and development objectives.
6. Promote non-discrimination as a basis for inclusive and stable societies.
7. Align with local priorities in different ways in different contexts.
8. Agree on practical coordination mechanisms between international actors.
9. Act fast but stay engaged long enough to give success a chance.
10. Avoid pockets of exclusion – address the problem of “aid orphans”.

Source: (OECD 2007)

State building is the current diction that frames donor investment. At the 2011 Busan High Level Forum on Aid Effectiveness, a self-selected group of 19 fragile and conflict affected states known as the g7+ concluded a “New Deal” with donors and international organisations. The New Deal calls for approaches that are 1) better tailored to fragile contexts 2) invest more in country systems, 3) support critical capacities, and 4) are FOCUSED – i.e. are country-led and owned transitions out of fragility, as well as aligning and managing aid and resources more effectively. **FOCUS** refers to **F**ragility assessment; **O**ne vision, one plan; **C**ompact with stakeholders and the public; **U**se Peace & State building goals to monitor progress; **S**upport political dialogue and leadership.

At international level, the OECD coordinates the only existing international network on fragile states – the International Network on Conflict and Fragility (INCAF). This network includes bi- and multilateral donors, international organisations and partner countries (including the G7+ countries). The purpose of INCAF is to develop consensus around responses to conflict and fragility by working on financing and aid architecture issues, peace building, state building and security, and harmonising and aligning their responses in fragile states. Policy documents emerging the OECD Development Assistance Committee have been developed by INCAF and therefore represent the most current, joined-up thinking of major development partners and fragile countries.

8.2 The importance of tailoring to context, the need for assessments, and for flexible country programme design, implementation and monitoring

Recent **World Bank** (2013), **Asia Development Bank** (ADB 2012) and **Africa Development Bank** (AfDB 2012) evaluations of investments in fragile states, **DFID** (2012) and **OECD** policy guidance (OECD 2011a, 2011b) all emphasise the importance of doing things differently in fragile states.

A brief synthesis of selected lessons learned from the evaluations/guidance on international lessons follows:

- Systematic and **thorough analysis or shared assessment** of the context, political economy and incentives at work is a key precondition for designing effective interventions that do no harm and can be delivered within local political realities.
- Analysis should not just focus on assessing problems and gaps but should also look at possible **drivers of stability** and institutional strengths. This type of analysis needs to be embedded within a wider set of organisational principles about **learning and integrating knowledge into practice**. Such a 'culture of analysis' and ability to feed findings of analysis into programming is critical to ensure strategies, programmes and day-to-day implementation is informed by contextual information.
- To work more effectively in fragile states, there is a need for i) **flexible and innovative programming** that can adapt to unexpected developments ii) **simpler project or programme design and accountability frameworks** with fewer objectives and criteria for assistance. Iii) A **theory of change** with an analytical explanation of the logic that underpins the results chain is very relevant in fragile states but will need to be flexible, responding to new circumstances, analysis and understanding iv) longer time frames and **regular operational monitoring and evaluation** of progress with the partner country and implementing partners (see Box 22).
- **Risk management** is essential for working in fragile states. The counterfactual costs and risks of inaction and non-engagement are high and widely recognised by donors. Joint assessments of the context support donor risk-taking. Risk management should be accompanied by an active management response.
- Closer **relations and coordination** between donors and partners including **joint risk and fragility assessments** (as per the New Deal), and increased presence on the ground are essential to improving the effectiveness of programmes in fragile states.
- Different approaches point to the need to **combine long term programming** grounded in an understanding of contextual risks with use of **faster and more flexible instruments** that can respond to particular opportunities, threats and events.

Box 22: MDTF: More flexible programming and innovative monitoring

The *Multi Donor Trust Funds* review, undertaken by DFID, stated that fund managers need to be innovative, pilot ideas and have the flexibility to reshape the programmes in order to optimize impact (DFID 2013). Flexibility also requires strong monitoring and review processes. The MDTF review recommended to adequately addressing the monitoring needs at the very outset (in terms of design, indicators, baselines and a properly resourced monitoring framework) to ensure timely, measurable results and to permit proper evaluation. The Common Humanitarian Fund in CAR and the Emergency Response Fund in Pakistan were based on limited needs analysis in conflict-affected areas, and in consequence tended to be supply-driven. By contrast, Yemen's Social Development Fund had effective monitoring at the level of outcomes (DFID 2013). Continual review, feedback and flexibility are vital to ensure success of pooled funds. Again this finding can apply to programmes more widely and not just to MDTFs.'

DFID is developing arrangements with a **number of NGOs on improving approaches to monitoring** including indicators of conflict and violence. This will include a call-down system for direct support to country offices. In addition, it recommends that data can be obtained in difficult environments but **investment needs to increase**. This may include commissioning new data, supporting national or other organisations' data collection, whilst building their capacity; triangulation of different types of data: surveys, administrative data and focus groups. Obtaining data will involve working **with local partners** (even in Somalia there are tertiary institutions trained in monitoring, and a range of companies competing for business); contracting in international companies; drawing on different data sources in more stable environments. Involving beneficiaries is a practical way of generating data (DFID uses mobile phones, digital cameras to verify data in DRC's 'Health village sanitation programme' managed by UNICEF).

Sources: (Commins et al 2013, DFID 2012)

ADB guidance emphasises the importance of **clear monitoring plans** and recommends joint **semi-annual reviews** involving stakeholders **including CSOs**. Frequent monitoring and site visits to ensure early warning of potential problems is recommended. ADB has a **policy of additional financing** which

allows them to start on a small scale and then scale up approaches that are shown to work, with modifications if necessary.

USAID uses fragility assessments and flexible programming for its support to countries defined as ‘in transition’ i.e. countries that are fragile but have developed a *Transition Strategy*, support for which may be an objective within a USAID cooperation strategy. Conflict, crisis and fragility dynamics analyses are conducted to determine whether sector-based interventions are appropriate to advance the goal of the transition process (USAID 2012). Contingency and scenario planning is built into the strategy, permitting resource reallocation in the face of renewed crisis, conflict or improvement. For complex environments (e.g. civil war), additional criteria apply relating to transition strategy content and procedures (USAID 2013).

The GAVI Alliance has recently introduced a new policy “GAVI and fragile states: a country-by-country approach” which aims to introduce new flexibilities for countries experiencing exceptional challenges. Details of the GAVI approach can be seen in Box 23.

Box 23: GAVI’s approach to working in fragile states

In 2012, GAVI approved a policy to develop a country-by-country tailored approach for countries experiencing short and long-term challenges in achieving their immunisation targets. Two approaches have been developed: i) a **‘tailored approach’** for chronically unstable countries. This approach is aligned and developed in conjunction with country multi-year immunisation planning processes and represents a joint country/GAVI alliance agreement for 3-5 years. The tailored approach is informed by **existing analysis**, data, GAVI and bilateral agencies’ assessments. The flexibilities are developed with country partners and are specific to each context ii) **one-off, short-term flexibilities** for countries experiencing **acute** man-made or natural disasters e.g. **reprogramming** cash support. GAVI is not a humanitarian organisation but can see a **transitional gap filling role** when humanitarian organisations retreat after a crisis and the country is resuming normality.

Identification of these countries was based on scoring countries (taken from the FSI and other sources e.g. WHO coverage reports) against a number of GAVI criteria. The identification process is run every year to make sure no new countries are missing from the list. **Eleven countries** have been identified for a tailored approach of which 2 countries (Nigeria and DRC) have started. So far no more countries have been added or removed as a result of an annual review of the list.

Flexibilities that could be extended include (but are not restricted to) TA to reprogramme cash support; flexibility in application and monitoring cycles to fit with national cycles; specific advocacy measures; additional TA; additional financial resources; collaboration through bilateral and non-state actors; reprogramming up to 50% of unspent cash support in emergencies; acceptance of emergency applications for HSS by countries in crisis; new or replacement vaccines in crisis situations; review and possible exemption of country co-financing and review of performance based funding following a crisis. In the case of Nigeria, one flexibility GAVI has accepted is state-level rather than national coverage data for vaccine support.

A number of **lessons learned have emerged from the policy development process** (there are few implementation lessons as yet):

- GAVI established an **expert technical working group**, which remained in place for duration of the policy development process. Members included GAVI Alliance partners, OCHA, UNHCR, OECD, bilateral partner, country representatives and experts. There also was a public consultation process
- Developing a tailored approach takes **time**, is **labour intensive** and is difficult, particularly with **no country presence**. GAVI relied heavily on its country partners, WHO and UNICEF. **Extra staff resources (additional Country Responsible Officers)** have been required in Geneva and by partners.
- Advice is to keep the tailored approach **simple** – there is often limited capacity in headquarters and at country level
- It is important to demonstrate long-term engagement but also use short time frames and process indicators for flexibilities.

Source: (GAVI 2014)

Designing programmes for conflict environments

DFID’s partners in southern Somalia were able to maintain programmes in areas controlled by militia by supporting District Health Boards that continually negotiated access. Engaging local leaders, women and health workers has proved vital for ensuring sustainability in a changing conflict landscape. Inputs from local communities are important to improve security and outcomes.

NGOs also need good long-term committed staff, many of whom should be local. In South Sudan potential partners for the Health Pooled Fund have to demonstrate contextual understanding, operational resilience and responsiveness in changing scenarios.

Some programmes have prioritised marginalised communities in the hope that they can also help to reduce poverty and might increase government legitimacy (e.g. DFID support to semi-arid areas of Kenyan nutrition programme; DFID support for all three Somali political zones with a development approach, including in areas of on-going conflict).

Several donors (including **DFID, ECHO/EU and USAID**) are trying to make humanitarian programmes have both development and sustainability features, and development programmes to have conflict resilience and disaster-response capabilities. Aid instruments and donors need to adjust to different levels of conflict and fluctuating levels of government capacity (DFID 2013). See Box 24 for donor approaches to district delivery in DRC.

Box 24: Donor approaches to strengthening services at district level in DRC

In DRC, both the EC's development programme, AIDCO, and the humanitarian branch, ECHO, has given grants to NGOs for district delivery in the northeast. The NGO Medair had district delivery programmes across more than 20 health zones with comprehensive activities including safe blood, monthly supervision visits, and improving consultation, immunisation and assisted delivery rates. The International Rescue Committee has had similar grants from OFDA and USAID for district delivery in many districts in the Kivus, and Merlin from DFID in Maniema. These grants varied in content, but aimed to support safe delivery, essential young child care, treatment for common diseases, as well as strengthening local community management via health centre committees and outreach via community volunteers.

A more consolidated model of service delivery in DRC is now being implemented with several donors giving support to district delivery, but the amounts allocated have reduced per district as more support has come centrally via both MOH and via disease programmes such as those supported by the Global Fund, PEPFAR and GAVI. While this has importance in building capacity in national disease control programmes, in promoting country ownership and oversight, large gaps remain in service provision, and there is a risk that a more vertical approach can risk reducing the capacity of health zone teams to plan for comprehensive health needs across their coverage area. Aims to strengthen citizen participation and accountability, and district health management may not be included. There may also be parallel use of an ill-defined community cadre, with separate funding streams for different sorts of CHWs in the same village. Nurse salary top-ups may not be included, except on vaccination or specific activity days. That said, Global Fund has supported district delivery via disease grants to effect in some districts within and near Kinshasa with money allocated for transport used by one district to enable their monthly supervision visits of health facilities.

Source: Team experience (NP)

Taking all the points discussed in section 8.2 into consideration, the Global Fund should consider having:

- A **Fragile States/COE committee**, independently of current fragile states working groups.
- A **Focal Point Person** for emergencies
- An **in office Expert** in the Technical Partnership and Advisory Department within the Strategy, Investment and Impact Division, SIID

8.3 Partner approaches to governance & oversight

Donors and country partners are using aid to strengthen strategic state functions essential for poverty reduction and to make progress on essential public reforms. As the central objective for engagement in fragile states, investment in governance continues to be framed around state building, focused on the central executive, supporting areas such as democratic governance, citizen voice and accountability, public sector management, security sector, civil service and judicial reform, corruption, and service delivery. The major institutions recognise the importance of strengthening institutional capacity and governance arrangements. The World Bank has highlighted governance challenges in its efforts to address the specific challenges in fragile states in its 2007 Governance and Anticorruption strategy.

Box 25: Inter American Bank institution building experience

The Inter-American Development Bank (IDB) in its evaluation of its support to Haiti following the earthquake, found that the strengthened coordination and joint action of development partners prior to the earthquake have proven successful in enhancing and strengthening governance, identified as essential for the effective reconstruction and development of the country. However, the slow process of institution building and lack of operational capacity to monitor performance hindered progress, which made it impossible to verify progress on meeting conditionalities. Components of grants for institutional support and training (10% of the total amount) were insufficient to overcome the capacity constraints.

Source: (IDB 2013)

Lessons from the MDTF in Afghanistan indicate that as government engagement increases over time it becomes increasingly important to define roles and responsibilities clearly in order to be able to deal with inevitable disagreements between donors and the government that arise (DFID 2013). A review of MDTFs found that fund managers need to provide timely technical advice to ensure more proactive government involvement and better results. Governance mechanisms should separate policy and oversight from project execution. There is increasing recognition (2011 World Development Report amongst others) of the vital role that **CSOs play in governance**, a role that needs to be understood, defined and developed (for example in strategy and design consultation, design, M&E and oversight).

8.4 Financial management & fiduciary controls

The **ADB** suggests that those designing support to fragile state where country systems are weak should consider 1) outsourcing financial management to private consultants or accountants and 2) using fiduciary agents to monitor payments. In cases where the public audit system is weak or has extensive delays, outsourcing auditing to private firms is recommended.

Where outsourcing to private suppliers is being considered, it is important to check in the design that there is capacity for contracting and enough suitable bidders. Where national capacity is low, then international bidders can be used with an explicit remit to develop local capacity. ADB also recommends avoiding complex designs of funding flows and using direct funding or reimbursement rather than imprest accounts. If such accounts are needed, then there should be provision for capacity development in financial management and monitoring.

The ADB have identified tools to help promote transparency including using CSOs for on-the ground verification of programme activities and pre-audit, and publicising contract awards and payments. **DFID** requests partners in the South Sudan Health Pooled Fund to comply with stipulations preventing any offence of the UK's Bribery Act 2010, and their Fund Manager (Crown Agents) operate their own anti-corruption policy. Contracts will be terminated if payment of bribes is identified.

A common approach in fragile states is to contract programme management, including fund management, to a third party via a competitive selection process. Typically this is an NGO, a UN agency or a private contractor. With the South Sudan Health Pooled Fund, the Fund Manager (or Management Agent/MA) (Crown Agents, contracted to **DFID** on behalf of multiple donors) is responsible for sub-contracting and delivering on the results chain, ensuring that outputs are measurable via the national health information system that is also supported by partners at county and state level. A clear log frame specifies targets for deliverables, and release of funds depends on performance reviews.

For example, DFID and SIDA support the Somali health sector through an NGO consortium led by Population Services International (PSI) which is the Fund Manager/Managing Agent (MA) contracted directly by DFID and responsible for sub-contractors and delivering on the results chain. Donors also support a pooled nutrition fund in Somalia, with UNICEF acting as Fund Manager. DFID, CIDA, SIDA, Australian Agency for International Development (AusAID) and EC contribute to the South Sudan Health Pooled Fund with Crown Agents acting as the Fund Manager (contracted to DFID), responsible for overall delivery including of sub-contractors, and in-built capacity building measures.

In all these cases, Fund Managers/Management Agents are appointed through competition with clear delineations of responsibilities between the donor and the Fund Manager/MA. The Global Fund could consider replacing the PR model with a Fund Manager/MA approach in a COE, selected through com-

petition and responsible for delivering grants, whether they are for one or more disease programs, combined three-disease district-level delivery or health system grants that serve all three diseases (and other diseases) focusing on PSM, FM, M&E (more detail in options section).

A Fund Manager/MA also plays a role in **DFID** and **SIDA** support to the Somali health sector, which uses an NGO consortium, with a lead NGO/Fund Manager (Population Services International) responsible for sub-contracting and delivery of results. PSI is responsible for all reporting of finance and outputs, with finance disbursed based on satisfactory reporting. **UNICEF** also acts as a Fund Manager to a donor pooled fund for nutrition in Somalia.

In all these cases, Fund Managers/Management Agents are appointed through competition with clear delineations of responsibilities between the donor and the Fund Manager/MA.

UNICEF also manages DFID's support to nutrition in semi-arid areas of Kenya using "humanitarian" funding in a more planned and sustainable way. Over a three year period, UNICEF uses NGOs for service delivery whilst also building nutrition capacity in the MOH, so that the acute crises of malnutrition can be pre-empted. NGO and private contractors are typically selected by open tender. This is comparable with the Global Fund approach of having PRs, although they have not in the past been selected by competitive tender and PRs are rarely private organisations apart from NGOs.

The **World Bank** also contracts third parties in the health sector, usually with a robust and integrated performance based component. Since the World Bank always works through government, the contracting is a joint undertaking with the government and its ministries of finance and health. The World Bank has been championing this approach since 2002 in Afghanistan, an approach that has since been taken up by other major donors in health e.g. **USAID** and **EC**. In South Sudan, the World Bank's current approach, in two States, is to contract health services through a NGO-Fund Manager, either with a NGO to support the county health department or directly with the county health department.

Some donors have established third party risk monitoring systems in order to compensate for lack of access to the field (e.g. security risks limiting donor's ability to travel in Somalia) and to achieve economies of scale and specialisation. The **UN Somalia Risk Management Unit (RMU)**, the joint **DFID/GIZ Nepal Risk Management Office (RMO)** provides interesting examples of this approach and supports donor-funded programmes and projects. Evaluations of the RMO in Nepal have positively reviewed its work in support of "Safe and Effective Development". The RMO has been effective in providing detailed security analysis and ongoing context assessment, including future scenario mapping for DFID and implementing partners. Furthermore, DFID also developed and implemented Basic Operating Guidelines. This set of 14 principles of engagement allow common approaches to programme management while remaining independent of forces involved in armed conflict in the country. These guidelines were so well received that they have been endorsed by 11 bilateral agencies, international NGOs and the UN (OECD 2011a, INCAF 2013a).

Box 26: Basic Operating Guidelines

The Basic Operating Guidelines were introduced in Nepal in 2003, in the context of the internal armed conflict between the State and the then Communist Party of Nepal (Maoist), and were revised with minor changes to the wording in 2007.

1. We are in Nepal to contribute to improvements in the quality of life of the people of Nepal. Our assistance focuses on reducing poverty, meeting basic needs and enabling communities to become self-sufficient.
2. We work through the freely expressed wishes of local communities, and we respect the dignity of people, their culture, religion and customs.
3. We provide assistance to the poor and marginalized people of Nepal, regardless of where they live and who they are. Priorities for assistance are based on need alone, and not on any political, ethnic or religious agenda.
4. We ensure that our assistance is transparent and we involve poor people and their communities in the planning, management and implementation of programmes. We are accountable to those whom we seek to assist and to those providing the resources.
5. We seek to ensure that our assistance tackles discrimination and social exclusion, most notably based on gender, ethnicity, caste and religion.
6. We recruit staff on the basis of suitability and qualification for the job, and not on the basis of political or any other considerations.
7. We do not accept our staff and development partners being subjected to violence, abduction, harassment

or intimidation, or being threatened in any manner.

8. We do not work where staff are forced to compromise core values or principles.

9. We do not accept our assistance being used for any military, political or sectarian purposes.

10. We do not make contributions to political parties and do not make forced contributions in cash or kind.

11. Our equipment, supplies and facilities are not used for purposes other than those stated in our programme objectives. Our vehicles are not used to transport persons or goods that have no direct connection with the development programme. Our vehicles do not carry armed or uniformed personnel.

12. We do not tolerate the theft, diversion or misuse of development or humanitarian supplies. Unhindered access of such supplies is essential.

13. We urge all those concerned to allow full access by development and humanitarian personnel to all people in need of assistance, and to make available, as far as possible, all necessary facilities for their operations, and to promote the safety, security and freedom of movement of such personnel.

14. We expect and encourage all parties concerned to comply strictly with their obligations under International Humanitarian Law and to respect Human Rights.

The Basic Operating Guidelines (BOGs) relate to the behaviour and standards that the BOGs signatories expect from themselves as development organisations, implementing partners and other actors in the communities in which implementing partners work. The BOGs are considered a statement of principles. They are intended to offer BOGs signatories, staff and implementing partners' protection from any challenges to operational space for development. They also make organizations and implementing partners responsible for working in a way that is transparent, accountable, impartial and inclusive (the four fundamental principles).

Source: (United Nations 2012)

The Somalia RMO was set up in response to challenges of remote working and the difficulty of managing fiduciary risks and monitoring the work of implementing partners – particularly UN agencies but also other partners and donors. Considerable progress has been made advancing the risk management agenda for the Somalia UN Country Team. Seen as a best practice, an RMU was established in Kabul, Afghanistan earlier this year. These two entities and the information they hold and services they could potentially provide would be worth exploring by CTs (e.g. for accessing recent assessment, even exploring their roles in site visits/data verification).

8.4.1 Access and Health Systems

Part of WHO's remit in every country is to support extensive policy dialogue and national planning. A recently established long term EC/WHO programme on "Supporting policy dialogue on national health policies, strategies and plans in selected countries" aims to strengthen WHO's role in policy dialogue including in South Sudan, Liberia, and Sierra Leone. WHO does not have a specific fragile states strategy but there are a number of activities relevant to countries in or emerging from crises. These include capacity strengthening in health planning for MOH staff and other stakeholders through the implementation of the **Analysing Disrupted Health Systems** in Countries in Crisis courses and reference guide designed for fragile states. The Global Fund could benefit from adopting such training programme tailored for Global Fund staff, Fund Programme Managers and Public Health Officers working on fragile states respectively.

In fragile states with more donor support, the approach to providing international support has included coordinated support for country-wide delivery of an Essential Package of Health Services (EPHS), implemented at a sub-national level. Performance-based contract mechanisms are increasingly used, whereby international and national NGOs are contracted to deliver the EPHS in close cooperation with the sub-national health authorities. For instance, in Afghanistan, NGOs are contracted for EPHS delivery all over the country, financially supported by three major donors.

Similar schemes, but with more emphasis on the NGOs assisting local health authorities to deliver the EPHS, have been developed in Liberia, South Sudan and Somalia (usually with intensive support by donors, UN agencies such as WHO and UNICEF in close collaboration with MOHs). DFID have just renewed their support for EPHS in 3 pilot regions across the Somali political zones (Pearson N, Khan S 2013) which demonstrate good outcomes in scaling-up safe delivery services for women and disease programmes for children, with potential impact on reducing maternal and young child mortality. In certain contexts, it may not make sense for the Global Fund to bring in additional agencies to act as PRs to deliver separate disease programmes, and a more integrated and complementary delivery mechanism may be much more cost-efficient and effective.

In addition to direct service delivery, donor support often includes measures to strengthen stewardship functions of the public sector e.g. In South Sudan, planning, management, supervision and monitoring functions particularly at sub-national level are supported through the pooled health fund. Specific MOH capacities, including policy and HR management tools, need to be supported long term (e.g. through DFID support for EPHS implementation in Somali zones). Appropriate community sensitisation and accountability is incorporated into many DFID programmes.

Supply and demand-side processes need to work together for quick gains in access. **Gap filling** in commodity supply is a feature of many **DFID** and **USAID** -supported programmes. Where there is a coordinated effort to expand access to an essential or basic package of services, the Global Fund programme can be tailored to complement and support this, including filling gaps in critical areas such as commodity supply. **GAVI** also plays a gap-filling role and envisions its support in fragile states could service gaps arising from the transition as emergency medical NGOs retreat from an acute crisis and a more normal situation resumes.

Pooled funding mechanisms

Pooled funds or MDTFs are one funding mechanism used to support service delivery in fragile states. They can be developed across sectors (such as emergency response to conflict in Pakistan) or sector specific (such as the South Sudan Health Pooled Fund). Pooled fund have also been used for service delivery in Afghanistan, Iraq, Sudan and Yemen. Such funds account for around 11% of ODA, with the World Bank acting as trustee for about half of total contributions. Total funding through 18 MDTFs in 2007 amounted to around US\$ 1.2billion.

Advantages of pooled funds include economies of scale, reduced transaction costs, simplified administrative and reporting systems, and to prevent a fragmentation of policies, institutions and services. They can improve accountability, predictability and timeliness of funding and increase government engagement. They can also help share and absorb political and financial risks to donors. They allow the partners to share fiduciary risks and the costs of fiduciary controls. But MDTFs have experienced drawbacks in practice; they have often been beset with difficulties including huge delays in set-up, disbursements and expenditure, partly due to preconditions and safeguards requested by the donors, and agency transaction costs can increase. Pooled funds need to be complimentary with other aid instruments.

Sometimes pooled funds are put under the authority of government with fiduciary oversight of a third party such as a multilateral or an international accounting firm. In Sierra Leone, additional safeguards were introduced, with ex -post verifications from international consultancies. A similar approach was used in Afghanistan with funds reimbursed after an external review was carried out.

The WB and UN are the usual fund trustees for MDTFs, but the manager function is often delegated, including to groups of NGOs or the private sector (such as the Health Pooled Fund (HPF) in South Sudan and Liberia). The private fund manager of the Basic Services Fund in southern Sudan prior to independence was considered to have efficiency advantages over the MDTF operating in the same period under WB management and government implementation (DFID 2013).

In a country where the pooled fund is working well, the Global Fund may want to consider joining, to support elements of service delivery, as part of the essential health package. This would also enable flexibility and harmonisation of its support with other donors e.g. by providing commodities for use in the essential package, or a separate contract to the same fund manager. This might be an option

where the fund is functioning well and where there are fewer options for PRs. One possibility in the Somali context might be to support Programme 6 (for HIV, TB and Malaria) of the EPHS in all regions of the country, via existing partners. Clearly the Global Fund's past experience in supporting pooled funds needs to be considered to avoid difficulties in meeting requirements.

The evaluation of pooled funds in fragile states conclude that the functions of the fund manager have to be clearly established, and effective fund managers for pooled funds require good quality staff and strong leadership – the ability to attract good staff needs to be considered in selection of the fund manager (as well as the suitability of the procedures and flexibilities that the agency can offer). Once donors understand the flexibilities under which the selected fund manager can operate they can adapt the design of the fund accordingly.

In addition, international policy guidance on engagement in fragile states argues for an increase in jointly managed and pooled funds and a longer term vision for TA, where personnel fit are embedded in national structures as soon as possible – a development already taking place to support CCMs in some COEs.

8.4.2 Country Ownership, Country Systems and Aid effectiveness

The New Deal includes participatory development of country compacts as a basis for international support. The Somalia compact, for example, endorsed in September 2013, sets out strategic objectives for peace and state building with a results matrix for measuring progress, with reporting and monitoring arrangements specified. It also establishes the aid coordination mechanisms at national and sector levels and financial architecture for international funding.

Sector specific compacts have also been developed in the health sector under the International Health Partnership Initiative that set out how government and donors will work together to improve health outcomes, improve harmonisation and mutual accountability and reduce aid volatility. Among the COEs defined in this report, Chad, DRC, Mali and Nigeria have such agreements. The Global Fund is already a partner of the International Health Partnership.

Using country systems is a core principle of aid effectiveness as well as in the New Deal. The Working Party on Aid Effectiveness has generated a consensus among donors and partners that 'use of country systems' should be nuanced to take into consideration donor and country contexts. Highlights include:

- The use of country systems (public financial management, procurement, planning, monitoring and statistical systems) is not an *all-or-nothing* approach but can be increased gradually in coordination with partner countries. Most donors have a history of using parts of country systems (e.g. PFM, PSM, M&E).
- Evidence suggests there are a number of examples of innovative incremental approaches to the use of country systems including measures to strengthen PFM systems (e.g. in DRC and Somalia; development by the Overseas Development Institute of the Local Services Support Aid Instrument for the Government of South Sudan with earmarked, traceable funds, identified in budgets and accounts by unique sort codes), selective strengthening of particular country systems and arrangements to certify implementing partners' financial procedures (e.g. **UNDP's** Harmonised Approach to Cash Transfers (see Box 28).
- When supplemental features and safeguards are introduced, these should be designed in a way that supports rather than undermines country systems and procedures.
- Sequential planning in fragile states is required that responds to the dynamic situation and allows greater use of country systems even while substituting for these systems in the short term. Examples include the dual track approach taken in Afghanistan where an Interim Authority Fund was set up to get funds flowing while longer-term funding mechanisms were put in place. GAVI also adheres to this approach i.e. longer-term capacity building alongside short-term flexibilities.
- Donors need to balance the opportunities of using country systems (to build national ownership, capacity and confidence in government) with associated political, programmatic, fiduciary and reputational risks.

Box 28: Harmonized Approach to Cash Transfers (HACT): A risk management approach

UNDP's Harmonised Approach to Cash Transfers (HACT) is a common operational framework for disbursing funds to implementing partners (NGOs and government ministries). It adopts a risk management approach. In 2012, 74% of UNICEF's funds in DRC passed through the HACT and much of this was spent through the health and education ministries. A number of risk assessments are conducted with implementing partners during programme design. The HACT then conducts audits and spot checks during implementation. This approach enables funds to be advanced to national entities. The HACT approach was estimated to have led to a reduction of transaction and operating costs of 50-60%, allowing more funds for development activities.

Source: (INCAF 2013b)

In fragile states where government is functioning poorly and may lack legitimacy or capacity, then the definition of country systems needs to take a broader view than the conventional focus on the public sector. For example, country systems in Afghanistan have been defined to include informal and local level institutions; NGO networks and UN Agencies (INCAF presentation, July 2013).

The **World Bank** applies the Community Driven Development (CDD) approach which channels funds through central finance ministries and then gives responsibility for use of funds to communities for community-determined projects to address local problems, often with technical support by NGOs or firms. This is not specific to fragile states, although it has been used in Afghanistan, Sudan and South Sudan. Evaluation of the CDD approach concluded that CDD projects have grown by number and commitment volume much faster in fragile states than in IDA countries that were stable. They have been effective in providing essential short-term development assistance to local communities, but they have not evolved over time and lack institutional sustainability (World Bank 2014).

8.4.3 Programme implementation and performance

A recent World Bank evaluation (World Bank 2014) indicates that programme performance has improved in fragile states in recent years. Findings point to several relevant factors at work (see Box 29). Especially of note are the increases in in-country staff and administrative budgets, major increase in TA, the simplification of design and implementation, and support to country systems.

Box 29: World Bank evaluation on assistance to fragile states

The World Bank's independent evaluation on the assistance of the World Bank Group to Low-Income FCAS (World Bank 2014) discusses possible explanations for why individual programmes in FCAS have started to perform better in recent years. These include:

- **Increased investment** from the World Bank in terms of **administrative budgets** and **international staff** deployed in FCAS country offices. The increase is also due to the effect of development policy lending which has increased in quantity and quality over the review period. Another factor is the increased lending in FY07–12 in transport and economic policy operations with high performance and improvement.
- Bank support for **analytical and advisory activities has increased** substantially including fivefold increases in spending on **TA to build institutional capacity** within FCAS, potentially contributing to improvements in project outcomes.
- Increased **reliance on country systems**, increased emphasis on the **simplification of project design and implementation arrangements**, and greater focus on the definition of **achievable results** recognising the long time frames for institutional change in such contexts.

The report has also some specific findings on the health sector where project outcome ratings have marginally improved:

*"Outcome ratings for the health sector have improved while those for the education sector have declined in FCAS. Health projects were more likely than education projects to use innovative implementation arrangements through **hiring service providers from the private and non-profit sector, and to utilize performance-based contracting**"*

Source: (World Bank 2014)

Results-based financing

Evidence on the potential of results-based financing is being generated under the Health Results Innovation Trust Fund (HRITF), set up in 2007 and managed by the **World Bank**. The programme includes design of pilots, their implementation and rigorous evaluation of results based initiatives intended to improve maternal and child health. Although not explicitly established as an initiative targeted to fragile states, it is noticeable that many of the 24 countries where the programme is operating are often defined as fragile. This includes 7 of the 19 COEs identified in this report – Afghanistan, CAR, DRC, Haiti, Nigeria, Pakistan and Zimbabwe (a Yemen pilot is in preparation).

Under the HRITF, results based financing is broadly defined to include payments to a government, manager, provider, or user of services after pre-defined results have been achieved and verified. Key features of the results based financing pilots include:

- Defined supply or demand-side interventions to improve maternal and child health;
- Incentive mechanisms to encourage more and better quality service delivery or uptake;
- Verification systems or mechanisms to validate data reports and quality measures, in order to inhibit inaccurate reporting, with the findings used to determine levels of funding; and
- Substantial impact evaluations and lesson learning from the pilots.

Whilst there are not yet full results from the impact evaluations in most cases, there are reports of promising results in Afghanistan, Burundi, DRC, Nigeria, Zambia and Zimbabwe (RBF 2013). They suggest that the approach can help to improve efficiency in service delivery, equity and accountability. Several countries demonstrate increased coverage with key interventions compared to control districts or facilities (HRITF Progress Report 2013). Most of the pilots reward quality as well as quantity of services and there is some evidence of improving quality of services.

The HRITF pilots are not free-standing – the pilots are linked with a broader World Bank IDA funded grant, so that there is funding available for service and capacity improvements as well as to incentivise achievement of results. The approach takes time to develop and introduce in many cases, and requires some different skills and more extensive verification than more standard funding mechanisms, which in itself poses costs and logistical challenges in difficult contexts. The World Bank is not the only agency using this approach – various mechanisms and approaches have been tested in different contexts, and so far the evidence is not sufficient to say that particular models are effective (Witter 2012).

Results-based approaches can also be applied to country allocations – as the Global Fund is considering under the NFM. The World Bank takes country performance (measured by the Country Policy and Institutional Assessment (CPIA) score and portfolio performance) into account in allocating IDA resources, as well as country population and per capita income.

The Global Fund has already provided performance-based funding at the level of the grants (with levels of disbursements and grant renewals depending in part on meeting targets), and the case studies noted some performance-based incentives for PRs linked to grant ratings. There could be scope for performance based payments to providers or users of services, drawing on the lessons from the HRITF, but recognising the increased verification requirements, and the time taken to establish these schemes, this would not be suitable in all the COEs (e.g. where even basic monitoring is a challenge).

Staff and ways of working

As development partners increasingly shift their focus to fragile states, many are developing new human resource strategies to support their field presence and impact. Although the Global Fund model does not include country presence, some of the initiatives and lessons learned support the staffing options presented in Section 10. Examples are illustrated the following box.

Box 30: Donor human resource strategies in fragile states

- **SIDA** is reviewing **staff requirements, composition and competency profiles** required to work with different partners in fragile states. Greater pre-deployment preparation, including **security and language training** is necessary as decision making authority is increasingly devolved. Due to the high cost of operating in fragile states and the high turnover of staff, SIDA is analysing where competencies are best placed, either in the field or at HQ. Experience of working in and with fragile states is increasingly recognised as important to taking on key management posts. A package of incentives needs to be anchored in a broader career management system.
- **GIZ** provides a work package that includes **tailor-made staff training courses** e.g. on specific risk and safety management.
- **The World Bank** has adjusted **travel budgets for HQ staff to allow greater ‘face time’** with clients in partner countries. It has also identified **individuals in advance to deploy quickly** to the field for prolonged (but short term) visits. It has increased incentives in high-risk environments.
- **CIDA** has developed cohorts for training and field deployment, as well as establishing rotational short term assignments where required.

Where donors do not have an in-country office, some have decided to work with others **via joint donor coordination offices**. For example, ADB has done this, and several European nations formed a joint coordination office in Juba for southern Sudan before independence.

Lessons learned from operating donor staffing strategies in fragile states (**SIDA, DFID, GIZ, CIDA, World Bank, AfDB**) include the need to: i) implement **financial and career incentives** for working in fragile states ii) strengthen local staff capacity although this also comes with risks (salary differentials, risk of corruption); and iii) promote a **change among senior management** and within the organizational culture in the way staff are equipped to engage in fragile states as packages of incentives can only go ‘so far’. **GAVI has increased staffing in Geneva to deal with extra work associated with developing tailored approaches**.

Through INCAF, **the World Bank, UNDP and DFID** have set up ‘talent management processes’ geared to fragile states. Other shared approaches include developing common competency frameworks, HR situation frameworks, and an HRM community of practice to exchange ideas and information.

Source: Experience sharing workshop on human resource management: summary conclusions (INCAF 2013)

8.4.4 Support in emergency situations

Many donors have a separately organised and funded humanitarian arm. **DFID** has a Conflict, Humanitarian and Security department (CHASE), and separate humanitarian budgets; **USAID** has its Office of Foreign Disaster Assistance (OFDA); the **EC** with DG-ECHO. The EC development programmes also have some flexibility to re-programme and take different measures for emergencies with guidelines on contractual arrangements with partners (EC Lignes Directives). **PEPFAR** do not perceive that they have a specific role in emergencies, which are handled by OFDA, but sufficient flexibilities have allowed them to react, for example during the 2011 crisis in Cote d’Ivoire where they were able to permit an implementing NGO to give 3 months of ARV supplies to clients so they did not run out during the disruption; build up buffer stocks at facilities; and reallocate funds to continue treatment across the border for people displaced into Liberia.

Many agencies are involved in response to epidemics, often with WHO and UNICEF supporting the MOH a national response with on-the-ground treatment centres either in government health centres or in isolation units run by NGOs. UNICEF and WHO, supported by ECHO, worked very closely with the Federal Ministry of Health across Northern Sudan in response to the cholera epidemics in 2006 and 2007. While there was a strong focus on rapidly installing cholera treatment centres and emergency chlorination, there was a substantial focus on supporting State Water Corporations in expanding the piped water supply, improving local water supplies and on improving sanitation (Pearson N 2007 & 2008). With expanded provision of clean water, the epidemic was confined to three states in 2007 despite widespread flooding, and further epidemics did not take place thereafter in Northern Sudan.

Humanitarian organisations e.g. International Committee of the Red Cross (ICRC) and Medecins Sans Frontieres (MSF) typically focus on medical emergency work. ICRC supports hospitals in conflict areas to provide acute trauma care to the wounded. For over a decade ICRC established and ran a hospital in Lokichogio, Kenya, with its own resources to provide care for the wounded from South Sudan. In Afghanistan, ICRC supported provincial hospitals with a focus on surgical care during conflict years. In

East Timor, ICRC established a surgical unit in the absence of government conflict surgery capacity after extensive looting by militia. Activities typically stop after the conflict subsides, leaving the surgical units difficult to sustain by governments thereafter. IFRC have been supporting the Somali Red Crescent (SRC), which is the only local NGO to work across all three Somali political zones. SRC have a very sustainable model of health care delivery via their Maternal and Child Health Centres. SRC only employ 2 to 3 health professionals and leave the community management committees to employ the guards, the cleaners and paramedics. They have operated a community health fund, into which families make voluntary contributions, which contribute to the maintenance of the centres. SRC have achieved relatively good rates of antenatal attendance, but had not developed the model to include maternities for safe delivery. This is changing, as they become delivery partners of the EPHS.

When there are major natural disasters, epidemics, refugee movements or acute conflict, all known to cause excess mortality, MSF is likely to stage a rapid response. Depending on the situation this may range from specialised hospital care, communicable disease control to provision of basic services. In countries experiencing chronic conflict, MSF will usually set up interventions, often in the form of support to basic services, in specifically set up clinics or in pre-existing health facilities. Programmes typically collect a range of data for monitoring purposes, usually a combination of service data and directly measurable impact on patients in their facilities. Impact at population level is usually not measured.

In principle, once the emergency or conflict is over and a more stable situation has returned (even if a country has a fledgling government) MSF will terminate its intervention (although MSF projects may stay for a long time, depending on the length of the conflict). Since conflicts may last for long periods some MSF projects may remain for over a decade or more. MSF does not consider itself a 'developmental' organization (unlike other NGOs who will do both emergency and development work) nor will it ever have an objective to contribute to state or peace building.

Humanitarian clusters as a coordination and governance mechanism

In 2005, in an attempt to increase coordination among humanitarian actors including local government and improve coherence in humanitarian response, the **United Nations** implemented a coordination mechanism called the Cluster Approach. For all clusters (sectors), a permanent global cluster has been established led by a Cluster Lead with a role to strengthen preparedness and technical capacity of response. For health, WHO is the global Cluster Lead. When a country or area is hit by a crisis, the UN (OCHA) can invoke the "Cluster Approach". Depending on local circumstances and needs cluster leads are appointed, which (frequently) may be the same as the global lead, but not necessarily so. The Cluster Approach will continue to be in place as long as the crisis lasts. This may range from a few months (in the case of a natural disaster like an earthquake) or much longer in a prolonged conflict.

Within the Cluster Approach, WHO leads the global health cluster and is typically the cluster lead for health in coordinating response with MOH's and international agencies. WHO staff interviewed were not aware of any involvement of the Global Fund in humanitarian cluster coordination in countries.

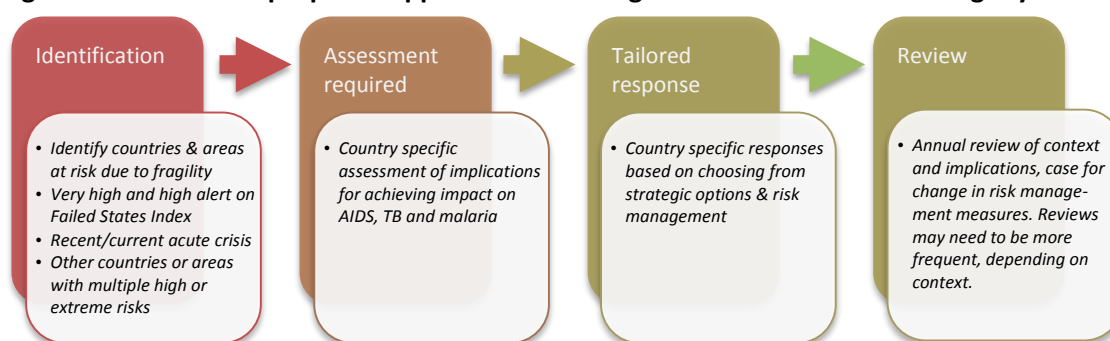
If the Global Fund is to play a more proactive role in providing support to (acute) crisis areas in countries where they have on-going programmes, engaging in the Health Cluster would facilitate coordination, identification of needs and priorities, and potential ways how the Global Fund could provide support. For instance, if Global Fund CCMs or PRs consider using existing stocks of commodities for the crisis population or even consider reprogramming, the Health Cluster will be the first port of call for coordination purposes. However, the Health Cluster does not have a broad health sector coordination remit and will typically consist primarily of agencies supported by emergency donors. The latter may have different priorities than Global Fund and interests may only partly overlap. This and the time-bound nature of Clusters make it a less feasible coordination mechanism to act as, for example, a CCM in COEs.

9. Recommended Approach for the Global Fund Operating in COEs

9.1 A country-by-country approach to operating in COEs

This review recommends that the Global Fund adopts a flexible, country-by-country approach to operating in COEs. This is in line with international consensus (OECD/INCAF) and partner experience (World Bank, ADB, AfDB, USAID, GAVI, DFID) on the importance of developing context-specific responses in fragile states and undertaking assessments, regular reviews and learning from implementation strategies. The Figure below illustrates the proposed process which is broadly consistent with approaches adopted by other agencies e.g. GAVI.

Figure 6: Overview of proposed approach for dealing with COEs with chronic fragility



An essential first step would be a **country-specific assessment** that goes beyond disease and programme issues to consider the wider political economy including fragility-related issues, social context, and operating conditions. The country-specific assessment should be used to define how the COE will be handled.

In the NFM, countries have a funding allocation and need to identify the allocation split between the three diseases, and also between the diseases and HSS. The country dialogue process will then identify how the Global Fund support will be used and the implementing arrangements, including PR selection. The NFM will conduct annual reviews of grant performance, but more frequent operational monitoring and reviews may be required, depending on the context. This approach is widely endorsed by the international community.

Box 31: Country specific assessment process for COEs

Purpose of Country COE Assessment: To identify how the fragility-related challenges in the COEs influence country dialogue and the processes that lead to allocation of the Global Fund resources, Concept Notes, choice of implementers and design of risk management measures. To understand the strengths and weaknesses in the health system and how other donors support it, and security and access challenges.

Objectives of COE Assessment

1. Understand the political economy, power and politics of key stakeholders; equity issues in different parts of the country and groups within the population; human rights concerns to identify how this influences access to HIV, TB and Malaria prevention and treatment, and other essential services – what services are delivered, to whom and who is excluded and what are the trends and risks in these areas. Focusing not just on HIV, TB and Malaria services, but wider issues such as regions or ethnic groups that are discriminated against, the nature of corruption, and the dynamics behind this, such as who makes decisions on resource allocation. The Global Fund could potentially link into the strong political economy, governance, security & fragility analyses of DFID and other donors in some countries. This could involve commissioning certain aspects of this analysis that would be specific to the Global Fund needs from other donors e.g. the politics of changing the status quo of Global Fund arrangements e.g. the appointment/change of PR arrangements, CCM representation and governance etc. It would also be worth exploring the results of joint multilateral Post Conflict Needs Analyses where they exist (e.g. Sudan (North and South), Pakistan, Yemen, Somalia, Liberia, Haiti, Afghanistan).

2. Review what works well across health and other basic services to identify where there are opportunities for the Global Fund to use, learn from, or piggy back onto. For example, if there is high coverage with immunisation and ante-natal care services, how is this achieved and could the same channels be used? If community workers, private drug sellers, grocery shops, NGO schools or military units are reaching communities when health services are not, how can these distribution and access systems be built on? Where the effective community structures, faith based institutions, local government or NGOs within the country are located? What technologies offer opportunities (e.g. mobile money transfer; texting for supplies management?).

3. Identify what partners are planning and doing in the health sector as well as the disease programmes and systems strengthening to identify delivery channels that might be available for the Global Fund support and to coordinate efforts. This is already part of the agenda for any country dialogue. The COE assessment should make sure to look at health as a whole rather than just disease programmes, and assess the track record of partners in delivering results. For example, what joint donor mechanisms are in place in district health service delivery and what measures are achieving results that the Global Fund could build on or use (such as contracting-out logistics or service delivery). More flexible partnership models are suggested for programming in COEs. The assessment needs to identify the partners on the ground who are making an impact in the challenging environment, including civil society, humanitarian and faith-based organisations, particularly ones with good track records in both health programme delivery and oversight.

4. Identify strengths and weaknesses of the health system with a focus on PSM, quality and reach of service delivery, and capacity for monitoring and assessing impact. This should look at how the 'fragility' affects delivery and how past efforts to improve systems and service delivery have fared.

5. Understand security and access issues. To understand where access is compromised and how services can be maintained in insecure areas. To reduce risk posed by insecurity threats to programming, to partner staff and Global Fund staff. To innovate and model on good programming practices in the particular COE.

How to conduct the assessment

Review what works well – could rely on analysis of coverage data, followed up with partners to identify what works where and why and who gets it to work effectively.

Understand other partners' support – may be known from past collaboration or can be collected as part of country dialogue process. Includes support to the health sector but also related areas such as capacity building of local state and NGOs, where and how they are working.

Health system assessments may be available e.g. in situational analyses of national strategic plans, mid-term reviews or annual reviews. Programme reviews, past PSM assessments, TA reports and PFM assessment will also be relevant.

Security and access – use any existing security assessments (UNDSS, OCHA, INGOs, donors, private security firms, RMO information). Further targeted assessment of security concerns to the Global Fund e.g. potential threats to CT staff, and to PR and SR staff. Threats to PSM. Learn from agencies that have maintained good access despite insecurity and explore partnerships for implementation. Identify potential security and assurance providers.

Output of the assessment: The purpose is to inform country dialogue and the process of deciding what to fund, choice of PR, delivery channels, flexibilities. One option would be to develop a QUART-type tool, tailored and used to feed into the country dialogue and grant making processes.

The proposed country-specific assessment **would be in addition to reviews** envisaged in the Grant Management Assurance Framework (e.g. past grant and programme performance reviews, reviews of proposed implementation arrangements and PRs) and would help mitigate against politically-driven or self-interested allocation and implementer selection, and the exclusion of MARPs where there could be high impact. The assessment **will feed into country dialogue** processes and help inform decisions regarding resource allocation, the selection of implementing agencies and the selection of strategies and risk management options appropriate to that setting.

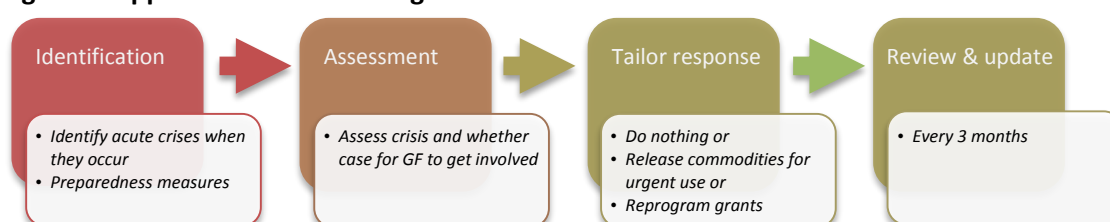
The aim is **not to have a lengthy assessment** just for the Global Fund. In line with international guidance and practice, it is strongly advised that the Global Fund links with donors and country partners to access existing **political economy assessments, joint Risk Assessments, joint Fragility Assessments, PFM assessments** (e.g. those being carried out in New Deal countries, between INCAF members, relevant country assessments undertaken by Risk Management Offices (RMOs) where appropriate) and/or commission an assessment with other donors, or a component of an assessment (e.g. to look at more Global Fund specific issues such as the political economy of the representation and effectiveness of CCMs). The objectives of the country-specific assessment and how to conduct the assessment are detailed in Box 31.

9.2 Recommended approach to operating in countries with acute emergencies

A country-by-country approach to operating in countries experiencing acute instability is also recommended and is in line with other partners' approaches such as GAVI and humanitarian partners. However, the country-specific assessment, as outlined for chronically unstable countries would not be applied for acute crises. Instead, it is recommended that the Global Fund links with Humanitarian Cluster mechanisms to benefit from any acute health assessments that are being carried out by emergency agencies. Via the Global Health Cluster, the Global Fund could collaborate around a common agenda and usefully input commodities and diagnostics during the acute phase, and support health systems development post-emergency.

Involvement in the health cluster could strengthen the Global Fund's capacity to carry out the steps outlined in the proposed approach depicted and explained below. Reprogramming, gap filling and possibly providing additional resources for acute crisis are strategies already in use by the Global Fund and are also in line with other partner approaches (e.g. USAID, GAVI, DFID).

Figure 7: Approach to Acute Emergencies



Box 32: Process for identification and action in acute emergencies

Stage	Action
Identification and Preparedness	Think ahead especially where crises are identifiable and fairly predictable: ensure in-country risk assessment and response plans are in place, allow for a buffer stock in country (and possibly in facilities in vulnerable areas), build flexibility into contracts, ensure procedures in place.
Assessment	When a crisis hits, in consultation with humanitarian and in-country partners, assess whether the case for Global Fund involvement. The Global Fund may need to contract TA from other donors or agencies for these assessments, or use assessments that are already produced by Health Cluster partners, to which specific Global Fund questions could be included (with the possibility of some flexible funding by the Global Fund).
Tailored Response	The Global Fund response would be based on options, tailored to the scale and effects of the situation.
Review	Progress and the need for reprogramming would be reviewed and updated quarterly

10. Options and Recommendations for Operating in COEs

10.1 Strategic options for operating in COEs

The findings of this review indicate that the Global Fund has already started to differentiate its response in COEs. This is built into the NFM with greater Secretariat engagement in supporting countries identify priorities, develop Concept Notes and selecting PRs. Innovative measures have been introduced to reduce fiduciary risks and make grant implementation more effective and efficient. Considerable flexibility has been allowed to cope with the conditions of countries in crisis.

The experience of other agencies and of the Global Fund suggests that there is more the Global Fund could do to maximise impact and enhance equity in COEs, and that a shift in approach is needed. This section presents:

1. A summary table of **options** available to the Global Fund for consideration. Where possible, a *preferred option* is identified, as is the reference to partners operating similar strategies. In many cases however, a number of different options collectively and individually will suit different contexts, making it difficult to single out any one, preferred option.
2. A summary table of **appropriate measures for different categories of COEs** and
3. A **set of broader recommendations** for the Global Fund. More detail analysis of each option (including their pros and cons), and analysis of the components of district delivery grants can be found in Annex Volume III.

The options put forward by this review include current practices and new measures that could be explored and adopted in different settings. The options are not a 'shopping list'. They have been assessed against the current Global Fund five-year strategy and founding principles, the OECD principles of engagement in fragile states, and the Busan Partnership for Effective Development Cooperation/Paris Declaration on Aid Effectiveness (see Annex 4). Moreover, the options are grounded in analysis and lessons learned from international and partners' experiences of operating in fragile states.

The options are not mutually exclusive – several or all could be selected where appropriate. It is important to recall that working in fragile states is, in its nature, unpredictable and difficult. International experience has demonstrated that there is no magic bullet or universal solution that can be rolled out and expected to work the same way in each fragile state. Testing and adapting existing and new approaches that deviate from past practices is necessary. This needs to be taken on board and embedded throughout the Global Fund.

Summaries of strategic options with preferred option recommendations

[Appendix 2: CCMs](#)

[Appendix 3: PRs and SRs](#)

[Appendix 4: LFA and FA; Human Rights, Equity and Coverage](#)

[Appendix 5: HSS and Maximising Synergies](#)

[Appendix 6: Strategic Partnership and Performance Based Funding](#)

[Appendix 7: Emergencies](#)

10.2 Tailoring responses to different categories of COEs

Whilst the response should be tailored to the specifics of each context, [Appendix 8](#) attempts to draw together different options for different types of COEs (using the sub-categorisation defined in the typology in section 5 of this report) to guide CTs further on how to adopt a series of measures. While the appendix refers to countries, these approaches can also be applied to challenging regions or provinces within countries.

10.3 Global Fund resourcing considerations in COEs

10.3.1 Strategic Initiative funding for acute emergencies

In line with other agencies such as GAVI, the Global Fund could make a corporate decision to allow some limited funding for emergencies, particularly when Global Fund-funded commodity stocks have been used to meet short term needs of an emergency. The fund would cover replacement of stocks in cases where this is justified.

Assuming the principle of funding the replacement of Global Fund-funded stocks is selected, the Global Fund would need to identify an appropriate amount to set aside. Suppose 50% of emergencies

need short term reallocation of grant funded resources and 30% of the commodities are reallocated. Assume 50% of these cases require extra funding to replace the commodities. Assume 6 emergencies in a year and support is available to low- and middle-income countries (LI/MIC) only (there are 87 LI and LMI countries eligible in 2013). Crudely, $6 \times 0.5 \times 0.3 \times 0.5 = 0.45/87=0.5\%$ => Allow for 0.5% of annual Global Fund funding for commodities and associated PSM costs to be replaced.

10.3.2 Allocating additional funding for COEs

In developing the allocation formula for the NFM, the Global Fund is considering whether to include some additional funding for COEs and how much this should be. Again, this approach is in line with many donor agencies and GAVI. Justification for additional funding for COEs: see Box 33.

Box 33: Additional funding justification for COEs

- Many of the COEs have poor security environments and weak infrastructure, **raising the unit costs** of service delivery (e.g. the need for extra security in storage and delivery by air of commodities in some settings). Insurance of commodities will tend to be more costly in insecure environments. Extra funding could compensate for these extra costs
- Poor security will also tend to **increase the costs of international support** as TA and other contractors (e.g. LFAs) will tend to pay staff extra and incur costs for security arrangements
- Weak information systems are a common characteristic of COEs. In the short term **additional collection and analysis of data are likely** to be required e.g. surveys for use in planning and independent verification of results, to mitigate risks of poor information undermining grant effectiveness
- The **costs of additional safeguards and risk management measures** used in COEs. For example, the fiscal or fiduciary agent is required and contracted by Global Fund but paid out of grant funds. If a management agent model is used, this will tend to add to programme costs to cover the enhanced management and capacity building roles they provide
- A strong case for **additional grant management resources at both design and implementation stages**. This might involve an enhanced CT and/or more inputs from LFAs or other partners. It could include flexible resources to address particular needs in the country dialogue, Concept Note development or management process (e.g. inputs to enable provincial civil society to engage in country dialogue, work to understand local political context in remote provinces for grant design, and monitoring implementation). This applies particularly in COEs with few other partners operating in health in the country and in large federal states where there are extra costs of tailoring the response to diverse contexts and COEs within the country.

The approach suggested is to allocate extra resources primarily for extra risk mitigation and grant management measures (i.e. points c), d) and e) above). The extra costs of operating in COEs due to higher unit costs (points 3, 4 & 5) will vary by country, and in terms of value for money, it would be hard to justify fully compensating for these when the resources would be taken from other more cost-efficient countries. In addition, this approach would raise questions around adjusting country allocations for operating costs more generally, which is not the current approach in the NFM.

The amount of extra allocation could be defined in two ways i) a fixed allocation per country to cover the relatively fixed costs per grant of risk mitigation measures such as FAs and extra independent verification or ii) a context-related amount proportional to the grant size in recognition of higher costs of grant management and risk mitigation related to the scale of the country and of grants. Based on a cost of FAs of some US\$ 0.3million per year per grant, it is suggested that the extra funding could take an approach along the following lines:

A fixed element: An extra US\$ 1million. per year per COE country, to cater partially for additional risk mitigation in COEs. This would give a total of US\$ 16million. for the 16 COEs on the current list excluding acute emergencies.

A context related element: Plus an average of US\$ 1.5million per country as additional resources for improving quality of grants and engagement, and additional risk management based on the country assessment and gaps identified and based on country portfolio size.

The total of US\$ 40million per year would be less than 1% of the proposed replenishment of \$5 billion per year.

The amounts suggested above are not based on a detailed costing but rather on making some allowance for the additional costs incurred in high-risk settings, without seeking to fully compensate for these. The amount could be built into the country grant total as part of their NFM allocation, with the

understanding that it is earmarked for risk mitigation and quality improvement. This is in addition to any central funding held for reimbursing commodities used in emergencies.

10.3.3 Secretariat role and resourcing

Donor experience of maximising their investments in fragile states points to the crucial role played by investing in staff both at headquarters (HQ) level and in the field. Many donor agencies (e.g. **World Bank, DFID, CIDA, GTZ**) are in the process of reforming (and sharing outputs of these reforms such as competency frameworks via INCAF) their staffing practices and related incentives, recognising that greater investment in staff is necessary if they are to work effectively in fragile states. This is all part of a tailor made approach – operating and investing differently in fragile states – compared to non-fragile settings. Although the Global Fund does not have a country presence, international lessons learned, such as the need to change staffing policies and practices in order to account for the special needs of operating in fragile states, piloting new approaches such as increased HQ staff missions in the field and greater ‘face time’ with country partners and so on, are relevant to the Global Fund.

Recommendations for investing in Secretariat staff

- **Prioritised CTs for COEs** All COEs have a dedicated FPM and higher percentage of other CT staff similar to High Impact Countries. 1 staff per country if large programmes (i.e. PO, M&E, FM, and PSM). More POs may be needed in large federal countries if provincial programmes are being developed and funded.
- **Extended country missions by staff** focused around key country processes and events e.g. programme reviews, NSP development, country dialogue events, Concept Note development etc. The duration of the extended visit could be determined by the timeline of the country processes involved.
- **Consider greater use of new or existing donor or UN representatives in COEs** to fulfil ‘ears and eyes’ role for the Global Fund (part-contracted or under MOU) particularly if there is limited access to the COE.
- **Tailor recruitment of staff for COEs.** Guidelines on CT selection with HR department could include recruitment of CT members with humanitarian experience, relevant language, and ideally same country experience. Salary premium for CTs working on/ living in/ > 25% time in COEs. Contracts stipulating travel potential travel to High or Extreme risk travel under MOSS guidelines
- **Enhanced security management for COEs.** Having an enhanced security management framework in place is in line with other major donors. CTs participate in five-day mandatory contracted Hostile Environment Awareness Training (country relevant). The Security team is linked more closely to Risk Management Dept. Contract security back-up at country level from UNDP, UNOPS, RMOs or private security firms, as appropriate. Use of UNHAS and Dept. of Peace-Keeping Operations flights. Clearer Duty of Care guidelines need to be elaborated for CTs working in COEs; Security team to have direct reporting to Risk Management and Grant Management as well as Administration. Need further communication portal for risk awareness.
- **Discretionary budget for CTs.** It is proposed that 1-2 % of every grant could be used for discretionary spending by CTs (e.g. for use on TA, risk management, surveys, meetings in third countries). Grants are usually not 100% spent so this would not require new funding. Discretionary funds (normal grants) would enable CTs to access rapid funding to reinforce activities related to grant implementation success, managed under normal Secretariat financial procedures (includes contracting of TA).

10.4 Recommendations for the Global Fund

Over the last few years, the Global Fund has introduced a risk management framework, differentiated management processes for specific situations, and is evolving its funding model which is designed to enable more flexible, focussed investments to achieve impact. Many of these changes will benefit the countries highlighted in this review. However, to date, there has not been a *specific differentiated policy* for working in COEs. Approaches have developed on a more ad-hoc basis, often dependent on the pro-activeness of individuals and country teams within the Secretariat and at country level (Global Fund Framing Document, 2013). **A more systematic and flexible approach is now needed** to ensure

new processes and systems can be operationalised in COEs and tailor-made responses can improve the effectiveness of Global Fund financing in COEs. The review makes the following recommendations:

1. The Global Fund should identify a group of countries and possibly regions that merit special attention. The review provides the criteria and initial selection of such countries, suggestively termed Challenging Operating Environments (COEs). The objective is to improve the impact and sustainability of Global Fund support in these countries.
2. In line with international practice and the approaches of other agencies to fragile states, there should not be a standardised approach applied to all grants in these settings. The Global Fund should adopt a country-by-country approach. This requires understanding the fragility-related, political, economic, social and governance contexts of each COE, designing and implementing tailored responses which are frequently monitored, adapted and developed further.

It is recommended that the Global Fund should focus on the most complex and challenging settings to enhance programme delivery and achieve results. Accordingly, the recommended approach for the identification of COEs should be based on the Failed States Index Very High and High Alert categories, and additional countries and regions facing particularly difficult situations or acute emergencies. At the time of writing this report, 19 countries were identified as COEs.

3. The Global Fund should build on the strengths of its current approach and the New Funding Model, which include considerable flexibility to tailor support and management arrangements to the country context. It should allow further flexibility and tailoring of the engagements in COEs.
 - Thorough country-specific assessment of the context to inform the development of the Concept Note and implementation arrangements (including informing the choice of partners).
 - Innovative grant designs that include provincial grants, combined three disease grants or capacity building grants to support specific areas of the health system (such as strengthening national procurement and supply management systems).
 - Collaboration with international and national partners in COEs where this will expand capacity for delivery and reduce risks in these environments.
 - Scope to invite in competent and trusted public, UN, non-government organisations and private entities to act as PRs and/or MAs. Select the most appropriate implementing organisations through more competitive processes and use service contracts, integrating capacity building into contracts. In choice of partners, identify those that have successfully implemented in the particular COE or similar context.
 - Greater flexibility to adapt coordination, governance and oversight structures, and grant and financial management arrangements to the context. Continue the practice of changing these during implementation if necessary (for example, changes of PR, use of fiscal agents, expanding the level/depth of LFA verification work, bringing in extra support for oversight and verification etc.). In common with other donor findings, consider extra investment in supporting strong oversight, monitoring and verification processes.
 - Encouraging country teams to spend more time in country, working and coordinating more closely with partners, integrating and complementing delivery mechanisms where it makes sense.
 - Going beyond NFM annual reviews where and when required. Tailor made approaches may require greater and more frequent operational reviews, monitoring, and evaluation.
4. The country teams working in COEs should select the most appropriate approach for each country and grant, depending on the assessment of context and partnerships in that environment. In line with the experience of other agencies, including GAVI, arrangements will need to be developed in conjunction with country partners. The options will need to be explored further, tested, adapted and developed.
5. Following on-going reforms within other donor agencies including GAVI, and the additional costs of tailoring approaches, it is recommended that the Global Fund invests in staff working on COEs and undertakes measures to improve security and access to those countries. This would include

(among others) prioritising country teams for *all* COEs in a similar way to the prioritisation of staff in High Impact Countries; having an enhanced security management framework in place; tailoring recruitment and skills for staff to work on CEOs; providing specialist security training and in-country back up to reassure staff when travelling.

6. Working in COEs is in its nature unpredictable and difficult and there are no universal simple solutions. As other agencies have found, working in fragile states is a process that needs continual adaption to changing contexts. It is recommended that the Global Fund systematically learn from its own experience and from others of what works well and less well in order to improve its practice in these contexts and communicate lessons learnt and experiences with Country Teams managing portfolios in COEs and other relevant stakeholders.
 - Developing more in-depth case studies of a few countries to better understand partner approaches (challenges, innovations) to operating in COEs and implications for the Global Fund. This could also assist in identification of partners and opportunities to support Global Fund support to that country (e.g. delegation of funds to another donor; particularly effective implementers; identification of institutions capable of monitoring; identifying sources of data for verification).
 - Documenting the process, lessons learned and costs of adopting the Global Fund COE approach including the mix of options used in different settings.
 - Piloting specific approaches to working differently in COEs e.g. developing guidance and promoting the use of non-CCMs and other alternative country coordination, management and oversight mechanisms in COEs. These models may also bring benefits/be useful in the future in non-COE.
 - Membership and participation in INCAF (International Network on Conflict and Fragility) which would provide a valuable learning forum on fragile states both for the Global Fund and for INCAF members interested in the experiences and challenges of operating a large global health partnership in COEs.
7. Improve Monitoring and Evaluation guidance on target setting in COE countries, including how to measure performance and how to include capacity strengthening and state building measures.
8. For acute emergencies it is recommended that the Global Fund should consider involvement in acute emergencies on a case by case basis in support of humanitarian relief agencies. The Global Fund should assess each emergency and decide a) whether or not to get involved b) whether to provide access to commodities in areas affected by emergency and/or c) whether grants need to be adapted because they are disrupted by the emergency. Some additional budget for emergencies would facilitate this approach.

The international community emphasises the importance of state building in fragile states; accordingly, the Global Fund could apply a stronger state-building lens when considering the impact of its grants. The first step would be to commission research and formulate a policy outlining how grants in COEs can potentially contribute to aspects of state building. This could be supported by state building/ institutional capacity building indicators in its QUART tool, Concept Notes, and grant agreements.

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Appendix 1: Approach to Acute Emergencies

Process for identification and action in acute emergencies	
Stage	Action
Identification and Preparedness	Think ahead especially where crises are identifiable and fairly predictable: ensure in-country risk assessment and response plans are in place, allow for a buffer stock in country (and possibly in facilities in vulnerable areas), build flexibility into contracts, ensure procedures in place.
Assessment	When a crisis hits, in consultation with humanitarian and in-country partners, assess whether the case for Global Fund involvement. The Global Fund may need to contract TA from other donors or agencies for these assessments, or use assessments that are already produced by Health Cluster partners, to which specific Global Fund questions could be included (with the possibility of some flexible funding by the Global Fund).
Tailored Response	The Global Fund response would be based on options, tailored to the scale and effects of the situation.
Review	Progress and the need for reprogramming would be reviewed and updated quarterly

Appendix 2: Summary of strategic options with preferred option recommendations – CCMs

CCMs: 4 options	Preferred option
	There are no new options here – they all currently exist but some could be more actively pursued.
1. Continue to use existing Technical Assistance approaches to strengthen CCMs but where commitment is lacking, focus instead on using a strong PR with additional oversight from CT. Existing approaches include Facilitated Eligibility and Performance Assessment, Minimum Standards and Short term TA to support Oversight and Governance process.	
2. Explore alternative coordination mechanisms such as humanitarian cluster coordination systems in certain contexts; promote and pilot test non-CCMs in cases where the CCM is weak, not legitimate and/or not functioning.	Lack of experience in engaging with humanitarian clusters may limit the appetite for option 2. Although non-CCMs could be suitable for COEs, there is currently only Somalia and Palestine as examples of this and this has been problematic. However, this is an area that could be further explored, with different approaches to CCMs piloted according to setting.
3. Invest in CCMs with more capacity through performance based frameworks and systems that assess quality of the CCM, possible contracting out of CCM Secretariat functions, recruitment and/or co-funding of international/national long term TA, TA through GMS but on a medium term basis with greater mentorship potential. The current CCM Performance framework is the framework for the Eligibility and Performance Assessment	Option 3 is probably the most practical option and could improve the effectiveness of CCMs through more performance-based measures and donor-funded longer-term embedded TA. USAID is already doing this in some countries and anecdotal evidence suggests this approach is working well. Embedded, long term and well planned TA to support country capacity is consistent with OECD guidance and INCAF consensus on use of country systems.
4. Encourage greater integration and/or broader scope of CCMs with existing national/sub-national disease or health sector coordinating mechanisms.	The preferred option is 4. However, scope to implement this option may be limited and dependent on a critical mass of donors, strong government leadership interested in sector coordination and considerable flexibility by the Global Fund to accept sector financial, accounting and programmatic reporting. Also, integration of some CCM functions into another organisation, e.g. the National AIDS Commission (NAC), assumes a level of institutional capacity, which may be variable in COEs (many NACs having also undergone reforms and restructuring due to inherent weaknesses in the NAC model). This option is preferred because it provides greater opportunity to embed the CCM within the institutional landscape for the long term, adheres to international principles on harmonisation and alignment, and improves Global Fund access, communication and collaboration with key partners – all factors important for effective working in COEs as found by key partners in their assessments (e.g. World Bank, DFID, AfDB, ADB). Governance and oversight is an integral role of the health sector coordination mechanism.

Appendix 3: Summary of strategic options with preferred option recommendations – PRs and SRs

PRs and SRs: 4 options	Preferred option
1. Continue to use existing approaches to tackling PR capacity e.g. PR standards and assessment; QUART tool to assess risk; use of Fiduciary Agents; change of PR; fewer SRs, TA to PRs and SRs, multi-lateral PRs, e.g. UN.	Option 1 largely represents existing strategies and already provides opportunities for differentiation to suit the COE context.
2. Invest in tailor-made capacity building measures prior to grant start-up that targets new or existing PRs/SRs and addresses common problem areas including Global Fund procedures and expectations, PSM, M&E and financial management.	Option 2 new/additional funding for COEs could be used to support early investment in PR capacity and understanding of Global Fund requirements, in order to improve grant performance and avoid obstacles and delays during implementation.
3. Contract Fund Managers/ Management Agents (MA) through open competition to implement grants in a country. Organisations would need to be capable of working in COEs of different severity and at different levels of the system. Their contracts would include equity, coverage and national capacity building objectives. Capacity building would reflect plans for an eventual transition to national management. Fund Managers/MAs could include local or international NGOs, public or private sector organisations.	The preferred option is 3 This would represent a new and different approach to the current PR/SR mode. Fund Managers/MAs are already being used by multiple donors in very difficult COEs. MAs would be appointed through a competitive process led by the CT and would be responsible for securing and contracting implementing partners and delivering through more robust results frameworks. The Global Fund would need to consider whether to use an MA per grant or per country. It would probably be more efficient to have an MA per country to benefit from synergies and efficiencies in grant management. The model could be tested before wider use to identify the additional benefits and costs of such an arrangement in difficult COEs. Competitive contracting of NGO and private sector organisations, with performance based frameworks and integrated capacity building components is a widely used strategy by bi- and multilateral agencies in fragile states (e.g. World Bank, DFID, SIDA, EC, USAID, and via pooled funds) .
4. Reduce and change the nature of contracts between PRs with SRs to improve efficiency and effectiveness. PRs could be MAs, awarded through competition who would engage organisations in Service Contracts (rather than as SRs) with funding based on delivery of clear results. Contracted organisations may need a small percentage of funds up front with most funding linked to delivery of outputs (pay for performance). May need shorter, smarter business cases particularly to ensure that KAPs are being targeted and reached effectively. Consider the use of provincial-level PRs in large federal COEs.	Option 4 could also work well, is being used already in some places and is in line with approaches used by the World Bank and other major donors . Experience and learning could be collected of the use of performance-related contracts (such as for SRs in Chad) to identify whether it improves performance and contributes to increasing equity compared to normal SR contracts in the unstable conditions of COEs.

Appendix 4: Summary of strategic options with preferred option recommendations – LFA and FA; Human Rights, Equity and Coverage

Expanding the Role of LFAs & FAs: 5 options	Preferred option
1. Apply the existing practice of higher LFA inputs in high-risk contexts, where appropriate. The countries (and provinces) defined as COEs may need to be considered for additional LFA resources depending also on Country Team capacity and the work of other donors and partners in the country. Review regularly to determine whether the extra resource levels allocated meet the needs in COEs. LFA services could be increasingly tailored to risk and Country Team needs, with possible expansion of their programmatic, finance, PSM and verification expertise.	Option 1 is the default, with options 2 and 3 increase implementation flexibility and possible impact through expanding the LFA role in COEs. Additional resources in response to the higher costs of operating in COEs is frequently considered/implemented e.g. by GAVI, ADB.
2. Expand the LFA health programmatic role and role in verification where there is limited capacity among partners and poorly performing CCMs. An LFA with more health specialist time could help identify missed opportunities in programming, improve efficiencies, and take on a more comprehensive performance verification role.	Option 2 is the preferred LFA option in very low capacity settings in the absence of other providers in the country. Additionally, if Global Fund remains committed to not having its own staff in country, then increasing the LFA role is an alternative to a full management agent or expanded FA role. The choice will partly depend on the LFA's capacity and strengths.
3. In emergency circumstances and some chronically fragile countries, rely on multilaterals to provide the 'eyes and ears' role where the LFA is unable to visit or cannot reach parts of the country. The use of UNDP's Harmonised Approach to Cash Transfers (HACT) could be explored for channelling funds to implementers, with inbuilt risk management strategies. Contracting could be explored with RMO's where appropriate (Somalia and Afghanistan) and other donors to see whether an eyes and ears role could be developed via contracts/MOUs.	Option 3 could be tested in a crisis or very difficult COE to see how Global Fund can adapt to delegating grant oversight to another agency. Other innovative implementation approaches such as the HACT is being used by UN agencies, including UNICEF and UNFPA. RMOs, set up by DFID and other donors, seem successful and are used by other partners.
4. Expand the remit of the FA and delegate more expenditure approval decisions to them. Use FAs for assurance against fraud, capacity building of PRs and SRs, add programmatic roles or TA and delegate more decisions to the agent.	FAs are an interim arrangement to allow continued grant implementation in contexts with poor financial accountability. The choice of option for FA depends on context. Option 4 builds in a clearer capacity building role and more TA, which should improve the quality of grants and the capacity of the PR organisation as well as improving sustainability. However in contexts with rapid change this may not be feasible. FAs are recommended and used by donor agencies including ADB.
5. Use an existing agency's approval and financial management oversight system as the FA e.g. World Bank or PEPFAR in specific cases.	Option 5 would require more new and radical changes to Global Fund systems and needs exploration with potential partners. It would be easier to implement in cases where the programmes are well harmonised.
Human Rights: Equity and Coverage: 2 options	Preferred option
1. Obtain and/or commission up-to-date research and (disaggregated) data to: identify and promote better targeting of KAPs in each COE; understand disease incidence and prevalence and the extent of service coverage among MARPs (e.g. by gender and age).	Both of these options are recommended to support better targeting of grants and programmes in COEs to large under-served groups (such as women, young children, displaced people and refugees). Data is likely to be available through UN and donor agencies and possibly national bodies. Equity/service coverage could be explored as part of the country-specific assessment but should also be an integral part of the country dialogue and Concept Note preparation. Getting data will be more complicated in countries in conflict.
2. Promote IDPs, long-term refugees and stateless people in NFM and national planning processes.	

Appendix 5: Summary of strategic options with preferred option recommendations – HSS and Maximising Synergies

HSS and Maximising Synergies: 4 options	Preferred option
1. Use existing (largely donor funded) delivery mechanisms for district delivery e.g. Fund Managers/MAs contracted to deliver district health services. Global Fund could provide commodities for use by the contracted organisations or give them grants for disease components within the Essential Package of Health Services (EPHS).	Option 1 is new and may be preferable in contexts, which have experienced NGO contracting mechanisms in place , as a way of improving efficiency through use of existing delivery channels and monitoring systems. It requires close harmonisation and working with the other funders and implementers, perhaps through using the same PRs/management agents. Contracting and support for EPHS via a pooled fund is an approach frequently adopted by donors in COEs including the World Bank, DFID, USAID, SIDA, EC.
2. Global Fund creates one grant that combines 3 diseases/HSS at district level in countries with poor access, very weak systems, and few external partners. Global Fund contracts PRs/MAs to deliver integrated services from a single grant (one agency per 1 to 3 districts (or more) delivering all disease components). Choice of agency would be oriented towards those a good record of delivering in COEs.	Option 2 is new and option 3 is expanded from current Global Fund practice. These options may be preferred in cases where making the basic system work is a top priority – essential to enable delivery of HIV/AIDS, tuberculosis and malaria services -and where agencies can be identified to support national system components like PSM, M&E or financial management. This approach could also be used in large federal states i.e. provincial grants either for components of the health system (PSM, M&E etc.) or for combined district delivery. Planned support to specific country systems (PSM) whilst also operating shorter term parallel systems is a strategy already used by the Global Fund (e.g. in Myanmar). Donors are already using MAs to deliver integrated services at district level in COEs e.g. USAID with MSH. Strengthening national systems is in line with other donor practices in COEs (e.g. INCAF members.) Global Fund support to one niche area of the health system would also be in line with (widely practiced) donor divisions of labour.
3. Invest in specific components of the health system in COEs e.g. through separate grants for PSM, M&E or PFM in COEs with very weak systems to build capacity for programming gains as well for positive synergies in the country's health system. These investments will need to be planned for the medium term until sustainable performance can be measured in the system, or until the country is no longer classified as a COE with weak systems.	
4. Piggy-back on other existing delivery mechanisms such as ante natal care (ANC) and child health days, which are reaching under-served groups in locations where normal district delivery mechanisms may be compromised.	Option 4 would build on what works in the country to maximise the reach of HIV/AIDS, tuberculosis and malaria services. This should be happening already but if not, should be discussed and included at Concept Note stage.
	Note: The intervention should be decided based on the country context, and contracting out may not be the best scenario for all situations. Furthermore, it may also be possible to combine some of the options, for example, Option 1 and 4, and on the other hand the options are not mutually exclusive, for example, Option 3 can be, and in some case should be, applied with any other options. Broad thinking is required to see which of these options can be applied in each country context and how to integrate them into the program design.

Appendix 6: Summary of strategic options with preferred option recommendations – Strategic Partnership and Performance Based Funding

Options for Strategic Partnerships: 3 options	Preferred option
At global level, the Global Fund could join OECD's International Network on Conflict and Fragility (INCAF) and WHO's Global Health Cluster	Both are new and recommended for international learning purposes i.e. keeping informed and accessing information on strategic approaches to fragility with potential synergies for harmonization with partner countries and other donors, and demonstrating commitment to working differently in COEs. Linking in with the Global Health Cluster would also facilitate options in individual COEs.
1. At country level, the Global Fund could explore greater participation in health sector development and coordination processes including participation in a donor division-of-labour within the sector both at national level and provincial level (e.g. in large federal states where provincial grants as per the health system strengthening (HSS) options above might be viable) and working more closely with partners to identify and address health system bottlenecks.	Option 1 is the preferred option for most COEs that have multiple donors and/or sector coordination processes. This option is already happening (in some High Impact COEs and South Sudan) but more could be done. Increasing participation in broader sector planning and coordination processes is a widely implemented practice by donor partners (DFID, World Bank, EC, SIDA) and concurs with international lessons on joint working and collaboration and would support the horizontal integration of Global Fund work.
2. Greater participation in IHP+ country compacts	Option 2 could be viable in IHP+ countries and would demonstrate commitment to harmonised donor support, country ownership and sustainability. Participation could identify ways for Global Fund grants to support broader HSS priorities or to improve financial management in the MOH.
3. Stronger linkages with country health clusters – through direct (email) contact with the Health Cluster Coordinator (often situated in WHO office) and participation in meetings during field visits.	Option 3 would be preferable in acute crises, enabling insights from other partners and close coordination in fast changing situations.
Options for Performance Based Funding: 3 options	Preferred option
1. Apply standard Global Fund PBF approach in COEs and recognise that COE country allocations are likely to reduce at the next allocation round in the most fragile CEOs.	
2. Use PBF approach with supplementary performance and results measurement. Provide additional financial support and technical inputs to increase verification of activities and impact, preferably through strengthening national health information and M&E systems.	Option 2 is the preferred option and is likely to give the best results, but option 3 may be needed in the start-up phase of grants in COEs. In the early stage of a grant, focus on key grant and system milestones may be more relevant. In situations with conflict and large areas of insecurity, standards of data need to be adapted to recognise the challenges. Where there is major disruption, a flexible approach is required, as in the past, which considers the impact of the context on a country's capacity to reach targets. There is international consensus on the need for flexible, simplified design, implementation and regular verification/monitoring visits in COEs (OECD, INCAF members, World Bank, AfDB, ADB).
3. Drop PBF element in the grant allocation for COEs, to allow for them to have an investment phase before they can start delivering maximum impact, at least in the start-up phase of the grant.	

Appendix 7: Summary of strategic options with preferred option recommendations – Emergencies

Support to Emergencies: 5 options	Preferred option
1. Global Fund does not respond in acute emergencies and programmes continue as planned, leaving other agencies to respond.	<p>The preferred options are 1, 2, 3 with the country teams (CTs) (and with CCMs if appropriate) selecting between these options according to context. In all cases, rapid decision-making and processes are required to ensure responsiveness to a fast changing situation. The situation should be closely monitored as the crisis unfolds with monthly to 6 monthly reviews depending on the pace of change. Reprogramming, gap filling with commodities, additional funding are all approaches used by partners such as GAVI, USAID, ADB.</p> <p>The really acute response ('in days') will be taken care of by 'typical humanitarian actors', like the MSFs, ICRC, etc. This is not Global Fund business. But the Global Fund can or should consider reallocation of stocks, if that would alleviate the situation. That's more a matter of weeks, once the immediate response has given way to a more prolonged response, if and when needed. Grant reprogramming should be considered in emergencies that, after their acute onset, are expected to last a considerable amount of time.</p>
2. Global Fund allows rapid access to resources to respond (e.g. stocks of commodities already in country to meet emergency needs). These could be funded from existing grants in some cases; in others it will be appropriate to replenish the used commodities from a central fund (using modest strategic initiative funds).	
3. Grant reprogramming to address emergencies (within existing grants) and its effect on planned grant activities. No extra funds assumed; rather adapt/simplify grants or delivery channels.	
4. Global Fund becomes global HIV/AIDS, TB and malaria commodity supplier in emergencies through existing grants and extra strategic initiatives funding. Supplies humanitarian agencies or existing PRs with three disease commodities to meet gaps in provision (e.g. antiretroviral therapies (ART) and MDR TB drugs).	<p>It is concluded that options 4 and 5 are not appropriate for the Global Fund: they would involve a substantial change in its remit and operational arrangements. The Global Fund is not set up to be a humanitarian agency and other agencies are better placed to respond in emergencies. Funding for emergencies is also organised in a different way.</p>
5. Global Fund sets up a special emergency fund to support gaps in the humanitarian response through additional strategic initiatives funding. Implementers could be prequalified emergency providers (MSF, Red Cross, UNHCR, private sector et al) and PRs (e.g. Government to respond to floods).	
	<p>If the Global Fund decides not to change its policy towards acute emergencies it could still enable humanitarian responses at global and country level by i) agreeing humanitarian agencies have access to negotiated prices and any buffer stocks for key commodities and ii) ensuring needs of long term refugees and IDPs are addressed in national strategic plans and considered in country dialogue). Both these measures are recommended.</p> <p>In addition to modest extra funding to cater for commodities needed in emergencies (as in option 2) through strategic initiatives funding, a modest contingency allocation could be planned into NSPs and Concept Notes, with a certain % flexibility foreseen in grant contracts in the case of emergencies.</p>

Appendix 8: Potential responses by type of COE

	Potential measures	When most suitable
Chronic instability, weak systems	Use existing sub-national delivery mechanisms where donors contract agencies for basic health service delivery. Provide commodities and possibly funding to enable delivery of HIV/AIDS, TB and malaria services.	In countries with multiple donors and a coordinated approach to contracting support to district or province services (e.g. S Sudan, Afghanistan). Use what works in cases where diverse providers or particular programmes work effectively at local level (e.g. DRC).
	Systems building grants for PFM, PSM, M&E, or District Delivery grants.	In countries with few donors and poor functioning and patchy coverage of systems (e.g. Chad).
	Use management agencies (MAs) and multilaterals as PRs, preferably selected through competitive bids.	Where locally based NGOs and Government PRs have shown insufficient capacity to manage grants and meet Global Fund requirements.
	Enhance CT's ability to function in COEs. Possibly appoint local representative (in another agency or LFA) to understand the evolving context and respond.	Where there are few other partners on the ground, country is not High Impact (with enhanced CT), multiple grants, rapidly changing context.
	Provide commodities in kind (e.g. through VPP).	In countries with poor procurement and financial management; or under ASP.
	FA or MA to deliver early capacity building to PRs and SRs to pre-empt problems	Especially for new PRs and SRs.
	Build capacity of CCM over medium term if functional, or ignore until context changes (if failing to improve under past efforts).	Strategy for CCM needs to be underpinned by wider understanding of political and human rights context.
Chronic instability, stronger systems	Use what works to target grants to under-served groups such as rural poor, IDPs and find ways to get to more inaccessible areas.	Build on elements of the services that work well to increase access to MARPs. Includes e.g. linking to ante natal care where this has high coverage, other outreach mechanisms
	Change PR and use MAs and multilaterals as PRs, preferably selected through competitive bids	In countries with continuing problems of corruption or inability to reach target key populations (e.g. in areas outside Government control)
	Provincial programme planning, grant management and implementation	In large federal states where services are managed by provinces (e.g. Pakistan)
	FA or MA to deliver early capacity building to PRs and SRs with exit strategy linked to milestones	Suitable for some ASP countries and/or where Global Fund has required change of PR
	Build capacity of CCM over medium term if it is functional, or ignore it until context changes if it has failed to improve under past efforts.	Strategy for CCM needs to be underpinned by wider understanding of political and human rights context
Acute crisis	Initial assessment to analyse likely impact of crisis on Global Fund and if there is an urgent need for HIV/AIDS, TB and malaria commodities.	Appropriate for all crises, as and when they arise
	Do nothing.	Where crisis is in a small area of country, and unlikely to affect Global Fund programmes and where national response can cope or humanitarian response is underway.
	Release commodities for use in emergency. Reimburse from central emergency fund or amend grant targets to allow use of resources.	Where commodities are in country, allow their use for rapid response if no other source available, e.g. nets for refugees.
	Reprogramming of Global Fund grants to deal with impact of crisis, e.g. change targets, reallocate funds, change implementers and/or simplify grants.	Where grants are disrupted or priorities change as a result of crisis, e.g. areas inaccessible, facilities destroyed, cross border movements.