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Global Fund Prospective Country Evaluation

2019 SYNTHESIS REPORT

REPORT PREPARED BY



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CAMBODIA



DEMOCRATIC
REPUBLIC OF THE
CONGO



GUATEMALA



MOZAMBIQUE



MYANMAR



SENEGAL



SUDAN



UGANDA

Contents

Acronyms and Abbreviations.....	iv
Executive Summary.....	vi
Introduction.....	vi
Early grant implementation.....	vi
Global Fund Business Model in Practice.....	vi
Thematic Analysis.....	vii
Addressing Human Rights, Gender and Key and Vulnerable Populations.....	vii
Building Resilient and Sustainable Systems for Health (RSSH).....	vii
Achieving Sustainability, Transition and Co-financing.....	viii
Increasing Value for Money.....	viii
Strategic Considerations.....	viii
Onboarding and implementation.....	viii
Grant monitoring and risk mitigation.....	ix
Human rights, gender, and key and vulnerable populations.....	ix
Resilient and Sustainable Systems for Health.....	ix
Sustainability, transition and co-financing.....	x
Value for Money.....	x
Future Directions.....	x
Chapter 1: Introduction.....	1
1.1 Background and objectives.....	1
1.2 Evaluation questions and approach.....	1
1.3 Methods.....	2
1.4 Summary of PCE portfolio characteristics.....	3
Chapter 2: Findings on grant implementation and analysis.....	3
2.1 Grant implementation along results chains.....	3
2.1.1 Grant initiation.....	3
2.1.2 Translation of inputs into activities: Early implementation.....	4
2.1.3 Translation of activities into outputs and outcomes.....	7
2.1.4 Baseline trends of coverage, outcomes and impact.....	9
2.2 How has the business model affected grant implementation?.....	11
2.2.1 Factors influencing grant implementation.....	11
2.2.2 Other findings related to the business model.....	13

2.2.3 Onboarding and implementation	14
Chapter 3: Findings related to Global Fund strategic/thematic priorities	16
3.1 Human Rights, Gender and Key and Vulnerable Populations	16
3.2 Resilient and Sustainable Systems for Health.....	23
3.3 Sustainability, Transition and Co-financing.....	29
3.3.1 Background.....	29
3.3.2 Overview of STC Policy Implementation.....	29
3.4 Value for Money	33
3.4.1 Economy.....	33
3.4.2 Efficiency.....	35
3.4.3 Effectiveness.....	38
3.4.4 Equity.....	38
Chapter 4: Summary, strategic considerations and future directions	40
4.1 Summary analysis and strategic considerations	40
4.1.1 The Global Fund business model.....	40
4.1.2 Thematic analysis	42
4.2 PCE provisional priority areas for 2019	46
References.....	48
Annex I: Global Theory of Change	I
Annex II: Results Chains.....	II
a) Malaria	II
b) HIV/AIDS	III
c) Tuberculosis (with an example of research question mapped for Senegal)	IV
Annex III: Timeline of key milestones by grant.....	V
Annex IV: Co-financing commitments and types of activities funded through co-financing.....	VI
Annex V. High level lessons learned.....	VII
Annex VI. Evaluation Limitations and Data Quality Limitations	X
Annex VII. Strength of evidence ranking.....	XII

Acronyms and Abbreviations

ACT	Artemisinin-based combination therapy
AGYW	Adolescent girls and young women
AIDS	Acquired immunodeficiency syndrome
AIM	Accelerated integrated management
ART	Antiretroviral therapy
ARV	Antiretroviral drug
CCC	Country Coordinating Committee
CCM	Country Coordinating Mechanism
CEP	Country Evaluation Partner
CRG	Community, rights, and gender
CSO	Civil society organization
CSW	Commercial sex worker
CT	Country Team
DHIS2	District Health Information System 2
DOTS	Directly observed treatment, short course
DRC	Democratic Republic of Congo
EHG	Euro Health Group
EQ	Evaluation question
FSW	Female sex workers
GAC	Grant Approvals Committee
GBV	Gender-based violence
GEP	Global Evaluation Partner
GHCC	Global Health Costing Consortium
HIV	Human immunodeficiency virus
HMIS	Health Management Information System
HRH	Human resources for health
IFMS	Integrated Financial Management System
IHME	Institute for Health Metrics and Evaluation
JHU	Johns Hopkins University
IBBS	Integrated bio-behavioral surveillance
IPT	Isoniazid preventive therapy
KPI	Key Performance Indicator
KVPs	Key and vulnerable populations
LFA	Local Fund Agent
LIC	Low-income country
LLIN	Long-lasting insecticide-treated net
LMIC	Lower-middle income country
M&E	Monitoring and evaluation
MAP	Malaria Atlas Project
MDR TB	Multidrug-resistant tuberculosis
MMT	Methadone maintenance therapy
MoFPED	Ministry of Finance, Planning and Economic Development [Uganda]
MoH	Ministry of Health
MoHS	Ministry of Health and Sport [Myanmar]
MOU	Memorandum of understanding
MSM	Men who have sex with men
MTCT	Mother to child transmission
NGO	Nongovernmental organization
NHA	National Health Account
NSP	National Strategic Plan
OIG	Office of the Inspector General
PAAR	Prioritized Above Allocation Request
PAHO	Pan American Health Organization
PCE	Prospective Country Evaluation

PCR	Polymerase chain reaction
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PPM	Pooled procurement mechanism
PQR	Price and quality reporting
PU/DR	Progress update and disbursement request
PR	Principal Recipient
PSM	Procurement and supply chain management
PWID	People who inject drugs
RAI	Regional Artemisinin-resistance Initiative
RAI2E	Regional Artemisinin-resistance Initiative 2 Elimination Program
RDT	Rapid diagnostic test
SARA	Service availability and readiness assessment
SO	Strategic Objectives
SR	Sub-recipient
STC	Sustainability, transition, and co-financing
TA	Technical assistance
RSSH	Resilient and sustainable systems for health
TASO	The AIDS Support Organization [Uganda]
TB	Tuberculosis
TERG	Technical Evaluation Reference Group
TRP	Technical Review Panel
TWG	Technical Working Group
UCSF	University of California San Francisco
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UNOPS	The United Nations Office for Project Services
UNAIDS	Joint United Nations Programme on HIV/AIDS
VfM	Value for money
WHO	World Health Organization

Executive Summary

Introduction

The goal of the Prospective Country Evaluation (PCE) is to provide a detailed picture of program implementation and, ultimately, the impact of Global Fund investments in eight participating countries: Cambodia, the Democratic Republic of the Congo (DRC), Guatemala, Mozambique, Myanmar, Senegal, Sudan and Uganda. Using a prospective, mixed methods approach, the PCE aims to ascertain the efficiency and effectiveness with which grants are operationalized and the extent to which the Global Fund business model is facilitating or hindering grant implementation. In short, the PCE seeks to understand the outcomes and impacts of the Global Fund's investments in country programs and how and why these results are occurring. Findings are intended to support timely program course correction and improvement. During 2018, the PCE focused on the early stages of grant implementation, examining how Global Fund's financial inputs translated into activities and programmatic outputs. Additionally, the PCE assessed objective data and stakeholder perceptions regarding grant progress, identifying key challenges related to the Global Fund business model and the achievement of Global Fund Strategic Objectives (SOs). This report presents a synthesis of these findings across the eight PCE countries, and related strategic considerations for the Global Fund.

Early grant implementation

Most grants in the PCE countries experienced delays during grant initiation and early implementation. These delays were primarily due to Sub-Recipient (SR) selection and onboarding, divergent timelines for the operationalization of catalytic matching funds, and simultaneous grant initiation and closeout processes. However, resulting implementation delays were mitigated in some instances by pre-emptive planning and active involvement by Global Fund Country Teams (CTs).

Financial absorption, defined as the percentage of the budget that was spent within a given time period, was substantially lower than budget allocations across all PCE countries. Absorption varied by disease and grant module. For example, total expenditure across all HIV grants in Q1 and Q2 of 2018 was only 13.9%, compared to 47.4% for TB and 30.4% for malaria. Median absorption for Q1 and Q2 across all grants was low (26.5%). In addition, no expenditure was observed in some program areas/modules in any PCE country, including comprehensive prevention programs for transgender people and supply chain management systems. Other modules performed relatively well: median absorption for program management and HIV prevention programs for the general population were 64.5% and 49%, respectively.

Despite low absorption rates across grants, the majority of countries are meeting or nearly meeting performance indicators. This is likely the result of on-going, routine activities by national programs that are shared across multiple funding streams. For example, activities including facility-based treatment for HIV, TB and malaria and routinely scheduled data review and validation meetings for health management information systems (HMIS) were continuously implemented despite disbursement delays. Disbursement delays were not reflected in the performance indicators, indicating a gap in monitoring, which is contributed to by the focus of Performance Frameworks on outcomes and impact, rather than programmatic outputs that may better reflect early implementation. This is particularly true for programs related to strategic objectives such as RSSH, gender, human rights and key and vulnerable populations. A potential implication is that the short-term assessments such as Progress Updates may not fully reflect grant performance. In 2019, as implementation progresses, the PCE will further examine the link between outputs, outcomes and population impact.

Global Fund Business Model in Practice

Despite delayed implementation of grants in the majority of PCE countries, many aspects of the business model facilitated implementation and functioned as designed. The 2018-2020 grants were signed on time at the end of 2017 and first disbursements to PRs were timely, enabling grant

implementation to start in early 2018, as planned. Where applicable, CTs were involved in finding solutions to early grant bottlenecks and/or approving flexibilities such as pre-ordering of commodities before grant signing or the pre-financing of SR activities to assist with the transition between grants.

However, some business model factors hindered grant implementation or did not function as designed. These factors included: concurrent grant closeout processes that reduced PR staff time for new grant initiation; the transition from international to domestic PRs, resulting in changes in monitoring and financial systems; the misalignment of timelines for approval and disbursement of matching funds with the timelines for the main grants; and the selection, contracting and onboarding of SRs, which created substantial bottlenecks in Q1-Q3 of 2018.

Elements of the Global Fund business model enhanced grant design and implementation of the Global Fund's strategic priorities. In Myanmar, DRC, Uganda, Mozambique and Senegal, matching funds increased investment and, in some cases, encouraged stronger program designs to address strategic priority areas. In Myanmar, the audit by the Office of the Inspector General (OIG) supported stakeholders to address emerging programmatic issues surrounding quality and access to services for key and vulnerable populations, despite stakeholders' concerns about undergoing a time-consuming audit process during grant initiation. The Global Fund Secretariat's use of grant management actions, including the inclusion of grant covenants related to the strategic priorities, were also considered enabling factors for improvements in design and implementation.

Thematic Analysis

Addressing Human Rights, Gender and Key and Vulnerable Populations

There was strong consensus among stakeholders across PCE countries that investments to address key and vulnerable populations and reduce human rights- and gender-related barriers were insufficient to adequately address structural barriers. In addition, stakeholders often had a limited understanding of issues surrounding gender and human rights, causing delays in planning, prioritizing and operationalizing initiatives. Initiatives to promote human rights often required new, cross-disciplinary partnerships (for example, with the legal community) that can be time consuming to form and these resulted in de-prioritization or implementation delays. Further, there were some discrepancies between key populations as defined by the Global Fund and key populations prioritized by country stakeholders.

Building Resilient and Sustainable Systems for Health (RSSH)

Increasing emphasis on resilient and sustainable systems for health (RSSH) at the global level was not reflected in increases in investment and absorption for RSSH within PCE countries. The proportion of the main grants allocated to RSSH differed among PCE countries, ranging from only 1.2% of total funds in Uganda to 16.8% in Senegal (considering "direct" RSSH investments only). RSSH investments were largely concentrated in three modules: Health management information systems, monitoring and evaluation (HMIS/M&E), human resources for health (HRH) and procurement and supply chain management (PSM), with limited investment in community responses and systems in the majority of countries. RSSH funds often represented short-term investments to cover programmatic gaps rather than strategic investments in health systems strengthening. Except for Myanmar (45%), average absorption across RSSH modules during Q1-Q2 2018 was very low, ranging from 1.0 to 30%. Notably, RSSH HMIS/M&E indicators performed well during Q1-Q2 2018, with most grants attaining an achievement ratio (the percentage of the target that was met) of 90% or higher, despite the limited absorption of RSSH investments over the same period. Global Fund RSSH investments are assessed by inputs and coverage indicators, rather than outcome or impact, which indicates that the current mechanism is principally set up to track the quantity rather than quality of RSSH investments. Performance metrics for RSSH typically focused on HMIS reporting or procurement and supply chain management, while metrics for other RSSH modules with a relatively high proportion of RSSH funds

(e.g. HRH) were not included. Our analysis also demonstrates the need for consistent categorization of RSSH inputs to accurately quantify RSSH investments—within and across grants, countries, over time.

Achieving Sustainability, Transition and Co-financing

Findings related to the sustainability, transition, and co-financing (STC) policy focused largely on co-financing requirements and their implications for supporting sustainable health systems. Global Fund documentation suggested that co-financing requirements were met in all eight PCE countries. However, countries lacked consistent mechanisms for stakeholders to confirm fulfillment of the co-financing requirement, and government health expenditure data were rarely made available to external partners for verification. Even when they do meet co-financing requirements, PCE countries remain heavily reliant on donor resources to finance the disease programs, posing a critical threat to transition readiness, programmatic and financial sustainability. There is evidence of countries embedding sustainability and transition considerations into program design and implementation, but there is a significant amount of work that needs to be done to make progress towards programmatic and financial sustainability.

Increasing Value for Money

Implementers in the majority of PCE countries are considering Value for Money (VfM) more consistently, including adoption of the pooled procurement mechanism (PPM), innovations in supply chain management and decentralization. These interventions have improved the economy and efficiency of commodity purchase, distribution and treatment, with prices paid for health commodities in two PCE countries falling below the Global Fund reference price. However, unit costs used for budgeting often do not reflect the true cost of inputs, and program management costs varied significantly across countries and by PR. Malaria programs in particular have seen improvements in efficiency and economy, including an overall decline in the cost per malaria case treated—a trend observed even in countries with declining incidence (Uganda, DRC). There is evidence that implementers are integrating cost effectiveness into program design, but these considerations were not employed in a systematic manner. In addition, stakeholders often discuss equity, but tradeoffs between equity, cost effectiveness and achieving programmatic targets are addressed differently between and within countries. The Global Fund’s monitoring tools are not able to systematically link financial and programmatic data for VfM analysis at the national level and do not collect information at the sub-national level, a data limitation that restricts analysis of VfM. Finally, there are still substantial financial barriers to accessing HIV, TB and malaria services, as measured by household out-of-pocket expenditure, in all eight PCE countries.

Strategic Considerations

Based on the findings, the PCE recommends the following strategic considerations for the Global Fund:

Onboarding and implementation

- Consider modification or differentiation of the three-year grant cycle and associated business model practices to smooth transition between grants, facilitate early grant implementation and enable adequate time for grant implementation, thus enhancing prospects of greater program impact.
- Update and strengthen guidance for CCMs and PRs on the selection and contracting of SRs to increasingly ‘front load’ PR/SR selection and contracting processes prior to grant implementation. Guidance should include:
 - Metrics that clearly define the time period within which SRs are expected to be selected and contracted by PRs.
 - PRs to work with identified SRs to ensure roles, scope of activities and budgets are agreed during grant making, ahead of the implementation period.
 - PRs should be strongly encouraged to effectively use Pre-Financing Policy flexibilities to facilitate SR preparation (e.g. staff contracting, pre-financing some activities) in advance of

grant implementation.

- Consider embedding matching funds in the timeline for the design, approval and implementation of the main grants to facilitate timely implementation of activities related to Global Fund strategic objectives.

Grant monitoring and risk mitigation

- Consider monitoring absorption rates by module and disease to facilitate identification of intervention areas that are progressing slowly and ensure that absorption is viewed in combination with other performance indicators (proximal and distal) to provide a more detailed assessment of grant implementation progress.
- Provide countries with plans to roll back and/or add flexibilities to the various financial risk mitigation measures employed, with clear expectations as to what the country would need to demonstrate in terms of capacity for these steps to be completed.
- Continue to identify areas where risk mitigation measures have burdened grant implementation and determine if the administrative burden can be lessened.

Human rights, gender, and key and vulnerable populations

- The Secretariat should ensure that Global Fund-supported programs clearly define key and vulnerable populations, aligned with national epidemiological context and that programs are designed to allow for tracking of progress against key intervention areas (e.g. disaggregation of male/female/trans sex workers, youth, women who inject drugs)
- Country stakeholders and the Secretariat should encourage more explicit promotion of gender and human rights integration throughout the grant lifecycle, particularly for TB and malaria, including:
 - Determine the appropriate mechanisms for ensuring that high-quality gender assessments are conducted (or integrated into other assessment practices); e.g. further direct engagement by Global Fund technical staff in specific country gender assessments
 - Ensure each CCM has a qualified gender expert engaged throughout the grant design and implementation process with the requirement that the gender expert is fully represented in all processes and decisions
 - Expand the requirements for addressing gender in funding requests and reporting, using clear guidance that is understandable for both CTs and reviewers
 - Programming and grant design (e.g. to address social norms, stigma, time use, and intra-household decision-making, not just sex-based targeting);
 - Implementation (e.g. collection and analysis of programmatic data disaggregated by key populations).
- The Secretariat and relevant partners should continue efforts to build in-country capacity and expertise on gender and human-rights related issues, through multiple avenues, such as:
 - Developing clearer and more accessible guidance on human rights and gender programming and implementation (already underway by Secretariat/CRG);
 - Ensuring technical assistance (TA) is consistent with country needs and facilitating countries seeking TA for reducing gender- and human rights-related barriers (e.g. help the CCM to know that the mechanism exists and see the value in accessing TA to enable stronger more gender responsive planning, implementation, and monitoring).
- Country stakeholders should more explicitly articulate the gender-related vulnerabilities of men/boys, women/girls, transgender and gender non-conforming individuals, the impact of these on disease-specific outcomes, and specific strategies to mitigate these effects in funding requests and designing disease-specific strategies.
- CCMs should encourage multi-sector approaches and facilitate collaboration among PRs with legal and other non-traditionally Global Fund stakeholders.

Resilient and Sustainable Systems for Health

- During the funding request development, consider mechanisms to incentivize stronger alignment

of crosscutting RSSH investments to longer-term national strategies for health system strengthening, rather than addressing short-term, disease-specific health system gaps.

- Improve standardization for categorization of RSSH investments within grant budgets to ensure accurate quantification of Global Fund contributions toward RSSH, including whether simplification is feasible or increased guidance and examples are necessary.
- Improve monitoring and measurement of the outcomes of RSSH investments, e.g.:
 - Clear articulation of expected RSSH outcomes, which can be translated into investment guidance, the modular framework and grant performance framework where relevant;
 - Stronger alignment of grant activities to indicators; and
 - Consideration (and development of) community systems and responses indicator(s) in the modular framework.

Sustainability, transition and co-financing

- The Global Fund Secretariat should consider restructuring the country co-financing requirement to more ambitiously increase domestic expenditure on health and the three diseases, with a view to ensuring that domestic financing increases to a level that more fully supports transition and sustainability objectives. Specifically, this might involve:
 - Expanding upon the co-financing requirement to better reflect the government's existing financial commitments overall and within the wider health financing landscape, e.g. by setting the co-financing requirement based on more parameters than the current two (progress towards 8% of general government expenditure on health, and the allocation amount).
 - Increasing the minimum level of co-financing that is acceptable to the Global Fund (i.e. increasing the co-financing requirement but not necessarily the co-financing incentive).
 - Strengthening the incentive for countries to increase domestic expenditure on health and the three diseases by making additional resources available to countries that invest above the minimum acceptable level of co-financing (via a separate mechanism than the existing incentive, which can only be taken away).

Value for Money

The Global Fund Secretariat, together with partners, should:

- Expedite work to collect unit/service delivery costs at the country level and use this as a basis for budgeting, with clear guidance on appropriate formulae to inflate estimates to allow for inflation, price changes, currency shifts, etc.
- The Secretariat should consider ways to strengthen country-level and/or grant-specific analysis of VfM (while considering the burden of reporting), such as by:
 - Collecting and analysing grant-specific output data for some indicators
 - Extending reporting tools to collect sub-national data
 - Creating performance targets that better address equity considerations
 - Requesting that PRs/countries report against quantitative trends for some indicators as proxies for efficiency and effectiveness, with qualitative explanations of what the trends represent, and how and why the observed trends occurred

Future Directions

The findings and strategic considerations outlined in this report will be reviewed and clarified through feedback mechanisms with key stakeholders, including the TERG. The findings from 2018 will be used to deepen country evaluation of whether, how and why the Global Fund's investments and the business model contribute to disease-specific and broader health and social impacts.

Chapter 1: Introduction

1.1 Background and objectives

The Prospective Country Evaluation (PCE) is a three-year prospective evaluation that aims to provide detailed insights into Global Fund implementation effectiveness and impact in eight countries. The PCE aims to evaluate the Global Fund's business model, investments, and impact to generate timely evidence in order to support policy and program improvements and accelerate progress toward meeting the Global Fund's Strategic Objectives (SOs).(1) Specifically, the PCE is examining the pathways between Global Fund investments and impact at the country-level, and in the context of domestic and other development partner investments; strengthening understanding of how Global Fund policies and processes play out in countries and how they can be improved; facilitating continuous improvement of program implementation and quality; strengthening country capacity to undertake and use more robust data; and highlighting lessons learned that can improve the Global Fund business model (see Annex V).(2)

The PCE is led by three Global Evaluation Partners (GEPs) in collaboration with Country Evaluation Partners (CEPs) in eight countries. The Euro Health Group/University of California San Francisco (EHG/UCSF) consortium is supporting Cambodia, Myanmar and Sudan; the Institute for Health Metrics and Evaluation (IHME)/PATH consortium is supporting the Democratic Republic of Congo (DRC), Guatemala and Uganda; and Johns Hopkins University (JHU) is supporting Mozambique and Senegal.

1.2 Evaluation questions and approach

Priority evaluation questions (EQs) for 2018 were agreed based on consultations with the Technical Evaluation Reference Group (TERG) and country stakeholders. EQs were also prioritized based on data availability, the potential to directly inform course-correction at the country-level, and ability to inform upcoming reprogramming and 2020 funding request timelines. Compared to last year's synthesis findings, which were generated based on an evaluation framework of four propositions (statements of intended benefits and expected outcomes) for the Funding Request and Grant-Making process, this year's synthesis report focuses on the following questions:

1. In which programmatic and/or priority areas and interventions is the Global Fund investing?
2. What is the status of progress in implementing the grant interventions?
3. How and why are these investments working or not working?
4. What factors facilitate or hinder grant implementation and performance?

Specifically, this report presents emerging findings on how Global Fund investments, the business model, and the implementation of Global Fund Strategic Objectives (SOs) have contributed to grant outputs that could ultimately contribute to positive disease and system-related outcomes and impact. Our findings contributed to answering the following high level EQs outlined in the 2016 Request for Proposal:

Impact: How do investments link and contribute to disease and broader health and social impacts?

Sustainability, transition and co-financing (STC): To what extent is the STC policy applied and contributing to preparing countries for sustainability and transition, and to increasing domestic resources?

Resilient and sustainable systems for health (RSSH): To what extent are Global Fund investments focused on RSSH? And to what extent does RSSH include community (health) systems?

Human rights: Are Global Fund investments being made towards removing human rights-related barriers to accessing services? What achievements have been made in this area?

Gender: To what extent are each grant's plans, programs and interventions gender-responsive? And how is gender-responsive programming being implemented through Global Fund grants?

Key and vulnerable populations: How well are key and vulnerable populations defined and effectively addressed through Global Fund investments?

Value for Money (VfM): How are the Global Fund, partners and country stakeholders approaching VfM? What effect does this have on VfM in Global Fund supported programs?

The PCE is using a theory-based approach to guide evaluation methods and analyses. The consortia developed a theory of change for the Global Fund business model (Annex I) and a related set of thematic evaluation frameworks based on Global Fund strategic priorities. Additionally, the consortia developed disease-specific results chains (Annexes II, a, b and c) based on available scientific evidence for prevention, care and treatment. The results chains demonstrate how inputs into the national disease programs translate to outputs, outcomes and ultimately impact. Indicators were selected for each output, outcome or impact box and will be measured across time, geography and population to determine *what changes are happening* within national programs. The linkages between the boxes in the results chains were interrogated to understand *how* and *why* the Global Fund’s investments and business model influenced the HIV, TB and malaria impact pathways.

These frameworks informed the choice of methods and tools adopted for data collection and analysis. The PCE’s prospective design was capitalized on to collect or acquire data that corroborates, supports, refutes, and/or expands upon findings as they emerged. The PCE has benefitted from a mixed methods approach that integrates both qualitative and quantitative data for analysis of inputs, facilitators, barriers, and program outputs.

1.3 Methods

Each GEP/CEP team employed methods appropriate to the data and expertise available (for more information on consortium and country-specific methods, please refer to the annual country reports). Briefly, each country tailored its analysis of the indicators embedded in the results chains based on an analysis of Global Fund grant investments, activities, and the priorities of national stakeholders. The consortia relied on existing and/or modeled secondary data from National Health Accounts (NHAs), routine health management information systems (HMIS), retrospective surveys such as Demographic and Health Surveys (DHS) and Service Availability and Readiness Assessments (SARA), and modeling such as Spectrum/Accelerated Integrated Management (AIM). Analysis of retrospective sources provided context and trends, while routine data provided early indications of program outputs from the current Global Fund grant period, including information on scale-up of national programs and implementation of new guidelines (for example, “Test, track, and treat”). Data were analyzed by sex, age, geography and other factors to provide context and additional evidence; quantitative results often led to targeted qualitative exploration and vice versa.

The process evaluation relied primarily on grant tracking e.g. process tracking through document review, meeting observations, key informant interviews and root cause analysis to ascertain what, when and how efficiently grants were being operationalized and the extent to which the Global Fund business model was helping or hindering grant implementation. Data were triangulated and crosschecked. Findings in the annual reports and the synthesis report were ranked based on Table 1, with the strongest evidence ranking being a 1 and the lowest ranking being a 4 (Annex VII). Employing all data and analyses above, the association of processes and outputs as well as expected outcomes and impacts were explored. The PCE is not without methodological limitations and country level data limitations (see Annex VI).

Table 1. Strength of Evidence for PCE Synthesis Findings 2018

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

1.4 Summary of PCE portfolio characteristics

The eight PCE countries vary in income category, disease burden, geographic location, and types of grant portfolio and environment. Grant applications were differentiated during the Funding Request phase. Most PCE applications underwent full (17) or program continuation review (10), and the remaining underwent tailored review (3). In the current grant period, the eight PCE countries received over \$2 billion combined (roughly 20% of the available funding in the 2017-2019 allocation) investment, ranging from \$38.2 million in Guatemala to over \$500 million in Mozambique. Most substantial investments are for malaria (\$992 million) and HIV (\$748million). Over \$60 million in additional catalytic funds was made available to five of the PCE countries to catalyze investments in key populations, human rights, adolescent girls and young women (AGYW), TB case detection, and data systems and use.

Table 2. PCE Portfolio Characteristics, Country Budgets, Catalytic funds 2017-19 Cycle, Total Signed(3–6)

PCE Country	CAM	DRC	GTM	MOZ	MYN	SEN	SDN	UGA	Total
High Impact Portfolio (2)	X	X		X	X			X	5
Core Portfolio (2)			X			X	X [§]		3
Challenging Operating Environment (2)		X					X		2
Adolescent Girls and Young Women Priority Country (3)				X				X	2
Reducing human rights barriers: Intensive Support		X (HIV, TB)		X (HIV, TB)		X (HIV)		X (all)	4
Income category (4)	Lower LMI*	LI	Upper LMI	LI	Lower LMI	LI*	Lower LMI	LI	
HIV burden (4)	High	High	High	Extreme	High	High	Low	Severe	
TB burden (4)	Severe	Severe	Low [^]	Severe	Severe	High	High [^]	Severe	
Malaria burden (4)	Severe	Extreme	Moderate	Extreme	Severe	High	High	Extreme	
Matching funds eligible (5)	NA	\$16.0	NA	\$19.7	\$19.3	\$2.5 [†]	NA	\$9.4	\$66.9
Finalized grant budgets for the 2017-2019 allocation period (6) USD, millions									Total
HIV		\$ 23.9	\$ 19.6	\$ 282.5	\$ 130.0	\$ 24.5	\$ 15.4	\$ 248.2	\$ 738.9
TB		\$ 18.7	\$ 12.3	\$ 41.9	\$ 94.0	\$ 12.2	\$ 12.3	\$ 18.4	\$ 209.8
TB/HIV	\$ 55.4	\$ 149.7		\$ 30.3				\$ 21.1	\$ 256.5
Malaria	\$ 42.8 #	\$ 350.6	\$ 6.3	\$ 167.9	\$ 84.6 #	\$ 36.3	\$ 100.8	\$ 190.3	\$ 979.6
Total	\$ 98.2	\$ 542.9	\$ 38.2	\$ 522.6	\$ 308.6	\$ 73.1	\$ 128.4	\$ 478.0	\$ 2,184.8

[†]Matching funds pending approval

[§] Portfolio category shifted from High Impact to Core in 2018

*Income category shifted between 2017 and 2018 Global Fund eligibility lists

[^]TB burden shift from moderate to low (Guatemala) and from moderate to high (Sudan) per 2018 Global Fund eligibility list

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

Chapter 2: Findings on grant implementation and analysis

2.1 Grant implementation along results chains

Chapter 2 summarizes progress implementing grant interventions, explores the drivers of progress (or lack thereof), and explains how the Global Fund business model has affected implementation. Although almost all grants included continuation of existing programs, we have focused on evaluation of funding under 2017-2020 awards in order to highlight features of implementation of a discrete funding cycle. Data from previous award periods are included wherever data are available to provide context for the observed results.

2.1.1 Grant initiation

Across the eight PCE countries, most grants have begun, albeit with delays and corresponding implications for efficiency. Annex III summarizes key milestones across the grants. Most PCE grants were signed during November-December 2017, with a few grants finalized during the first quarter of 2018.

Guatemala was an outlier – its malaria grant extension and new HIV grant not being signed until July and September 2018 respectively, due to funding requests being sent for iteration (grant extensions were put in place to cover the gap).

Across all PCE grants, most initial disbursements were made in a timely fashion between December 2017 and February 2018. DRC, Uganda, Mozambique, Myanmar and Senegal's grants have matching funds, the approval of which was closely aligned with the timing of the main grant's signature in Mozambique and Myanmar. This was not the case everywhere and in Uganda, DRC and Senegal, matching fund approvals and disbursements were delayed between five and eight months and/or remain outstanding (in Senegal, as of December 2018). DRC, Myanmar, Sudan and Uganda received second disbursements from Global Fund to the Principal Recipient (PR) between May and September 2018.

The efficiency of grant implementation was affected by delays in contracting Sub-Recipients (SRs). Though Global Fund guidance strongly recommends that PRs identify SRs during grant making to ensure disbursement-readiness prior to grant signing (7), the timing of PR/SR contract initiation and signature varied widely across PCE grants. Some grants (TB/HIV in Cambodia, HIV-HIVOS in Guatemala, TB-UNOPS in Myanmar, and HIV-CNLS in Senegal) began PR/SR contract or memorandum of understanding (MOU) signing in January 2018, shortly after grant signing; others did not sign PR/SR contracts until mid-2018 (TB/HIV in DRC, HIV-FDC in Mozambique, and HIV and TB/HIV in Uganda). Timing of first disbursements from PRs to SRs generally aligned closely to the timing of PR/SR contract signing.

2.1.2 Translation of inputs into activities: Early implementation

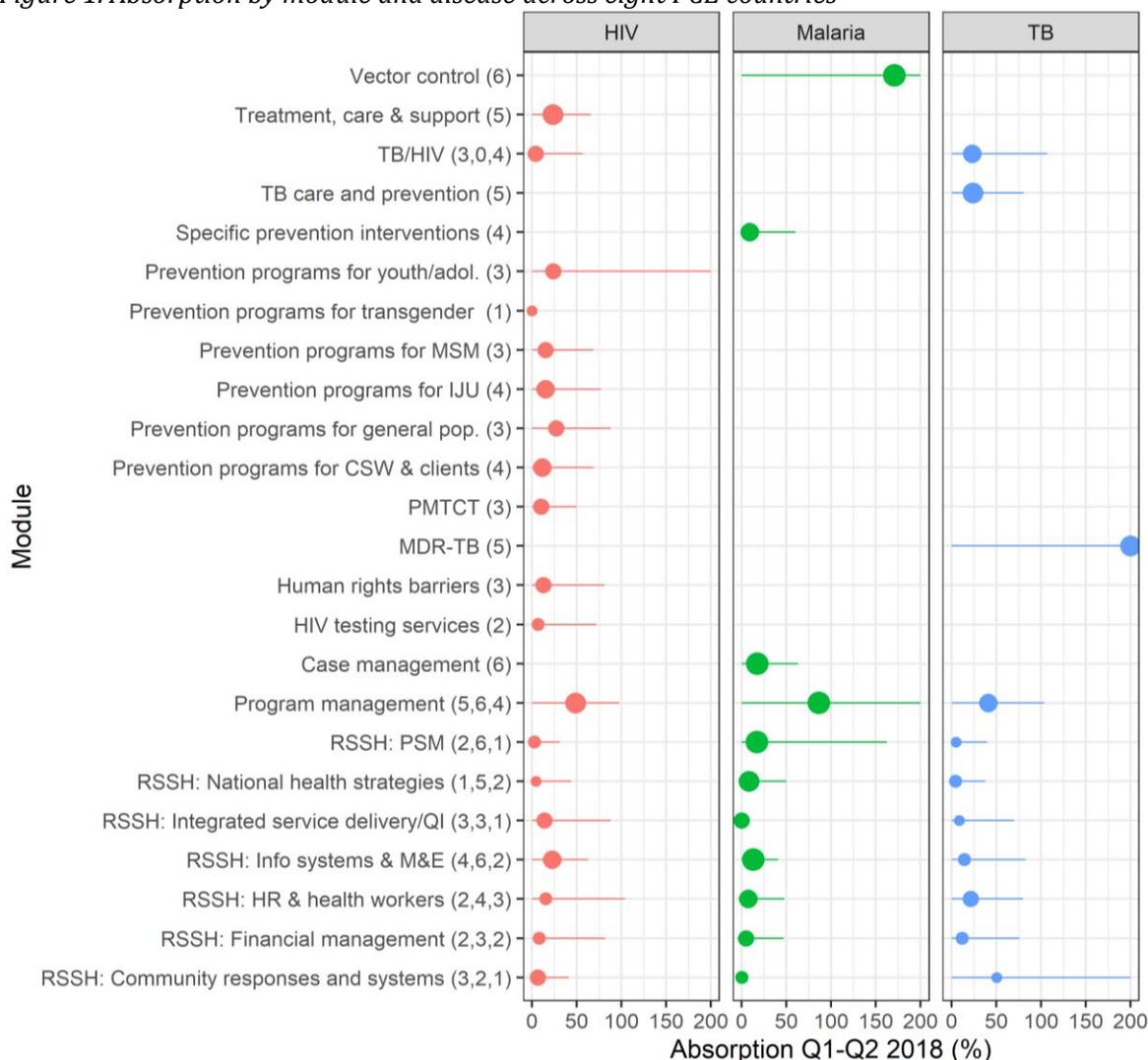
Absorption of funds (and thus implementation of activities) was substantially lower than planned, according to expenditure analysis from PUDR data January-June 2018. HIV expenditure in Q1 and Q2 of 2018 was only 13.9% of the original budget across the eight PCE countries. Absorption has varied widely by activity too, with expenditure on some modules such as comprehensive prevention programs for transgender people and procurement and supply chain management systems not beginning at all during Q1 and Q2. Expenditure for other activities, such as prevention programs for general population and program management, have been higher, at a mean of 37.9% absorption, with Myanmar (the maximum) executing 85.5%.

Overall absorption of funds was higher for TB grants, which spent 47.4% of their budgeted amounts in Q1 and Q2. Again, some modules were able to absorb more than others, for example community responses and systems achieved a mean of 50.6% absorption (Myanmar was an outlier with 294% absorption in this category) and multidrug-resistant tuberculosis (MDR-TB) achieving a mean of 315.5% absorption (Mozambique was an outlier with 2295% absorption). For malaria, overall absorption was higher than HIV but lower than TB, at around 30.4%. Vector control had the highest absorption across malaria grants (mean: 170.9%; DRC was an outlier at 1538%¹), while integrated service delivery and quality improvement (mean: 0%, min: 0%, max: 0%) and community responses and systems (mean 0.4%, min: 0%, max: 4%) absorbed very little.

Several RSSH modules, including national health strategies, procurement and supply chain management systems, and integrated service delivery and quality improvement had universally low absorption, with an average of 7.3% across all PCE countries. Absorption by module and disease, synthesized across all PCE countries, is shown in Figure 1; each point indicates the average absorption with the range showing the minimum and maximum percentages.

¹ Explanation from PU/DR: "Acquisition of ITNs for mass campaign not initially planned in the approved budget: Integrated in the budget pending the letter of implementation"

Figure 1. Absorption by module and disease across eight PCE countries



Observations with absorption more than 200% are not displayed

Points represent the average absorption across each country/disease, with range showing minimum and maximum

Parentheses show the number of countries (out of eight) having Q1-Q2 absorption data for each disease and size of the point correlates to this number (larger dots indicate more countries reporting this data)

Drivers of low early absorption are numerous; several were consistent among PCE countries. As might be expected, delays in SR contracting and disbursement were among the reasons for low early absorption. With important early milestones in grant initiation falling behind schedule, implementation of grant activities (and thus grant spending) also fell short of plans (although some program activities continued, albeit with limited functioning and/or temporarily accessing other funding streams – see findings below). Other drivers of low absorption related to grant architecture and grant management issues such as PR transition (Guatemala, Sudan, Cambodia, Senegal), SR selection/signing (DRC, Uganda, Senegal, Mozambique, Cambodia), variable Country Coordinating Mechanism (CCM) leadership (Guatemala, Mozambique), early budget revisions (Cambodia, Sudan, Uganda, Senegal), and administrative processes including compliance with risk mitigation measures and procedures for grant closure (Mozambique, Myanmar, Uganda, Sudan). Further, a number of country-specific contextual factors played important roles in early grant implementation progress e.g. the cash and fuel crisis in Sudan. Section 2.3 presents the in-country evidence for hindering factors, as well as our analysis of factors that helped to promote early implementation where it was successful.

Although absorption of funds is one important measure of implementation progress, it is incomplete. Most PRs have begun planning-related activities not reflected in overall absorption. Perhaps more importantly, absorption numbers overlook the *quality* of implementation for the sake of *quantity*. For example, RSSH-related activities may start slowly due to their complex nature, which often includes numerous stakeholders and extensive planning beyond routine programmatic activities. As a result, RSSH activities often appear to perform poorly in terms of early absorption (Fig. 1), despite important gains in stakeholder engagement and multi-sector planning. In addition, some country stakeholders perceive that an overemphasis on absorption may encourage grant recipients to focus on activities that are more quickly absorbed. This could have significant implications for VfM. Though difficult to attribute solely to an overemphasis on absorption, cross-country analysis suggests that grant budgets have become more commoditized over time. For example, commodity procurement in Uganda accounted for 15.8% of all budgets in the 2012-2014 grant cycle, 32.1% in 2015-2017, and 40.6% in 2018-2020.

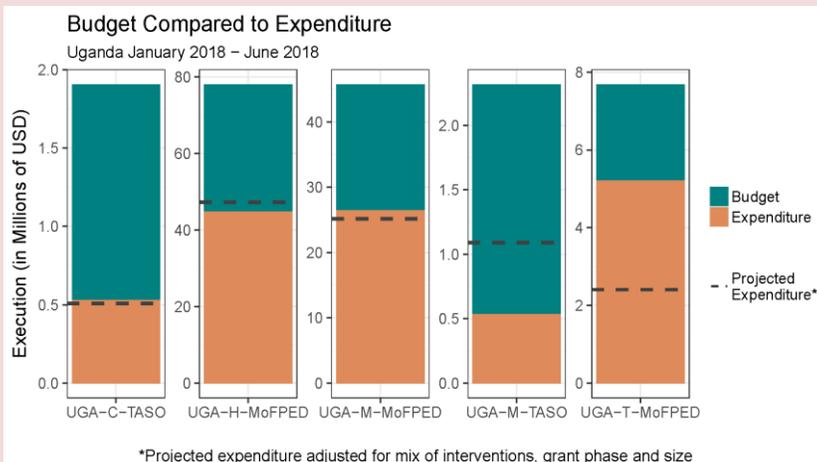
A focus on absorption raises another issue: what level of absorption is realistic to expect. Historically, Global Fund grants have rarely achieved full absorption. Since 2012, only 70.4% of cumulative budgets across all grants were absorbed. Other funders also reportedly have low absorption rates, albeit higher than Global Fund grants, which are often larger and more complex than grants from other donors. PEPFAR reports indicate that overall absorption among PCE countries receiving PEPFAR funding has been 80.1% since 2012².(8) These numbers are difficult to compare, however, among other reasons because PEPFAR expenditures operate according to different restrictions and timelines. Historical Global Fund absorption rates differ by module as well, with HIV treatment, care and support averaging 86% absorption by grant closure and prevention programs for youth and adolescents averaging 21%. Setting realistic absorption expectations requires careful attention to grant characteristics, since grants typically achieve lower absorption in their first semester. Smaller and less complex grants tend to absorb more while RSSH and TB grants tend to absorb less. The box below highlights a novel “Projected Absorption” framework for setting such expectations.

“Projected Absorption” - An alternative approach to set expectations about absorption of funds and evaluate grant progress

To set more realistic targets for absorption, and to track current grant performance against those targets, we have developed a framework for *Projected Absorption*. Using historical data and six predictive grant characteristics (mixture of interventions, grant size, quarter, number of modules, disease and country), we can quantify the level of expenditure each grant would achieve if past trends continue, beyond simply examining the average per module or quarter alone.

Projected Absorption can be monitored to determine whether grants are on track, under-performing or exceeding past trends. The figure demonstrates the application of this framework in Uganda. Although absorption is low, three grants (UGA-C-TASO, UGA-H-MoFPED and UGA-M-MoFPED) are actually on track compared to projections. One grant however, UGA-M-TASO is under-absorbing compared to previous grants, while UGA-T-MoFPED is actually exceeding past trends.

The PCE is monitoring *Projected Absorption* in select countries to track grant performance in a more realistic and nuanced way.



² These statistics among Guatemala, DRC and Uganda only due to data availability. For PEPFAR data, only 2014-2016 data available for DRC, and the entire Central American Region without country-specific details were available for Guatemala.

Despite challenges in early grant implementation, activities carried over from prior grants largely continued, and some new activities were able to begin. For the most part, the activities that have not halted or delayed are activities that are integrated with broader national programs. Examples include facility-based case management of TB, HIV and malaria, mass campaigns of long-lasting insecticide-treated nets (LLINs) (in some countries) and routine data review and validation meetings for health management information systems. Such activities, although often supported through Global Fund grants, are shared across multiple funding streams and therefore continue (potentially with limited functioning) despite lack of access to Global Fund support. Some SR-based activities have continued implementing as well. For example, progress updates from the first half of 2018 indicated that social mobilization and community engagement activities for malaria began in both Uganda and Sudan.

However, other Global Fund-supported activities were delayed or paused due to issues mentioned above. Every PCE country has at least one module for comprehensive prevention programs for key and vulnerable populations (KVPs) that achieved zero absorption so far in 2018. Another notable example was “last-mile” commodity distribution, which reportedly slowed or stopped in many regions of DRC during Q1 2018. As noted (and further in section 2.2), SR-related bottlenecks impacted grant implementation. SRs are often contracted to carry out activities that support national programs, and thus it is foreseeable that they would have the most delays. However, there were some instances of PRs stepping in to conduct activities originally designed for SR implementation. For example, in Uganda the civil society organization (CSO) PR stepped in to conduct training and supervision related to routine data reporting.

2.1.3 Translation of activities into outputs and outcomes

Reflecting that the provision of core services did not stop between grants, early performance against grant coverage targets is mixed but generally high, with most countries achieving or nearly achieving targets on most performance indicators. Country reports demonstrate trends in output indicators, many of which continue to improve, but are typically the purview of national programs with Global Fund input. PRs also reported progress toward performance indicators in the first six months of implementation. Shown in Figure 2, most countries were achieving or nearly achieving targets on most performance indicators. Among HIV indicators for example, the median percent target achievement (“achievement ratio”) was 79% across the PCE countries reporting.³ For example, for the performance indicator “TCS-1(M): Percentage of people living with HIV (PLHIV) currently receiving antiretroviral therapy” three of four PCE countries achieved at least 100% of their target.

TB achievement ratios were generally higher, with a median of 95.5% across all indicators and all PCE countries. TB care and prevention indicators among the PCE countries reporting⁴ met an average of 97.8% of the targets (min: 72% in Guatemala; max: 117.3% in DRC). Achievement ratios were even higher among malaria indicators, especially those focused on case management (CM median achievement ratio 99.8%⁵). For example, achievement ratios for “CM-1b(M): Proportion of suspected malaria cases that receive a parasitological test in the community” were 99.6% in Mozambique and 112% in DRC; however, Senegal reported only a 29.7% achievement ratio for this indicator. Overall, 79.5% of countries’ malaria targets across all indicators were at least 80% met, with a median achievement ratio of 99%⁶.

On the other hand, achievement ratios for performance indicators focused on key populations were low, with a median achievement ratio of 15.2%⁷ (min: 14.4% in Mozambique, max: 16.2% in DRC). This may be partly explained by the performance indicators related to key populations being some of the few that

³ This statistic excludes Myanmar and Senegal that reported no relevant data in progress updates

⁴ For TB care and prevention indicators, the countries reporting are Guatemala, DRC, Uganda, and Mozambique

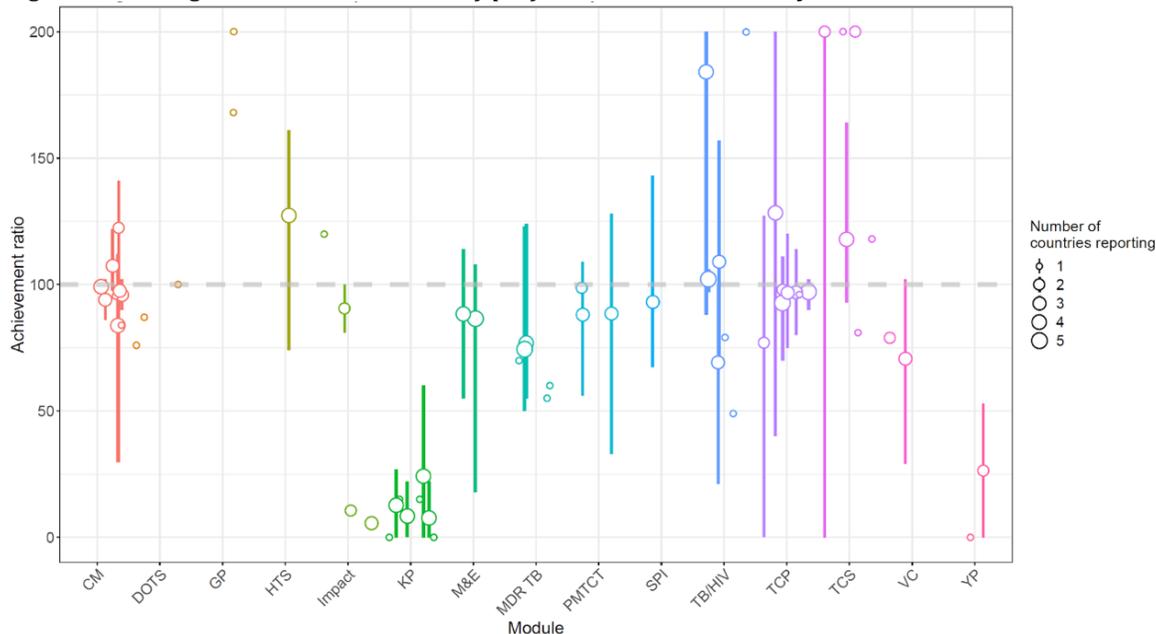
⁵ The countries reporting on CM indicators are DRC, Uganda, Senegal, and Mozambique

⁶ This statistic excludes Guatemala that reported no relevant data in progress updates

⁷ This statistic applies only to DRC, Sudan, and Mozambique due to reporting in progress updates

are focused on grant-specific outputs, where the implementation of activities is reliant on Global Fund funding.

Figure 2. Average achievement ratios of performance indicators by module



Bars represent the max and min, and points are the mean by module-intervention across countries and grants
 Note: where the max, mean, or min for a given module-intervention was higher than 200, it was limited to 200 for clarity in this figure

Target achievement is often uncorrelated with absorption levels. Figure 1 and Figure 2 above both show examples where grant recipients met or nearly met their targets despite relatively low grant execution in the short term (first two quarters of grant cycle). This apparent contradiction is perhaps a reflection of the statement above, that performance indicators are too distal to immediately respond to lapses in Global Fund activity. This finding is empirically supported; the PCE has observed essentially no correlation ($r=0.025$) across the eight PCE countries between average absorption and average target achievement by module. The high achievement in relation to performance indicators is primarily because the indicators are focused on coverage, outcome and impact metrics that relate to the overall national program performance (rather than output metrics that can be attributed directly to grant performance, such as continuity in their contribution to the national program).

The process of target setting itself may partially explain this misalignment. Although PCE data are still being analyzed, some explanations about how targets are set have emerged. Among them are the tendency to set targets based on a simple projection of secular trends, the motivation to set targets in accordance with National Strategic Plan (NSP) goals without sufficient vetting of these objectives, adjustments according to financial gap analysis, and the tendency to set targets based on generic international guidelines. As a result, selected indicators may not respond to short-term changes in Global Fund investment. The appropriateness of targets for performance indicators has implications beyond just performance monitoring, and the PCE will continue to analyze these issues.

Misalignment between programmatic data and short-term implementation progress has implications for Global Fund’s grant ratings, which are partly based on target achievement, influence Annual Funding Decisions and are reported to the Board. The lack of correlation between the two could: 1) result in inaccurate grant ratings; 2) create perverse incentives to implementers, by placing an over-emphasis on absorption, which encourages implementers to budget for activities that can be spent quickly and easily, possibly at the expense of activities that might have more impact; and 3) pose a risk to

the Secretariat's grant management function, and the Board's governance function, at least in the short term.

While an over-emphasis on absorption for monitoring grant performance has drawbacks, short-term implementation progress remains an essential first condition for grant impact, and indicators of grant performance should reflect that. Some indicators are more specific to actual activities, for example, indicators relating to key and vulnerable populations, and these do appear to be responding to lapses in implementation. Work Plan Tracking Measures are another option for monitoring short-term grant performance and implementation progress, but these appear to be used inconsistently across countries. The lack of reported data on grant-specific outputs (except in some cases) and data at the sub-national level fundamentally compromises analysis and measurement of VfM and could hamper efficient portfolio management.

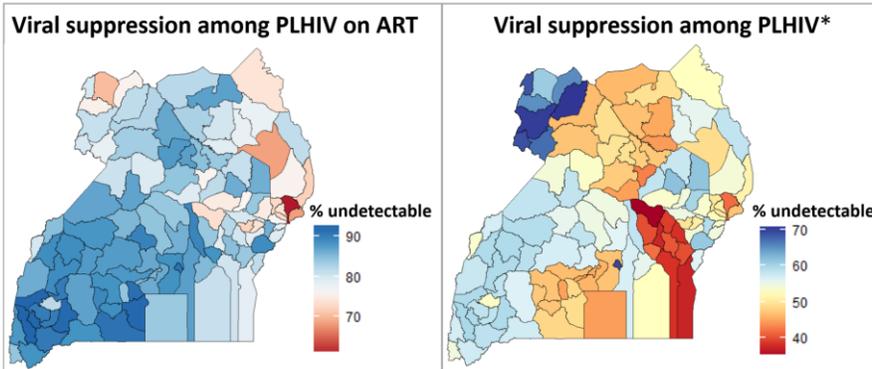
Some of these issues could be overcome by collecting data on outputs achieved through the implementation of grant activities, thereby allowing for better linkage between financial data and programmatic data (i.e. on investments and results) and facilitate analysis of efficiency and effectiveness at the country level. Analysis of data along the results chain at the sub-national level would also facilitate more comprehensive and systematic analysis of equity across the Global Fund portfolio. In the context of countries targeting interventions to increasingly concentrated epidemics, this sub-national analysis will become ever more important.

2.1.4 Baseline trends of coverage, outcomes and impact

During early grant implementation, the PCE measured implementation progress through financial inputs and programmatic outputs. While these outputs contribute to treatment outcomes and population-level disease impacts, delays in grant implementation across all eight PCE countries indicated that current grants have yet to create observable changes further along the results chain. Selected information on historical trends is highlighted below. More complete historical information on results chains are included in the appendices of country-specific annual reports. As implementation progresses and prospective outcome data become available, the PCE will further examine the link between inputs, activities, outputs, coverage, outcomes and population impact within current awards. The PCE Consortium is in the process of designing analytical models to measure the association between investments, outputs, coverage, outcomes and impact. The primary challenge to this analysis is data availability, as described in the annual country reports and in Annex VI. To address this challenge, PCE is using statistical techniques to combine both retrospective and prospective data from health facilities with information from relevant surveys.

In Uganda, for example, the most recent AIDS Indicator Survey was conducted in 2011 (9), but the PCE has been able to combine monthly data from Uganda's Viral Load Dashboard (which reports viral suppression among PLHIV enrolled in care) with two cluster-randomized HIV prevalence surveys to generate sub-national estimates of viral suppression among PLHIV. (10) These estimates indicate that the percentage of PLHIV on antiretroviral therapy (ART) with an undetectable viral load has remained relatively constant at the national level, from 87.2% of PLHIV who received a viral load test in 2014 to 87.7% in Q1 and Q2 of 2018. However, viral suppression ratios differed substantially when analyzed sub-nationally and when adjusted to include PLHIV who did not receive a viral load test. Figure 3 illustrates viral suppression among PLHIV on ART who received a viral load test (a facility-based outcome) and among all PLHIV, regardless of ART enrollment.

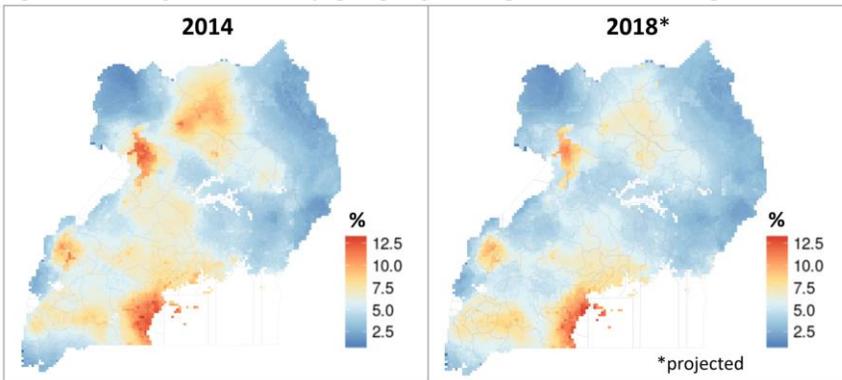
Figure 3. Viral suppression among PLHIV on ART vs. all PLHIV), Uganda, Q1/Q2 2018



*Represents all PLHIV, regardless of whether they are enrolled in care.

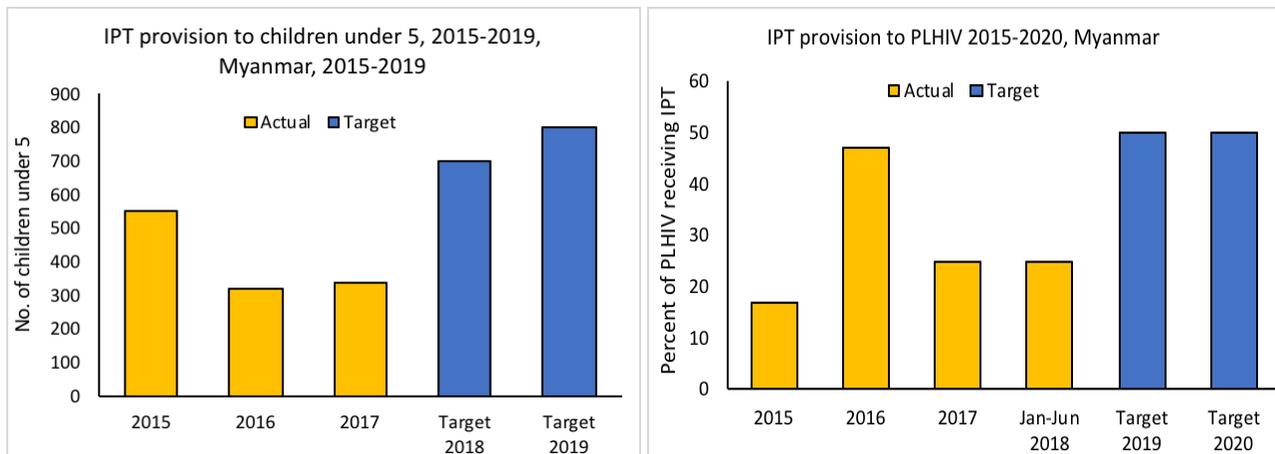
By creating facility and district-level estimates of patient and population outcomes, the PCE is preparing to examine the sub-national association between financial inputs, treatment coverage and incidence, and prevalence and mortality for HIV (Figure 4). While financial investments in the outputs of national disease programs are ongoing, the PCE will continue to focus on the prospective impact of the current grants in the context of historical trends whenever historical data are available.

Figure 4. HIV prevalence by geographic region over time, Uganda



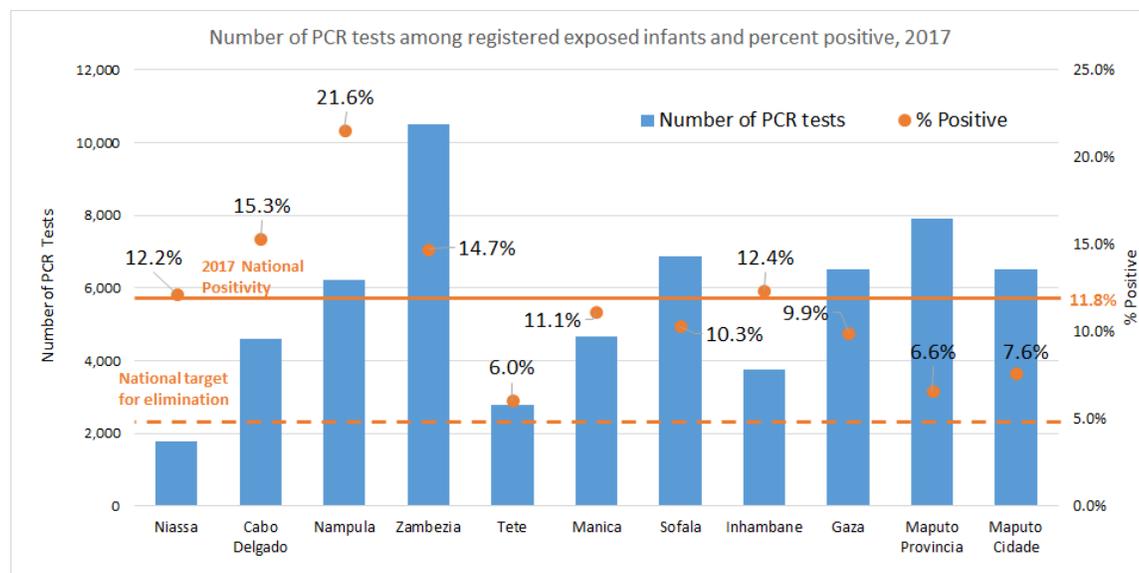
Similarly, in Myanmar, the PCE examined coverage of prevention interventions such as isoniazid preventive therapy (IPT) among PLHIV and children under five, as shown in Figure 5. These outcome data are critical to understanding the impact of Global Fund investments in TB prevention and will be analyzed against TB incidence data as those data become available.

Figure 5. Coverage of isoniazid preventive therapy (IPT) among PLHIV and among children under five



In Mozambique, the PCE is analyzing the number of polymerase chain reaction (PCR) tests for early infant diagnosis of HIV conducted for exposed infants and the percent of tests that are positive by province. 2017 data indicate that there are some provinces that need to be targeted for increased attention and funding. These data were not available when the current grants were made but should guide reprogramming to address the high mother-to-child transmission (MTCT) rate and relatively lower number of tests performed in some provinces. As 2018 data become available, they will be analyzed to determine whether any province can reach the national target of <5% that is recommended for MTCT elimination.

Figure 6. Number of tests for early infant HIV diagnosis among registered exposed infants and percent HIV positive by province, Mozambique, 2017(14)



Preliminary strategic considerations:

1. Consider monitoring absorption rates by module and disease to facilitate identification of intervention areas that are progressing slowly and ensure that absorption is viewed in combination with other performance indicators (proximal and distal) to provide a more detailed assessment of grant implementation progress.
2. Provide countries with plans to roll back and/or add flexibilities to the various financial risk mitigation measures employed, with clear expectations as to what the country would need to demonstrate in terms of capacity for these steps to be completed.
3. Continue to identify areas where risk mitigation measures have burdened grant implementation and determine if the administrative burden can be lessened.

2.2 How has the business model affected grant implementation?

2.2.1 Factors influencing grant implementation

A range of factors related to the Global Fund business model influenced early grant implementation. These findings emerged from our analysis of disease results chains, particularly the links between Global Fund investments, progress in translating investments into activities and whether activities are being implemented on time and as planned to achieve grant outputs. Analysis from the eight PCE countries suggested that the most significant explanatory factors influencing activity implementation were:

Multiple concurrent Global Fund processes underway at the beginning of the implementation period reduced PR staff time and attention from grant start up. Most PCE countries spent the first six

months simultaneously starting current grant implementation and closing previous grants. This was reported as time consuming in several countries, particularly for senior PR staff.⁸ In some cases, such as in Myanmar, Senegal and Uganda, grant closures diverted PR staff time away from focusing on new grant initiation. In Uganda, grant closure processes for 2015-17 are still on-going with country stakeholders noting that the simultaneous responsibility caused delays in key grant initiation milestones (such as timely submission of PU/DRs for January-June 2018). In Sudan and the DRC, activities from previous grants were still being implemented in early 2018 and this slowed the closure of those grants and delayed subsequent start up processes for new grants. In Sudan, this applied to program continuation grants – old grants needed to be closed first before ‘new’ (continuation) grants could start.

The transfer of PRs, notably from international organizations to national ministries, represents an important shift towards strengthening country ownership and sustainability but created initial problems for some grants, which slowed grant implementation. The transfer of PR to national entities in Cambodia, Sudan and Senegal involved new and/or changed implementation structures. Grant implementers were not always familiar with revised fiduciary and accountability systems, adding time for adoption and disbursement. Additionally, risk mitigation procedures for national PRs were often stricter than procedures for CSOs and international PRs, increasing the administrative burden and prerequisites for disbursements. While these procedures have the potential to mitigate misuse of funds by national ministries and programs, they sometimes contributed to delays. For example, in Senegal, a one-year renewable contract designed as a risk mitigation strategy for the new PR delayed SR signing. As the Global Fund increasingly shifts responsibilities to national systems, the benefits of additional financial monitoring may also result in tradeoffs for absorption, particularly during initiation and early implementation.

Selection and contracting of SRs by PRs during the grant implementation period were a significant bottleneck to operationalizing activities, particularly those activities targeting strategic priorities.

In the majority of PCE countries, the selection, contracting and disbursement processes by PRs to SRs often extended beyond the Global Fund’s recommended timeline of ‘early grant implementation’ and this delayed implementation. Even SRs selected on time (e.g. in Q3 or Q4 of 2017) experienced contracting delays. Apart from late selection, explanatory factors included re-launching selection processes not completed to the Global Fund’s standards or satisfaction; cumbersome, multiple approval and signatory requirements; lengthy negotiations between PRs/SRs regarding roles, scope and activities, including in response to budget reductions; and the size and complexity of new grant management arrangements introduced for this implementation period. For example, in DRC, 29 SR contracts were required, 10 of which involved new SRs subject to capacity assessments by the PR. In Sudan, 14 new SRs and Implementing Units were introduced and subject to capacity assessments undertaken by a new PR. This was even though both countries had submitted differentiated funding requests (e.g., program continuation for TB, HIV and malaria/RSSH in Sudan, and malaria in DRC; and tailored review for TB/HIV in DRC) which was intended to allow more time for grant implementation. In both cases, delayed contracting and disbursements delayed activities targeting key and vulnerable populations and/or human rights and resulted in budget revisions and/or re-programming early in the implementation period.

The Global Fund business model promotes country ownership by assigning responsibility for SR selection, assessment and contracting to PRs, under the oversight of the CCM. However, there may be trade-offs between ensuring quality SRs are selected, the time required for contracting, and concomitant impacts on grant planning, implementation and performance. For example, delays in Uganda’s grants resulted in the need for ‘acceleration planning’ with PRs and SRs adjusting work plans to ensure catch up on the implementation of planned activities.

⁸ In 2014 the Global Fund made efforts to simplify and accelerate grant closure processes including differentiating types of closure and steps required. However, the timeline for each type of closure was not differentiated and closure processes are expected to take eighteen months in total from planning to final closure.

Misalignment of matching funds approval and disbursement processes contributed to grant implementation delays in DRC, Senegal and Uganda but not in Myanmar. In Uganda, later approval and disbursement in relation to the main grant created additional administrative challenges. For example, all related grant documents, performance frameworks, and budgets required updating. Matching fund implementation plans included activities scheduled to start in Q1 2018, unrealistic given that the Global Fund Board only approved Uganda's matching funds request in April 2018. In addition, ministry SRs did not want to sign separate MOUs for the main grant and matching funds. Because some SR contracts were linked to matching funds approval, contract finalization was also delayed. In DRC, matching funds activities for human rights, HMIS, and TB missing cases were only approved in April/May 2018, requiring budget updates, with funds disbursed in May/June. In Senegal, matching funds approvals are still pending, following delays in the submission process due to confusion about the purpose of the funds and difficulties in determining which priorities would meet Global Fund requirements. In contrast, Myanmar matching funds were approved and integrated into the main grants in December 2017 and were thus initiated with no major delays. The "knock-on" effects from misaligned and/or delayed matching funds approvals observed during early grant implementation in some countries could be addressed by embedding matching funds into the timeline for the main grants, which is an area the Global Fund Secretariat is actively working to revise and adapt.

Global Fund CTs played a positive enabling role in early grant implementation. Business model flexibilities supported grant transition and start up. Evidence from Cambodia, Sudan, Myanmar, DRC, and Uganda indicates that CT engagement and rapid frequent communication were important facilitators in resolving grant implementation bottlenecks and/or addressing other country specific issues. Additionally, business model flexibilities proved important for grant transition and start up. Examples included:

- *Pre-ordering of commodities and/or pre-financing of SR activities* e.g. while waiting for contract signatures in DRC; and supporting commodity procurement in late 2017 in Uganda to ensure no gaps in early 2018 stocks – a mechanism identified as a critical facilitator to support transition between grants.
- *Flexibility in budgeting* e.g. in Uganda where an ACT overstock was identified, and funds were re-allocated towards rapid diagnostic tests (RDTs) which have an increased unit price.
- *Use of grant savings* e.g. in Cambodia: Savings from the previous grant were used to respond to the regional malaria grant Intensification Plan to address the significant increase of malaria cases.
- *Bridge funding and/or three-month extensions of previous grants* facilitated transition to new grants, including for program continuation grants, in DRC and Senegal. Using funds from the upcoming 2018-2020 grant, an HIV grant extension in Guatemala enabled the continuation of HIV services while decisions about iteration were being resolved.
- *Rapid reprogramming* and ability to adjust approved budgets enabled a Senegal PR to support monitoring and reporting by allocating grant funds to PR operating costs. PR operating costs were not included in the first budget as funds were used to meet a 10% RSSH funding requirement. In Sudan, the RSSH prioritization process resulted in a set of planned activities that were not agreed by the implementing units and needed changing. Agreement for early reprogramming enabled changes to planned activities and budgets.

2.2.2 Other findings related to the business model

CCMs played an active role during the funding request phase when stakeholder involvement was key, but their grant oversight role during implementation has been mixed. Evidence was mixed from the PCE countries regarding the effectiveness of CCM oversight of early grant implementation. In Uganda and Sudan, the role of the CCM was perceived to be weaker and less visible than during the funding request and grant making phase. Other PCE countries reported improved CCM effectiveness as the result of restructuring and/or technical support in Guatemala and DRC, respectively, or engagement

during grant start up in Senegal where the CCM played an important role in guiding reprogramming. The Mozambique CCM is undergoing restructuring and has had limited capacity to oversee grant start-up.

Evidence from Cambodia, Myanmar, Sudan, and Uganda indicated that discussion and resolution of bottlenecks was not always the purview of the CCM but tended to be addressed by CTs, PR/SRs and/or others such as executive committees, technical working groups or sub-committees. While helpful, in some contexts these groups had their own constraints, such as members who were often not involved in service delivery, which potentially reduced their ability to identify implementation challenges. The role and effectiveness of CCM grant oversight, as well as other aspects of CCM reform will be further tracked in 2019, and in line with the implementation of the Evolution Project taking place in DRC, Guatemala, Mozambique and Uganda.

Partnerships exist, built on comparative advantages related to expertise, leverage and capacity, but their role in identifying and addressing grant implementation weaknesses is less clear. Initial findings observed that many technical and development partners are engaged in countries (even where their financial contributions are small) with well-defined roles that are coordinated and mobilized around Global Fund specific and/or other health-related issues, including in Cambodia, DRC, Myanmar and Sudan. However, the extent to which partnership efforts are geared towards analyzing and addressing grant implementation weaknesses is less clear. The role and effectiveness of Global Fund partnerships as a strategic enabler for translating grant investments to grant outputs, including through technical support, may be an area for further PCE tracking, in line with the results/recommendations from the thematic review of technical support partnerships underway.

2.2.3 Onboarding and implementation

Program continuation did not always represent a continuation of a similar mix of interventions in the grant, with implications for financial and programmatic risk, and there is mixed evidence for whether the approach has sped up implementation. Evidence from Mozambique, Senegal, DRC and Sudan indicated that program continuation accelerated grant initiation in some cases, but not entirely due to the continuation of PRs and sometimes SRs from the previous grant. However, this design feature was not specific to the program continuation approach and the timeliness of processes was also experienced in other PCE countries where PRs were retained, such as in Myanmar.

Findings from Sudan indicate that program continuation – intended to enable implementation of the same Global Fund grant design for a further three years assuming no *material change* – did not work as intended for the HIV or malaria/RSSH grants due to reduced allocations. In all cases, Sudan's program continuation grants experienced start up delays. For HIV, significant budget reductions led to changed activities, requiring a major overhaul of KVP programs. For malaria/RSSH, getting new agreements from implementing units on grant activities to be implemented led to reprogramming even before the continuation grant started. Based on the Global Fund Applicant Handbook's definition of "material change," there clearly was material change to the HIV grant, which means the grant was approved based on different activities and assumptions.(15) In DRC, the simplified funding request approach (e.g., program continuation for malaria and tailored review for TB/HIV) contributed to faster grant signing but did not increase the amount of time for grant implementation because of significant changes in the grant management arrangements, namely the shift to transversal SRs (discussed further below).

There was evidence of the operationalization of the Challenging Operating Environment (COE) policy principles through an innovative provincial approach to grant implementation in DRC.

Innovative grant management arrangements were adopted in DRC with the intention of simplifying and improving grant coordination and operational efficiency. Grants are now operationalized through provincial-level transversal SRs designed to manage all three disease areas in one province. This approach has been challenging due to the coordination and cooperation required. For example, mistimed PR disbursements to SRs (one PR disbursed faster than the other) had repercussions for activity implementation. While it is too early to judge the potential impact of this new model on achieving grant

outputs, there are considerable risks to implementing changes at this scale (e.g. 28 SRs, 16 of which will have transversal responsibilities), speed (without a phased-in approach) and without changing the PR model (continued use of disease-specific PRs for malaria and TB/HIV, split disbursements and potential split accountabilities).

Additionally, DRC is piloting a provincial approach as part of its strategy for differentiated engagement, a model that aims to strengthen the capacity of provincial authorities and decentralize management through increased CT presence at the provincial level. There is evidence that the increased CT presence has helped bring more awareness to implementation bottlenecks and helped identify quicker solutions; however, it has proved challenging to operationalize, and while innovative, the approach has been slow to define clear activities and is not well understood at the country-level.

The Global Fund’s approach to financial risk mitigation is viewed as effective at mitigating risk but results in tradeoffs for budget absorption and/or sustainability. As shown in Table 3, in addition to the important risk mitigation roles played by the Secretariat, CCM, LFA and Office of the Inspector General (OIG), several countries have additional risk mitigation measures in place. While these measures represent important barriers to misuse of Global Fund investments, the breadth of financial risk mitigation measures was often cited by stakeholders as disproportionate to the existing financial risk, reducing overall VfM. For example, in Myanmar, stakeholders stated that PR UNOPs created positive changes in budgeting, planning, implementation and monitoring and evaluation (M&E) but identified the Restricted Cash Policy as an implementation barrier. This policy led to a reluctance among government staff to travel and seek reimbursement through Global Fund processes and a preference to use funds from other donors where such restrictions do not apply.

Use of these financial risk mitigation measures also implied that payment and procurement functions and processes are operated outside national government systems and are therefore unable to improve national fiscal capacity. While there are clear benefits to these policies in terms of transparency, there are important implications for the Global Fund’s sustainability objectives covered in the STC section below.

Table 3. Financial risk mitigation measures in place for one or more grants

Country	Int'l agency as PR	Fiduciary Agent	Fiscal Agent	Restricted Cash Policy	Procurement Agent	Payment Agent
Cambodia					✓	
DRC			✓			
Guatemala					✓	
Mozambique					✓	✓
Myanmar	✓			✓	✓	✓
Senegal					✓	
Sudan	✓		✓	✓		
Uganda						

Various Global Fund business model components have worked to influence grant design to strengthen the focus on Global Fund strategic priorities. As seen in chapter 3.1, grant investments specifically designed to address strategic priorities such as human rights and gender-related barriers and KVPs are often low. Aspects of the business model are being leveraged to enhance the focus on strategic priorities in grant design and implementation. This is being achieved through:

- Matching funds, which have increased investment in strategic priorities in Myanmar, DRC, Uganda, Mozambique and Senegal (Table 2). In Myanmar, this also encouraged stronger program design to address strategic priority areas.

- The Secretariat’s use of grant management actions and grant covenants that reinforce strategic priorities in grant implementation. In Myanmar for instance, grant covenants included in final grant agreements related to KVPs (e.g., scaling up services to prisoners), and transition and sustainability (e.g., transitioning the PR and phasing out staff seconded to the MoH). In DRC and Uganda, grant covenants re-emphasized co-financing requirements.
- Use of Performance or Grant Management Letters following analysis of PU/DRs to encourage implementers to improve grant performance, including reporting on management actions agreed to upon grant approval.
- Use of OIG audit such as in Myanmar, which catalyzed stakeholder commitment to address emerging program issues in line with Global Fund strategic priorities.
- In Sudan and Uganda, the securing of funding under the Global Fund’s Emergency Fund to support services to key and vulnerable populations in emergency settings including US \$3.2m for the provision of malaria services in refugee camps and selected states in Sudan and US \$3.5m to the malaria grant to cover commodity gaps for refugees in Uganda.

Preliminary strategic considerations:

1. Consider modification or differentiation of the three-year grant cycle and associated business model practices to smooth transition between grants, facilitate early grant implementation and enable adequate time for grant implementation, thus enhancing prospects of greater program impact.
2. Update and strengthen guidance for CCMs and PRs on the selection and contracting of SRs to increasingly ‘front load’ PR/SR selection and contracting processes prior to grant implementation. Guidance should include:
 - Metrics that clearly define the time period within which SRs are expected to be selected and contracted by PRs.
 - PRs to work with identified SRs to ensure roles, scope of activities and budgets are agreed during grant making, ahead of the implementation period. PRs should be strongly encouraged to effectively use Pre-Financing Policy flexibilities to facilitate SR preparation (e.g. staff contracting, pre-financing some activities) in advance of grant implementation.
3. Consider embedding matching funds in the timeline for the design, approval and implementation of the main grants to facilitate timely implementation of activities.

Chapter 3: Findings related to Global Fund strategic/thematic priorities

3.1 Human Rights, Gender and Key and Vulnerable Populations

Promoting and protecting human rights, key and vulnerable populations (KVP) and gender equality are interrelated themes/concepts comprising Strategic Objective 3 of the Global Fund’s 2017-2022 Strategy.

This section summarizes key findings across PCE countries related to initiation and early implementation of KVP, human rights- and gender-related activities.

3.1.1 Catalytic Investments for Human Rights, Gender, and Key and Vulnerable Populations

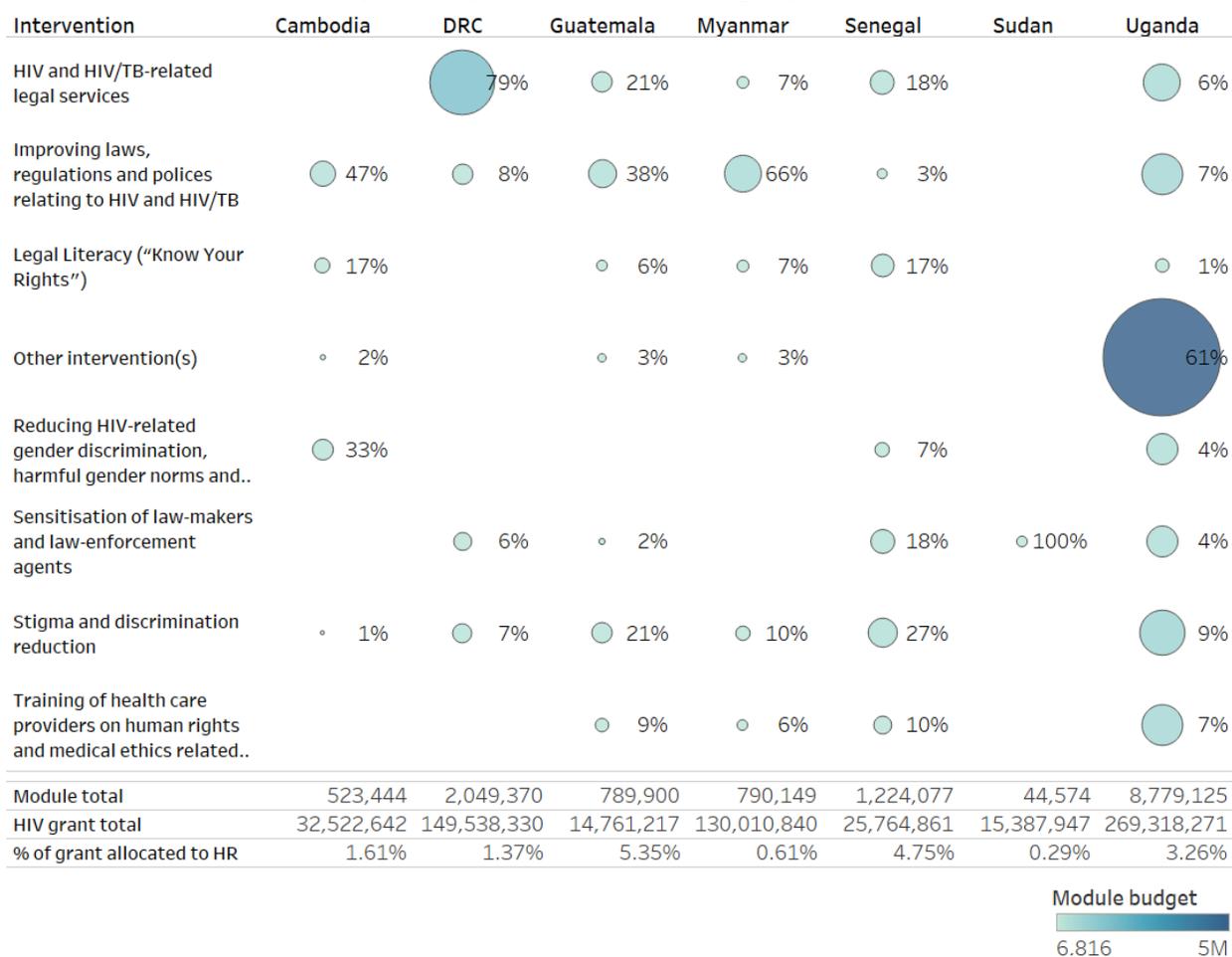
DRC, Mozambique, Myanmar, Senegal, and Uganda qualified for matching funds to support activities focused on human rights and KVPs, including AGYW (Table 4). To date, matching funds have been approved and incorporated into most qualifying country grants except Senegal. Senegal was delayed in requesting matching funds due to challenges in developing the implementation plan for matching funds activities. The Senegal plan was presented at a CCM-convened meeting at the end of October 2018 and has since been submitted to the Global Fund Board for review and approval.

Table 4. Matching funds prioritizing gender, human rights, and key and vulnerable populations

Country	Matching Funds Priority Area	Currency*	Communicated Matching Funds	Requested Matching Funds	Matching Funds Incorporated into Grants	Board Approval Date
DRC	HIV/AIDS - HR	USD	3,000,000	2,999,675	2,999,675	Apr-18
Mozambique	HIV/AIDS - AGYW	USD	6,000,000	6,000,000	5,990,361	Dec-17
Mozambique	HIV/AIDS - HR	USD	4,700,000	4,700,000	4,699,999	Jun-18
Myanmar	HIV/AIDS - Key Pop	USD	6,300,000	6,300,000	6,300,000	Nov-17
Senegal	HIV/AIDS - HR	EUR	1,247,540	1,090,775	pending	pending
Senegal	HIV/AIDS - Key Pop	EUR	980,210	980,208	pending	pending
Uganda	HIV/AIDS - HR	USD	4,400,000	4,400,000	4,400,000	Apr-18
Uganda	HIV/AIDS - AGYW	USD	5,000,000	5,000,000	5,000,000	Apr-18

* Currencies match those reported in Global Fund documents indicating Senegal’s matching funds will be disbursed in EUR rather than USD.

Figure 7. Percent of budget allocated to interventions within the “programs to reduce human rights-related barriers to HIV services”, and percent of Global Fund HIV budget (2018-2020 allocation) allocated to module



* Values for Senegal are based on the matching fund request, which is still pending final approval. Conversion rate of 0.8911 Euro per USD was used.
 **This figure only captures human rights funding under one specific module and therefore does not present the full envelope of human rights investments in PCE countries (e.g. figures for DRC do not include interventions such as addressing stigma and discrimination against MSM, gender-based violence prevention and treatment programs, and legal literacy which are classified under other budget modules).

Figure 7 lists interventions funded in each PCE country (except Mozambique) within the human rights module “programs to reduce human rights related-barriers to HIV services” along with the percentage of funding allocated to each intervention, and the overall percentage of the total Global Fund HIV budget in each country allocated to this human rights module, which ranged from 0.6% in Myanmar up to 4.8% in Senegal. A limitation of this analysis is the focus on only the above-mentioned human rights module; future PCE analyses will incorporate CRG’s methodology for summarizing investments in reducing human rights related barriers by aggregating across a broader set of relevant modules.

Irrespective of catalytic fund eligibility, key informants across PCE countries agreed that human rights, gender and KVP allocations are insufficient. Declining grant funding may limit program impact in these areas. For example, Cambodia had US\$100,000 budgeted over 3 years for in-prison HIV testing, but recent arrests quadrupled the number of people who inject drugs (PWIDs) imprisoned since the funding request was drafted. Moreover, Cambodia’s TB budget included only \$50,000 for inmate screening, care, and support. Key informants stated that the allocation underestimated need. DRC stakeholders expressed concern that 2018-2020 budget cuts for KVP activities would hamper program target achievement. DRC’s prevention budget for AGYW fell from US\$4 million in previous grants to US\$1 million for 2018-2020. Mobile counseling and treatment in DRC were cut from seven to five sessions per quarter. In Guatemala, HIV-related human rights allocations for this funding cycle declined from 6% to 5% of the total grant. In Myanmar, Global Fund support to community networks, important for stigma reduction, have declined in the current implementation period, and stakeholders have attributed this to the overall decline in the Global Fund grant allocation. This was reported to have negatively affected the implementation of human rights activities, and other funding sources are now being sought to support the networks in the light of insufficient funds from the Global Fund. In Sudan, sharp HIV program budget cuts for KVPs were offset somewhat by innovative service delivery models piloted in eight states.

3.1.2 Human Rights and Gender Technical Assistance Requests

The Global Fund has attempted to support design and development of human rights and gender interventions through guidance documents, policies, Community, Rights and Gender (CRG) technical assistance (TA), and human rights baseline surveys. DRC, Mozambique, Senegal and Uganda are among 20 countries selected to receive intensive support for human rights- and gender-related activities under Global Fund Strategy 2017-2022. Uganda’s baseline survey report is due for release soon. Reports for the other three countries were released in 2018, though not in time to inform funding requests. Draft reports provide cost estimates for comprehensive human rights and gender programs but note that data gaps and hesitation of many programs to provide costing data are significant limitations. In DRC, a workshop is planned in 2019 to discuss the baseline results and recommendations; it is unclear whether reprogramming or additional resources will be provided to expand human rights and gender activities.

PCE countries have requested CRG TA for human rights-related but not gender-related activities.

The CRG offers TA to civil society and community-based organizations during different phases of the funding cycle, from country dialogue, to funding request and grant making, to implementation. Across PCE countries, TA requests were for human rights- rather than gender-related activities. Cambodia received CRG TA during the previous funding cycle under the Special Initiative. CRG also filled TA requests to support human rights matching funds applications in Mozambique and Senegal, and human rights programming for the Guatemala HIV funding request. Ugandan CSOs benefited from CRG TA during early implementation. DRC, Myanmar and Sudan have not requested CRG TA during the current cycle.

3.1.3 Summary of human rights-, gender-, and KVP-related activities in comparison to Global Fund guidance

Human Rights

SO3 focuses on removing human rights-related barriers to accessing prevention, care and treatment services for the three diseases. The Global Fund key program areas for HIV and TB programs are presented in Figure 8 below, along with the interventions being targeted in PCE country grants.

Figure 8. Key Global Fund interventions to address human rights-related barriers in country grants

Key GF program areas	CAM	DRC	GTM	MOZ	MYN	SEN	SDN	UGA	Disease
Reducing discrimination against women	●	●					●	●	■ HIV ■ TB ■ Mal
Legal literacy	●	●	●	● ●	●	●	●	●	
Legal services	●	●	●	●	●	●	●	●	
Meaningful participation of affected populations		●	●	● ●					
Improving services in prisons & detention centers	●	● ●	●	● ●	● ●	●		●	
Ensuring confidentiality and privacy				●					
Improving malaria services for refugees & others affect..				●	●	●		●	
Mobilizing & empowering patients & community grou..			● ●			●		● ● ●	
Monitoring & reforming laws, regulations & policies	●	●		● ●	●		●		
Sensitization of law-makers & law enforcement agents	●	●	●	●	●	●	●	●	
Stigma & discrimination reduction	●	●	●	● ●	●	●	●	●	
Training for health care providers on human rights ..	●	●	●	● ●	● ●	●		●	
Undertaking human rights & gender assessments of mal..						●			

Overall, PCE human rights-related grant activities are well represented in HIV grants but there is less focus in TB and malaria grants. Human rights activities across all countries focused primarily on HIV/AIDS, possibly because the only human rights-related key performance indicators (KPIs) also focus on HIV. Uganda’s TB/HIV request included human rights-related interventions targeting both diseases but were not specifically listed in Uganda’s malaria budget. Currently, these findings are based principally on document review. KII data should be collected to corroborate. Figure 9 below illustrates which KVP are included in Global Fund-supported programs by country and disease area.

Gender

The Global Fund Gender Equality Strategy focuses on the needs of women and girls, as gender dynamics reduce the ability of women and girls to advocate for their own interests, increases their vulnerability to disease, and limits their access to care. Guidance documents also recognize that:

- The forms and effects of gender inequality differ for men, women, boys, girls, and gender non-conforming individuals; health programs should promote gender equality for women, girls, transgender and gender non-conforming individuals, as a critical aspect of their health strategy.
- Men face greater vulnerability to TB due to gender-defined occupational roles (e.g. as miners).
- Women’s marginalization and gender-related vulnerability is entrenched in harmful cultural norms and retrogressive laws; such vulnerabilities may comprise lack of autonomy, reduced educational and economic opportunity, forced or early marriage, third party (e.g. spousal) control over health care access, and various forms of violence in private or public spaces.

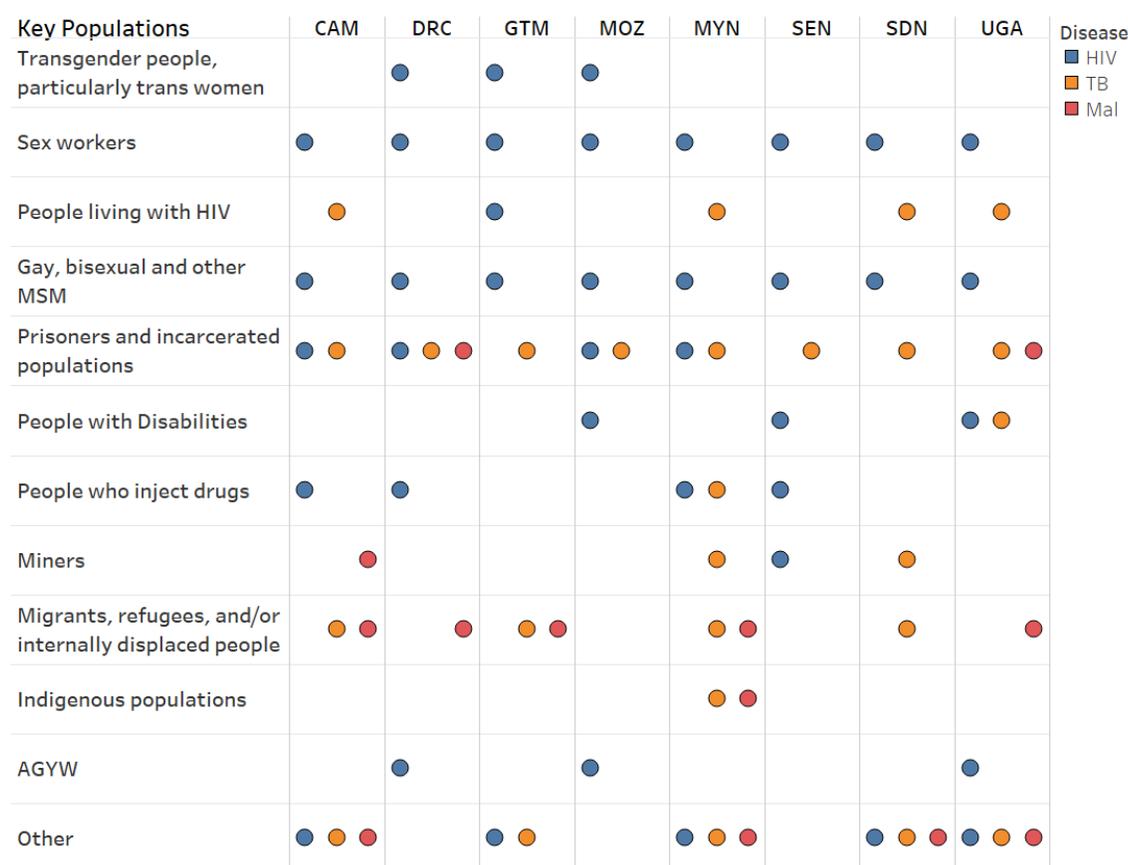
In PCE countries HIV/AIDS programs were more gender responsive; TB and malaria activities less so. This may be in part because the only gender-related KPI focuses on HIV/AIDS, leading grant recipients to see gender-related TB and malaria programming as lower priorities. Gender responsive HIV/AIDS interventions focus mainly on AGYW: the DRC targets transgender men and women, and Guatemala targets transgender women. Across PCE countries, despite greater TB prevalence in men, most programs lack interventions that address men’s gender-related risks. Uganda’s grant application highlights malaria’s gender dimensions, but gender analysis and planning are not comprehensive or robust.

Key and vulnerable populations

Global Fund defines key populations in the context of HIV, TB and malaria as groups experiencing a high epidemiological disease burden along with reduced access to services and/or who are criminalized or otherwise marginalized. Vulnerable population have increased vulnerability in a particular context but may not fit the full definition of a key population. Effectively defining and addressing the needs of KVPs is important to achieving the eradication of HIV, TB and malaria epidemics.

Generally, the Global Fund and country definitions of KVP groups broadly align. However, inconsistencies exist, particularly in relation to what groups constitute key and vulnerable populations. Figure 9 maps KVPs targeted through Global Fund grants by country and disease and shows that disease programs (to some extent) target KVPs as defined by the Global Fund (16,17). However, there are also many ‘other’ KVPs for HIV, TB, and malaria that are not addressed. While some KVPs align with the Global Fund definitions, many country-defined KVPs are not included. This raises questions around the appropriateness of the Global Fund’s KVP definitions, which have potential implications for investments for program targeting and coverage of KVPs (such as, is the Global Fund targeting the most appropriate KVPs for that country context, do we know the size of those populations, etc.?).

Figure 9. Key and vulnerable populations targeted through Global Fund programming(18)



Other categories include:

<p>Other HIV:</p> <ul style="list-style-type: none"> • Fisher people: Uganda, Senegal • Bridge populations (truckers, security forces, traders, tourism): Senegal • Pregnant women: Senegal • Partners of PLWH: Cambodia • Partners of MSM: Cambodia • Partners of PWID: Cambodia • Clients of FEW: Cambodia • Partners of sex workers: Guatemala • High risk individuals not identifying as KVP: Myanmar 	<p>Other TB:</p> <ul style="list-style-type: none"> • People living with diabetes: Cambodia, Guatemala, Myanmar, Senegal, Uganda • People living in overcrowded housing / urban slums: Senegal, Uganda • Elderly people: Cambodia, Myanmar • TB contacts: Cambodia, Uganda • Students: Senegal • Health care workers: Myanmar • Urban and rural poor: Myanmar 	<p>Other Malaria:</p> <ul style="list-style-type: none"> • Pregnant women: Sudan, Uganda • Children <5: Senegal, Sudan, Uganda • Forest workers, dwellers: Cambodia, Myanmar • Seasonal workers: Cambodia, Myanmar • Military, border, armed groups: Myanmar • Camp/settlement occupants: Myanmar
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3.1.4 Enabling and constraining factors to implementing Global Fund-supported interventions and activities addressing human rights, gender, and key and vulnerable populations.

Gender and human rights dimensions are not well understood or discussed among stakeholders, which caused delays in conceiving of, prioritizing and operationalizing initiatives in Myanmar, Sudan, Mozambique, and Cambodia. Evidence suggests that limited understanding of Global Fund policies and guidance related to gender and human rights among program planners and implementers affects program implementation. In Mozambique, key informants well acquainted with both Global Fund guidance and donor experience suggest that lack of human rights sector experience is a major barrier. In particular, key informants stated that the MoH had limited experience with the legal dimensions of human rights programming. In Cambodia – similar to last year’s findings – there is concern that human rights-related interventions are not well operationalized due to difficulties in translating human rights concerns into interventions. Contributing factors may include the technical language used in Global Fund guidelines and the difficulty of adapting guidelines to local contexts. Key informants reported limited understanding of human rights issues, particularly in malaria and TB, for which few gender or human rights-focused country analyses exist. Current evidence is insufficient to confirm these tentative findings, which the PCE will continue to investigate further. For instance, it is unclear whether key informants expressing these concerns took part in or were aware of CRG TA provided. Asked about gender disparities and adequacy of the current response, a majority of Myanmar stakeholders stated that there were ‘no gender issues’ related to grants or health service provision. Sudan seems to show limited recognition of gender inequity in disease risk and burden, and evidence suggests inadequate programming of strategic, high-impact, gender-responsive investments to prevent new HIV, TB and malaria cases and deaths. Similarly, there is a lack of explicit gender strategies by PR/SRs across PCE countries, despite general claims of gender awareness. Efforts currently underway by the Global Fund Secretariat CRG to develop implementation guidance may help in operationalizing human rights and gender activities.

Across PCE countries, a common finding was lack of clarity about specific interventions to address gender vulnerabilities related to the three diseases, including how such vulnerabilities might affect grant objectives, investments, or outcomes. Program managers may see interventions targeting women – e.g., specific targeting for female drug users or malaria prevention for women and children – as gender responsive. However, such interventions lack a gender focus and often only address disease-specific issues rather than gender-related vulnerabilities. Sex-specific targeting (e.g., targeting for males or females based on disease prevalence) is complementary to, but distinct from, gender-responsive programming and thus may only partially dismantle gender barriers. One exception is the SASA! pilot project in DRC, started in 2017, that aims to reduce AGYW’s vulnerability to gender-based violence (GBV) and HIV by working in the community, schools and health centers to change harmful social norms. In Sudan and Senegal, HIV/AIDS grants place more emphasis on addressing high-risk groups, including MSM and female sex workers (FSW), leaving gaps related to women and girls, including GBV. Absent a concrete focus on gender-related vulnerabilities, it may be difficult for Global Fund programming to have a

significant impact on women's marginalization and the harmful cultural norms, attitudes, beliefs and practices that perpetuate it.

An enabling factor in Cambodia, Myanmar, Senegal, Sudan, and Uganda was key stakeholder involvement during country dialogue, funding request and grant making, and implementation.

However, lack of or slow engagement with specific stakeholders in DRC, Senegal, and Uganda was a barrier. Strong partnerships between government departments in Myanmar appear to be strengthening HIV and TB interventions for prisoners. Sudan has formed successful national and local partnerships between grant implementers and police, prison authorities, the health sector, and local community and religious leaders, to remove human rights-related barriers to service (e.g., stigma and discrimination) and solidify support for interventions targeting KVPs. In Cambodia, key informants report that active involvement of KVP representatives during the funding request and grant making process, and country coordinating committee (CCC) activities has helped. KVP representatives often raise gender and human rights related issues at CCC and other meetings; their participation keeps these issues on the CCC agenda. In Senegal, strong KVP representation in Global Fund structures and processes facilitated meaningful engagement, as evidenced through observations of CCM-convened meetings and KIIs.

Some Senegal SRs report not being meaningfully engaged during grant making, which they perceive as contributing to discrepancies between budget allocations and operational needs as well as unrealistic target setting. Despite an inclusive country dialogue, DRC appeared to lack meaningful participation from civil society groups. Lengthy contract negotiations between PRs and civil society SRs might have been avoided had SRs been engaged earlier. Earlier SR involvement was a common suggestion in Cambodia, DRC, Mozambique, Senegal and Uganda. Seeking SR input during grant making would ensure that SRs have a voice in setting the targets they will later be responsible for achieving.

SR contracting delays in Cambodia, DRC, Mozambique, Senegal and Uganda hindered launch of KVP- human rights-, and gender-related interventions. PRs often rely on SRs with community experience to deliver KVP, human rights, and gender-focused interventions; implementation of these activities was delayed due to lags in contracting. In Cambodia, DRC, Mozambique, Senegal and Uganda, SRs lacked signed contracts and disbursements until Q2 or even Q3 of 2018, which contributed to low absorption rates. In Uganda, AGYW interventions did not begin as scheduled due to delays in both contracting and signing government MoUs. These delays were attributed to disagreement over proposed implementation modalities and the delayed arrival of catalytic and matching funds. First disbursements in DRC occurred in late June 2018 due to protracted PR-SR negotiations over scope of work and budget. In Cambodia, human rights related activities scheduled to start in 2018 were delayed. Evidence suggests that Cambodia's late start implementing its HIV grant deprioritized human rights-related work in 2018. The separate application process for catalytic funds provided additional support for recipients, but also meant that some SRs could not be contracted until catalytic funds were received. In Mozambique, both main grant funds and catalytic funds arrived out of phase with the government's fiscal year, triggering a special review process that required 1-2 additional months before funds could be disbursed.

Preliminary strategic considerations:

1. The Secretariat should ensure that Global Fund-supported programs clearly define key and vulnerable populations, aligned with national epidemiological context and that programs are designed to allow for tracking of progress against key intervention areas (e.g. disaggregation of male/female/trans sex workers, youth, women who inject drugs).
2. Country stakeholders and the Secretariat should encourage more explicit promotion of gender and human rights integration throughout the grant lifecycle, particularly for TB and malaria, including:
 - Determining the appropriate mechanisms for ensuring that high-quality gender assessments are conducted (or integrated into other assessment practices); e.g. further direct engagement by Global Fund technical staff in specific country gender assessments.
 - Ensuring each CCM has a qualified gender expert engaged throughout the grant design and implementation process with the requirement that the gender expert is fully represented in all processes and decisions.
 - Expanding the requirements for addressing gender in funding requests and reporting, using clear guidance that is understandable for both country teams and reviewers.
 - Programming and grant design (e.g. to address social norms, stigma, time use, and intra-household decision-making, not just sex-based targeting).
 - Implementation (e.g. collection and analysis of programmatic data disaggregated by key populations).
3. The Secretariat and relevant partners should continue efforts to build in-country capacity and expertise on gender- and human rights-related issues, through multiple potential avenues, such as:
 - Developing clearer and more accessible guidance on human rights and gender programming and implementation (already underway by Secretariat/CRG).
 - Ensuring TA is consistent with country needs and facilitating countries seeking TA for reducing gender- and human rights-related barriers (e.g. help the CCM to know that the mechanism exists and see the value in accessing TA to enable stronger more gender responsive planning, implementation, and monitoring).
4. Country stakeholders should more explicitly articulate the gender-related vulnerabilities of men/boys, women/girls, transgender and gender non-conforming individuals, the impact of these on disease-specific outcomes, and specific strategies to mitigate these effects in funding requests and designing disease-specific strategies.
5. CCMs should encourage multi-sector approaches and facilitate collaboration among PRs with legal and other non-traditionally Global Fund stakeholders.

3.2 Resilient and Sustainable Systems for Health

Building RSSH is another of the four strategic objectives outlined in the Strategy 2017-2022, to be achieved through seven modules and operational objectives.(1) The Global Fund recognizes that strong health systems are essential to attaining universal health coverage, accelerating the end of the epidemics, and ensuring countries can address the health challenges facing them. Investments in RSSH are necessary to expand and strengthen systems to address health issues in a sustainable, equitable and effective manner.(19)

As reported in the PCE Year 1 Synthesis Report, there was some initial confusion in several countries about how the Global Fund prefers RSSH allocations to be managed (integrated vs. stand-alone). However, in all PCE countries RSSH investments were embedded within disease-specific funding requests, rather than as stand-alone submissions, and in many cases, the RSSH investments were largely embedded within the malaria funding requests⁹. During the early implementation phase, the PCE's aim

⁹ There is some variation for the RSSH components of the malaria grant in Sudan, which have a separate project management unit and are implemented separately to the core disease activities.

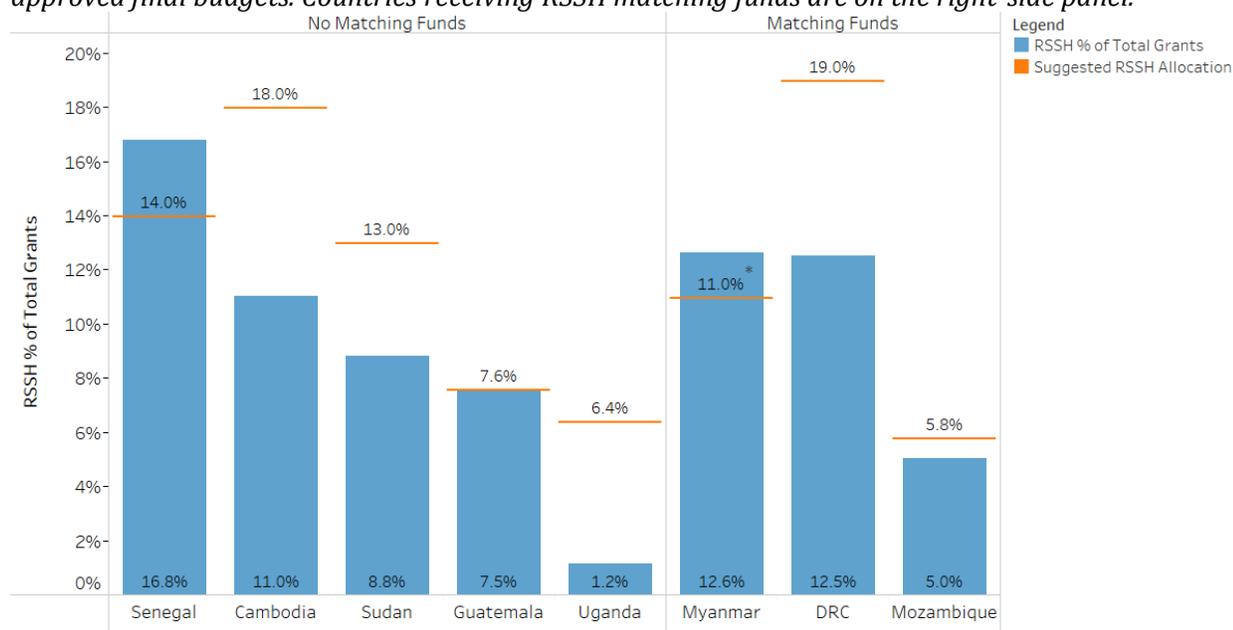
was to assess RSSH investment and expenditure patterns, including the extent to which RSSH components were implemented on time and as designed. Our analyses focus on “direct” RSSH investments, meaning interventions and activities tagged in the final budgets by one of the seven RSSH modules, and therefore do not capture contributory RSSH investments included under different module names.

Increased prioritization of RSSH at the global level does not appear to be supported by increased RSSH investment at the country level. Given the inclusion of RSSH as a strategic objective in the Strategy 2017-2022, there was an expectation for “strong investments in RSSH” in the current funding cycle. The allocation letters encouraged each country to “maintain or increase” RSSH investment relative to the 2014-2016 level, and also referenced the Global Fund RSSH guidance note that suggested allocating 5–11% of grants to RSSH.(19) There is substantial variability in both the level and proportion of direct RSSH investment in main grant allocations, ranging from 1.2% (US\$5.5 million) in Uganda to 16.8% (US\$12.5 million) in Senegal. DRC allocated the highest absolute amount to RSSH: US\$68.0 million (12.5%). Except for Uganda, all PCE countries met the minimum guidance of 5%. Only Senegal and Myanmar, however, surpassed the encouraged level in the main allocation relative to the 2014-2016 funding cycle, while Guatemala and Mozambique nearly met it (Figure 10). In the case of Myanmar, 15% of the total HIV and TB funding request was requested for RSSH and was later reduced to 12.6% during grant making. The investments focus on strengthening procurement and supply management, HMIS, financial management, human resource challenges. Additionally, the RSSH investments include some program management costs, particularly salaries, office and transportation costs. Evidence indicated that the CT provided strong advice at the concept note development phase, which may have influenced investment levels. In Sudan, poor performance and absorption in the prior HSS grant contributed to a decision not to increase RSSH investment in the current cycle.

In addition to RSSH funding through the main allocation, three PCE countries—Myanmar, Mozambique, and the DRC—each received \$3 million in matching funds for RSSH: Data systems, data generation, and data use. These matching funds increased the total RSSH funding by 4.6% in DRC, 7.3% in Myanmar, and 13.1% in Mozambique, offering evidence that the matching funds mechanism was successful at catalyzing further funding for RSSH above and beyond the main allocation.

A substantial amount of RSSH investment was included in the prioritized above allocation request (PAAR). The register for unfunded quality demand indicates 17% of the total US\$736 million unfunded across PCE countries is classified as RSSH(20). A Global Fund TRP desk review of RSSH investments in PCE countries found on average 26% of PAARs were comprised of RSSH investments. (21) For example, Uganda’s malaria PAAR contained 21% RSSH investments and Mozambique’s TB/HIV PAAR contained 47% RSSH investments. In both cases, RSSH within the PAAR comprised approximately two-thirds of all RSSH investments combined. In Uganda, after embedding the stand-alone RSSH funding request within the malaria funding request, many RSSH investments were shifted to the PAAR due to prioritizing key commodities where a funding gap remained. Incorporating RSSH investments in the PAAR instead of the main allocation suggests lower prioritization of RSSH, given that the PAAR is not a guarantee that such activities will be funded.

Figure 10. Percent of direct RSSH investment allocation out of total grant portfolio, by country, based on approved final budgets. Countries receiving RSSH matching funds are on the right-side panel.



* The Myanmar allocation letter suggested 5-11% of the budget be dedicated to RSSH.

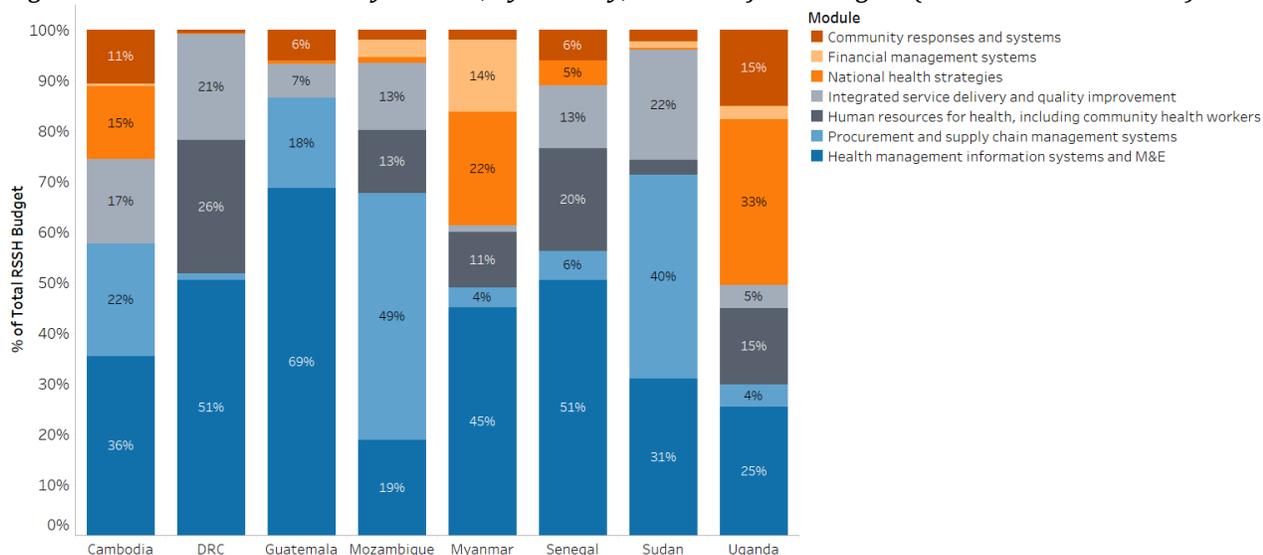
RSSH investments were largely concentrated in three modules: HMIS/M&E, HRH, and PSM. Half of PCE countries invested in all seven RSSH modules (Mozambique, Myanmar, Sudan, and Uganda); DRC, Guatemala, and Senegal did not invest in financial management systems, and Cambodia and Guatemala did not invest in human resources for health (HRH).

In all PCE countries, RSSH investments more heavily targeted HMIS/M&E (Figure 11, dark blue bar) with an average of 40.7% of RSSH funds across the eight countries. This finding is in line with emerging evidence from the Technical Review Panel’s RSSH review detailing strong investment in DHIS2 (22). Furthermore, the RSSH matching funds support data system strengthening through a focus on reducing fragmentation and parallel reporting systems in DRC and Myanmar.

There were also substantial investments in the HRH (dark grey bar) and procurement and supply chain management (PSM) (light blue bar) modules. HRH allocations were highest among countries classified as low income and mostly focused on system support rather than system strengthening: In DRC, HRH investments (26% of RSSH) support salary top-ups for healthcare workers; in Senegal, HRH funding (20% of RSSH) supports interventions to retain and strengthen the health workforce (including community health workers); HRH investments in Mozambique (13% of RSSH) span all MoH grants in supporting capacity building of community level workers; and in Uganda HRH investments (15% of RSSH) went toward supporting salaries at the national level for technical and coordination staff within the National Malaria Control Program. HRH allocations were lower (Myanmar, Sudan) or not included (Cambodia, Guatemala) among countries classified by Global Fund as lower- or upper-LMIC (lower-middle income countries).

Mozambique (49% of RSSH) and Sudan (40% of RSSH) both invested heavily in PSM, while Cambodia (22% of RSSH) and Guatemala (18% of RSSH) also contributed about 20% of RSSH funds toward this module. Given substantial Global Fund allocation toward treatment commodities, PSM has historically been an area of strong RSSH investment due to the importance of drug stock management and distribution systems.

Figure 11. RSSH investments by module, by country, based on final budgets (2017-2019 allocation).



Uganda (15% of RSSH) and Cambodia (11% of RSSH) were the exceptions: Uganda invested in community-based monitoring, social mobilization, and community-led advocacy, while Cambodia invested in social mobilization, building community linkages, collaboration and coordination, as well as institutional capacity building, planning and leadership development through the RAI2E grant. Mozambique (US\$19.0 million) included a sizable community systems investment within the PAAR. As grant implementation progresses, the PCE will gather further evidence to understand bottlenecks in operationalizing the community systems module (evidence points to absorption challenges in Q1-Q2 2018; see Figure 12).

Many RSSH investments are considered shorter-term gap investments rather than longer-term investments in more sustainable health system strengthening needs. Evidence from PCE grant analyses and stakeholder interviews call into question whether the Global Fund is making enough of the “right” RSSH investments needed to strengthen and sustain health systems. In Cambodia, RSSH investments are mainly targeting “fixable” and “shorter term” issues and lacking strategic focus, rather than tackling systemic “longer term” challenges facing the country, such as human resource capacity. In Uganda, most direct RSSH investments target the malaria program with limited integration efforts (e.g. HRH investments support national malaria control program). In Myanmar, the HRH investment is largely spent supporting seconded staff on project coordination and logistics related to Global Fund grants. This does little to address the major health workforce shortages facing the country. In Sudan, the scattered approach to compiling RSSH activities to fill gaps in short-term disease-specific work plans is thought to have resulted in limited investment in community systems. Stakeholders note this as a missed opportunity for Global Fund contributions to Sudan’s intended national policy shift toward health promotion and primary care. This PCE finding triangulates with the TRP’s RSSH desk review which found that on average 64% of RSSH investments in PCE countries were rated as “supporting” while only 36% were rated as “strengthening,” suggesting most countries could go further in making investments to sustain health systems.(22) Linking back to the funding request phase, our findings suggest increased guidance and TA be considered in supporting country decision-makers to make informed decisions about which RSSH investments, in line with the NSPs, would yield maximum impact.

Absorption across RSSH modules during Q1-Q2 2018 was generally low, in part due to the factors hindering implementation more generally. PU/DR absorption data from Q1-Q2 2018 indicated limited progress in implementing RSSH activities during the first semester (Figure 12), including countries with extremely low absorption (Uganda, 1%; Sudan, 7%), moderately low absorption (Mozambique, 15%;

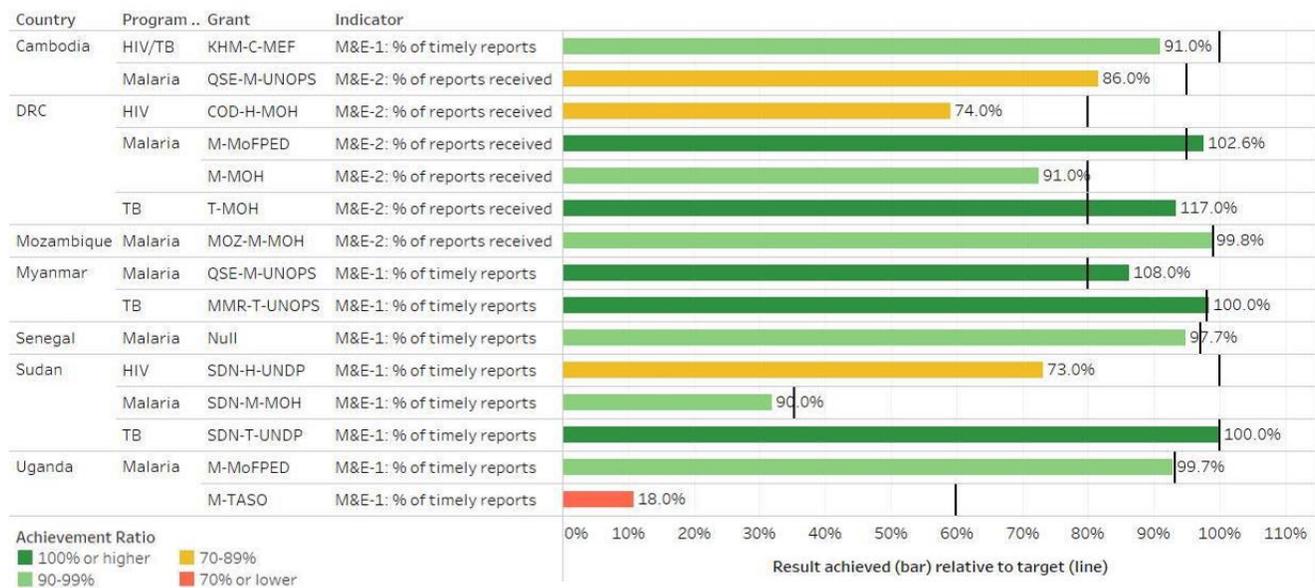
DRC, 18%; Cambodia, 20%; Senegal, 30%), and only one country with medium absorption (Myanmar, 45%). That Myanmar’s overall RSSH absorption is higher relative to other countries is driven by the large proportion of the budget allocated to program management (salaries, transport, office costs), particularly within the HRH and financial management systems modules, whereas the HMIS/M&E and PSM modules include interventions intended to provide structural support and have much lower absorption levels at 39% and 28%, respectively. The delays in RSSH implementation are due to similar factors hindering overall grant implementation (Section 2.2), such as SR selection and contracting, country-level administrative and logistical hurdles, timing of disbursements, PR staff turnover, delays in planning and approvals, and bureaucratic sign off for research activities. In addition, there was indication of implementation bottlenecks linking back to experience of prior HSS grants. For example, in Uganda emerging evidence from national stakeholders indicates some “hesitation to use” Global Fund investments on “soft” activities (non-procurement/non-commodity), particularly for requisitions directed to the district-level, given concerns that funds could be inappropriately managed.

Figure 12. Absorption by RSSH module, by country, across grants with RSSH investments, Q1-Q2 2018.

Module	Cambodia	DRC	Mozambique	Myanmar	Senegal	Sudan	Uganda
Community responses and systems	34.0%		0.0%	114.8%	26.0%	4.0%	0.0%
Financial management systems	47.0%		19.0%	78.9%		0.0%	
Health management information system and M&E	10.4%	11.3%	6.2%	38.9%	30.3%	27.0%	5.4%
Human resources for health, incl. community health workers		48.6%	13.8%	74.4%	25.5%	0.0%	0.0%
Integrated service delivery and quality improvement		0.0%	0.0%	68.1%	14.8%	0.0%	0.0%
National health strategies	50.0%	0.0%	0.0%	36.7%	58.6%	0.0%	0.0%
Procurement and supply chain management systems	0.0%	0.0%	19.1%	28.2%	0.0%	9.0%	0.0%
Total (all RSSH modules)	20.2%	17.8%	15.0%	45.2%	29.8%	7.2%	1.0%

Among funding requests with RSSH investments, coverage indicators predominantly align with the HMIS/M&E module, missing an opportunity for monitoring other key RSSH priorities. Most grants with RSSH investments contain only one RSSH-related coverage indicator in the performance framework, usually related to either the timeliness or completeness of HMIS reporting. RSSH M&E indicators performed well during Q1-Q2 2018, with most grants attaining an achievement ratio of 90% or higher (Figure 13, green bars), despite the limited early absorption of RSSH investments in the HMIS/M&E module over the same period (Figure 12, ranging from 5 to 39%). Apart from investments in monitoring systems, including DHIS2, this suggests current RSSH indicators are insufficient to measure the diversity of RSSH investments and their contribution to outcome achievement, which could limit Global Fund’s ability to monitor progress toward the RSSH strategic objective.

Figure 13. Achievement progress on RSSH HMIS indicators, by PCE country, by grant, Q1-Q2 2018.



Senegal and Guatemala also included a PSM coverage indicator in their malaria grants. There were no additional coverage indicators tied to any other RSSH module, including HRH where there were sizeable Global Fund investments. The modular framework does not include RSSH indicators related to community systems or national health strategies, which points to the broader challenge of prioritizing these areas and tracking their performance and contribution to overall targets. This PCE finding triangulates with an issue highlighted by the TRP’s RSSH desk review, namely concerns about weak RSSH performance metrics and the limited number of RSSH indicators.(23) For example, there were three funding requests that contained no RSSH indicators in the performance framework: Guatemala’s HIV (4.1% RSSH allocation) and TB requests (5% RSSH allocation) and Mozambique’s TB/HIV request (5.3% RSSH allocation).

Inconsistent categorization of RSSH inputs pose challenges to quantifying the Global Fund’s overall RSSH investment. Global Fund RSSH investments are assessed by input and coverage indicators, rather than outcome or impact, which indicates the current mechanism is principally set up to track the quantity rather than quality of RSSH investments. Per the Modular Framework Handbook, investments in cross-cutting systems interventions should be categorized according to one of the seven RSSH modules (“direct” RSSH), while investments in disease-specific interventions that also contribute to systems should be categorized according to the relevant disease module (“contributory” RSSH)(24). As “direct” RSSH investments do not capture the full complement of disease-specific system-strengthening activities, some CTs have performed internal analyses of RSSH investments across grants. In addition, the Secretariat has prepared RSSH country results profiles for high impact countries using the revised tracking methodology. These various analyses have resulted in noticeably different RSSH totals, which further underscores the complexity of designating an intervention as RSSH. In addition, PCE grant and budget analyses, highlight several categorization challenges, for example:

- *Disease-specific RSSH activities miscategorized as “direct” investments*, e.g. in Uganda, salary support for several positions with the National Malaria Control Program (HRH module) and malaria research studies (national health strategies module) together comprised 48% of the “direct” RSSH investments, despite lacking any crosscutting component.
- *Categorizing operating costs as RSSH*, e.g. in Myanmar, RSSH financial management systems investments largely support PR and SR operating costs associated with running a Global Fund financial risk mitigation approach (the Managed Cash Flow system), comprising 14% of “direct” RSSH

investments, while HRH investments support staff on project coordination and logistics to meet Global Fund objectives (11% of “direct” RSSH), which in neither case addresses the major financial management or HRH challenges facing the country.

- *Underrepresentation of the community systems and responses module*, e.g. in Guatemala, limited investment in the community systems module was surprising given the need for “last mile” efforts in finding TB cases; however, community outreach and case finding activities are classified as TB care and prevention (per modular framework guidance).

Accurately assessing RSSH investments within and across grants, countries, and over time is a challenge. It depends on how country applicants are categorizing activities in the budget, including whether vertically oriented disease-specific community responses should be considered direct or contributory RSSH, and whether investments made in “servicing” Global Fund grants (e.g. operating costs) should be considered RSSH. Beyond RSSH investment inputs, more immediate attention is needed to track how Global Fund RSSH investments translate into meaningful and sustainable systems strengthening.

Preliminary strategic considerations:

1. During the funding request development, consider mechanisms to incentivize stronger alignment of crosscutting RSSH investments to longer-term national strategies for health system strengthening, rather than addressing short-term, disease-specific health system gaps.
2. Improve standardization for categorization of RSSH investments within grant budgets to ensure accurate quantification of Global Fund contributions toward RSSH, including whether simplification is feasible or increased guidance and examples are necessary.
3. Improve monitoring and measurement of the outcomes of RSSH investments, e.g.:
 - Clear articulation of expected RSSH outcomes, which can be translated into investment guidance, the modular framework and grant performance framework where relevant.
 - Stronger alignment of grant activities to indicators.
 - Consideration (and development of) community systems and responses indicator(s) in the modular framework.

3.3 Sustainability, Transition and Co-financing

Figure 14: STC Model (18)

3.3.1 Background

The Sustainability, Transition and Co-financing Policy (STC) provides a framework for engaging with countries in planning for sustainability and aims to enable successful transitions from Global Fund support. The approach is differentiated based on proximity to transition but emphasizes that regardless of where a country sits on the development continuum, sustainability considerations should feature prominently in program design and planning, including sound financial planning, budgeting capacity, and resource mobilization strategies.



3.3.2 Overview of STC Policy Implementation

All governments have made commitments to meet or exceed Global Fund co-financing requirements, with an increased trend towards supporting commodity costs. A majority of PCE countries have historically met the Global Fund’s co-financing requirements and in some cases exceeded required commitments for current grants. Co-financing requirements state that during grant implementation, countries must demonstrate progressive government health expenditure and increased co-financing of Global Fund-supported programs, focused on taking up key costs of national disease plans.

Despite depreciation of local currency, high inflation rates, and other economic challenges, low income countries (LICs) such as Uganda, DRC, and Mozambique have met core co-financing requirements, previous willingness to pay requirements, and accessed the full co-financing incentive for the 2017-2019 allocation. Domestic resources, when specified, are allocated to commodities, funding health system infrastructure, and government staff salaries. Senegal stands as an exception. While Senegal has reached core co-financing requirements, previous willingness to pay commitments for the 2014-2016 allocation were not met, and there was insufficient government commitments to access the co-financing incentive. There was only a 36% realization of commitments for HIV, TB, and Malaria, and current program data shows that government investment for the three supported programs declined by 21% during FY2015-2017 when compared to the FY2014-2016 investment(25).

Lower-LMICs have exceeded co-financing requirements with governments committing 27% (Myanmar), 16% (Cambodia), and 131% (Sudan) of the Global Fund allocation for the current grant period. At least 50% of the additional co-financing must be invested in disease program interventions for lower-LMICs, per the STC policy. Government commitments are projected to include procurement of ARVs, methadone maintenance therapy (MMT), MDR-TB drugs, and malaria commodities, human resources, and infrastructure. As an upper-LMIC, Guatemala's malaria and TB programs are projected to transition from Global Fund resources due to the anticipated shift to upper middle-income country status in 2020-2022. The country has met co-financing requirements and has steadily increased domestic investments across the three disease areas. Specifically, the government plans to take on procurement of second-line drugs for TB, absorb human resource positions within the malaria program, and continue resourcing for ARVs.

Even when countries do meet co-financing requirements, PCE countries remain heavily reliant on donor resources to finance the disease programs, posing a critical threat to transition readiness, programmatic and financial sustainability. Government commitments to HIV programs are only covering between 3% (Mozambique) and 30% (Cambodia) of the total national program budget, with external donors providing the majority of funding (Figure 15). The gap between government and external donor support towards total program budgets is even greater in low-income countries like Uganda, Senegal, and Mozambique where approximately 7%, 4%, and 4%, respectively, of government resources are going towards TB program budgets for the 2018-2020 implementation period (Figure 16). Additionally, TB funding gaps for this time-period are also quite high for Uganda and Senegal (up to 52% and 76%, respectively). However Guatemala, as an Upper-LMIC, is an exception and covering 68%, 75%, and 47% of malaria, HIV, and TB programs expenditures through government resources(26,27). Malaria program funding landscape data was not available across PCE countries to be included in this analysis.

Where historical trends are available, analysis suggests that for lower-LMICs, government resources account for a greater proportion of total program budgets, although this is primarily due to the decline in external resources rather than increases in government funding. Such is the case in Myanmar, Cambodia, and Sudan, where external funders have reduced overall financial commitments. Global Fund support accounts for 50% of the total HIV program budget in Myanmar, 60% in Cambodia, and 21% in Sudan (Figure 15). In Myanmar, non-Global Fund external funding for HIV and TB programs is expected to decline from US\$44 million in 2016 to about US\$12 million in 2020, potentially leaving Myanmar with a larger unmet funding gap(28). Cost efficiency strategies have been employed through geographic prioritization and government spending has increased, but these efforts are unlikely to be enough to address the current unmet funding gap, which is currently 26% for HIV and 33% for TB (2017-2020) in Myanmar. Such a heavy reliance on external funding is a critical threat to transition readiness and programmatic and financial sustainability for all countries. However, for countries further along the development continuum to maintain disease control and prevention programs after the departure of external funding by Global Fund and other donors, sustainability and readiness planning is that much more critical.

Figure 15. HIV 2018-20 Funding Landscape

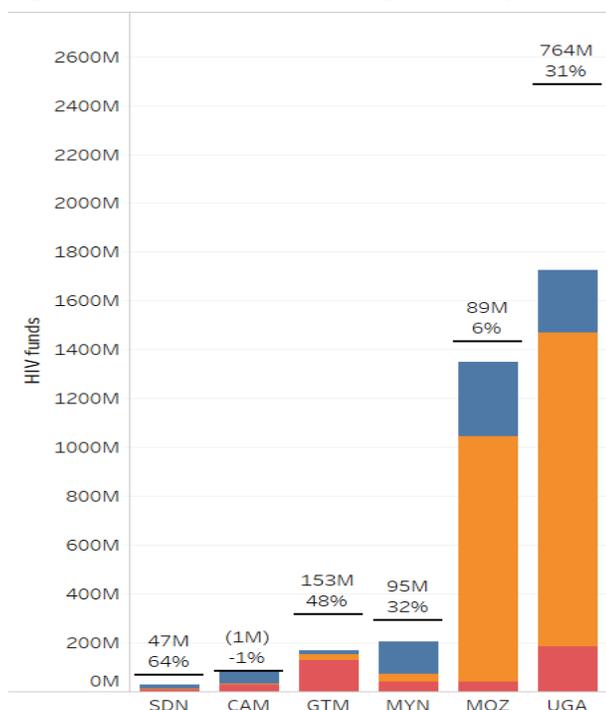
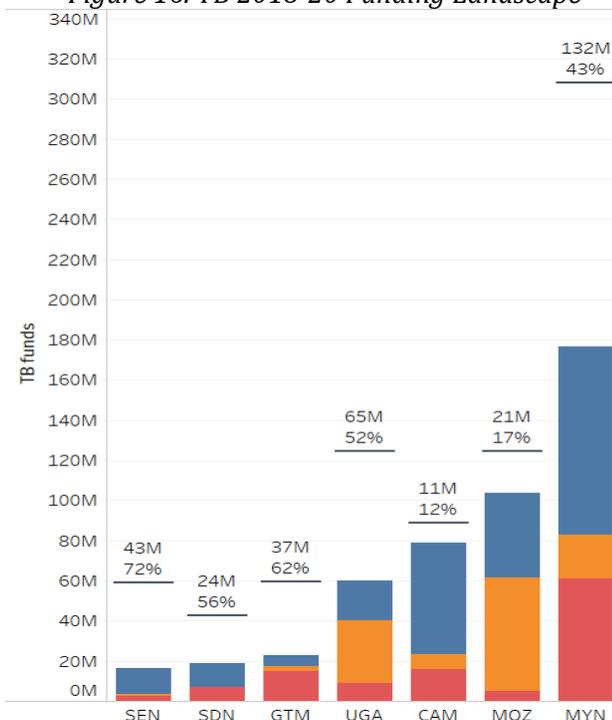


Figure 16. TB 2018-20 Funding Landscape



Source of funds
 ■ GF (2018-20) HIV Funding Allocation
 ■ External Resources (Non-GF)
 ■ Government Resources

Source of funds
 ■ GF TB Funding Allocation
 ■ External Resources (Non-GF)
 ■ Government Resources

HIV costs
 ■ Total Needs Costing (2018-20)

TB costs
 ■ Total Needs Costing (2018-2020)

Note: 2018-20 data unavailable for DRC and Senegal 2018-20 funding landscape data unavailable for DRC
 Sources: Global Fund Health Financing Overview reports, funding request documents, and national strategic plans

There is evidence of countries embedding sustainability and transition considerations into program design and implementation. Most notably, this includes long-term sustainability planning in LIC and LMICs¹⁰ (Cambodia, Myanmar, and Uganda) and preparation for transition in Guatemala¹¹. Additionally, DRC has made progress aligning and integrating with national systems (e.g., strong investments in HMIS and discontinuing reporting through parallel systems).

Grant analysis and document review demonstrated that sustainability and transition considerations were integrated into grant design and national strategic plans in Cambodia, Myanmar, Guatemala, and Senegal. For example, Guatemala has embedded a sustainability and transition plan into the TB NSP and is developing a sustainability plan annex to the HIV NSP. Additionally, the HIV NSP in Senegal has prioritized the mobilization of domestic resources to sustain the national HIV response. A transition readiness assessment in Cambodia found that funding shortfalls in prevention would lead to an increase in HIV

¹⁰ Sustainability planning, as defined in the STC Policy, involves five core aspects: Strengthening of NSPs; development of health financing strategies; alignment and integration of systems; identifying efficiencies and enhancing optimization of disease responses; and increased domestic financing of national disease response and interventions financed by the Global Fund (including interventions focused on key populations and human rights and gender).

¹¹ The STC Policy states that transition preparedness involves: development of transition preparedness assessments and transition strategies and work plans; progressive and accelerated government financing of key interventions; enhanced focus on KVPs and structural barriers to health; enhanced focus in Global Fund grants on addressing sustainability and transition gaps including contracting of non-state actors by Governments (i.e. social contracting), strengthening M&E and procurement systems; and reducing dependence on Global Fund financing for key interventions.

incidence and compromise the sustainability of the HIV response. Uganda also finalized their health financing strategy, which aims to develop and implement a Social Health Protection system and increase effective pooling of finances to strengthen strategic purchasing mechanisms. This evidence points to countries starting early on sustainability and transition planning regardless of their transition status and identifying country-specific challenges to address in order to transition from external funding successfully.

In most countries, external stakeholders, such as CSOs, advocates, and evaluators, have not been able to verify in a timely manner whether co-financing commitments have been fulfilled. Each government differs in domestic financing, budgeting and reporting structures, and therefore outside of National Health Accounts (NHAs), there is no consistent mechanism to tracking co-financing across countries. As such, the Global Fund has created unique co-financing tracking systems specific to each country. While these Global Fund systems exist, such as the Program Finance Database run by the health finance team, this data is not available to outside stakeholders. Additionally, the Global Fund Operational Policy Manual provides examples of mechanisms for tracking co-financing commitments during grant implementation, which include disbursement/ expenditure against earmarked budget allocations, funds release for procurement orders, and many others. The majority of the provided mechanisms rely on robust in-country financial tracking systems, which do not exist in most PCE countries. While domestic expenditure on commodities may be tracked through the Price and Quality Reporting database, the majority of disease-specific and health systems contributions have not been tracked systematically across countries. This is partly a function of poor financial systems in many countries, with some requesting Global Fund support to strengthen these systems, such as Guatemala's SICOIN system and Uganda's IFMS system. Six of eight PCE countries, with the exception of Myanmar and Mozambique, are currently implementing NHAs. However, while NHAs are one of the primary mechanisms for tracking domestic financing and fulfillment of co-financing commitments, most mechanisms are inherently retrospective in nature and do not provide real-time information on government expenditure to governments or stakeholders.

Community based organizations, advocates, and external evaluators need accurate co-financing information to understand what country resources are going toward and how they are funded within the larger funding envelope. This information is also necessary for budget advocacy purposes. Additionally, evaluators require timely co-financing data to assess the true utility of the co-financing incentive.

Preliminary strategic considerations:

1. The Global Fund Secretariat should consider restructuring the country co-financing requirement to more ambitiously increase domestic expenditure on health and the three diseases, with a view to ensuring that domestic financing increases to a level that more fully supports transition and sustainability objectives. Specifically, this might involve:
 - Expanding upon the co-financing requirement to better reflect the government's existing financial commitments overall and within the wider health financing landscape, e.g. by setting the co-financing requirement based on more parameters than the current two (progress towards 8% of general government expenditure on health, and the allocation amount).
 - Increasing the minimum level of co-financing that is acceptable to the Global Fund.
 - Strengthening the incentive for countries to increase domestic expenditure on health and the three diseases beyond the minimum acceptable level of co-financing.

3.4 Value for Money

This section presents one finding on the Global Fund's ability to measure VfM, and then our findings against each of the 4Es. In response to TERG feedback, we have sought to categorize these when possible, and where findings relate to multiple components of VfM, we have sought to state this in the finding statement.

Misalignment between the Global Fund's financial and programmatic reporting tools hampers efficient portfolio management and analysis/measurement of VfM. The Accelerated Integrated Management (AIM) initiative was launched in 2015 to enable efficient portfolio management for the Secretariat, PRs and CCMs by integrating and aligning core processes (related to grant application, implementation, M&E, risk management), data, and systems through a single software package – the Grant Operating System. The intention was to allow for better measurement of VfM by linking robust and timely data on investments and results. Our finding on the misalignment between financial and programmatic data indicate that this has still not been fully realized and that the system is not yet in place to enable efficiencies in portfolio management and analysis/measurement of VfM. In addition, the system does not currently collect data on budgets, expenditure or activities implemented at the sub-national level, which further restricts the Global Fund Secretariat's ability to systematically analyze VfM considerations within countries, which could yield significant benefits, as shown below.

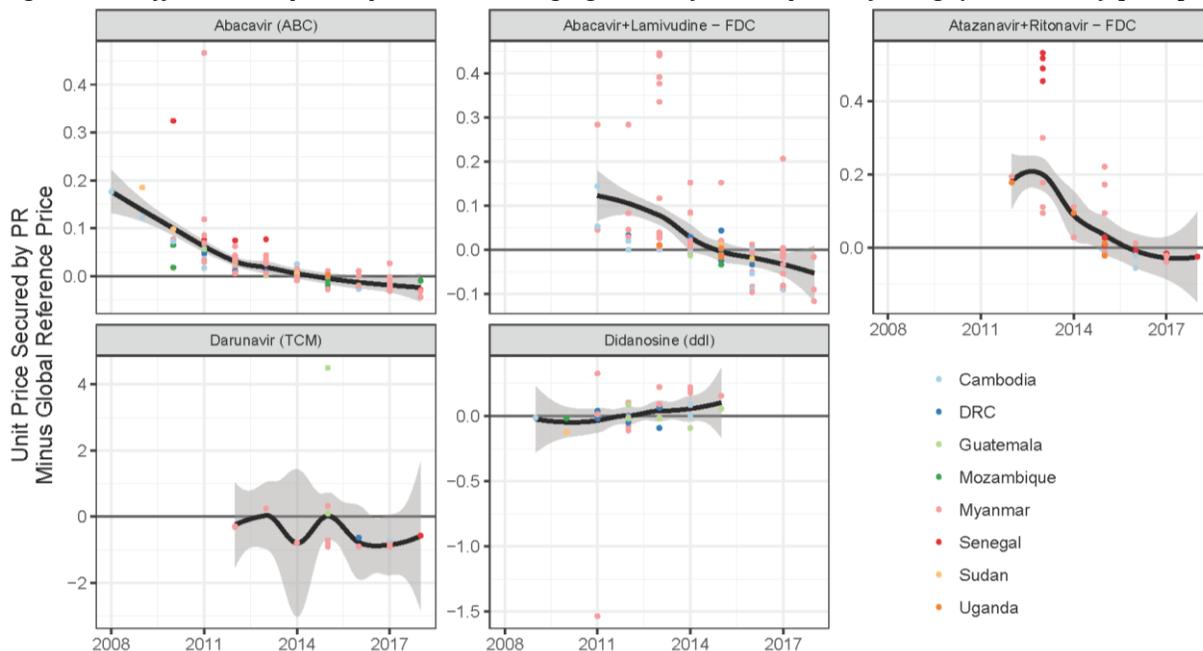
3.4.1 Economy

Initial analysis of price and quality reporting (PQR) data in PCE countries suggests that economy has improved over time, with prices paid for most health commodities decreasing and, in many cases, declining below the global reference price.¹² Economy is based on whether inputs (e.g. staff, consultants, raw materials and capital) are purchased of an appropriate quality at the best possible price. Across the eight PCE countries, prices paid for ARVs, TB medications and antimalarial medications largely decreased over time. In many cases, prices were at or below the global reference price (mean and median) by 2018. Many commodities tracked through PQR do not have a corresponding reference price. Among those that do, most ARVs and antimalarials were procured through the Pooled Procurement Mechanism (PPM; 65% and 68%, respectively). Most TB medications were procured through the Global Drug Facility (38%) or direct from the manufacturer (35%). As such, substantial volumes of commodities were procured outside of the Global Fund's procurement systems, which aim (among other things) to ensure that competitive market prices are achieved.

As shown in Figure 17, the prices paid for Abacavir, Abacavir+Lamivudine and Atazanavir+Ritonavir (the most common ARVs with an available reference price, totaling 23 million USD) have substantially declined relative to the global reference price over time. Similar declines were observed for other diseases. Our analysis further shows that the procurement mechanism achieving the lowest prices varies by commodity. In summary, the PPM achieved the lowest prices for antimalarials, irrespective of drug, while country central medical stores achieved the lowest prices for ARVs and direct procurement from manufacturers achieved the lowest prices for TB drugs, although this was very close to the prices paid via the Global Drug Facility.

¹² The reference prices in this section are taken from the Global Fund's Price Reference Reports accessed through the Global Fund Price and Quality Reporting webpage, which is continually updated and may not be fully comprehensive of all procurement transactions. The PQR website indicates that the prices reflect a 'summary of main international reference prices and recent market data' collected by partner organizations and are used for indicative purposes only. These reference prices reflect an average that does not take into account time trends.

Figure 17. Difference in prices paid and average global reference price by drug (2008-2018) [USD]



There are some other instances where changes to procurement arrangements have affected economy and/or efficiency. In Cambodia, the decision to shift from UNICEF to UNOPS as the procurement agent for the HIV program is estimated to reduce management and PSM costs by more than US\$400,000 per year.¹³ In DRC, stakeholders anticipate that use of the PPM will leverage economies of scale and limit procurement delays. In Guatemala, plans to manage procurement through PAHO are similarly expected to enhance economy. However, stakeholder efforts in Sudan to use a local procurement agent instead of UNDP and UNICEF to reduce management costs were not permitted by the Global Fund from a financial risk mitigation perspective. In Mozambique, the PR was not able to obtain a tax clearance certificate/exemption for procured commodities, which meant that additional costs were incurred.

There is evidence to suggest that the unit costs used as a basis for budgeting do not closely reflect the actual cost of inputs, posing a risk to both the economy and efficiency of Global Fund support. The clear incentive for stakeholders is to ensure that sufficient resources are available to implement the planned activities, in order to avoid requesting additional resources from the Global Fund and to meet grant targets within the agreed resource envelope. In Cambodia and Myanmar, the budgeted unit cost for inputs tend to be based on the estimates used for previous grant budgeting exercises, which are known to be inflated to allow for changes in prices and currency shifts and inflation, which can be significant when budgeting up to four years in advance. In Guatemala, budgeted unit costs for Ethionamide and Levofloxacin were overestimated by 10% and 72% respectively, while Cycloserine was underestimated by 32% according to the national TB program.¹⁴ Collectively, these medications account for nearly 4% of Guatemala's TB grant (US\$256,205). Whereas the quantity of inputs is scrutinized during grant making and linked to output targets, there is little evidence of input unit costs being subject to the same level of scrutiny. However, these unit cost estimates have a significant impact on the overall budget. For instance, in Myanmar alone, a change of 10% to the unit cost for travel related costs would result in a net saving/gain to the budget of over US\$5 million (which is 3.5 times greater than the size of the regional TB grant being proposed and almost as much as the funds received for key population matching funds). As such, uncertainty around whether unit costs reflect actual prices and the extent to which they have been

¹³ Savings have largely been realized due to UNOPS agreeing not to include in this budget the salary and management costs of locally based staff who are already employed by the agency in country.

¹⁴ GTM-T-MASPAS detailed budget and National TB Program data on supply management and distribution.

inflated to a ‘reasonable’ level poses a substantial risk to both economy and efficiency. The Global Fund’s support to the Global Health Costing Consortium (GHCC) seeks to address this issue by providing both a repository and reference prices for unit costs for HIV and TB interventions from published and grey literature. However, our review of this database suggests that cost estimates are only available in four out of eight PCE countries, three of which contained cost estimates for only 25 or fewer interventions, and many were extracted from studies more than 10 years old.¹⁵

3.4.2 Efficiency

There is evidence across countries of stakeholders making efforts to improve grant efficiency, defined as maximizing outputs for a given level of input, particularly in countries facing significant reductions in program budgets allocations. In Cambodia, stakeholders reported a range of efforts to change program management arrangements to reduce costs and minimize the impact of reduced budget allocation on grant activities. This included the shift in procurement arrangements noted above and a change in the design of outreach services that reduced oversight costs. Uganda also shifted from a standalone to embedded RSSH grant at the recommendation of the Global Fund, partly to reduce program management and administration costs, though some stakeholders seem skeptical that this arrangement is so far working. As such, the potential gains in efficiency have not yet been realized. In Guatemala, Myanmar and Senegal, there was a reduction in the number of SRs for the current grant, which was imposed due to the reduction in budget from the previous grant period, but also with a view to improving efficiency. DRC has taken a further step by arranging “transversal” SRs who manage all three diseases in their designated province. However, in some countries there is still a very high number of implementing agencies, including Sudan, where disbursements to one SR (UNFPA) are subsequently divided over 48 SSRs, which is administratively complex to manage and has led to some delays in disbursement, as well as incurring some level of management costs among each separate entity.

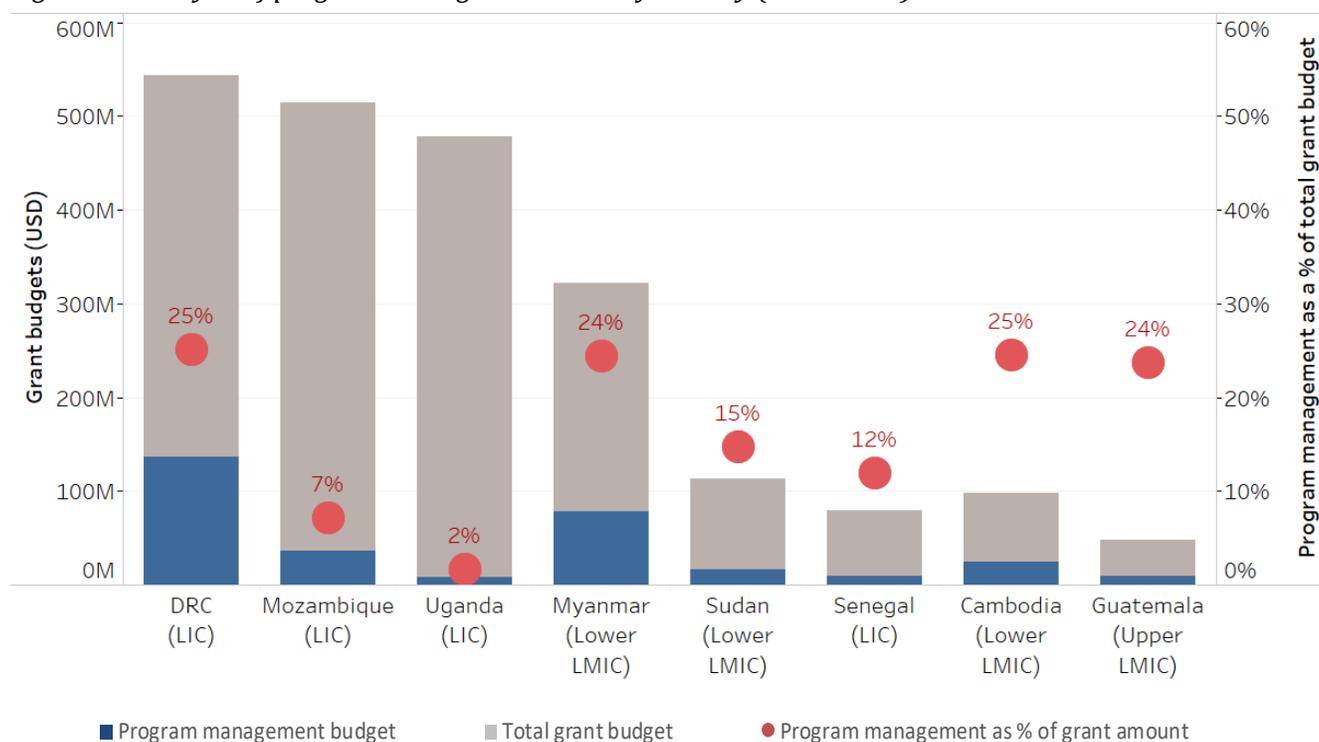
Program management costs vary significantly across countries and by type of PR, with substantially higher costs for UN agencies and CSOs than for governments. According to the Global Fund modular framework, program management primarily covers costs related to policy, planning, coordination and management of national disease control programs, including the costs of developing NSPs and annual operational plans and budgets; oversight, TA and supervision from national to subnational levels; human resource costs of staff seconded to national programs; some infrastructure costs; among others. Program management also includes the costs for specific activities related to managing Global Fund grants, including at the program-, PR- and SR-level, such as related to developing grant documents; M&E; oversight and TA related to Global Fund grant implementation; PR and SR human resource and other operational costs; and coordination with national program, district and local authorities.

As shown in Figure 18, the budget for program management as a proportion of the total grant budget varies from 2% in Uganda to 33% in Guatemala, with no clear link between a country’s stage along the development continuum and the program management budget (either in absolute terms or as a percentage of the total grant budget).¹⁶ There is also no clear link between the size of grants and the proportion of the grant required for program management. For instance, even among the four countries with the smallest grant budgets, program management costs still vary from 12% in Senegal (equivalent to US\$10 million) to 25% in Cambodia (equivalent to US\$24 million). Program management costs also vary as a proportion of the grant across diseases, from 9% for HIV, 16% for TB and 19% for malaria. Our observations in country suggest that this is at least in part due to the very different ways in which countries utilize Global Fund resources and structure the budgets during the funding request and grant making process.

¹⁵ Uganda is the exception to this with cost estimates available for 175 or fewer interventions.

¹⁶ As countries progress along the development continuum it would be reasonable to expect countries to assume more of these central costs of running the national programs, with Global Fund support targeted more towards addressing KVPs and specific program gaps.

Figure 18. Analysis of program management costs by country (2018-2020)



Our analysis does show that program management costs are significantly higher for UN agencies and CSOs (which are mostly international) than for governments. As shown in Table 5, program management costs account for 5% of the total grant budget across all PCE countries and grants for government PRs, as compared to 26% for UN agencies and 27% for CSOs. While comparisons are difficult due to variations in the mandate and operational structures of other organisations/initiatives, a review of the project management costs associated with administering grants for some other organisations suggests a similar experience – for instance, with costs varying between 7% (usually for government grantees) and 30% (usually for international NGOs and UN agencies).¹⁷

The analysis suggests that if UN agencies were not required to act as PRs as a financial risk mitigation measure¹⁸, then program management costs could be substantially reduced. If program management costs were reduced to 7% of the total grant budget in Myanmar and Sudan, in line with the average for

¹⁷ For instance:

- Program management accounts for 7% of Gavi's total HSS support over the strategic period 2016-20, of which the vast majority to provided to governments. Accessed [here](#).
- TB REACH application guidelines state that human resource, M&E and administrative overhead costs should account for no more than 32% for grants up to US\$1m, provided mainly to NGOs. Accessed [here](#).
- For USAID, overheads charged by contractors/grantees vary between 7-30% of grant value, depending on whether the contracted agency is profit or not for profit. Accessed [here](#).
- For DFID grants made through the Global Partnership for Education overall program management and administrative costs can go as high as 30% in rare cases where there are lower value grants in fragile and conflict-affected states. Accessed [here](#).
- The Bill and Melinda Gates Foundation place a cap on indirect (i.e. general overhead and administration) costs of 15%, although direct program management costs (which could include staff salaries, travel expenses, materials) could be charged in addition to this. Accessed [here](#).
- Analysis of grants provided through PEPFAR between 2007 and 2016 found that indirect costs accounted for between 8-20% of total grant value, although again this does not include direct program management costs. Accessed [here](#).

¹⁸ This measure is instituted when one of the following impacts occurs (or is likely to occur) which cannot be mitigated by other risk mitigation measures: (a) impact on overall grant objectives; (b) financial loss resulting from financial capacity issues; and (c) reputational damage to the Global Fund due to fraud, corruption or further inadequate financial controls.

government PRs across PCE countries, this would result in savings in the order of US\$30 million over the period 2018-20.¹⁹

Table 5. Analysis of program management costs across all PCE countries and grants (2018-20)

PR type	Grant amount	Program management budget	Program management as % of grant amount
Government	US\$ 1,212,209,626.00	US\$ 62,481,939.00	5%
UN	US\$ 318,629,984.00	US\$ 81,322,786.99	26%
CSO	US\$ 655,802,400.00	US\$ 174,192,923.00	27%

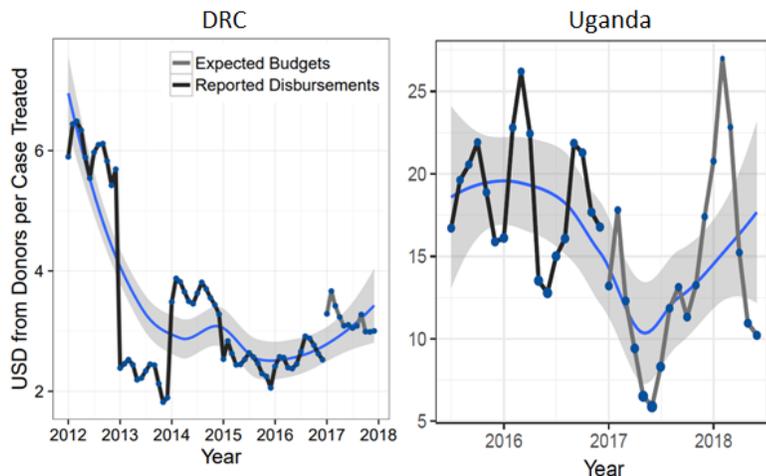
There is also evidence of stakeholders making changes to program design arrangements to improve efficiency, again particularly in countries facing significant reductions in budget allocations. In Cambodia, outreach services were redesigned to reduce costs while maintaining coverage in high burden areas to minimize the impact of a significant reduction to the national program resource envelope on grant activities. In particular, prevention activities for KVPs have been increasingly targeted to just those areas where high numbers of KVPs are thought to be living. The recognized risk of this is that the activities may not be appropriately targeted and/or the infection may move through communities where there are no prevention activities in place. In Sudan, KVP prevention programs were cut in 10 states but retained in the eight states with the highest HIV prevalence among KVPs in the interest of improving efficiency. The distribution of LLINs has also been better planned and coordinated between partners so this can take place only once a year instead of twice to improve efficiency. In DRC, numerous activities are rolling out to improve efficiency. For one, bundled commodity distribution across programs is being implemented with positive expectations for efficiency, requiring fewer vehicles and human resources per shipment. Further, a process known as rationalization is consolidating external donors to geographic zones to avoid duplication of efforts and inefficiencies around logistics and administration, among other benefits. In Senegal, initiatives to improve integration of HIV and TB programs include joint and integrated planning, establishment of a national steering committee for HIV/TB coinfection, and coordinating mechanisms between the central and regional levels. In Mozambique, trainings, supervision and quarterly technical meetings have been decentralized to the province level (with the Global Fund supporting the provinces directly) to avoid process bottlenecks at the central level.

Our initial analysis suggests that the efficiency of malaria programming is improving. Based on financial data across all donors in DRC and Uganda, and reported numbers of cases treated by national programs and HMIS, the PCE is observing a generally declining trend in the cost per malaria case treated, as shown in Figure 19. For example, DRC absorbed approximately US\$6 per case treated in 2012, which fell to approximately US\$3 by 2016. Similarly, in Mozambique, the PCE has estimated a total program cost (but excluding patient costs) of US\$3 per malaria case treated in 2017. These ratios were higher for Uganda given the lower prevalence of disease, but still declined over the period of 2015 to 2018 from approximately US\$18 per case treated to US\$15 per case treated. Recent declines in the underlying burden of disease in Uganda have led to the latest increases in 2018.²⁰ While attributing these improvements to any one initiative is challenging, the multiplicity of efforts (described here and annual country reports) in the interest of efficiency and effectiveness are believed to be contributing to this success.

¹⁹ The RAI2E malaria grant in Cambodia and Myanmar was excluded from this analysis, although if it were to be included the potential savings would increase to \$59 million.

²⁰ These figures reflect all donor investment intended for malaria treatment (according to OECD DAC and CRS databases). Treatment counts have been corrected for missing data and outliers where possible (see Annex 2).

Figure 19. Donor investment for malaria treatment compared to confirmed cases treated



3.4.3 Effectiveness²¹

Cost-effectiveness considerations appear to be incorporated into program design and decision making in most settings (such as through modeling) but not in a systematic manner, having implications for efficiency, effectiveness and equity. There is some evidence in all countries of grant interventions being targeted to correspond with burden of disease and address the specific needs of key populations, although how this allocation has been made has varied considerably. Advanced modelling techniques were used to potentially inform funding requests in 10 out of 24 disease programs across the PCE countries for the 2018-2020 cycle.²² Evidence from the PCE countries indicates that these modelling exercises have been of varying utility. For instance, in Cambodia and Myanmar, AEM modelling was conducted that included cost-effectiveness analysis on optimal HIV service strategies based on the disease epidemiology and overall resource envelope. This was then used to inform the design of the funding request, and in Myanmar this led to an increase in targeted programs to address identified needs (e.g. PWID in Kachin State). However, TB modelling has not been employed to the same extent, partially because in both countries it was based on out dated prevalence survey data, which was not felt to be a useful guide on how to target activities. For malaria also, where elimination activities are proposed for a number of geographic areas through the regional RAI2E grant, we are not aware of any systematic cost-effectiveness analysis of elimination versus non-elimination strategies used to inform programming. Rather, stakeholders have reflected that elimination activities have been introduced in as many geographic areas as the resource envelope would permit. In Guatemala also, recent geographic program prioritization was carried out explicitly with the intent to be more inclusive of indigenous populations (among other factors), with more interest in improving equity than cost-effectiveness. In Mozambique and Sudan, while cost-effectiveness considerations are taken into account, we understand that these can be superseded by political decisions on the allocation of resources between states and regions (such as for TB, for which resources and commodities are simply allocated equally between states), and not systematically used as the basis for decision-making. More generally, the PCE's analysis of effectiveness will be expanded in 2019 alongside a greater focus on the impact of Global Fund support.

3.4.4 Equity

More could be done to ensure that Global Fund-supported activities (and their benefits) are fairly distributed amongst target recipients. Our findings above, notably in relation to KVP, human rights and gender suggest that the Global Fund grants have not been designed to sufficiently address barriers/issues to ensure universal access to health and disease-specific services. Removing these

²¹ How well outputs achieve/deliver desired outcomes.

²² File shared by the Global Fund Secretariat in June 2018 titled 'Allocative Efficiency Modelling Support and KPI4 Assessment Plans for PCE'.

barriers is critical to fairly distributing the benefits of Global Fund support amongst target recipients (i.e. to improve equity by ensuring that the benefits of activities are fairly distributed among target recipients). This could include a review of the gender-related dimensions of equitable access to services and reduction of vulnerabilities for men, women, boys, girls, and transgender individuals.

Our analysis of the correlation between Global Fund investments and the distribution of program interventions to burden of disease and need also supports the finding (although this does vary by country). For instance, in Myanmar, our analysis of PWID population size estimates in Kachin State (a state characterized by high levels of injectable drug use) suggests that while MMT intervention coverage and needle/syringe distribution at the township level are approximately matched to the size of the PWID population, the number of ART support sites and harm reduction sites to population size is less balanced. It should be noted country is now seeking to address this concern. In DRC, Mozambique and Sudan, our initial analysis suggests that the distribution of services and commodities are correlated with burden of disease.²³ In Guatemala, the national program uses a more nuanced distribution plan that incorporates target areas for elimination and previous rounds of mass distribution of bed nets as well.

There is some evidence to suggest that the Global Fund target setting vis-à-vis available resources has been counterproductive to the prioritization of hard-to-reach areas. In Myanmar, there is some evidence that the Global Fund's requirement to set ambitious targets (which stakeholders feel are overly ambitious) with a modest resource envelope meant that activities had to be focused in areas where TB burden is high, but also where the cost of service delivery is low. Because the Global Fund budget is insufficient to access all hard-to-reach areas (where the service delivery cost is high), prioritizing these areas would not allow for the achievement of Global Fund targets. Relatedly, in Sudan, the reduced budget coupled with ambitious targets for HIV KVP services has led to the need to trial innovative service models that have not been trialed fully and have yet to demonstrate their effectiveness, which poses some degree of uncertainty that the approaches may not be effective enough to reach the targets.

Although there are some examples of Global Fund support being used to reduce financial barriers services, significant barriers to accessing HIV, TB, and malaria are still experienced in some countries. High out-of-pocket payments for health care are a characteristic of many low and middle-income countries. For instance, in the eight PCE countries, out-of-pocket spending as a share of total health expenditure is estimated to be 61.6% in Cambodia, 36.7% in DRC, 52.3% in Guatemala, 71.3% in Myanmar, 36.8% in Senegal, 63.8% in Sudan and 39.5% in Uganda.²⁴ Only in Mozambique (6.5%) is this number below the recommended level of 20% required to achieve low rates of catastrophic and impoverishing health expenditure(29). Out-of-pocket spending on HIV is sometimes substantially lower, estimated at 0.9% in Cambodia, 0.3% in DRC and 0.2% in Mozambique. The other PCE countries have out-of-pocket HIV expenditure levels that are somewhat higher though, estimated at 5.9% in Guatemala, 4.1% in Myanmar, and 9.7% in both Sudan and Uganda.²⁵ Local estimates from 2013 in Senegal put out-of-pocket HIV spending at 39% of the total. Other diseases, though less systematically assessed, tend to be much higher in terms of out-of-pocket spending. In Senegal for example, estimates from 2013 indicate that out-of-pocket expenditure constitutes 58% of spending for TB and 37% for malaria. In Cambodia, DRC also, household out-of-pocket expenditure accounts for 60% of total health expenditure. In Mozambique, out-of-pocket malaria spending is estimated to be 24%.

²³ In Sudan, our analysis of estimated MSM and FSW population sizes by state in relation to the number of peer educators trained in 2017 by state suggests that there is a positive correlation for both. In Mozambique, LLIN usage among children under five is found to be high and fairly equally distributed across socioeconomic groups. In DRC, malaria commodities were found to be distributed with high correlation to where case notifications are highest, but the national program also simply uses population estimates as a guide due to high prevalence.

²⁴ File shared by the Global Fund Secretariat in June 2018 titled 'Allocative Efficiency Modelling Support and KPI4 Assessment Plans for PCE'.

²⁵ File shared by the Global Fund Secretariat in June 2018 titled 'Allocative Efficiency Modelling Support and KPI4 Assessment Plans for PCE'.

Evidence in Myanmar suggests that the Global Fund’s support for the living costs of TB patients has been a critical factor in reducing the (often significant) financial barriers associated with accessing TB services and is associated with Myanmar’s high MDR-TB treatment success rates as compared to regional and global levels(30). In Uganda as well, over US\$1.7 million have been allocated to socioeconomic approaches in their combined HIV/TB grant, the effects of which will be explored as implementation begins.

Preliminary strategic considerations:

The Secretariat, together with partners, should:

1. Expedite work to collect unit/service delivery costs at the country level and use this as a basis for budgeting, with clear guidance on appropriate formulae to inflate estimates to allow for inflation, price changes, currency shifts, etc.
2. Consider ways to strengthen country-level and/or grant-specific analysis of VfM (while considering the burden of reporting), such as by:
 - Collecting and analysing grant-specific output data for some indicators.
 - Extending reporting tools to collect sub-national data.
 - Creating performance targets that would better address equity considerations.
 - Requesting that PRs/countries report against quantitative trends for some indicators as proxies for efficiency and effectiveness, with qualitative explanations of what the trends represent, and how and why the observed trends occurred.

Chapter 4: Summary, strategic considerations and future directions

4.1 Summary analysis and strategic considerations

This section summarizes the analyses and related strategic considerations based on the findings presented in the preceding sections. These findings have been categorized into considerations related to the business model and thematic areas as observed during the early implementation period of the 2018-2020 grant cycle across the eight PCE countries. Importantly, the strategic considerations are preliminary, and finalization will require further discussion with the TERG and other stakeholders.

4.1.1 The Global Fund business model

The Global Fund business model is a complex web of structures, policies and procedures designed to facilitate the impact of country grants on the three diseases. Our observations suggested that many aspects of the business model functioned as intended and assisted with early grant implementation. In order for the 2018-2020 grants to start on time in January 2018 to ensure a three-year grant implementation period, grants were signed at the end of 2017. Planned first disbursements from the Global Fund to PRs were largely on time, which enabled implementation, and flexibilities were approved to ensure grant transition and early implementation. Some CTs were proactive in resolving early grant bottlenecks, there was evidence of grant conditions and grant monitoring tools being used to strengthen grant performance, and there was evidence of business model ‘levers’ being used to enhance grant design and implementation in order to address strategic priorities. Despite these successes, challenges remained, and some aspects of the Global Fund business model warrant further consideration.

Onboarding and implementation

We identified four key challenges related to early grant implementation, which suggest an overarching need to smooth grant transition:

- The assumption that three years were available for implementing the activities of the grant was not borne out in the PCE findings. Significant delays were experienced across seven of the eight PCE countries and this reduced the time available for activity implementation. Delays were largely due to: modification or adaptation of national PR arrangements; protracted selection, contracting and onboarding of implementers; and implementing concurrent processes of close-out activities, early

reprogramming, and any additional requirements (e.g. hosting an OIG visit, the human rights baseline survey, or CCM evolution pilot team). Based on evidence from last year's synthesis report, we can expect 6-9 months of Year 3 to also include parallel funding request and grant making processes and the start of grant closure activities, all of which will take place alongside the implementation of the current grants. The result is a significantly shortened grant implementation cycle and/or potentially reduced managerial attention to implementation.

- Country ownership and accountability processes built into the business model for the selection, capacity assessment, contracting, and 'on-boarding' of SRs is a country-led responsibility assigned to PRs, overseen by the CCM. As such, this is an area where there is less Global Fund guidance and support, despite SR contracting issues being a major obstacle to the timely implementation of grants in the majority of the PCE countries.
- The added value of the differentiated funding request and grant-making process previously appreciated was not found to have significant rollover benefit during early implementation. Specifically, program continuation grants did not routinely result in more efficient early implementation and did not enable the 'rolling' continuation between grants that was expected. Additionally, in some cases the grants did not represent a true "continuation" of activities because budget reductions forced significant changes to the grant design. This potentially increases programmatic risk as the grant was approved by the TRP under different assumptions about the activities to be implemented.
- Finally, while matching funds appeared to have achieved the goal of increasing investment in Global Fund priority areas, Uganda and DRC experienced delays in approval and disbursement of matching funds, creating administrative challenges, delays in contracting and overall delays in implementation of the main grant. The "knock-on" effects from misaligned and/or delayed matching funds approvals observed in some countries during early grant implementation could be addressed by embedding matching funds into the timeline for the main grants, which is an area the Global Fund Secretariat is actively working to revise and adapt.

Preliminary strategic considerations:

1. Consider modification or differentiation of the three-year grant cycle and associated business model practices to smooth transition between grants, facilitate early grant implementation and enable adequate time for grant implementation, thus enhancing prospects of greater program impact.
2. Update and strengthen guidance for CCMs and PRs on the selection and contracting of SRs to increasingly 'front load' PR/SR selection and contracting processes prior to grant implementation. Guidance should include:
 - Metrics that clearly define the time period within which SRs are expected to be selected and contracted by PRs.
 - PRs to work with identified SRs to ensure roles, scope of activities and budgets are agreed during grant making, ahead of the implementation period. PRs should be strongly encouraged to effectively use Pre-Financing Policy flexibilities to facilitate SR preparation (e.g. staff contracting, pre-financing some activities) in advance of grant implementation.
3. Consider embedding matching funds in the timeline for the design, approval and implementation of the main grants to facilitate timely implementation of activities.
4. The Secretariat should consider trying to better link financial and programmatic data by collecting data on the specific outputs achieved through grant implementation, as well as collecting data at the sub-national level, at least for some indicators.

Grant monitoring

Despite delays in early grant implementation, most PRs reported achieving or nearly achieving the majority of their KPIs. However, many of these indicators were population-level outcome indicators,

reflecting a long-term trend rather than the performance of early grant-associated activities. The selection of performance indicators by PRs is likely motivated by the KPI framework, which focuses on grant outcomes as opposed to more proximal output indicators for implementation activities. Furthermore, it should be noted that few indicators included in the PU/DRs reflect key strategic priorities such as RSSH, gender and human rights.

Together with the potential misalignment of indicators, the juxtaposition of grant performance metrics and low rates of absorption raises important questions about the process of performance indicator selection and grant monitoring and assessment during the early implementation period. This may pose a risk to the Secretariat's grant management function and possibly even the Board's governance function.

Preliminary strategic considerations:

1. Consider monitoring absorption rates by module and disease to facilitate identification of intervention areas that are progressing slowly and ensure that absorption is viewed in combination with other performance indicators (proximal and distal) to provide a more detailed assessment of grant implementation progress.

Risk mitigation

Core aspects of the Global Fund business model and architecture (CTs, CCMs, PRs, LFA, partners) are involved in assessing and managing risks (programmatic, financial, institutional) that threaten Global Fund investments and impact. Our findings indicate that a strong focus on managing fiduciary risk translated operationally into high levels of scrutiny. Additionally, there has been frequent 'layering-in' of specific fiduciary risk mitigation measures, including the use of separate procurement agents and systems, which have both helped and hindered implementation and absorption.

While these measures prevent the misuse of funds and help to ensure that grant funding continues, financial risk management can become disproportionate to the overall financial risk posed, limiting programmatic sustainability and impact. For example, there is evidence that some stakeholders avoid approaches that are challenging to document or seek reimbursement for but are potentially rewarding, including activities related to the strategic priorities and RSSH. Rather, stakeholders often prioritize funding activities and line items that can be easily tracked.

Preliminary strategic considerations:

1. Provide countries with plans to roll back and/or add flexibilities to the various financial risk mitigation measures employed, with clear expectations as to what the country would need to demonstrate in terms of capacity for these steps to be completed.
2. Continue to identify areas where risk mitigation measures have created barriers to grant implementation and determine if the administrative burden can be lessened.

4.1.2 Thematic analysis

During the early phase of this grant implementation cycle, the PCE, in conjunction with the TERG, chose to focus on four thematic areas: 1) RSSH, 2) STC, 3) KVP, human rights and gender, and 4) VfM. A summary of key findings and strategic considerations related to these thematic areas follows.

Human Rights, Gender, and Key and Vulnerable Populations

There was a strong consensus across PCE countries that KVP, human rights and gender allocations were insufficient. Five PCE countries – DRC, Mozambique, Myanmar, Senegal, and Uganda – qualified for catalytic funds, a key source of support for KVP, human rights and gender activities. Four have already received the additional funding, but administrative delays associated with operationalizing Global Fund guidance has resulted in implementation delays for these interventions.

Gender and human rights dimensions are not well understood or discussed among stakeholders, causing delays in conceiving of, prioritizing and operationalizing initiatives. Human rights initiatives that require understanding new content and forming new partnerships (e.g. with the legal community) may fall to a lower priority because of the time associated with building new relationships and understanding the key concept. In many of the PCE countries, in part because of these delays, absorption was low in the first few quarters of 2018 for gender and human rights activities.

Preliminary strategic considerations:

1. The Secretariat should ensure that Global Fund-supported programs clearly define key and vulnerable populations, aligned with national epidemiological context and that programs are designed to allow for tracking of progress against key intervention areas (e.g. disaggregation of male/female/trans sex workers, youth, women who inject drugs).
2. Country stakeholders and the Secretariat should encourage more explicit promotion of gender and human rights integration throughout the grant lifecycle, particularly for TB and malaria, including:
 - Determining the appropriate mechanisms for ensuring the that high-quality gender assessments are conducted (or integrated into other assessment practices); e.g. further direct engagement by Global Fund technical staff in specific country gender assessments
 - Ensuring each CCM has a qualified gender expert engaged throughout the grant design and implementation process with the requirement that the gender expert is fully represented in all processes and decisions
 - Expanding the requirements for addressing gender in funding requests and reporting, using clear guidance that is understandable for both country teams and reviewers
 - Programming and grant design (e.g. to address social norms, stigma, time use, and intra-household decision-making, not just sex-based targeting)
 - Implementation (e.g. collection and analysis of programmatic data disaggregated by key populations).
3. The Secretariat and relevant partners should continue efforts to build in-country capacity and expertise on gender- and human rights-related issues, through multiple potential avenues, such as:
 - Developing clearer and more accessible guidance on human rights and gender programming and implementation (already underway by Secretariat/CRG)
 - Ensuring TA is consistent with country needs and facilitating countries seeking TA for reducing gender- and human rights-related barriers (e.g. help the CCM to know that the mechanism exists and see the value in accessing TA to enable stronger more gender responsive planning, implementation, and monitoring).
4. Country stakeholders should more explicitly articulate the gender-related vulnerabilities of men/boys, women/girls, transgender and gender non-conforming individuals, the impact of these on disease-specific outcomes, and specific strategies to mitigate these effects in funding requests and designing disease-specific strategies.
5. CCMs should encourage multi-sector approaches and facilitate collaboration among PRs with legal and other non-traditionally Global Fund stakeholders.

Resilient and Sustainable Systems for Health

RSSH is a core aspect of both the Global Fund business model and one of four strategic objectives. It is essential for maximizing the Global Fund impact of investments for HIV, TB and malaria, and creating a sustainable healthcare system capable of responding to the needs of the community. Our analysis of RSSH investments across the eight PCE countries revealed significant variability in both the scope and scale of the investments. The percent of direct RSSH investment ranged from a low of 1.2% in Uganda to a high of 17.7% in Senegal. Additionally, we found that RSSH investments disproportionately target HMIS/M&E, while there is often limited investment in community responses and systems.

Building on findings presented above, we note challenges with both absorption and performance monitoring for RSSH investments. Absorption for RSSH investments was very low in most countries. In addition to the reasons noted above, concerns about using RSSH funding for activities without clear performance metrics emerged, furthering challenges around misalignment of activities and performance.

Preliminary strategic considerations:

1. During the funding request development, consider mechanisms to incentivize stronger alignment of crosscutting RSSH investments to longer-term national strategies for health system strengthening, rather than addressing short-term, disease-specific health system gaps.
2. Improve standardization for categorization of RSSH investments within grant budgets to ensure accurate quantification of Global Fund contributions toward RSSH, including whether simplification is feasible or increased guidance and examples are necessary.
3. Strengthen monitoring for RSSH investments through stronger alignment of grant activities to indicators; consider including community systems and responses indicator(s) in the modular framework.
4. Improve monitoring and measurement of the outcomes of RSSH investments, e.g.:
 - Clear articulation of expected RSSH outcomes, which can be translated into investment guidance, the modular framework and grant performance framework where relevant.
 - Stronger alignment of grant activities to indicators.
 - Consideration (and development of) community systems and responses indicator(s) in the modular framework.

Sustainability, transition and co-financing

Findings related to the STC policy during the early implementation phase focus largely on co-financing requirements and their implications for creating sustainable health systems. Global Fund documentation suggests that co-financing requirements are being met in all eight PCE countries. However, countries lack formal mechanisms for stakeholders to confirm fulfilment of the co-financing requirement, and government health expenditure data are rarely made available to external partners for verification. Government co-financing commitments also typically focus on commodities as opposed to programmatic interventions. We also note one example of external loans obtained to meet the co-financing requirement.

The PCE also observed a positive shift towards investment in programmatic sustainability, and in some cases increased preparedness for transition. However, the PCE notes particular concerns, often country-specific, around the continued use of international PRs and parallel systems for data collection, commodities procurement and other processes. This lack of integration into the existing health system represents a continued barrier to sustainability and transition.

The Global Fund Secretariat should consider restructuring the country co-financing requirement to encourage ambitious increases in domestic health expenditure. Specifically, this includes strengthening the incentives for countries to increase domestic expenditure for the three diseases beyond the minimum co-financing requirement. These increases in domestic financing could be incentivized by providing contingent access to additional funding in the current or subsequent grant cycle, allocated either through the main grant allocation, PAARs, or catalytic funding. If incentives were provided via catalytic funding, the additional funding could serve the dual purpose of encouraging sustainability planning and further stimulating activities focused on the strategic priorities²⁶. Such an approach could also increase dialogue between the Global Fund Secretariat and country stakeholders on the long-term objectives of the Global Fund for transitions and sustainability. However, it is important to note the ongoing need for contextual flexibility in setting co-financing requirements, particularly in COE settings and when increased in

²⁶ The provision of matching funds already requires countries to commit an equal level of domestic resources to areas of strategic importance to the Global Fund.

domestic health expenditure will come at a substantial opportunity cost (for example, if there will be a proportionate decrease in funding for other disease priorities or RSSH).

Preliminary strategic considerations:

1. The Global Fund Secretariat should consider restructuring the country co-financing requirement to more ambitiously increase domestic expenditure on health and the three diseases, with a view to ensuring that domestic financing increases to a level that more fully supports transition and sustainability objectives. Specifically, this might involve:
 - Expanding upon the co-financing requirement to better reflect the government's existing financial commitments overall and within the wider health financing landscape, e.g. by setting the co-financing requirement based on more parameters than the current two (progress towards 8% of general government expenditure on health, and the allocation amount).
 - Increasing the minimum level of co-financing that is acceptable to the Global Fund (i.e. increasing the co-financing requirement but not necessarily the co-financing incentive).
 - Strengthening the incentive for countries to increase domestic expenditure on health and the three diseases by making additional resources available to countries that invest above the minimum acceptable level of co-financing (via a separate mechanism than the existing incentive, which can only be taken away).

Value for Money

The Global Fund's current monitoring tools are not able to systematically link financial and programmatic data for the analysis of VfM at the country level. These tools also do not collect information at the sub-national level, a data limitation that further restricts analysis of VfM. However, examples from most PCE countries indicate that VfM is being considered more consistently by implementers. The introduction and adoption of the PPM and innovations in procurement management, including de-centralization, have improved the economy and efficiency of commodity purchase, distribution and treatment costs. In addition, countries facing budget reductions have used innovative cost savings to continue to deliver programs.

Effectiveness and equity have posed greater challenges. Although cost effectiveness is often considered in multiple sectors, it is not being used in a systematic manner for decision-making. Similarly, equity is often discussed, but tradeoffs between equity, cost-effectiveness and programmatic targets are dealt with differently between and within countries.

Preliminary strategic considerations:

The Secretariat, together with partners, should:

1. Expedite work to collect unit/service delivery costs at the country level and use this as a basis for budgeting, with clear guidance on appropriate formulae to inflate estimates to allow for inflation, price changes, currency shifts, etc.
2. Consider ways to strengthen country-level and/or grant-specific analysis of VfM (while considering the burden of reporting), such as by:
 - Collecting and analyzing grant-specific output data for some indicators.
 - Extending reporting tools to collect sub-national data.
 - Creating performance targets that would better address equity considerations.
 - Requesting that PRs/countries report against quantitative trends for some indicators as proxies for efficiency and effectiveness, with qualitative explanations of what the trends represent, and how and why the observed trends occurred.

4.2 PCE provisional priority areas for 2019

This plan outlines the areas of work in 2019 based on a continuation of 2018 PCE activities, including an enhanced focus on the Global Fund's contribution to outcomes and impact in the final full year of PCE implementation. Significant lessons emerged from the PCE in 2018. The PCE hopes that these lessons will be discussed further and will inform ongoing evaluation activities, including a **greater prioritization of the 2019 scope of work**, which would result in changes to this provisional plan. Based on the findings from the early grant implementation phase, in 2019 the PCE will focus on deepening its evaluation of whether, how and why the Global Fund's investments contribute to disease-specific and broader health and social impacts, including:

Impact assessment: The PCE will continue to triangulate current and emerging empirical evidence to assess the link between financial resources to national disease programs and changes in the level and quality of service coverage. In 2019, we will go beyond the current level of analysis to focus more on novel analysis of indicators and statistical relationships between those indicators; this will build on our 2018 analytic foundation of triangulating across datasets, correcting data quality concerns where possible, and correlating linkages along the results chain. This may involve defining new impact evaluation questions (where appropriate) and/or new pathways in the results chains. This will also strengthen our understanding of what changes to the Global Fund's inputs to country programs result in (i.e. in terms of the achievement of outcomes and impact).

More specifically, impact analysis in 2019 will measure as many indicators along results pathways as possible given the available data and relevance to grant budgets, and go on to measure the correlation between inputs and activities/outputs, outputs and outcomes/impact to the extent that data allow. This may require us to:

- Further address data availability and quality;
- Continue to assess data gaps and supportive efforts to strengthen routine data systems;
- Continue to obtain access to additional data sources;
- Triangulate and analyze empirical data;
- Assess spatial and temporal relationships and trends between links of the results chain;

As a consequence of this effort, the PCE may be positioned to contribute in the following additional ways:

- Support establishment of best practices for indicator definitions, size estimation and measurement of service delivery;
- Track national and grant results against targets. For targets derived from routine program data, this can be done prospectively. For targets derived from non-routine program data (e.g. special surveys), we will update progress towards results once data become available.
- Revisit the 2019 impact evaluation questions as needed/appropriate and identify new opportunities for impact evaluation beyond 2019.
- We further anticipate performing standardized data quality assessments on key routine data sources, the results of which will help inform us on the overall quality and whether and how we should use the data

Process evaluation: The PCE will continue to use a mixed methods approach to understand how and why changes are occurring along the results chain, from inputs to outputs, outcomes and impact. This approach includes continuous process tracking and root cause analysis to explain the links between indicators in the results chain. Across the PCE countries, many grants experienced delayed implementation in 2018; in 2019, we anticipate that there will be more implementation progress across grants that will allow for process evaluation of new milestones such as reallocation or reprogramming, and may identify new root causes related to the quality, timeliness, efficiency, or impact of grant implementation.

More specifically, process evaluation in 2019 will:

- Continue to track progress in grant implementation of activities and achievement of grant outputs;
- Prioritize thematic areas by country for primary data collection and deep dive analysis;
- Identify root causes of implementation barriers or facilitators, including root causes of poor absorption;
- Continue to gather evidence on why grants are/not meeting targets, programmatic implications of target setting, and flexibility of the business model to change targets during grant implementation.
- Continue analysis of other business model processes such as grant closures, budget reviews, reprogramming.
- Review the role and effect of risk mitigation strategies during grant implementation.
- Evaluate effectiveness of differentiated grant implementation arrangements (e.g. new PRs, transversal SRs in DRC).
- Track use and effectiveness of grant monitoring and oversight processes by the Secretariat (e.g. use of management actions) and Global Fund architecture (e.g. CCM grant monitoring/oversight function).
- Continue analysis of technical partners' roles in grant implementation and technical support provision.
- Deepen understanding of how RSSH investments are strengthening the health system.
- Deepen understanding of how and whether countries are planning for transition and sustainability.

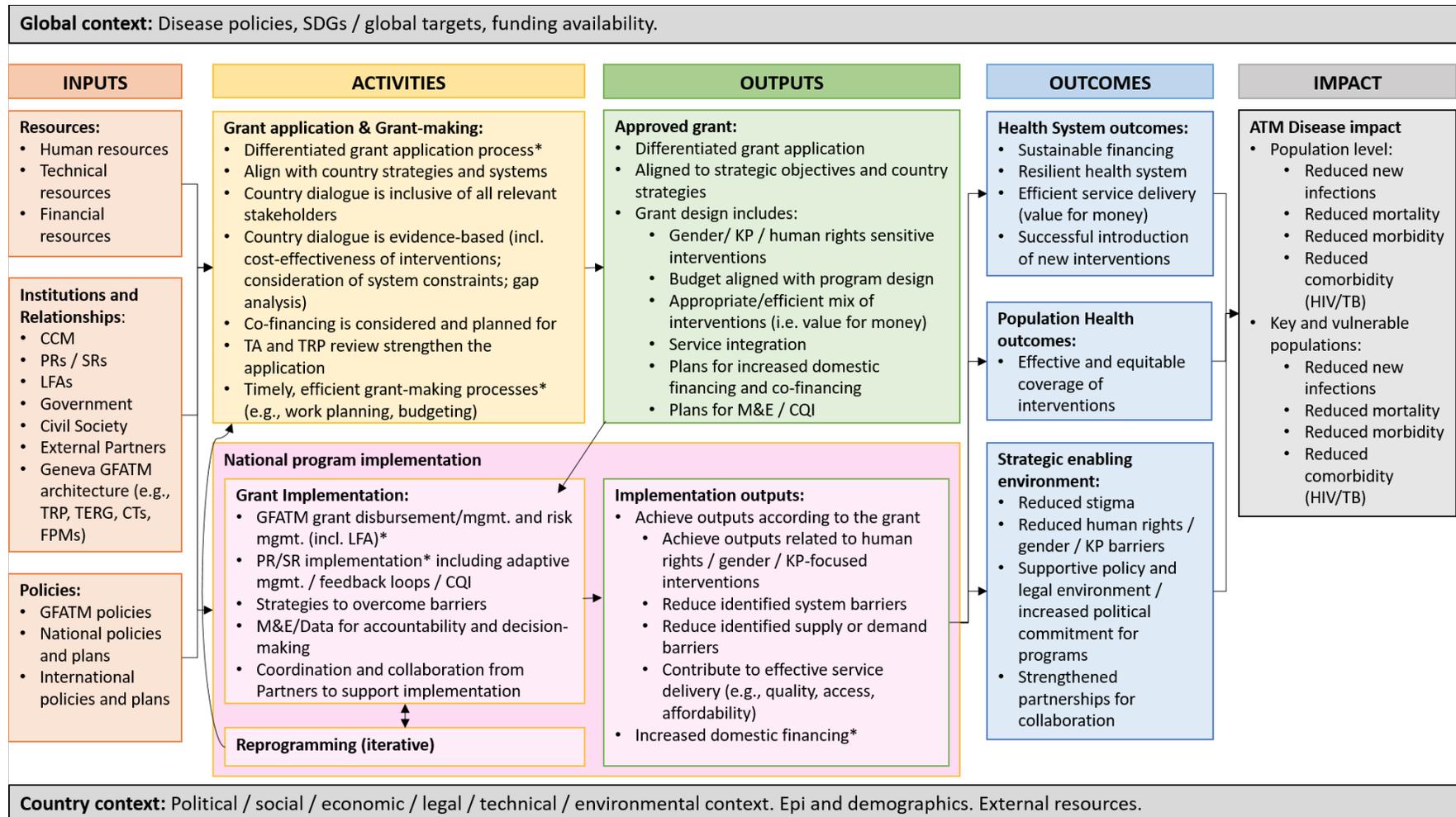
Use of findings: The PCE will continue to produce annual reports and hold annual dissemination meetings to share, vet, and discuss implications of the evaluation findings; however, based on lessons learned (Annex V), the PCE in 2019 will put additional emphasis on sharing timely findings throughout the year with relevant stakeholders. Sharing findings backed by robust evidence and aligned with the timing of policy windows or critical data use periods will encourage use of the findings. The approach may look different by country and could include informal or formal presentations, policy briefs, or other direct engagement with stakeholders. We can learn from experiences in DRC, where the PCE team shared timely findings from their data quality assessment with the Director and Data Manager of PNLP, and Uganda, where the PCE team identified operational challenges during subnational data collection activities that were shared with national MOH officials and thereby promptly addressed. The ability to disseminate emerging findings in a timely manner is a core strength of prospective evaluations and provides an opportunity for the PCE to contribute to continuous quality improvement.

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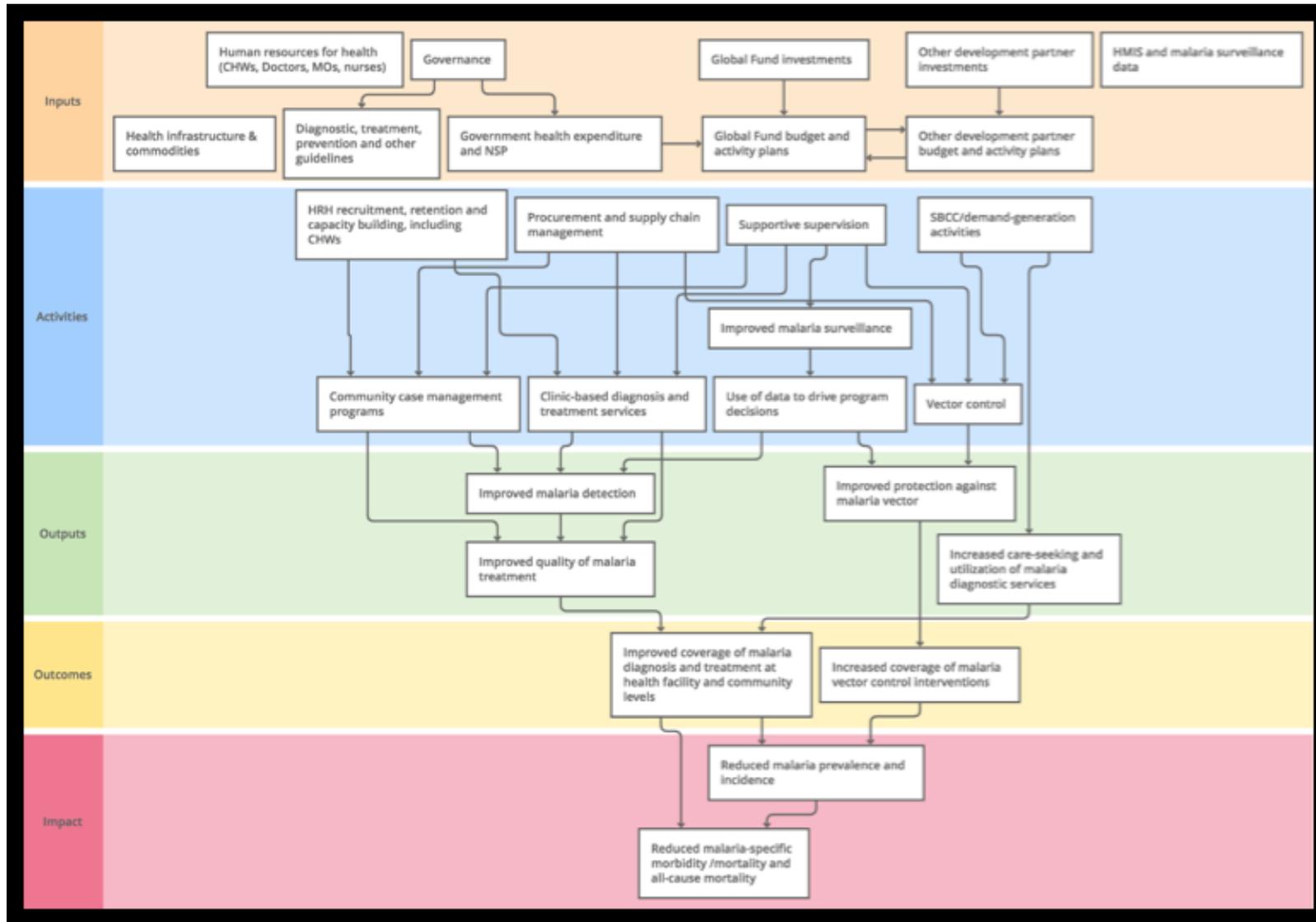
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Annex I: Global Theory of Change

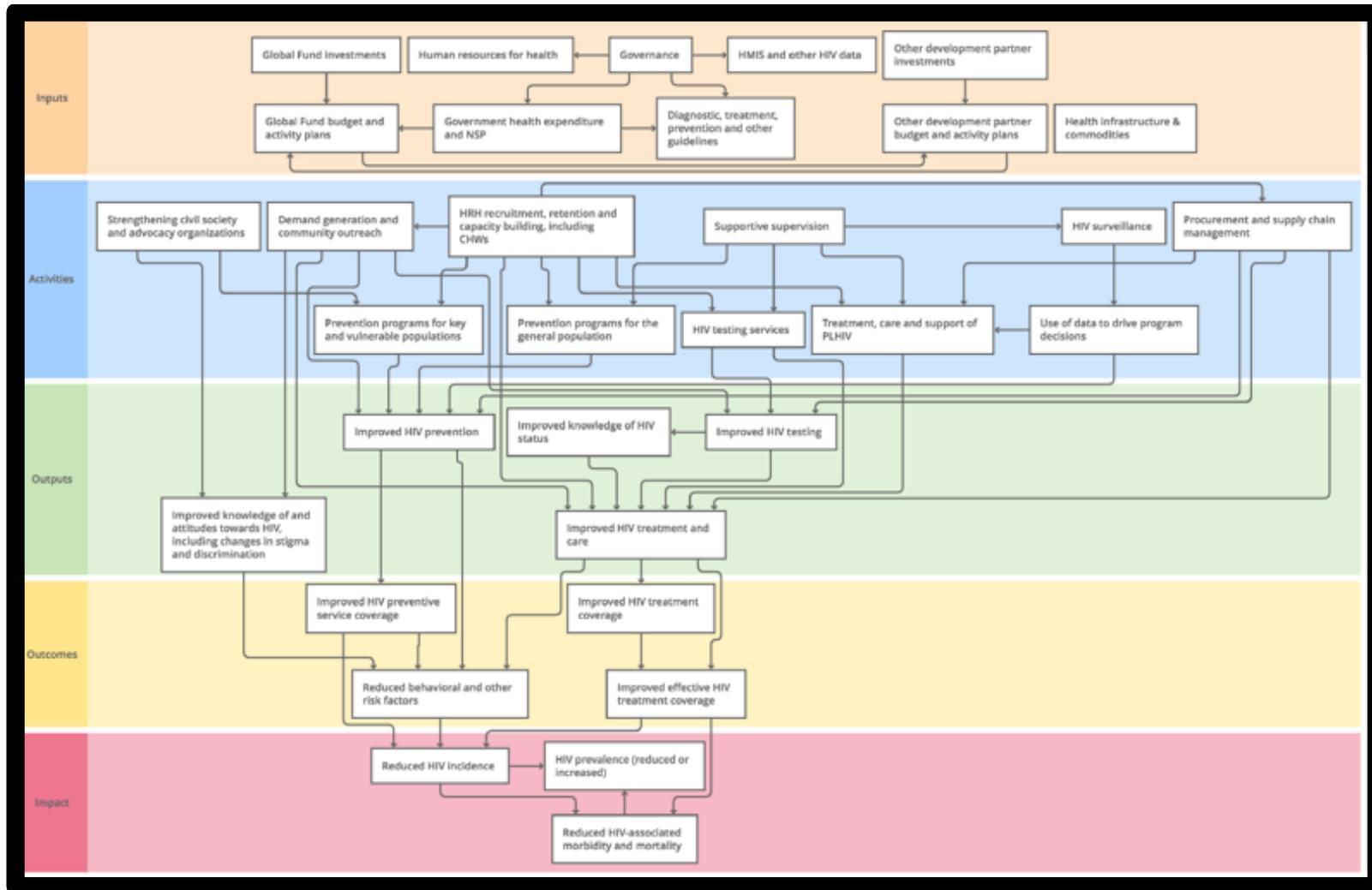


Annex II: Results Chains

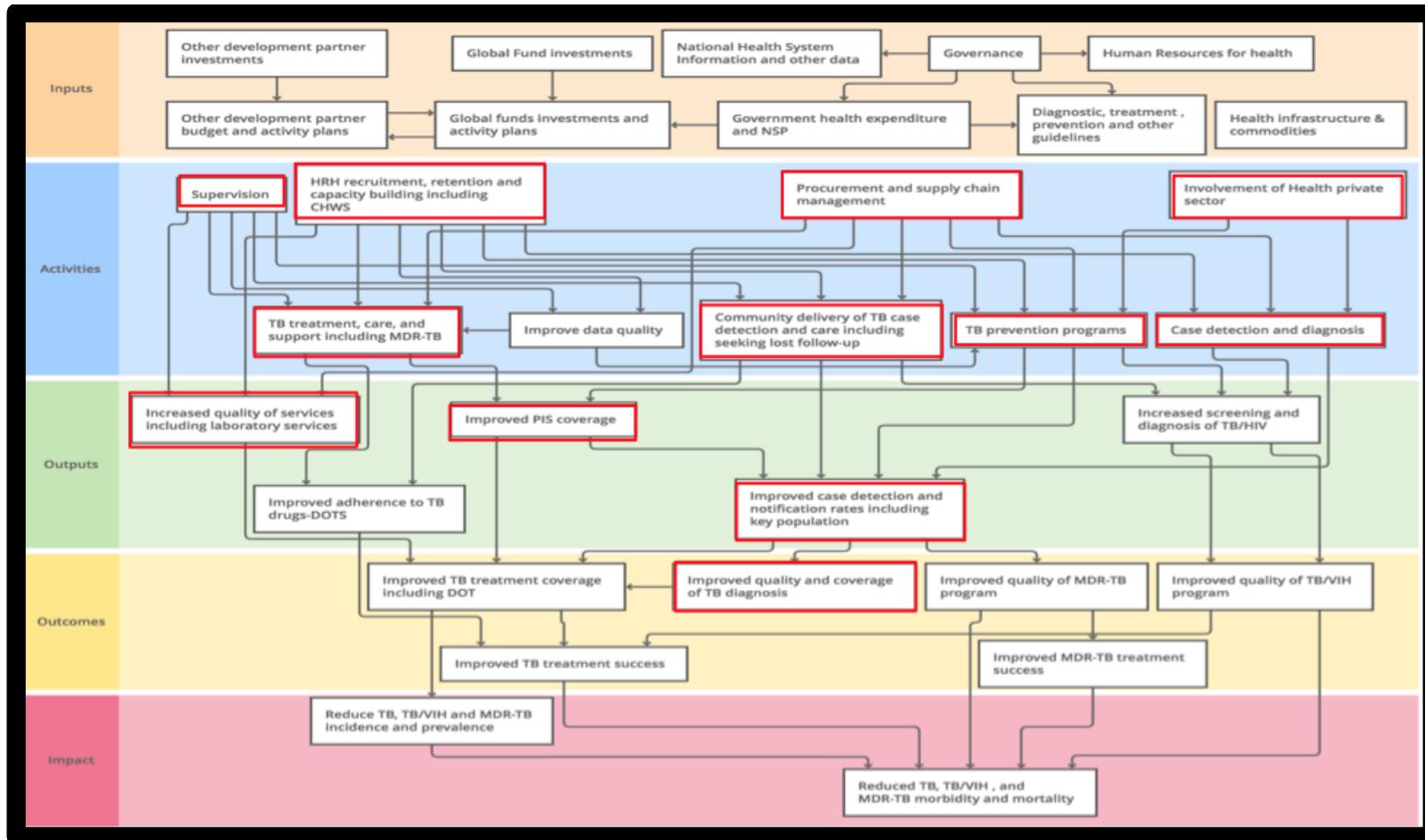
a) Malaria



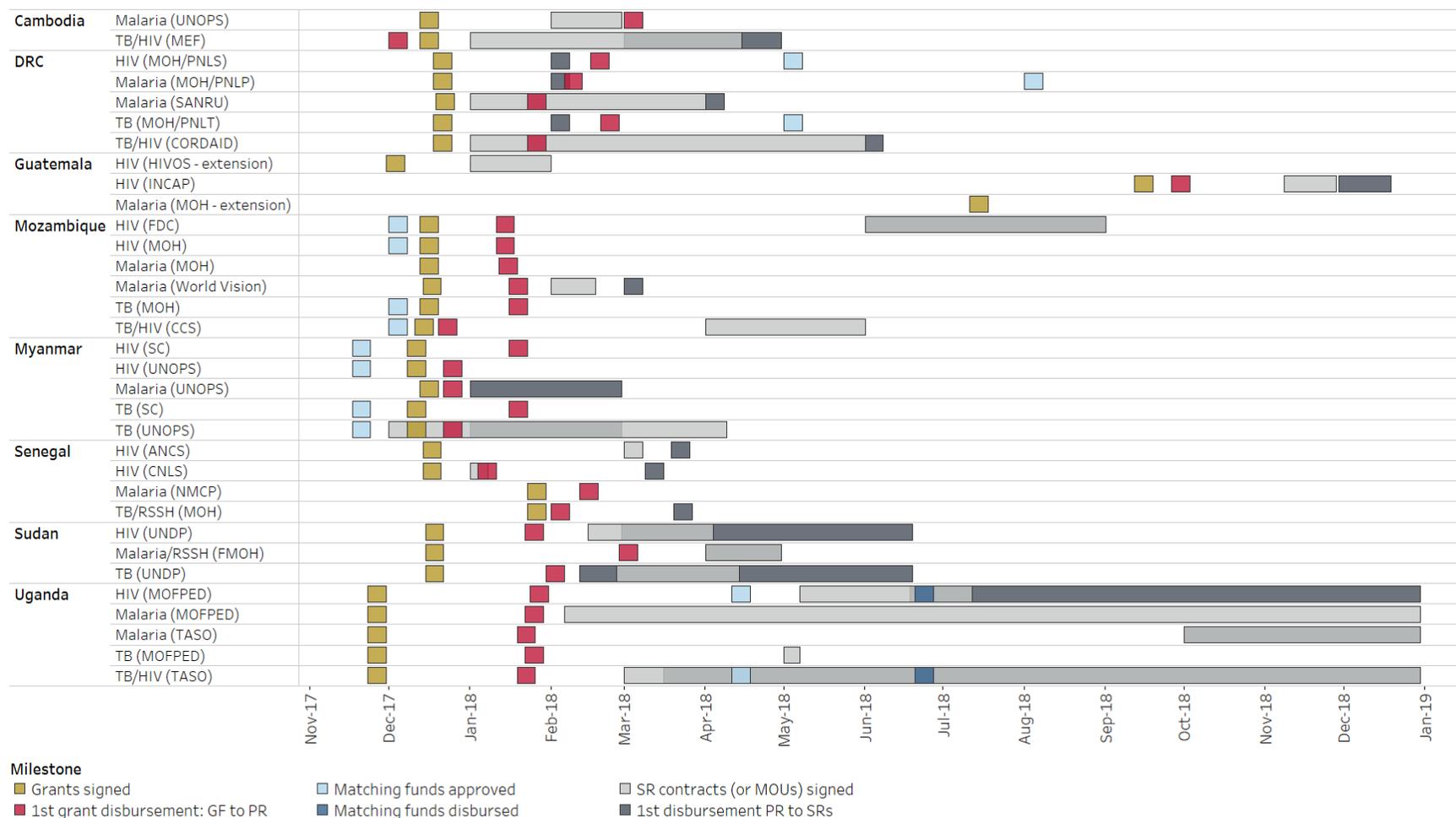
b) HIV/AIDS



c) Tuberculosis (with an example of research question mapped for Senegal)



Annex III: Timeline of key milestones by grant



Annex IV: Co-financing commitments and types of activities funded through co-financing

Country – Income category	Grant	Willingness to Pay Commitments for 2014-16 (or prior) allocation	Co-Financing Commitments for 2017-2019 allocation	Description of activities (as available)
DRC – LI	TB		\$7,345,434	(2017-2019) Salaries and salary allowances, operating budget, health services equipment project (PESS), performance-based financing (PBF)
	HIV		\$12,873,775	
	Malaria		\$3,309,429	
	PNTS		\$946,432	
Guatemala – Upper LMI	TB	\$40,000.00	\$877,423.00	Second line TB drugs, Human resources
	HIV	\$4,500,000	\$2,950,585.00	Human resources
	Malaria	\$6,000,000	\$944,798.00	Human resources
Uganda – LI	TB	\$2,700,000	\$300,000.00	ART HIV Prevention Programs (US\$ 6.5 Million), TB Care and Prevention, RSSH, and Program Management
	HIV	\$10,600,000	\$30,300,000.00	
	Malaria	\$3,600,000	\$300,000.00	
Sudan – Lower LMI	TB			Commitment data unavailable
	HIV			
	Malaria			
Cambodia – Lower LMI	TB	\$8,300,000.00	\$16,000,000.00	Contractual staff salaries, ARVs
	HIV	\$25,100,00.00	\$26,500,000.00	
	Malaria	\$14,600,000.00	\$20,600,000.00	
Mozambique – LI	TB	\$28,000,000.00	\$25,000,000.00	
	HIV			
	Malaria			
Senegal – LI	TB	\$2,482,986.42	\$2,447,414.79	Did not meet STC requirements
	HIV	\$11,278,225.46	\$4,981,530.23	
	Malaria	\$2,497,793.22	\$7,371,692.82	
Myanmar – Lower LMI	TB	\$5,500,000.00	\$39,400,000.00	ARVs, Anti-TB drugs and other health commodities. Co-financing of the Global Fund-supported programs by taking up key costs of national disease plans.
	HIV	\$7,000,000.00	\$53,800,000.00	
	Malaria	\$7,600,000.00	\$41,500,000.00	

Annex V. High level lessons learned

PCE considerations	Lessons learned from PCE 2017-2018
<p>PCE team structure</p> <ul style="list-style-type: none"> • Effectiveness of GEP/CEP model for prospective evaluation • Developing capacity of CEPs 	<ul style="list-style-type: none"> • Strong linkages between GEP and CEPs are essential; in-person working time at critical points in the PCE reporting cycle and regular calls are most effective for collaboration. Tools such as Dropbox, Basecamp, and Dedoose also aid collaboration. • It works well to have CEP technical positions at 100% FTE in some locations. Consultant-based CEP model is challenging because the model of this prospective evaluation requires regular engagement with national stakeholders, frequent follow up, and a sufficient LOE to track all three disease areas. • Successful CEP teams have sufficient staffing with a balance across qualitative and quantitative expertise, and integration between the technical areas. Most CEP teams are struggling with the allotted LOE which is deemed insufficient for the range of issues the PCE is being asked to focus on. • Successful opportunities and strategies for CEP capacity building have included cross-CEP learning opportunities (in-person; webinars; TERG meetings), introducing new software and methods; and gradual transition of report-writing responsibilities from GEP to CEP (with heavier GEP input Y1; More balanced in Y2; CEPs leading in Y3). • Additional CEP capacity strengthening is needed around technical writing and writing to a specific audience, analysis of and rating of evidence, generating key findings from the evidence, and understanding the policies and practices of the business model. • Until now, there has been no 'lead' consortium responsible for coordinating and organizing GEP calls, notes, synthesis, and collaboration. Having a lead organization could improve the efficiency and effectiveness of cross-consortia collaboration. • There have been continued challenges to consortia being at different timelines due to contracting delays and this has affected inputs into cross consortia work.

<p>PCE approach / platform / methods</p> <ul style="list-style-type: none"> • Use of PCE analytical frameworks (e.g. results chains) • Managing the scope of PCE • What's needed for strong synthesis • Value-add 	<ul style="list-style-type: none"> • There are data access challenges (routine HMIS data; survey data) across many PCE countries although this is improving as countries become more familiar with PCE. • The prospective nature of PCE is challenging to implement given reliance on secondary information and the fact that grant implementation has only started recently. But PCEs are adding value through data triangulation of existing sources and through timely documentation of successes and challenges during implementation. • Results chains are helpful analytical tools to understanding the links between inputs, activities, outputs, outcomes and impact; but using them as a presentation or organizing framework is a significant amount of work given the scope (functions of the business model, range of thematic areas, complexity of grants across three diseases etc) and was distracting at the September TERG meeting and ultimately didn't appear to be what the TERG wanted. • GEP/CEP teams have been challenged by the array of PCE analytical tools and evaluation frameworks established and their application - particularly the 'integration' of the results chains with thematic and business model considerations and explanations. This is new to all PCE implementers and takes to do and requires a clear vision of the approaches which is not easy to communicate unless in-person, and/or by doing a joint analysis. • PCE teams need TERG decisions/guidance on the priority areas of the evaluation. Teams are not staffed to go into depth on all themes or address emerging requests from TERG and CT members (which are sometimes out of original scope). A limited number of more specific evaluation questions per phase would allow for deeper analysis, and the TERG Secretariat could support the PCE teams to identify TERG/CT requests that are out of scope. Balancing priorities is also an important consideration for primary data collection since many stakeholders work across all the PCE topic areas and we don't want to overburden them with data collection. • Balancing competing priorities from multiple stakeholder audiences - the TERG, Strategy Committee, Secretariat - is difficult and can be challenging to manage and/or can 'derail' the focus of existing work while trying to meet all these needs. • We should not assume that all stakeholders conceptualize topics in the same way; for example, the TERG and CT may not conceptualize gender the same way. The PCE team should over-communicate to ensure alignment among stakeholders. • More resources, discussion and planning time spent cross consortia in Q1 of each year would help align approaches to synthesis. • Meeting TERG timelines has meant that this year (as with 2017) there has not been adequate time to address the annual reports and synthesis reports well. PCE experiences of discussing and assembling synthesis findings within a short period of time while also still working on country findings does not allow for sufficient analysis and iteration and potentially compromises the quality of the output.
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<p>PCE reporting and dissemination</p> <ul style="list-style-type: none"> • Quarterly, annual reports and synthesis reports • Reporting timelines and deadlines • Managing TERG Sec • Key audiences • Dissemination 	<ul style="list-style-type: none"> • Dissemination needs to be aligned with critical data use periods. For example, there was a missed opportunity in Guatemala where the reprioritization process wasn't able to be used by national program due to timing. Deliverables could be timed to these data use opportunities. • The reporting requirements for the PCE are demanding and may not be the best use of CEP/GEP time. For example, it would be helpful to reassess whether quarterly reports necessary. • The prospective nature of the evaluation may be better suited to shorter, more frequent briefs with timely findings. The annual report could summarize the briefs and comment on whether/how they've been used. • Future PCE platforms should include dedicated funding for communication, knowledge translation, and dissemination – this is not necessarily a core function/skill of the existing CEP and GEP. • Timing of annual and synthesis reports needs to be staggered, and preferably not during the Christmas/New Year holiday season when many people take time off, making it difficult to work across GEPs and CEPs. • Clarify and balance target audiences for reports – country stakeholders, CT, TERG, Strategy Committee. • More feedback from the TERG on how the Strategy Committee is using the PCE findings is important for the teams and also the country stakeholders who understand that the PCE findings from their countries is feeding into more strategic processes.
<p>PCE / TERG / CT engagement</p> <ul style="list-style-type: none"> • Reporting at TERG meetings • Instructions from TS pre and post meetings 	<ul style="list-style-type: none"> • TERG presentation formats sent to the teams sometimes constrain the findings presented. TERG presentation guidance could be more flexible in this regard, giving some overriding objectives of the presentations and no of slides but leaving it to the teams to design the slide set. • Each TERG meeting requires extensive CEP and GEP preparation to develop presentations (high transaction costs) and the frequency of the meetings along with the PCE reporting requirements means that the PCE teams moves from one deliverable to the next which limits CEP time for data collection. Consider fewer TERG meetings per year where PCE presents. • PCE teams need consistent feedback from the TERG over time. Advocating for the use of results chains is an example of changing direction between TERG meetings which resulted in considerable time effort and resources used and represented a change in our approach and direction of PCEs. • TERG Secretariat focal points need to be consistent in their communication and information sharing with each GEP. Occasionally GEPs receive different documents, resources, or information - although recent improvements in Basecamp for document sharing is helpful progress. It would also be helpful to use the GEPs to interview the Secretariat periodically to gain further insight into specific initiatives, policies etc. • CT engagement early and often is important, including ensuring the goal/objective/methods and audience of the PCE is clearly communicated. More clarity is needed on the role of the CT in the PCE.

Annex VI. Evaluation Limitations and Data Quality Limitations

The PCE is not without methodological limitations and country level data limitations. In this annex, we will describe some of the crosscutting limitations of the data in the PCE countries and strategies to mitigate these limitations. Further details on country-specific data availability and quality limitations can be found in the country reports.

Evaluation limitations:

Different epidemic contexts make synthesis difficult. In addition, each of the GEP/CEP teams employed methods appropriate to available data, method preference and expertise.

Selected data limitations with examples and mitigation strategies are listed below:

1. Data likely exists in the country but is not available/accessible to PCE team in a timely and ongoing manner.

This is perhaps the most common data problem faced by the PCE. In certain countries, program stakeholders commit to sharing data during meetings, but either require extensive follow-up, or are unable to share in a timely manner despite all efforts made by the CEP to obtain the data. Alternatively, data are provided once and not continuously for the whole course of the PCE. For example, in Sudan, back-entry of data for ART centers with the recently rolled out TIER system was prioritized over data entry going forward, so timeliness of data availability is a challenge

Mitigation strategies: 1) Continued development of relationships with in-country partners. 2) Obtain direct access to HIS systems (e.g. user password for DHIS2)

2. There is limited or no central storage of data at national level.

The lack of central storage at the national level is problematic for several reasons. When only aggregated data is stored at the national level, important disaggregations may be lost, such as the cross section of age and sex, or HIV testing modality together with age or sex.

For example, in Sudan, laboratory data (parasitological-confirmed malaria tests) are unavailable at the national level. In Myanmar, TB treatment success at the national level does not include disaggregation by age or sex, limiting the ability to explore differences among subpopulations.

Mitigation strategies: Obtain disaggregated sub-national data in order to maintain subpopulations at national level and/or use other data as proxy for data that is unavailable.

3. Parallel reporting systems create discordant data sets.

In addition to potentially discordant datasets, parallel systems prohibit easy integration with other general health information systems and may limit the capacity for program scale-up.

For example, oversight of the PMTCT program in Sudan was transitioned from the National HIV Control Program (CNCD) to the Reproductive Health Unit. However, both programs still receive reports, and old reporting tools with varying indicators are still in circulation at facilities even after the new registers were printed and rolled out. This has resulted in duplicate and conflicting sets of data with PMTCT indicators. In Cambodia, there are at least ten HIV-related databases running or under development, which creates a high burden for staff at both national and local levels.

Mitigation strategies: Where possible, obtain both/all sets of data to determine whether trends, patterns are similar, and investigate with program stakeholders to understand divergent data.

4. There is a lack of population-based surveys to estimate population-level coverage indicators.

The existence of a population-based survey such as a malaria indicator survey, nationally representative HIV survey, or integrated bio-behavioral survey (IBBS) for key populations, allows for valuable analyses. However, if no comparable survey is planned during the life-span of PCE, assessing change over time with the same or comparable rigorous data source is not possible. For example, while PHIA can be used to estimate community viral load in Uganda, similar surveys are not available in most other PCE countries.

Mitigation strategies: 1) Rely on proxy indicators, program data, and/or modeling to fill in gaps. 2) Advocate for funding/planning of follow-on studies where most important and feasible (e.g. serial IBBS' among key populations)

5. There is limited data on, or disaggregations within national data on, key and vulnerable populations.

Data systems may not capture indicators about risk factors, including occupation, migrant status, or residence in camps or informal settlements. For example, there is limited information on malaria among residents of camps and settlements in Sudan and no historical data on TB in prisoners in Myanmar. Additionally, HIV treatment status and viral load suppression data among key populations is also often unavailable.

Mitigation strategies: 1) Employ special studies where they exist and extrapolate to larger populations, if appropriate. 2) Identify facilities within or near conflict zones or settlements to identify IDP populations.

6. There is a lack of subnational resource tracking systems (except in few cases, e.g. Guatemala).

Data on distribution of commodities such as HIV reagents, malaria rapid tests, or medicines is unavailable at the subnational level. In Myanmar, commodities purchased through Global Fund are managed through a central system and there is limited information on distribution to states/regions.

Mitigation strategies: 1) Natural language processing of financial data / standardizing modular classification.

7. Data completeness and coverage is variable.

Data completeness and coverage is variable across disease areas and countries. For example, in Sudan, reporting of malaria cases through HMIS averages only 30-50% of facilities, severely limiting the ability to draw conclusions from these data. Data systems in the middle of scale-up, such as DRC's transition from national program data to DHIS, have limited coverage. Additionally, VL coverage is often limited to select ART centers, and reporting is not yet streamlined into routine ART reports in many countries.

Mitigation strategies: 1) Correct bias in data (e.g., VLS in Uganda) through imputation and outlier removal

Annex VII. Strength of evidence ranking

Key Findings								
CHAPTER 2								
Section 2.1 - Grant implementation along results chains								
Strategic Consideration: Consider monitoring absorption rates by module and disease to facilitate identification of intervention areas that are progressing slowly and ensure that absorption is viewed in combination with other performance indicators (proximal and distal) to provide a more detailed assessment of grant implementation progress.								
Across all PCE grants, most initial disbursements were made in a timely fashion between December 2017 and February 2018.	DRC	CAM	GTM	MOZ	MYN	SDN	SEN	UGA
Absorption of funds (and thus implementation of activities) was substantially lower than planned.	DRC	CAM	GTM	MOZ	MYN	SDN	SEN	UGA
Drivers of low absorption are numerous; several drivers were consistent among PCE countries.	DRC	GTM	MYN	SDN	SEN	UGA	CAM	MOZ
Although absorption of funds is one important measure of implementation progress, it is incomplete.	CAM	UGA						
Section 2.2 - How has the business model affected grant implementation?								
Strategic Consideration: Consider modification or differentiation of the three-year grant cycle and associated business model practices to smooth transition between grants, facilitate early grant implementation and enable adequate time for grant implementation, facilitating greater program impact.								
Multiple concurrent Global Fund processes underway at the beginning of the implementation period reduced PR staff time and attention from grant start up.	MYN	SDN	UGA	SEN				
Strategic Consideration: Update and strengthen guidance for CCMs and PRs on the selection and contracting of SRs to increasingly 'front load' PR/SR selection and contracting processes prior to grant implementation.								
Selection and contracting of SRs by PRs during the grant implementation period was a significant bottleneck to operationalizing activities, particularly those activities targeting strategic priorities.	CAM	DRC	SDN	SEN	UGA	MOZ	GTM	
Strategic Consideration: Consider embedding matching funds in the timeline for the design, approval and implementation of the main grants to facilitate timely implementation of activities.								
Misalignment of matching funds approval and disbursement processes contributed to grant implementation delays in DRC, Senegal and Uganda but not in Myanmar.	DRC	MYN	SEN	UGA				
Other Key Findings								
Global Fund Country Teams (CTs) played a positive enabling role in early grant implementation. Business model flexibilities supported grant transition and start up.	DRC	CAM	MYN	SDN	SEN	UGA		
The transfer of PRs, notably from international organizations to national ministries, represents an important shift towards strengthening country ownership and sustainability but created initial problems for some grants, which slowed grant implementation.	CAM	SDN	SEN					
CCMs played an active role during the funding request phase when stakeholder involvement was key, but their grant oversight role during implementation was mixed.	CAM	SDN	DRC	SEN	UGA			
Partnerships exist, built on comparative advantages related to expertise, leverage and capacity, but their role in identifying and addressing grant implementation weaknesses is less clear.	CAM	DRC	MYN	SDN	MOZ			

Program continuation did not always represent a continuation of a similar mix of interventions in the grant, with implications for financial and programmatic risk, and there is mixed evidence for whether the approach sped up implementation.	DRC	SDN	SEN	MOZ		
There was evidence of the operationalization of the Challenging Operating Environment (COE) policy principles through an innovative provincial approach to grant implementation in DRC.	DRC					
The Global Fund's approach to financial risk mitigation is viewed as effective at mitigating risk but results in tradeoffs for budget absorption and/or sustainability.	CAM	MYN	SDN			
Various Global Fund business model components have worked to influence grant design to strengthen the focus on Global Fund strategic priorities.	DRC	MYN	SDN	UGA		
CHAPTER 3						
Section 3.1 - Addressing human rights, gender, and key populations						
Strategic Consideration: The Secretariat and relevant partners should continue efforts to build in-country capacity and expertise on gender- and human rights-related issues, through multiple potential avenues, such as: developing clearer and more accessible guidance on human rights and gender programming and implementation (already underway by Secretariat/CRG); and ensuring TA is consistent with country needs and facilitating countries seeking TA for reducing gender- and human rights-related barriers (e.g. help the CCM to know that the mechanism exists and see the value in accessing TA to enable stronger more gender responsive planning, implementation, and monitoring).						
PCE countries have requested CRG technical assistance (TA) for human rights-related but not gender-related activities.	SEN	UGA				
Strategic Consideration: Country stakeholders and the Secretariat should encourage more explicit promotion of gender and human rights integration throughout the grant lifecycle, particularly for TB and malaria, including: determining the appropriate mechanisms for ensuring the that high-quality gender assessments are conducted (or integrated into other assessment practices); ensuring each CCM has a qualified gender expert engaged throughout the grant design and implementation process with the requirement that the gender expert is fully represented in all processes and decisions; expanding the requirements for addressing gender in funding requests and reporting, using clear guidance that is understandable for both country teams and reviewers; programming and grant design; and implementation.						
Overall, human rights-related grant activities are well represented in HIV grants but there is less focus in TB and malaria grants.	GTM	MOZ	MYN	SDN	SEN	DRC UGA
Strategic Consideration: The Secretariat should ensure that Global Fund-supported programs clearly define key and vulnerable populations, aligned with national epidemiological context and that programs are designed to allow for tracking of progress against key intervention areas (e.g. disaggregation of male/female/trans sex workers, youth, women who inject drugs).						
Generally, the Global Fund and country definitions of KVP groups broadly align. However, inconsistencies exist, particularly in relation to what groups constitute key and vulnerable population.	CAM	SDN	UGA	MYN		
Strategic Consideration: Country stakeholders should more explicitly articulate the gender-related vulnerabilities of men/boys, women/girls, transgender and gender non-conforming individuals, the impact of these on disease-specific outcomes, and specific strategies to mitigate these effects in funding requests and designing disease-specific strategies.						
Gender and human rights dimensions are not well understood or discussed among stakeholders, which caused delays in conceiving of, prioritizing and operationalizing initiatives in Myanmar, Sudan, Mozambique, and Cambodia.	CAM	MYN	MOZ	SDN	DRC	

Across PCE countries, a common finding was lack of clarity about specific interventions to address gender vulnerabilities related to the three diseases, including how such vulnerabilities might affect grant objectives, investments, or outcomes.	CAM	MYN	MOZ	SDN	DRC			
Strategic Consideration: CCMs should encourage multi-sector approaches and facilitate collaboration among PRs with legal, and other non-traditionally Global Fund stakeholders.								
An enabling factor in Cambodia, Myanmar, Senegal, Sudan, and Uganda was key stakeholder involvement during country dialogue, funding request and grant making, and implementation. However, lack of or slow engagement with specific stakeholders in DRC, Senegal and Uganda was a barrier.	MYN	DRC	SEN	UGA				
Other Key Findings								
SR contracting delays in Cambodia DRC, Mozambique, Senegal, and Uganda hindered launch of KVP-, human rights-, and gender-related interventions.	DRC	CAM	MOZ	SDN	SEN	UGA		
Irrespective of catalytic fund eligibility, key informants across PCE countries agreed that human rights, gender and key population allocations are insufficient.	DRC	MOZ						
Section 3.2 - Building resilient and sustainable systems for health								
Strategic Consideration: During the funding request development, consider mechanisms to incentivize stronger alignment of crosscutting RSSH investments to the longer-term national strategies for health system strengthening, rather than addressing shorter-term, disease-specific health system gaps.								
Many RSSH investments are considered shorter-term gap investments rather than longer-term investments in more sustainable health system strengthening needs.	CAM	UGA	MYN	SDN	MOZ			
Strategic Consideration: Improve monitoring and measurement of the outcomes of RSSH investments, for example: clear articulation of expected RSSH outcomes, which can be translated into investment guidance, the modular framework and grant performance framework where relevant; stronger alignment of grant activities to indicators; consideration (and development of) community systems and responses indicator(s) in the modular framework.								
Among funding requests with RSSH investments, coverage indicators predominantly align with the HMIS/M&E module, missing an opportunity for monitoring other key RSSH priorities.	DRC	CAM	MOZ	MYN	SDN	UGA	GTM	SEN
Strategic Consideration: Improve standardization for categorization of RSSH investments within grant budgets to ensure accurate quantification of Global Fund contributions toward RSSH, including whether simplification is feasible or increased guidance and examples are necessary.								
Inconsistent categorization of RSSH inputs pose challenges to quantifying the Global Fund's overall RSSH investment.	GTM	MYN	UGA	DRC				
Other Key Findings								
Increased prioritization of RSSH at the global level does not appear supported by increased RSSH investment at the country level.	DRC	CAM	MOZ	SDN	UGA	GTM	MYN	SEN
RSSH investments were largely concentrated in three modules: HMIS/M&E, HRH, and PSM.	DRC	CAM	GTM	MOZ	MYN	SDN	SEN	UGA
Absorption across RSSH modules during Q1-Q2 2018 was generally very low, in part due to the factors hindering implementation progress more generally.	DRC	GTM	MOZ	SDN	SEN	UGA	CAM	MYN
Section 3.3 - Sustainability, transition, and co-financing								
Strategic Consideration: The Global Fund Secretariat should consider restructuring the country co-financing requirement to more ambitiously increase domestic expenditure on health and the three diseases, with a view to ensuring that domestic financing increases to a level that more fully supports transition and sustainability objectives. Specifically, this might involve: expanding upon the co-financing requirement to better reflect the government's existing financial								

commitments overall and within the wider health financing landscape, e.g. by setting the co-financing requirement based on more parameters than the current two (progress towards 8% of general government expenditure on health, and the allocation amount); increasing the minimum level of co-financing that is acceptable to the Global Fund; and strengthening the incentive for countries to increase domestic expenditure on health and the three diseases beyond the minimum acceptable level of co-financing.								
All governments have made commitments to meet or exceed Global Fund co-financing requirements, with an increased trend towards supporting commodity costs.	DRC	CAM	GTM	MOZ	MYN	SDN	UGA	SEN
Even when countries meet co-financing requirements, PCE countries remain heavily reliant on donor resources to finance the disease programs, posing a critical threat to transition readiness and programmatic and financial sustainability.	DRC	CAM	MOZ	MYN	SDN	SEN	UGA	GTM
In most countries, external stakeholders, such as CSOs, advocates, and evaluators, have not been able to verify whether co-financing commitments have been fulfilled.	CAM	MYN	SDN	DRC	GTM	SEN	UGA	
Other Key Findings								
There is evidence of countries embedding sustainability and transition considerations into program design and implementation.	DRC	GTM	MOZ	SEN	UGA	CAM	MYN	SDN
Section 3.4 - Value for Money								
Strategic Consideration: The Secretariat should expedite work to collect unit/service delivery costs at the country level and use this as a basis for budgeting, with clear guidance on appropriate formulae to inflate estimates to allow for inflation, price changes, currency shifts, etc.								
Strategic Consideration: The Secretariat should consider ways to strengthen country-level and/or grant-specific analysis of VfM (while considering the burden of reporting), such as by: Collecting and analysing grant-specific output data for some indicators; Extending reporting tools to collect sub-national data; Creating performance targets that better address equity considerations; Requesting that PRs/countries report against quantitative trends for some indicators as proxies for efficiency and effectiveness, with qualitative explanations of what the trends represent, and how and why the observed trends occurred.								
Economy								
Initial analysis of price and quality reporting (PQR) data in PCE countries suggests that economy has improved over time, with prices paid for most health commodities decreasing and, in many cases, declining below the global reference price.	DRC	CAM	GTM	MOZ	MYN	SDN	SEN	UGA
There are some other instances where changes to procurement arrangements have affected economy and/or efficiency.	CAM	MYN	DRC	GTM	MOZ	SDN		
There is evidence to suggest that the unit costs used as a basis for budgeting do not closely reflect the actual cost of inputs, posing a risk to both the economy and efficiency of Global Fund support.	GTM	CAM	MYN					
Efficiency								
Misalignment between the Global Fund's financial and programmatic reporting tools hampers efficient portfolio management and analysis/measurement of VfM.	DRC	CAM	GTM	MOZ	MYN	SDN	SEN	UGA
There is evidence across countries of stakeholders making efforts to improve grant efficiency, defined as maximizing outputs for a given level of input, particularly in countries facing significant reductions in program budget allocations.	CAM	DRC	GTM	MYN	SDN	SEN	UGA	
Program management costs vary significantly across countries and by type of PR, with significantly higher costs for UN agencies and CSOs than for governments.	DRC	CAM	GTM	MOZ	MYN	SDN	SEN	UGA

There is evidence of stakeholders making changes to program design arrangements to improve efficiency, particularly in countries facing significant reductions in budget allocations.	DRC	CAM	MOZ	MYN	SDN	SEN		
Our initial analysis suggests that the efficiency of malaria programming is improving.	DRC	UGA						
Effectiveness								
Cost-effectiveness considerations appear to be incorporated into program design and decision making in most settings (such as through modeling) but not in a systematic manner, with implications for efficiency, effectiveness and equity.	CAM	MYN	GTM	SDN	DRC	MOZ	SEN	UGA
Equity								
More could be done to ensure that Global Fund-supported activities (and the benefits of these activities) are fairly distributed amongst target recipients.	DRC	GTM	MYN	SDN	CAM	MOZ	SEN	UGA
There is some evidence to suggest that the Global Fund target setting vis-à-vis available resources has been counterproductive to the prioritization of hard-to-reach areas.	MYN	SDN						
Although there are some examples of Global Fund support being used to reduce financial barriers to services, significant barriers to accessing HIV, TB and malaria are still experienced in some countries.	MYN	CAM	SEN	UGA				