

# **Technical Review Panel Observations Report**

Grant Cycle 7  
Windows 1 and 2

October 2023

# Table of Contents

---

<b>1. Executive Summary</b>	<b>4</b>
1.1 Purpose of the report and TRP lessons learned approach	4
1.2 Overview of the TRP GC7 review windows 1 and 2	4
1.3 TRP funding request quality assessments	6
1.4 Issues and actions raised by the Technical Review Panel	8
1.5 Key cross-cutting TRP observations from window 1 and window 2 funding requests	8
1.5.1 Most applicants faced significant prioritization challenges	10
1.5.2 Need for greater focus on collaboration among partners at country level	13
1.5.3 Variable progress on sustainability and examples of social (public) contracting	14

---

<b>2. Overall Contribution of Funding Requests to the Goal of Ending AIDS, Tuberculosis and Malaria</b>	<b>15</b>
2.1 TRP observations on HIV funding requests	15
2.1.1 HIV prevention	15
2.1.2 Diagnosis, treatment, and care	17
2.1.3 Advocacy for and promotion of legislative, practice, program, and policy changes	19
2.2 TRP observations on the TB funding requests	22
2.2.1 Find and treat all people with drug-susceptible-tuberculosis (DS-TB) and drug-resistant-tuberculosis (DR-TB)	22
2.2.2 Scale up TB prevention	23
2.2.3 Improving the quality of TB services across the TB care cascade	23
2.2.4 Deploying new tools to address gaps in continuum of care	24
2.2.5 Advocacy for and promotion of legislative, practice, program, and policy changes	25
2.3 TRP observations on malaria funding requests	28
2.3.1 Vector control coverage	28
2.3.2 Equitable access to quality, early diagnosis, and treatment	28
2.3.3 Implement interventions, tailored at sub-national level	29
2.3.4 Drive toward elimination	30
2.3.5 Accelerate malaria reduction in high-burden areas and achieve sub-regional elimination in select areas of sub-Saharan Africa	30

---

2.3.6	Strategically implement special interventions and balance these against core interventions	30
2.3.7	Need to review underlying allocation criteria in view of 20 years of changing situation on the ground	31
<hr/>		
<b>3.</b>	<b>Overall Contributions of Funding Requests to the 2023-2028 Global Fund Strategy Mutually Reinforcing Contributory and Evolving Objectives</b>	<b>33</b>
<b>3.1</b>	<b>Maximizing people-centered integrated systems for health to delivery impact, resilience and sustainability</b>	<b>33</b>
3.1.1	People-centered Integrated Health Services	34
3.1.2	Community systems and community-led programming	36
3.1.3	Strengthen generation and use of quality, timely, transparent, and disaggregated digital and secure data at all levels	37
3.1.4	Strengthen the ecosystem of quality supply chains	38
3.1.5	NextGen market shaping focus on equitable access to quality health products	38
3.1.6	Better engage and harness the private sector	39
3.1.7	Deepen partnerships between governments and non-public sector actors including public (social) contracting	40
<b>3.2</b>	<b>Maximizing the engagement and leadership of most affected communities to leave no one behind</b>	<b>43</b>
<b>3.3</b>	<b>Maximizing health equity, gender and human rights</b>	<b>47</b>
3.3.1	Scale up comprehensive programs and approaches to remove human rights and gender-related barriers across the portfolio	48
3.3.2	Deploy quantitative and qualitative data to identify drivers of HIV, TB and malaria inequity and inform targeted responses, including by gender, age, geography, income and for KVP	49
3.3.3	Leverage the Global Fund's diplomatic voice to challenge laws, policies and practices that limit impact on HIV, TB and malaria	50
<b>3.4.</b>	<b>Mobilizing increased resources</b>	<b>51</b>
3.4.1	Catalyze domestic resources for health	51
3.4.2	Strengthen focus on value-for-money to enhance economy, efficiency, effectiveness, equity and sustainability	53
3.4.3	Leverage blended finance and debt swaps	54
3.4.4	Support country health financing systems	55
<hr/>		

# 1. Executive Summary

The first two Grant Cycle 7 (GC7) Technical Review Panel (TRP) review meetings were held in Geneva - window 1 from 29 April to 5 May and window 2 from 3 to 14 July 2023. These were the first in-person TRP review meetings since 2018. TRP Leadership invited 48 and 71 members to participate in window 1 and window 2 respectively from a newly refreshed pool of 162 diverse members covering five TRP expertise areas (1) HIV; (2) tuberculosis (TB); (3) malaria; (4) efficient and sustainable systems for health (ESSH) which includes resilient and sustainable systems for health (RSSH), health financing and pandemic preparedness and response; and (5) equity, human rights and gender (EHRG) expertise areas.

## 1.1 Purpose of the report and TRP lessons learned approach

This report fulfils the TRP's mandate to report its lessons learned to the Board, Strategy Committee, Applicants, the Global Fund Secretariat and Technical Partners to inform strategy, policy, and operations of the Global Fund. The report was developed by a working group comprising 9 TRP members (1 representative each from HIV, TB, Malaria and EHRG and 2 from the ESSH expert groups; and TRP Chair and Vice Chair) with support from the TRP Secretariat. The primary source of evidence for this report is the documented TRP outcomes from the window 1 and window 2 funding requests. The working group collated and analyzed key and cross-cutting observations from the TRP Review and Recommendations forms as well as results from the Funding Request Quality Survey. The working group also considered additional information from TRP member reviews of COVID-19 Response Mechanism (C19RM) Portfolio Optimization Wave 2 grant applications as well as secondary data analysis of window 1 and window 2 funding requests<sup>1</sup> provided by the Global Fund Secretariat.

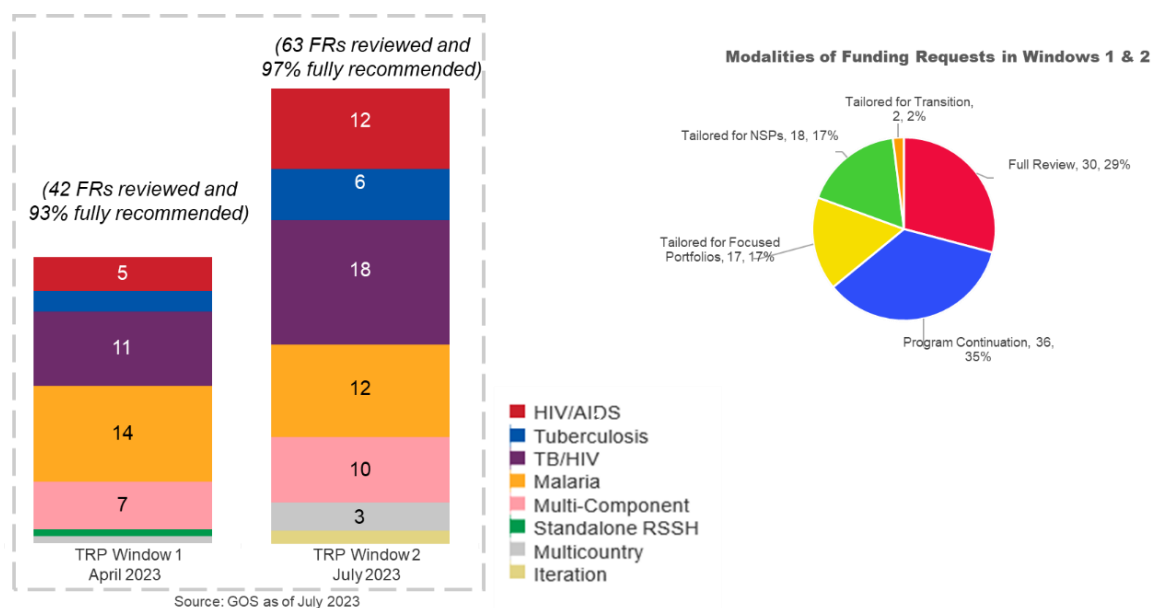
## 1.2 Overview of the TRP GC7 review windows 1 and 2

Approximately 200 funding requests are expected to be reviewed by the TRP in the 2023-2025 allocation period (GC7). During GC7 window 1 and window 2, the TRP reviewed 105 funding requests and recommended a total of US\$9.68 billion in allocation funds for grant-making representing 73.8% of GC7 allocated funds. A total of US\$5 billion in Prioritized Above Allocation Requests (PAAR) was recommended to be registered as unfunded quality demand. Thirty-nine (93%) out of 42 funding requests in window 1 were fully recommended for grant-making. Sixty-one (97%) out of 63 window 2 funding requests were fully

---

<sup>1</sup> Note that Funding Request data used in this report (including from budgets, performance frameworks, etc.) captures the initial submission from applicants. Budgets and Performance Framework activities and targets evolve during grant-making negotiations, often because of TRP recommendations.

recommended for grant-making – 1 funding request was iterated, and 1 integrated funding request was split in two due to 1 iterated component.



The following tables summarize the funding outcomes of window 1 and window 2 TRP reviews specifically showing allocation and catalytic matching funds and multicountry amounts that were recommended for grant-making.

Source of funding	Window 1 Recommended Amount (US\$)	% total GC7 communicated amount	Window 2 Recommended Amount (US\$)	% total GC7 communicated amount
Allocation	4,906,353,063	37%	4,776,379,165	36%
Matching Funds	98,250,000	36%	104,700,000	38%
Catalytic Multicountry	50,000,000	44%	N/A	N/A
<b>Total</b>	<b>5,054,603,063</b>		<b>4,881,079,165</b>	

Matching Funds Priority area	Window 1 Recommended Amount (US\$)	% of Matching Fund priority area	Window 2 Recommended Amount (US\$)	% of Matching Fund priority area
HIV Prevention	17,800,000	36%	15,750,000	32%
TB: Find & successfully treat the missing people with DS-TB and DR-TB	34,000,000	41%	32,000,000	39%
Incentivizing RSSH quality and scale	24,000,000	34%	30,200,000	43%
Effective community systems & responses	12,000,000	28%	14,600,000	34%
Scaling up programs to remove human rights and gender related barriers	10,450,000	33%	12,150,000	39%
<b>Total</b>	<b>98,250,000</b>		<b>104,700,000</b>	

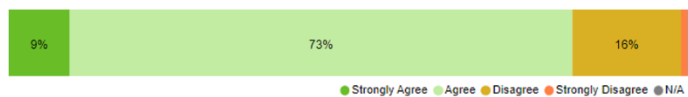
### 1.3 TRP funding request quality assessments

The TRP does not expect any funding request to be perfect but as part of its independent and differentiated review, the TRP assesses the quality of funding requests. The TRP recommended 93% of window 1 and 97% of window 2 funding requests for grant-making, assessing them on delivering strategically focused and technically sound responses that are aligned with the epidemiological context and maximize potential for impact. While the TRP has seen notable improvement in quality of funding requests over time, it is evident that some applicants still struggle, mostly likely due to limited capacity and/or suboptimal technical assistance. This is not only concerning sustainable capacity to develop good quality funding requests but more importantly quality program delivery.

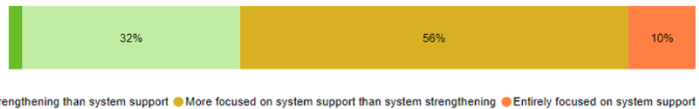
Although focus is still more on system support, the TRP observed strategic focus on RSSH in 85% of window 2 funding requests recommended for grant-making, 8 points higher than in window 1 and 14 points higher than GC6 allocation period. Among funding requests which included investments in pandemic preparedness, the TRP saw that appropriate investments were being made (77% positive over both windows) and that these investments complemented C19RM (76% over both windows).

#### TRP funding request quality survey: RSSH

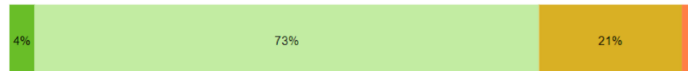
**Focus on RSSH:** The funding request demonstrates a strategic focus on resilient and sustainable systems for health to improve effectiveness, efficiency and sustainability of the disease program(s).



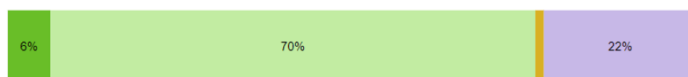
**Focus on RSSH:** To what extent does the funding request demonstrate focus on systems strengthening or systems support.  
Source: TRP funding request quality survey. W1 & W2 funding requests fully recommended for grantmaking, N=101, Charts rounded



**Pandemic Preparedness:** The funding request demonstrates appropriate investments to strengthen pandemic preparedness and response.



**Pandemic Preparedness:** The funding request investments in Pandemic Preparedness and Response are complementary to COVID19 Response Mechanism investments.

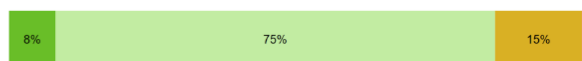


Source: TRP funding request quality survey. W1 & W2 funding requests fully recommended for grantmaking, excluding N/A responses, N=82, Charts rounded

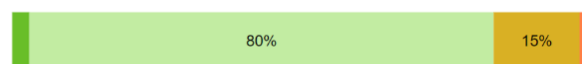
The TRP observed substantive improvements in how funding requests addressed sustainability (87% positive in window 2 compared to 79% in window 1); value for money (89% positive in window 2, 77% in window 1), and co-financing (73% in window 2, 64% in window 1). This is a significant shift from GC6 when this question integrated sustainability and co-financing and only had a 67% positive rating. The score on community systems and responses was lower in window 2 than window 1 but still broadly positive (75% in window 2, 87% in window 1).

## TRP funding request quality survey: Sustainability

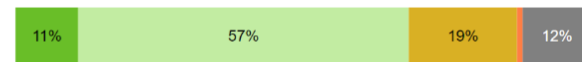
**Sustainability:** The funding request adequately identifies and addresses challenges to sustainability (in line with the TRP Review Criteria).



**Value for Money (VfM):** The funding request invests in increasing program quality, addresses key bottlenecks to program efficiency, strives for economy in provision of program inputs, and addresses equity issues in health services utilization.

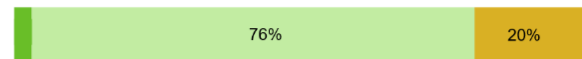


**Co-financing:** The focus of the co-financing commitments as described in the funding request are appropriate for the country income-level and diseases profiles, and address key challenges to sustainability of program outcomes.



● Strongly Agree ● Agree ● Disagree ● Strongly Disagree ● N/A

**Community Systems & Responses:** To what extent are the roles of community-led and -based organizations in service delivery articulated in the funding request?



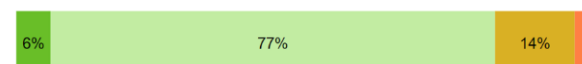
Source: TRP funding request quality survey. W1 & W2 funding requests recommended for grantmaking, N=101, Charts rounded

■ Well-articulated ■ Poorly articulated ■ Not articulated

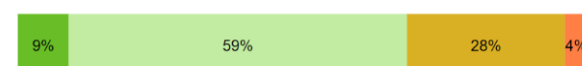
The TRP also saw strong positive movement on equity in window 2 funding requests (87% positive in window 2, 77% in window 1). Scores on gender (69% in window 2, 69% in window 1, 58% in GC6) and human rights (67% in window 2, 64% in window 1, 66% in GC6) were relatively consistent compared to window 1, but gender has made progress since GC6. It should also be noted that the TRP commenced Gender Equality Marker (GEM) assessments on all funding requests in GC7. The analysis of the TRP assessments is being conducted by the Global Fund Secretariat as they lead the GEM process.

## TRP funding request quality survey: Equity, gender and human rights

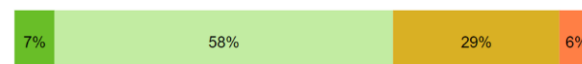
**Focus on Equity:** The funding request demonstrates investment in equitable health outcomes with proposals to address structural barriers and improve access.



**Focus on Gender:** The funding request maximizes gender equality by considering and addressing gender inequalities and gender-related barriers that impact on health outcomes.



**Focus on Human Rights:** The funding request ensures that human rights-related barriers to accessing services are adequately analyzed and addressed to achieve the set targets.

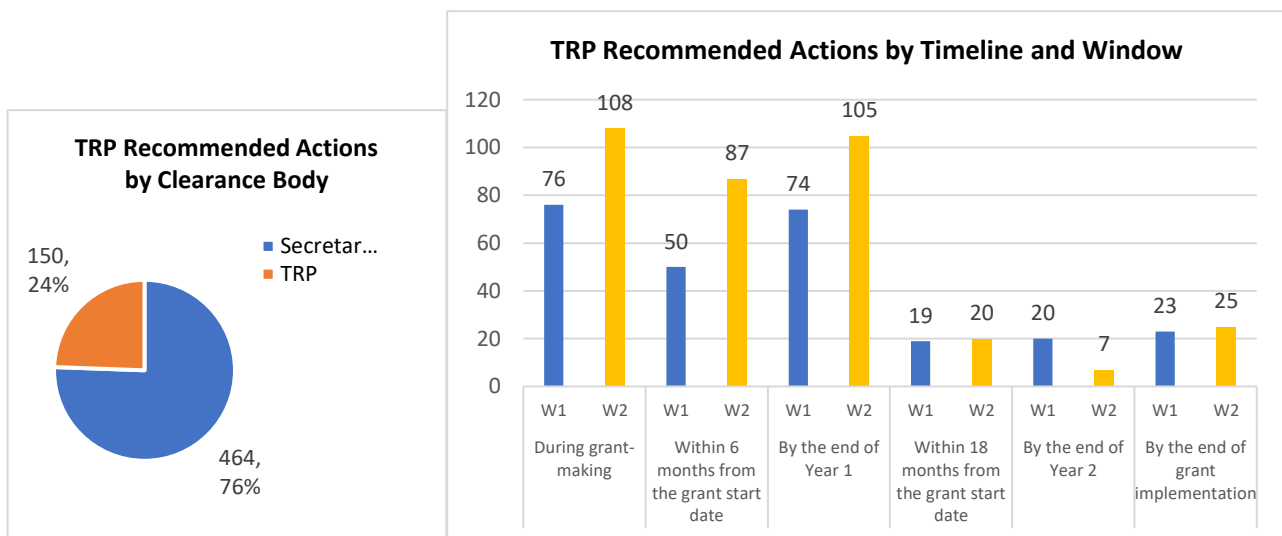


● Strongly Agree ● Agree ● Disagree ● Strongly Disagree

Source: TRP funding request quality survey. W1 & W2 funding requests recommended for grantmaking, N=101

## 1.4 Issues and actions raised by the Technical Review Panel

While the TRP, in line with its [Review Approaches Manual](#), takes a differentiated approach to the recommended maximum number of main issues to be addressed by the applicants for each of the funding modalities, the number of these issues is a proxy of quality of funding requests. Noting that the TRP review is only one part of the process for applicants to access funding, attention to and addressing TRP issues, actions and recommendations is an important lever to ensure that grant investments translate to impact. During GC6, the TRP Secretariat made significant improvements to its processes of tracking TRP recommendations. Over time the TRP increasingly assigns more issues and actions to be cleared by the Secretariat instead of coming back for TRP clearance. The timing of clearance of issues can also ensure course correction during grant-making or early in implementation. For window 1 funding requests, 29% of actions should be cleared during grant-making, 19% within the first six months of implementation and 28% by end of year 1 (76% total) – thereby giving opportunity for course correction. This tracks well with window 2, where 31% of actions should be cleared during grant-making, 25% of actions were assigned to be cleared within the first 6 months of implementation, and 30% should be cleared by the end of year 1 of implementation (86% total).



## 1.5 Key cross-cutting TRP observations from window 1 and window 2 funding requests

The TRP congratulates applicants for strong funding requests which demonstrated a deliberate use of a range of national data to guide selection of interventions as well as an improved differentiation, especially within focused portfolios.

- For HIV specifically, there was an increased recognition of more key populations and more intersectionality with, for example, the inclusion of trans and gender diverse



people, women prisoners who inject drugs, etc. In addition, there was better prioritization and budgeting of advanced HIV disease in window 2 after noting limited prioritization in window 1 funding requests.

- With respect to TB, the TRP saw the optimization of new diagnostic tools, including molecular WHO-recommended rapid diagnostics (WRD), chest x-rays and computer-aided detection (CAD); as well as the use of routine data, supplemented by research, to optimize programming.
- By window 2, malaria funding requests increasingly demonstrated use of data for risk stratification, prioritization and targeting of interventions. Furthermore, the TRP saw an increased number of gender and Malaria matchbox assessments conducted with some funding requests using these assessments to guide interventions. It also noted greater recognition of punitive legal environments as impacting access to services.
- More funding requests showed an increase in quantity and quality of RSSH investments, compared to GC6. Furthermore, RSSH investments were consistently synergistic with and complementary to C19RM investments; even when not a Global Fund RSSH “priority” country.
- Funding requests showed increasing focus on integration. Notably, the new RSSH Gaps and Priorities Annex promises to be an effective tool to bolster integrated people-centered services if used adeptly across all disease programs (instead of vertically) and with unifying Ministry of Health (MOH) stewardship.
- Furthermore, integrated funding requests or multiple funding requests from same country coming to the same TRP review window promoted integration and improved the TRP’s visibility of health system gaps and missed opportunities for integration.
- The TRP has observed commendable instances of integration in areas such as lab optimization, the involvement of community health workers (CHWs), community-led monitoring, health information and health product management systems, including the intersection of human rights and gender considerations across the three diseases.
- Despite these improvements, more integration of HIV, TB, and malaria programs with reproductive, maternal, neonatal, child and adolescent health (RMNCAH), sexual and reproductive health (SRH), and Primary Health Care (PHC) services is required.
- The TRP also noted missed opportunities for aligning CHW with the broader human resources for health (HRH) policies and budgets as CHWs continue to be treated as gap-filling at PHC level.

### **Recommendations to Applicants on cross-cutting issues**

1. In the pursuit of people-centered services, it is imperative to allocate resources for community systems strengthening components (such as community-led monitoring) driven by local communities themselves.
2. Continue presenting integrated funding requests. In cases where an applicant is developing multiple funding requests, it is recommended that these be submitted in the same window.
3. Integration in the funding request should transition into implementation, to be overseen by Country Coordinating Mechanisms (CCMs). Close collaboration between the CCMs and the MoH, other relevant Ministries, and stakeholders, including local communities is critical to develop and sustain integration opportunities.

4. Adapt CHW programming in line with the [WHO Primary Health Care Operational Framework](#), and other normative guidance, prioritize integrated training, and supportive supervision where applicable, and provide necessary commodities and ensure a stronger gender lens and safer working conditions.
5. Conduct mapping of CHWs across all programs and funding sources including C19RM, harmonize CHW remuneration and progressively assimilate CHWs into primary health care systems and government payroll.
6. Safer programming should consider risks of gender-based violence (GBV) and insecurity for female CHWs.

### **Recommendations to the Secretariat & Partners on cross-cutting issues**

1. To encourage integration within country programs, meaningful harmonization and coordination is needed. In addition, applicants need further guidance on (i) what to integrate, (ii) where to integrate, and (iii) why (with a focus on outcomes noting integration is not an end in itself).

#### **1.5.1 Most applicants faced significant prioritization challenges**

Going into GC7 it was clear that countries would face some of the most challenging and difficult decisions in a context with severely limited fiscal space. This challenge was apparent in the TRP window 1 and window 2 reviews.

- The TRP acknowledges the tremendous efforts made by applicants to manage trade-offs and the Secretariat and Technical Partners for the many tools that were introduced in GC7 to help countries with prioritization. However, the TRP observed the need to review and streamline some of the tools, provide more clarity to applicants and manage expectations in funding requests since the Global Fund allocations cannot cover all country needs.
- The TRP observed that allocation budgets tend to be spread thinly or in some cases essential life-saving commodities were frontloaded in the first two years leaving huge unfunded gaps in year 3 of grant implementation. TRP also observed an alarming trend of critical interventions being relegated to unfunded quality demand (UQD), with some PAAR amounts exceeding double or more the size of allocation funding.
- The TRP further observed persistent gaps in availability, quality, and use of data to inform prioritization decisions. Disaggregated data encompassing gender, age, sub-populations, geography, and key populations are frequently absent or underutilized. In some instances, Human Rights & Gender assessments were either poorly reflected in funding requests, or not used at all. Equity, human rights, and gender investments are commonly placed in PAAR.
- The TRP remains concerned about high management costs which at times concealed expenses within other intervention budgets - even in funding requests with critically constrained allocation funding.
- As window 1 and window 2 funding requests move into grant-making, the challenge will be how to fill gaps in allocation funding, which is compounded by rising program

delivery and management costs and a huge UQD. The TRP challenged many applicants and the Secretariat, to not only find efficiencies in grants, but to step up domestic resource mobilization efforts, honor co-financing commitments and leverage all in-country investments in health and other sectors.

- While some window 1 and window 2 funding requests mentioned increased natural disasters and climate change, the TRP recognizes the need for funding requests to better reflect and address how country programs will address the impact of climate change on health.

In addition to prioritization pressures on allocation funding, the TRP observed that many applicants were either over or under ambitious in their programming.

*Examples of too little ambition included:*

- Scale-up of pre-exposure prophylaxis (PrEP) was often confined to specific demographics or urban areas and limited introduction of innovative tools such as Dapivirine-Ring and long-acting cabotegravir (CAB-LA). The HIV cascade for children encounters suboptimal performance, warranting further attention.
- TB targets set for treatment coverage, detection of drug-resistant (DR)-TB, child TB case identification, TB preventive treatment (TPT), and the establishment of decentralized services for both child TB and DR-TB are often not ambitious enough.

*Examples of unrealistic ambition included:*

- Inappropriate prioritization and sequencing of new tools before addressing essentials such as managing advanced HIV disease, retaining people on treatment in settings that for instance, still struggle with poor HIV cascades. Some countries are proposing scale-up of CAB-LA, yet these efforts are being pursued without robustly structured HIV prevention programs.
- While adopting ambitious approaches to laboratory strategies, the TRP noted a gap in domestic funding of or attention to lab infrastructure, acquiring essential equipment, and enhancing the human resources capacity beyond the life of the grants.
- In some malaria funding requests, there were ambitious targets for intermittent preventive treatment of malaria for pregnant women (IPTp-3) without adequate attention to low antenatal care coverage.
- There was a mismatch between country ambition to adopt new tools and readiness to use them (e.g., proposal includes deployment of digital X-rays with computer-aided detection (CAD) in mobile vans, but no internet for artificial intelligence).
- Applicants tended to incorporate Global Fund strategy language /vocabulary/ terminology (particularly in relation to gender, human rights and community) within funding requests but there were significant gaps in prioritization in allocation budgets and the capacity to effectively realize these objectives.

## **Recommendations to Applicants on prioritization**

1. Target interventions to priority and underserved populations considering geographic focus and disaggregated data including, but not limited to, key populations, age, and gender. When there are data gaps, qualitative insights from EHRG assessments can provide valuable context.
2. Utilize malaria risk stratification and/or available data to guide prioritization and sub-national tailoring of interventions to maximize coverage and impact.
3. In generalized HIV epidemics, even in the absence of precise key population data, informed models and existing data can effectively guide the national HIV response.
4. Funding requests should include assessments of needs and barriers faced by key and vulnerable populations and corresponding recommendations to plan integrated, people-centered TB services.
5. Funding requests should be rooted in the priorities and needs of individual countries, rather than “ticking-boxes” and thinly peppering funding requests with activities to implement ALL Global Fund Program Essentials, at the expense of strategic prioritization within the allocation amount. Applicants should explain the rationale for their decisions on trade-offs to maximize VfM.
6. Access to treatment is a human right and ethical commitment which must be prioritized within allocation funding and, increasingly, government funding rather than relying on PAAR.
7. Avoid excessive program management costs and redirect resources for higher programmatic efficiency, yielding tangible results.
8. While encouraging ambition, the TRP advises applicants to be realistic and more data driven when setting targets in the funding requests, including by (i) ensuring accurate gap analysis, (ii) setting the right expectation about what Global Fund allocations can achieve, (iii) matching Performance Framework targets with what is achievable.
9. Prioritize and sustain core services when planning for new interventions (maintain Prevention Mother to Child Transmission (PMTCT), condoms, linkage to treatment and care from community-based active case finding, etc.).
10. Plan for readiness to adopt new tools considering country context and health system capacity

## **Recommendations to Technical Partners on prioritization**

1. Strengthen consultants that support applicants to develop funding requests ensuring fundamentals are adequately prioritized, costed and planned.
2. Assist applicants to manage trade-offs and more rigorously focus resources on appropriately tailored interventions in line with country context and normative guidance. This will require a Whole-of-Global Fund Partnership approach working with other Global Health Institutions in a transparent and meaningful manner.
3. Update guidelines on what to do when burden and needs are increasing against the backdrop of diminishing resources and share useful tools to help applicants avoid funding being thinly spread (not just say “prioritize”).

## Recommendations to the Secretariat on prioritization

4. Review intended vs. actual role of Program Essentials in country dialogues on funding requests and provide guidance to applicants on how Program Essentials should be used within country context and complementing, but not replacing global normative guidance, national strategic plans, programs, and the need for prioritization.
5. The TRP appreciates the "[Decision-Making Aide for Investments into HIV Prevention among Adolescent Girls and Young Women](#)" (Global HIV Prevention Coalition & UNAIDS, April 2023) which is a useful prioritization tool and recommends that this is shared with future applicants.

### 1.5.2 Need for greater focus on collaboration among partners at country level

The TRP observed funding requests with shortcomings in partnership and collaboration at the country level, resulting in potential sub-optimal impact of programs.

- In some countries, national leadership (e.g., Ministry of Health) is not coordinating in-country partners effectively, leaving for example a fragmented support to national program implementation, inconsistent levels of salary for health workers, uncoordinated supply systems, and some parts of the country covered while others not.
- Furthermore, while the Global Fund acknowledges the importance of inclusive partnership, encompassing the full range of donors, civil society, and private sector, evidence in the funding requests suggests further improvement in country dialogues and CCMs is required to center community-led and key population organizations in program design, planning and implementation.
- In addition, the TRP's review of impact of Global Fund investment was often limited by an inadequate or insufficient description of activities and investments of external and domestic resources as documented in the funding landscape tables, programmatic gap tables and the RSSH Gaps and Priorities Annex.
- Finally, private sector engagement in several funding requests was noted to remain sub-optimal with inconsistent mapping of private sector activities (usually disease focused). The TRP noted ambition to leverage private sector for domestic resource mobilization for long-term sustainability but a lack of concrete action/plans.

## Recommendations to Applicants on collaboration among partners

1. Within the context of Global Funds investments, CCMs should support MoH to take a greater role in coordination of the full range of partners and ensure stewardship of national programs. To fulfil this coordination role CCMs and MoH are advised to maintain an up-to-date mapping of health donors and supported activities.
2. CCMs should continue to meaningfully engage with the full range of communities and community-led organizations and ensure investment in and utilization of community-led monitoring and community system strengthening interventions.

3. Future applicants in GC7 are requested to provide a complete picture of investments and activities of in-country partners in existing annexes to funding requests.

### **Recommendations to the Secretariat and Partners on collaboration among partners**

1. In-country partners to help build the governance and stewardship capacity of MoH and other national institutions to support, guide, and engage with private sector, donors, civil society, and other actors. They should also organize and support platforms that facilitate this collaboration.

### **1.5.3 Variable progress on sustainability and examples of social (public) contracting**

The TRP welcomed a greater focus on programmatic and financial sustainability in funding requests. Funding requests also demonstrated greater reflection of the role of communities through a deliberate introduction of social (public) contracting. However, in some cases there were still ongoing challenges in enabling the legal structure for public contracting. In addition, despite overall financing challenges, TRP was encouraged by examples of increasing domestic financing across countries at different points in the development continuum, including in Challenging Operating Environments (COEs) (e.g., picking up a greater share of commodity costs). Finally, the TRP noted promising examples of innovative financing agreements to complement Global Fund financing – e.g., synergies with multilateral investments, virtual pooling.

On the other hand, the TRP observed sustainability concerns, e.g., when public sector and CHW remuneration was included in funding requests with no transition plan to domestic funding. Furthermore, in some funding requests there was a lack of reliable information on domestic health expenditure (i.e., resource tracking) and inadequate planning for financial sustainability. The TRP also saw evidence of community system strengthening investments, while structural and legal, human rights and regulatory barriers remained unaddressed.

### **Recommendations to Applicants and Secretariat on sustainability**

1. Applicants to improve visibility of financial sustainability through better coordination at the country level and closer tracking of health expenditures and domestic financing for HIV, TB, and malaria.
2. TRP advises the Secretariat to be increasingly strict in approving salaries and top-ups in grants. While ensuring that community health workers are adequately remunerated, the Secretariat should require a timebound agreement on how these salaries will be transitioned into national budgets (directly by government or through public contracting).

3. The Global Fund Board and Secretariat should continue to use their diplomatic voice to engage with Governments where hostile environments are a barrier to effective health programming, in respect of human rights and civil society space.

## **2. Overall Contribution of Funding Requests to the Goal of Ending AIDS, Tuberculosis and Malaria**

### **2.1 TRP observations on HIV funding requests**

Overall, the TRP notes significant improvement in HIV proposed programming with countries adopting the UNAIDS targets of 95-95-95. A significant number of countries with generalized epidemics showed improving cascades and there was increasingly greater focus on key populations in concentrated epidemics. The TRP observed increased attention to prevention and an enhanced precision and focus on Adolescent Girls and Young Women (AGYW) and key and priority populations programming in allocation funding.

Most HIV funding requests presented strong testing and treatment programs, well aligned with WHO/UN guidance, and several included innovations such as self-testing, virtual consultations – often leveraging opportunities created by the COVID-19 pandemic, scale up of combined prevention components and differentiated service delivery approaches. However, the TRP was concerned by suboptimal use of available data and information in the rationale of funding request investments. Applicants struggled with prioritization within the context of limited HIV allocation amounts and constrained domestic fiscal space. Consequently, there were gaps in the extent to which funding requests met the growing antiretroviral therapy (ART) and comorbidities needs – due to increased longevity.

#### **2.1.1 HIV prevention**

The Global Fund first key strategic shift in its 2023-2028 strategy is intensified focus on prevention. TRP observed larger investments requested for HIV prevention compared to the previous allocation cycle. HIV prevention modules account for approximately US\$730 million or 20% out of US\$3.6 billion in allocation funding in HIV modules in GC7 window 1 and window 2. Still, significant elements of HIV prevention, including for PrEP scale up, prevention among key populations, were found in PAAR including in Core and High Impact countries. TRP has a limited visibility of domestic investments in prevention to assess if the increased Global Fund's investments in prevention are matched by increasing domestic resources because of incomplete prevention gap tables and limited funding landscape analysis.

**Pre-Exposure Prophylaxis:** The TRP observed a greater focus on PrEP though with various levels of ambition. While GC7 is the second grant cycle with more consistent PrEP opportunities for applicants, scale and pace of implementation are often limited for impact. Among 60 funding requests with an HIV component, 43 applicants specifically included PrEP medications, and only 6 funding requests planned for Long-Acting Cabotegravir (CAB-LA) while 7 foresee procuring the Dapivirine ring with the Global Fund support. Even among those with new options for PrEP, the number of units and budgets were highly limited. TRP had no visibility to PrEP plans within national budgets. The TRP also observed major gaps in planning PrEP programming, including a lack of data-driven rationale for targets, missing demand creation among key populations, offering to some key populations and geographies but not others, age eligibility of 18 years in countries with high incidence among adolescents and young people, and no strategies to reach pregnant and breastfeeding women among vulnerable and key populations.

**Key populations and AGYW:** The TRP noted better use of data and normative guidance to prioritize HIV prevention for key populations and AGYW, especially in Global Fund's AGYW priority countries. People who use drugs are an emerging high-risk group and are increasingly included in funding requests from 22 countries (40% from Africa region and 22% from High-Impact Asia region). TRP observed that for some countries, it is the first-time it is planned to offer prevention interventions to people deprived of liberty (which since 2022 are listed as separate key population by WHO<sup>2</sup>) and for others they have been re-introduced for Global Fund to fund the gaps. Furthermore, trans and gender diverse people were included in 28 countries' requests (44% from Africa, 16% from High-Impact Asia and 16% from Latin America and Caribbeans among few others). Some applicants will introduce new programming for key populations, for example, start opioid substitution therapy or start serving men who have sex with men where sex between consenting adult men is criminalized.

Despite these improvements, the TRP observed insufficient attention to all the key populations identified in normative guidance including people deprived of liberty, people who inject drugs, trans and gender diverse people and other vulnerable populations such as forcibly displaced people. Furthermore, even when planned, in several funding requests, key population programming continues to be limited by data gaps, low size estimates leading to low investment planning and delays in interventions. Some groups of key populations were excluded in surveys or from services previously available in countries due to repressive legal environments. Insufficient attention is paid to subpopulations and intersectionality and the connections between various key and vulnerable populations. While the TRP welcomed use of the updated 2023 Global HIV Prevention Coalition's [Decision-making Aide for Investments into HIV Prevention Programmes among Adolescent Girls and Young Women](#), gaps remained in differentiation and precision targeting especially in settings with low and moderate HIV incidence.

---

<sup>2</sup> WHO (2022). Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment, and care for key populations.



The TRP observed good examples of use of matching funds for key populations included: good PrEP coverage and promotion of integrated prevention packages to expand outreach where relevant and engaging new information technologies or offering support for addressing legal, social, gender, economic challenges that limit access and uptake of services. There was evidence of use of lessons from or plans to scale up innovative approaches piloted during GC6 to augment impact in some Program Continuation funding requests.

The TRP still notes missed opportunities for increased people-centeredness and reach of the different underserved populations, in some cases because of limited allocations and tough prioritization. As in previous grant cycles, important services gaps relate to sexually transmitted infections, TB screening and linkages, viral hepatitis, mental health and psychosocial support, gender-based violence, gender assertive hormone therapy, emerging alcohol and drug consumption including non-opioids and Chemsex. TRP observed few prioritized and tailored packages and approaches for people with overlapping risks and vulnerabilities. Post-exposure prophylaxis (PEP) was budgeted inconsistently.

**Condom programming:** revitalization of condom programming was observed in some countries, but despite high HIV burden several funding requests failed to plan for enough quantities and varieties of condoms and lubricants to meet the needs and demand especially among key populations.

### **2.1.2 Diagnosis, treatment, and care**

HIV diagnosis, treatment and care achievements are being evaluated through the analysis of cascades of continuum of care. Despite many countries with generalized epidemics showing improved cascades and more funding requests with improved AGYW targeting, the TRP continued to observe data-related gaps with missing, inconsistent, or underused gender, age, sub-population, and geographic disaggregation, as well as incomplete key population size estimates – which are all critical for precision prevention and accelerating the UNAIDS 95-95-95 goals. Some applicants continue to struggle with particularly poor cascades and insufficient plans to address challenges at each stage of the cascade, while several funding requests did not provide enough details on how applicants were undertaking differentiated service delivery. The TRP noted insufficient HIV prevention cascades, with data on non-communicable diseases, mental health and co-infections often lacking. Outdated, delayed, and incomplete epidemiological, integrated, and biobehavioral surveys lead to inaccurate size estimates and programming among populations. Funding requests showed a limited uptake of the simplified bio-behavioral surveillance survey (Bio-Behavioral Survey-light) in settings with COE and limited resources.

The TRP observed a missed opportunity to increase ambition in testing and expansion of differentiated testing, including rapid, self-testing and provider assisted referral/index testing in some contexts. Barriers often included a lack of robust planning and data to allow targeting for high impact differentiated testing. Some applicants continue to delay adoption of

normative guidance such as WHO-recommended testing and diagnostic algorithms, decentralizing antiretroviral therapy (ART) from tertiary or secondary care and insufficient planning for higher-scale viral load testing. 48 out of 60 FRs including some middle-income countries and funding requests tailored for transition which cover most other rapid diagnostic tests through their domestic funding requested for HIV self-testing. Six high impact countries in Asia and in Sub Saharan Africa planned more than one HIV self-testing option. Several countries in West and Central Africa and Focused portfolio countries plan for relatively small amounts for self-tests, while others mainstreamed this tool including in COE settings.

Worrying leakages across the PMTCT cascade were observed in addition to limited progress towards elimination of vertical transmission across several Core, High Impact, and Focused countries, especially in COEs. There was also suboptimal attention to triple elimination across window 1 and window 2 funding requests.

Forty-nine funding requests specifically included HIV treatment and differentiated service delivery for children under 15 in their budgets. However, there is limited analysis and progress in closing the pediatric cascade, lack of clear targets and strategic focus on pediatric case finding and management, including insufficient use of finer-age disaggregation for tailored interventions leading to poor performance, low antiretroviral coverage, and missing interventions for pediatric HIV in countries with unmet needs. Funding requests often paid insufficient attention to adolescent HIV, and they inadequately addressed treatment complexities and adherence challenges in this population group.

The TRP acknowledges an increasing number of funding requests budgets including diagnosis and management of advanced HIV disease (AHD) with a total investment request of US\$89 million representing a 2.5% of the US\$3.6 billion total investment in allocation funding in HIV modules. Integrated management of common co-infections and comorbidities in adults and children with a total investment of US\$144 million requested represents a 4% of the US\$3.6 billion in allocation funding in HIV modules.

Some applicants, even those close to reaching 95-95-95 targets, missed opportunities to address AHD and to include management of co-infections and non-communicable diseases integration. The TRP also saw insufficient ambition to implement interventions to reduce AIDS-related deaths with lack of budget allocation for essential commodities for AHD and TB/HIV integrated service delivery. In addition, the lack of progress was seen on the introduction of dolutegravir (DTG) as second line treatment and variations in regimens being used for second line HIV treatment. The TRP lacks visibility if essential medications for non-communicable diseases are covered by domestic health systems as they should and gaps if any. Only one country specifically included a medication assortment which is expected to address non-communicable diseases. Hepatitis C treatment was included in 13 funding requests and only 11 countries plan to use point of care technology for STI, HPV and Viral Hepatitis (often with TB), with only two countries planning for *Neisseria gonorrhoeae* and *Chlamydia trachomatis* GeneXpert cartridges.

A few countries set up and described effective systems for preventing loss or reaching lost-to-follow-up and measuring/addressing treatment adherence, referring to the cascade as a linear process when it is not. Many funding requests lacked details of how they will achieve

synergies between the Global Fund financing and domestic investments for testing, treatment, and viral load suppression.

### **2.1.3 Advocacy for and promotion of legislative, practice, program, and policy changes**

The TRP observed a positive trend to allocate resources for breaking down human rights and gender-related barriers, encompassing challenges rooted in legislation, including criminalization targeting some key vulnerable populations, stigma and discrimination across all settings, violence, and other socio-cultural issues. Legal literacy, gender-based violence (GBV)-related work and support are more often directly integrated and budgeted in HIV prevention packages, especially for key populations, which contributes to their sustainability. The TRP saw three funding requests which specifically linked to reforming criminal laws and legal reforms under Breaking Down Barriers and Matching Funds. Furthermore, the TRP acknowledges and welcomes the growing incorporation and use of assessments of human rights programs, gender assessments and stigma index in funding requests, which contribute to the enhancement of HIV responses. Of the 60 HIV funding requests, 39 countries had a specific gender assessment done in the last 5 years. However, the quality and use of these assessments was observed to be variable. Investments directed at addressing key populations, particularly through community-led interventions, remain insufficient and there is a resurgence of criminalization of behaviors linked to HIV transmission. More detailed observations on equity, human rights and gender are included in Section 3.3.

#### **Recommendations to Applicants on HIV**

##### *Precision combination prevention*

1. Tailor HIV prevention packages to the needs of specific segments of key and priority populations (especially for younger key and priority populations) considering age, gender, specific vulnerabilities, and intersectionality of vulnerability. Applicants should aim for well-budgeted combination prevention programming. This includes addressing the legal environment to directly impact key populations' ability to access services.
2. Prioritize and budget for PrEP within the core allocation funding request, especially for key and priority populations with the highest vulnerabilities.
3. The TRP encourages applicants to move toward greater ambition and innovation in prevention programming. The applicants should consider expanding the limited programming of long-acting cabotegravir and Dapivirine ring to other populations and geographic areas and find efficiencies to scale up.
4. Review prevention guidance, especially related to condom programming, and applicants to aim to attain the Global HIV Prevention Coalition funding targets.

##### *Key populations programming*

5. Based on epidemiological context and vulnerability, ensure inclusion of interventions and budgeting for "all" relevant key populations in line with [WHO Consolidated Guidelines for HIV, Hepatitis and Sexually Transmitted Infections for Key Populations](#).
6. Enhance the inclusion of all key and vulnerable communities in HIV service delivery, surveys, and evaluation, addressing their unique needs.

7. More ambition and investment for an impactful scale and quality assurance of harm reduction is needed, including needle and syringe programming, opioid substitution therapy, naloxone distribution, and human rights programming, given high levels of criminalization of drug use and possession.

*Provide quality, people-centered diagnosis, treatment, and care.*

8. Continue to improve the availability and use of incidence, burden, cascades and other data disaggregation by geographies, key population and subpopulations, gender, age, considering overall burden of disease and coverage of interventions for other related comorbidities, to target investments more precisely.
  - a. If precise data is not available, use qualitative data such as HRG assessments, for a reality check on context and social factors.
  - b. If key population data estimates are not available, use modelling (if funding available) and available secondary data, utilizing the Global Fund's Prevention Outcome Monitoring Tool<sup>3</sup>.
9. Ensure that biobehavioral surveys and population size estimates are current, prioritized for timely availability and cover all populations and that this data is used to guide program implementation. Rationalize surveys within budgetary constraints.
10. Differentiate care packages by epidemiological context, providing details on each step of the cascade and strategies to improve and cover gaps in normative treatment even if not funded by the Global Fund, adding more details in funding requests on differentiated service delivery approach based on population and geography.
11. Plan and accelerate the pace of rapid ART initiation, transition to dolutegravir-based regimens (adult and children) and access viral load testing and early infant diagnosis.
12. Develop more detailed plans concerning known barriers and challenges to testing such as linkage following HIV self-testing.
13. Reinvigorate focus on quality of care, treatment adherence, reaching those lost-to-follow up, and longevity.

*Elimination of vertical transmission*

14. Minimize leakage in the prevention of mother-to-child transmission cascades using clear strategies, with these interventions going into the core allocation funding request rather than the PAAR. In countries which are close to elimination of vertical transmission, increased attention to the perinatal and postnatal period and leakages across the cascade are required.

*Treatment optimization*

15. Adopt [2022 WHO Guidelines for diagnosing, preventing and managing cryptococcal disease among adults, adolescents and children with HIV](#), and consider the addition of Flucytosine as part of preferred treatment regimen.
16. Ensure sufficient funds are budgeted for the inpatient management, diagnostics, and therapeutics for the management of potential fatal opportunistic infections.
17. Prepare for the further transition to Dolutegravir-based regimens including in virally unsuppressed persons on first line therapy and Protease Inhibitor-based second line regimens and act with speed when new normative guidelines in this regard becomes available. Not only will this be more cost-effective but will simplify resistance monitoring.

*Children and adolescents HIV care*

---

<sup>3</sup> Annex 2 in *Global Fund (2022). [Measurement Guidance for Global Fund Supported HIV Prevention Programs](#), 2022.*

18. Renew a focus on children and adolescents living with HIV: from testing, to treatment, adherence, viral load testing and suppression. These should be linked to PMTCT and to maternal and child health services.
19. More quickly adopt new normative guidance on pediatric treatment. Consider the new dosing recommendations in forthcoming guidelines to facilitate faster adoption of recommended dolutegravir regimens.

## **Recommendations to the Secretariat & Partners on HIV**

### *Precision combination prevention*

1. Technical Partners to support countries in adjusting condom programming in line with evolving guidance, supporting strategies to increase condom uptake, and developing related sustainability strategies.

### *AGYW & key populations programming*

2. Technical Partners to work with the Global Fund Secretariat to ensure that new, improved guidance is provided, and support given to applicants on programming for AGYW, specifically encouraging greater disaggregation of risk and related differentiation of interventions for this population with a focus on HIV prevention outcomes.
3. TRP appreciates the "Decision-Making Aide for Investments into HIV Prevention among Adolescent Girls and Young Women" (Global HIV Prevention Coalition & UNAIDS, April 2023) which is a useful prioritization tool and recommends the development of other similar tools targeting other Key and Vulnerable groups.
4. Technical Partners to share regional best practice on key population mapping, programming, and quality assurance, including technical assistance for programming among people who inject drugs in Sub-Saharan Africa.
5. UNAIDS, together with other technical partners and the Global Fund Secretariat, to support improved availability and consistency of data on coverage of and investments in HIV prevention for key populations from all funding sources.

### *Quality, people-centered diagnosis, treatment, and care*

6. Partners should support improved use of all available data including epidemiological and cascade analyses, with the increased attention to HIV prevention cascades and sufficient disaggregation of prevention and care cascades by gender, age, geography, and subpopulations.
7. Support countries to update HIV diagnostic algorithms especially in the context of the changing epidemic.
8. For partners, to produce more guidance and case studies on common barriers to differentiated testing and strategies countries have used to overcome them.
9. Develop more directive guidance for dolutegravir transition planning including for children.
10. Partners and Secretariat should work with applicants to accelerate uptake of normative guidance with urgency.

### *Treatment optimization*

11. The Global Fund, Technical Partners, and other major donors to align messages, and funding policies on AHD, CD4 recommendations and management of

coinfections/comorbidities in restrictive funding environments ensuring effectiveness of HIV clinical management.

*Prevention of Mother to Child Transmission and children and adolescents HIV care*

12. Partners and Secretariat should work with applicants to accelerate and support the uptake of normative guidance on Pediatric treatment.
13. The TRP recommends robust monitoring to address any ongoing implementation issues to ensure PMTCT cascade progress and that treatment coverage for children and adolescents is achieved as per the set targets and that the uptake of dolutegravir-based regimen improves.

## **2.2 TRP observations on the TB funding requests**

The TRP commends applicants for continued efforts to find more people with TB by deploying new technologies for diagnosis and adopting a differentiated approach to reach key and vulnerable populations relevant to their country context. However, to maximize the impact of finding more people with TB, more attention should be paid to providing a continuum of quality TB care by addressing the gaps in/between the TB diagnosis, treatment, and prevention cascade.

### **2.2.1 Find and treat all people with drug-susceptible-tuberculosis (DS-TB) and drug-resistant-tuberculosis (DR-TB)**

The TRP observed greater use of digital chest X-ray (CXR) with/without computer-assisted detection (CAD) software, and WHO-recommended rapid diagnostics (WRDs) to find missing people with DS-TB and DR-TB. Funding requests also increasingly incorporated innovative approaches such as active case finding among key and valuable populations, and private sector, and civil society engagement in TB programming. TRP found inclusion of the four steps of the TB diagnostic cascade – set by WHO as the standard for universal access to rapid TB diagnostics<sup>4</sup>. Furthermore, the TRP observed that TB matching funds catalyzed interventions in the 16 eligible applicants (Global Fund's TB priority countries) in window 1 and window 2 and enabled them to plan for additional impact by scaling up their implementation in targeted populations and additional geographic areas.

While noting the above progress, the TRP observed limited tailoring of TB case finding among key and vulnerable populations in different contexts. For instance, coverage in remote areas and urban slums was often not at scale. Funding requests tended to miss opportunities to invest in finding children with TB and TB among people with comorbidities such as malnutrition, diabetes mellitus, and silicosis among other mining settings. Gaps were also observed in linkage of people diagnosed with TB to treatment initiation. Funding requests rarely described approaches for integrated monitoring and evaluating e.g., how data from different routes of finding people with TB will be integrated into the health information systems and routinely used in TB cascade analysis.

---

<sup>4</sup> WHO standard: universal access to rapid tuberculosis diagnostics (18 April 2023).  
<https://www.who.int/publications/i/item/9789240071315>

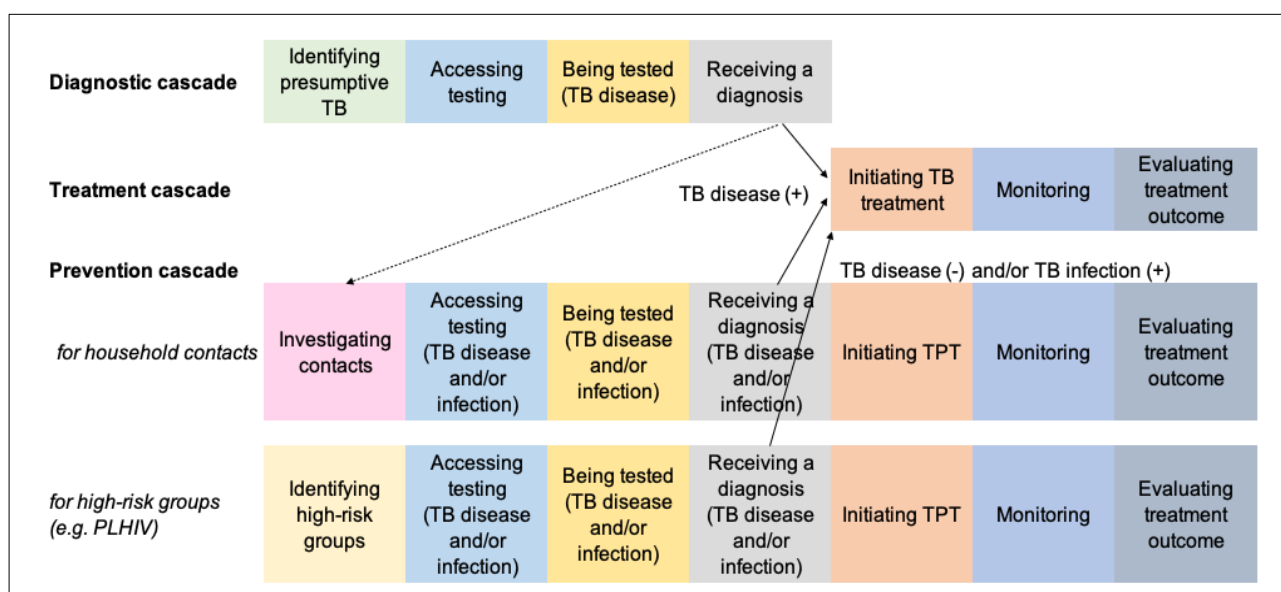
### **2.2.2 Scale up TB prevention**

The TRP noted increased prioritization of TB preventive treatment (TPT), including introducing new shorter TPT regimens for people living with HIV newly enrolled in care and children (aged <5 years) household contacts of people with bacteriologically confirmed TB. Furthermore, some funding requests planned to expand TPT eligibility for all household contacts of bacteriologically confirmed TB cases and other high-risk groups in each setting. However, the targets were not ambitious enough given the availability of new shorter TPT regimens and the increasing number of contacts as more people with TB are found through WRDs. Only a small number of funding requests described how they will monitor and evaluate the TPT initiation and completion, including drug adverse reactions. Moreover, no information on the contact investigation cascade including TPT was presented in most funding requests. Just a few applicants plan to introduce new diagnostic tools for TB infection such as TB antigen-based skin tests and Interferon-Gamma Release Assays (IGRAs). The limited accessibility to those TB infection diagnostic tools should not constrain access to TPT among PLHIV and children under 5 years of age who are household contacts of people with active TB since it is not a precondition for initiating TPT.

### **2.2.3 Improving the quality of TB services across the TB care cascade**

Quality assurance aims to systematically address gaps between practices and desired standards through management decisions, process improvement, and quality redesign. The TRP commends many applicants for recognizing the need for continuous quality improvement in TB care to improve treatment outcomes and for proposing interventions to accelerate this by introducing non-product innovations such as integrated people-centered services, digital adherence technologies, and community engagement.

However, the TRP also recognized the weakness of maintaining the quality of TB treatment and care services including insufficient evaluation of TB care for adolescents with TB due to lack of information. Very few funding requests planned active TB drug safety monitoring and management (aDSM), especially among people with DR-TB, while it should be an integral component of quality TB care. Most applicants created stand-alone, fragmented mechanisms to monitor and improve each cascade of prevention, diagnosis, and treatment separately (figure below), with applicants failing to identify and address cascade gaps.



## 2.2.4 Deploying new tools to address gaps in continuum of care

The Global Fund Strategy (2023-2028) places greater focus on accelerating the equitable deployment of and access to innovations to address the gaps in the continuum of TB care rapidly. To achieve this, it is important to implement and scale up new innovative tools for TB care in a timely manner. The TRP observed that all applicants adopted at least one of the most recent tools and innovations (table below)<sup>5</sup> in their funding requests to accelerate their interventions in TB programming, addressing their gaps effectively and efficiently.

<b>Screening</b>	<ul style="list-style-type: none"> <li>• Digital CXR with/without CAD software</li> <li>• TB antigen-based skin tests</li> </ul>
<b>Diagnosis</b>	<ul style="list-style-type: none"> <li>• WRD</li> <li>• LF-LAM for PLHIV</li> <li>• LPA for first- and second-line TB drugs</li> </ul>
<b>Treatment</b>	<ul style="list-style-type: none"> <li>• All-oral DR-TB regimens, including 6- month regimens.</li> <li>• 4-month DS-TB regimen for children with non-severe TB</li> <li>• Pediatric fixed-dose combinations (FDCs) and formulations for all forms of TB treatment</li> <li>• Digital adherence technologies</li> </ul>
<b>Prevention</b>	<ul style="list-style-type: none"> <li>• New shorter, combination therapies (3HP, 1HP and 3HR)</li> </ul>

However, the TRP also observed that some applicants appeared to struggle with “prioritization” and “optimization” of new tools or innovations under the limited available resources and limited capacity of the health system accepting them. Applicants proposed the limited deployment of new tools due to trade-offs based on available resources. For

<sup>5</sup> Global Fund, Information Note: Tuberculosis, Allocation Period 2023-2025 (29 July 2022) [https://www.theglobalfund.org/media/4762/core\\_tuberculosis\\_infonote\\_en.pdf](https://www.theglobalfund.org/media/4762/core_tuberculosis_infonote_en.pdf)



example, digital CXR with or without CAD for TB screening and WRD (GeneXpert, Truenat, LAMP) for TB diagnosis were planned to be deployed in many funding requests to find more people with TB. However, the proposed coverage of people with access to these tools was limited in the allocation with most of it placed in the PAAR.

Several applicants did not plan how they would optimize the effective and efficient use of the new tools and innovations with limited resources and in their health system context. For example, some applicants planned to deploy WRD without the laboratory diagnosis network optimization assessment and maintenance plan. Other applicants planned procurement of CXR without clear screening algorithms and adequate staffing for interpretation of results or adopting new treatment regimens and diagnostics without sufficient readiness for supply chain management.

### **2.2.5 Advocacy for and promotion of legislative, practice, program, and policy changes**

The TRP recognized that applicants identified key and valuable populations at high risk of TB (e.g., men, children, adolescents, people deprived of their liberty, internally displaced people (IDPs), migrants, and miners, etc.) through epidemiological analysis and defined a differentiated approach to reach different populations and link those in need to TB care. However, some key and vulnerable populations still face barriers to accessing case-finding services both in community and health facility settings due to stigma and discrimination, language barriers, distance, and affordability of user fees and transport costs. Although more applicants acknowledged low treatment coverage among children and adolescents with TB (compared to adults), they lacked ambition and strategic interventions to address this huge gap.

Approximately half of the applicants conducted TB-specific gender and other CRG assessments within the last five years or as part of the most recent National Strategic Plan process and proposed interventions and activities that directly respond to the gender-related differences, inequalities, or barriers identified in the gender assessment. There are good examples where the assessments have been used to propose innovative interventions including in prisons and closed settings. However, utilization of the findings and recommendations from gender and human rights assessments to inform interventions is suboptimal, as glaring gaps persist in using the recommendations to prioritize interventions.

## Recommendations to Applicants on TB

### *Finding and treating all people with DS-TB and DR-TB*

1. Develop the screening approaches and algorithms for their targeted key and vulnerable populations and monitor and evaluate them to address the need for holistic approaches to designing and supporting the entire diagnostic cascade.
2. Consider operational research to facilitate the selection of the most appropriate algorithm for screening and linkage to diagnosis and care and implement targeted interventions to the right geographies and populations to optimize yield.
3. Systematically use stools for WRDs to detect TB in paediatric clients and urine for TB-LAM (lipoarabinomannan) to detect TB in PLHIV.
4. Clearly position new diagnostic tools for TB infection in the TB prevention cascade and put in place the necessary structure to support their introduction, including training of healthcare workers, procurement, and supply management, recording and reporting, and quality assurance.
5. Apply TB diagnostic cascade analysis to identify and reduce gaps in various case-finding strategies in both health facilities and communities to ensure a better continuum of care.
6. Where relevant, establish registers of people with presumptive TB integrating data from various entry points and approaches.
7. Use rates of presumptive TB rate/100,000 population and sputum positivity rates (e.g., the proportion of people with bacteriologically confirmed TB out of all people with sputum examination results) to understand better the quality of TB case finding services in health facilities and communities and prevent and support those lost-to-follow up between diagnostics and treatment.

### *Scale up TB prevention.*

8. Set more ambitious targets for TPT provision to maximize the impact of the investment.
9. Establish a mechanism to monitor and evaluate the TPT implementation to ensure target identification, screening, initiation, and completion of TPT without adverse drug events. In addition, this TPT monitoring should have links to monitoring and evaluation of (i) investigation of household contacts and (ii) new enrolment of PLHIV as entry points in the TB prevention cascade.

### *Improve the quality of TB services across the TB care cascade.*

10. Further ensure that person-centred care, including care for people with TB and comorbidities, such as HIV infection and diabetes mellitus, and adherence support is provided using non-product innovations and recognize the need for 'youth-friendly' services for adolescents with TB.
11. Identify the root causes of undesirable outcomes in people with DR-TB, if these are not known yet, and develop approaches to address them.
12. Ensure monitoring and management of TB drug safety, especially in people with DR-TB.
13. Integrate stand-alone TB diagnosis, treatment, or prevention cascades into a continuum of TB care cascade and analysed to facilitate the identification of gaps to be addressed. These should be followed up with necessary interventions to link and support, i.e., for people with presumptive TB who are found to have TB to initiate and complete their TB treatment and for people with PLHIV and household contacts of bacteriologically confirmed TB cases to start and complete TPT.

*Advocacy for and promotion of legislative, practice, program, and policy changes*

14. Implement a differentiated approach to service delivery for key and vulnerable populations, including children and adolescents, to ensure their access TB care services without any barriers.
15. Prioritize TB-specific gender and other CRG assessments to inform changes needed in legislation, program, and practice.
16. Ensure that the findings and recommendations of CRG assessments are translated into concrete interventions to address the gaps and advocacy for policy changes, as relevant.

**Recommendations to the Secretariat & Partners on TB**

*Finding and treating all people with DS-TB and DR-TB*

1. Technical partners should provide technical assistance and support operational research to produce the cascades and define the optimal algorithms to link the community-level and population-focused approaches with TB diagnosis and care.
2. Technical partners should support establishing integrated data flow from the community and population-focused interventions of finding 'missing' people with TB to the general TB information management system in health facilities and analyzing those data to address the gaps in diagnostic and treatment cascade.
3. Collaborate more with relevant technical partners working on children and adolescents programming such as UNICEF to accelerate actions on childhood TB.

*Scale up TB prevention.*

4. Technical partners to provide technical assistance to applicants in (i) planning and achieving higher targets of TPT coverage, (ii) establishing the mechanism to monitor and evaluate the progress of TPT interventions as part of the TB prevention cascade, and (iii) creating an enabling environment to introduce and deploy new diagnostic tools for TB infection for decision making on TPT provision.

*Improve the quality of TB services across the TB care cascade.*

5. Technical partners to support applicants to maximize the impact of finding more people with TB by ensuring their linkage to TB cure and treatment completion, preventing the development of drug resistance, and improving the quality of TB care, including monitoring drug adverse events and other comorbidities in each person with TB.
6. Technical partners should assist applicants in constructing and analyzing available data in a cascade of each diagnosis, treatment, and prevention as a cascade of TB care.

*Deploying new tools to address gaps in continuum of care.*

7. Technical partners should assist applicants in deciding which new tools and innovations first to deploy in their context and within the available resources and redesigning their system to enable these tools and innovations to deliver a maximum impact on their programs.
8. Technical partners and the Global Fund should further prioritize TB in market-shaping to reduce the cost of new tools and innovations as applicants face tough prioritization with limited resources.

## **2.3 TRP observations on malaria funding requests**

While some countries are seeing encouraging progress reflected in malaria funding requests for 2023, particularly towards elimination in low-transmission settings, other countries showed a stagnation or deterioration in progress in reducing malaria burden, particularly those with high burden. Overall, the TRP noted a positive move towards increased stratification and sub-national tailoring of interventions, though further progress in this area is needed. The TRP observed that country funding envelopes in the current funding cycle are often insufficient to cover all populations at risk with access to diagnosis and treatment and vector control. Additional resource mobilization is needed in the context of a lack of resources for adequate coverage of essential interventions in many countries, and this shortfall presents a significant risk to overall progress.

TRP observations are presented under seven major categories below.

### **2.3.1 Vector control coverage**

The TRP noted countries working to adjust the mix of indoor residual spraying (IRS) and insecticide-treated nets (ITNs) to maximize efficiency, value for money and obtain full coverage of at-risk populations. However, several countries have insufficient funds for vector control within the allocation budget to cover all at-risk populations (through ITNs or IRS). In this context, the TRP has noted:

- Higher-cost IRS is used instead of next-generation ITNs in some areas without clear epidemiological justification, reducing overall population coverage possible within the available budget.
- Essential vector control requirements are included in the PAAR whilst lower priority activities are included within the allocation budget.

Some applicants, consistent with previous TRP requests, have replaced IRS with effective ITNs to improve coverage, or plan to do so.

Multiple applicants face vector resistance to pyrethroids. The basis for deciding which alternative is most appropriate, piperonyl butoxide (PBO) or Dual Active Ingredient (AI) ITNs, remains unclear. WHO recommendations suggest Dual AI ITNs are preferable, on limited evidence, but are marginally more expensive and so this may compromise the achievement of full coverage. There is also a concern that these ITNs may not maintain their effectiveness for the full 3 years of the recommended mass campaign replacement cycle.

### **2.3.2 Equitable access to quality, early diagnosis, and treatment**

The TRP observed that countries are making significant progress on expanding access to case management and prophylaxis, through community-based care and efforts to address challenges to access for vulnerable populations. However, the TRP found several apparent concerns.

As with vector control, part of the budget for essential case management for at-risk populations is frequently in the PAAR. Full coverage with essential case management should be prioritized within the allocation budget where resources allow, and this should include commodities and referral mechanisms for severe malaria.

Intermittent preventive therapy in pregnancy (IPTp) is frequently inadequate, with low coverage of IPTp, particularly for a third visit (IPTp3), and a lack of clear funded plans to address this.

Some countries are planning to use multiple first-line artemisinin-based combination therapies (ACT), aiming to address concerns of growing parasite resistance. The TRP notes that:

- Use of multiple regimens, while potentially justified in larger countries with documented resistance, complicates delivery and training and can increase overall costs. Anti-malarial drug choice should be implemented strictly according to WHO technical guidance.
- Where countries are adding new drug regimens, or changing ACT type, sourcing experience and technical support from other countries that have recently transitioned in this way is likely to improve outcomes.

Some countries are considering mass drug administration (MDA) for subregional elimination. The TRP notes that this is expected to only result in temporary reductions in burden, due to re-introduction from nearby areas.

Rising *hrp2/hrp3* (HRP2) gene deletions are raising the need to include close monitoring the sensitivity of HRP2-detecting rapid diagnostic tests (RDTs), and access to molecular diagnostic capacity to monitor the levels of gene deletions.

### **2.3.3 Implement interventions, tailored at sub-national level**

The TRP has observed an increase in funding requests with detailed national malaria risk stratification, including both geographical and population-based risk, and several countries are prioritizing and tailoring their interventions to maximize impact based on this risk stratification.

Some countries, whilst having stratified data, have not tailored their programs to respond to this. In the context of stagnating or deteriorating burdens, and in near elimination, this is of heightened importance. This should include not only geographical tailoring, but specific targeting to reach underserved population groups identified as having poor access or exclusion from services.

Where resources are insufficient, applicants would benefit from support and guidance from technical partners to prioritize full coverage of effective and efficient vector control and access to effective and efficient case management in the highest-burden populations, thus maximizing impact on malaria mortality and then expanding the interventions based on sub-

national tailoring. Learning from other countries with successful prioritization and tailoring of implementation may assist in maximizing impact.

### **2.3.4 Drive toward elimination**

The TRP recognizes an increase in countries with sub-national stratification and tailoring of interventions to address foci and outbreaks in near-elimination areas, in line with WHO guidance.

However, some countries are facing a choice between supporting core interventions in areas of high burden or using resources to further sub-national elimination strategies. The TRP notes that core interventions in stable transmission areas should not be compromised to further sub-national elimination.

In areas nearing elimination, some variance is noted from WHO recommendations. Whilst local tailoring is necessary, a high priority should be applied to maintaining monitoring, diagnosis, evaluation, and response consistent with malaria case investigations using some form of the 1-3-7 framework proposed by Cao et al.<sup>6</sup> and WHO's best practice recommendations.

### **2.3.5 Accelerate malaria reduction in high-burden areas and achieve sub-regional elimination in select areas of sub-Saharan Africa**

Several high-burden countries are facing very concerning stagnating or rising malaria burdens. The TRP notes that several applicants were approaching this as 'business as usual' in their funding request, and lacking either a thorough situation analysis or, in some cases, tailored actions based on such an analysis when it had been done.

The TRP notes the importance of conducting, and then applying the findings of, a root-cause analysis of lack of progress in these situations. The following factors should be considered in the situation analysis at a minimum: changing malaria epidemiology, funding gaps and lags in program performance, trends in core intervention coverage/access, intervention failures, health system and community barriers, as well as natural, human, and economic disasters. Technical support from countries and entities that have successfully conducted such analyses and acted on them is recommended. Mid-term program reviews should be considered for this purpose, with findings expected to inform the next Global Fund application.

### **2.3.6 Strategically implement special interventions and balance these against core interventions**

Countries are facing challenges in introducing or scaling up special interventions, particularly seasonal malaria chemoprevention (SMC) and perennial malaria chemoprevention (PMC),

---

<sup>6</sup> Cao J, Sturrock HJW, Cotter C, Zhou S, Zhou H, Liu Y et al. Communicating and monitoring surveillance and response activities for malaria elimination: China's "1-3-7" strategy. PLoS Med. 2014;11(5):e1001642

in the face of inadequate resources to support core interventions. This is exacerbated by questions regarding advisability of introducing additional SMC rounds in areas with longer transmission seasons.

The TRP notes the WHO recommendation to ensure full coverage of diagnosis and treatment and effective vector control first and recommends that countries follow this path. Accurate targeting of special interventions consistent with evidence-based WHO guidance, with monitoring in place to determine coverage and effectiveness, is imperative when these are added or scaled up within applications.

### **2.3.7 Need to review underlying allocation criteria in view of 20 years of changing situation on the ground**

Unlike HIV/AIDS and tuberculosis, population-wide malaria transmission is rapidly responsive to behavioral and environmental factors. Malaria allocations are based on disease burden from two decades ago, which considers the underlying situation prior to Global Fund investments – this is intentional to reflect the height of each country’s malariogenic potential and prevent the loss of previous gains. The allocation methodology also includes a process to adjust the formula amounts based on country context, including significant recent increases in malaria burden.

The TRP has observed instances where major natural disasters (floods) have greatly changed malaria epidemiology, leading to rapid increases in burden. This can result in rapid exhaustion of essential case management commodities, human resources, and requirements for vector control. If additional resources are not made available, transmission and mortality will increase further in the unprotected population.

While these cases are relatively uncommon, they can rapidly reverse years of gains in malaria control in such settings. A flexible or increased funding response until the underlying changes in environmental or other risk have resolved would reduce the risk of losing the gains from previous Global Fund investment.

## **Recommendations to Applicants on malaria**

1. Where countries have replaced IRS with effective ITNs to improve coverage, or plan to do so, monitoring and outbreak response should be in place to support this, and ITN selection should be based on entomological data with good behavioral support. Consultation with countries that have successfully transitioned from IRS to ITNs would be valuable in this regard.
2. The TRP notes the importance of countries prioritizing continuous distribution to vulnerable groups between campaigns to address deteriorating net efficacy.
3. Applicants to work with technical partners in selecting the most appropriate approach to growing pyrethroid resistance.
4. In line with WHO guidance, prioritize full coverage with core interventions (access to effective case management and effective vector control) in the Allocation budget, whilst ensuring good monitoring and response, identification of vulnerable populations and targeted special interventions. This may require adjusting the mix of effective ITNs and IRS to ensure maximum vector control coverage of at-risk populations.
5. Consider utilizing other country expertise through lessons learned for complex program changes including change of antimalarial therapy, change in core vector control, and root-cause analyses of deteriorating or stagnating disease burdens.
6. Follow WHO guidance, and only consider MDA (outside of emergency responses) when at-risk populations are first adequately addressed by core interventions.
7. Gender and equity assessments should also be deployed where they assist in identifying sub-populations that require additional focus.
8. Applicants should follow the latest WHO guidelines for management of severe malaria, including striving to establish and support a strong referral system for severe malaria in remote settings where pre-referral RAS is used. The TRP recommends this be clearly articulated in funding requests.
9. Applicants to focus on building sufficient capacity and human resources to implement complete foci responses in countries that are in the elimination.



## **Recommendations to the Secretariat & Partners on malaria**

1. Consider the context of reversed epidemiological trends due to natural disasters and other factors, including impacts of climate change when reviewing the malaria burden criteria in the allocation methodology. In addition, to respond flexibly to rapid increases in malaria transmission, determine whether such cases should be factored in the three-year allocations or whether Emergency Funds would be better suited.
2. Guide applicants on the importance of fully covering at-risk populations with core interventions ahead of special interventions and sub-national elimination, and how to manage special interventions and elimination in this context. Where resources are insufficient, such guidance needs to assist in prioritization of effective vector control and case management to the highest-burden populations to maximize impact on malaria mortality first, then expanding coverage based on sub-national tailoring.
3. Strengthened advice on the mix of ITNs and IRS would help applicants to ensure that all at-risk populations are fully covered by the most effective and efficient vector control intervention. Applicants would benefit from further guidance on the use of PBO vs Dual AI ITNs in areas of pyrethroid resistance.
4. Support is needed for national and external resource mobilization to address significant gaps in core intervention coverage, and the ability to innovate to drive toward elimination, that is limited within the current funding envelope.

## **3. Overall Contributions of Funding Requests to the 2023-2028 Global Fund Strategy Mutually Reinforcing Contributory and Evolving Objectives**

### **3.1 Maximizing people-centered integrated systems for health to delivery impact, resilience and sustainability**

Compared to GC6, the TRP observed an increase in RSSH investments at 11.4% of total FR budgets. The TRP observed that, out of US\$ 1.1 billion requested for RSSH modules overall during window 1 and window 2, applicants primarily prioritized investments for the “Monitoring and Evaluation Systems” (digitalization & integrated health information and management system (HIMS)), the “HRH and Quality of Care” and the “Health product management systems” modules. Moreover, investments in “Community Systems Strengthening” and “Laboratory Systems” were largely synergistic with and complementary to C19RM investments.

However, the TRP still noted more emphasis placed on systems support rather than systems strengthening especially in financially constrained environments and settings with chronic shortage of a skilled healthcare workforce. While the TRP acknowledges a few countries

that have transitioned healthcare workforce to domestic funding sources, it observed that many funding requests included remuneration for public sector health providers and CHWs funded out of the allocation budget, often not linked to timebound plan for transition and long-term sustainability. Additionally, the TRP noted that when technical assistance was provided to accelerate systems strengthening, detailed plans for skills transfer and handover to governmental entities were often missing, posing a risk to long term sustainability of interventions beyond the grant cycle period and potentially hindering national ownership.

### **3.1.1 People-centered Integrated Health Services**

Funding requests were observed to reflect greater emphasis on integration. Submission of integrated funding requests or concurrent submission of funding requests for different components within the same window provided the TRP with greater visibility into opportunities for integration across areas such as service delivery, training, supervision, quality improvement, supply chain, and M&E.

Planning for integrated services requires that countries perform a gap analysis and prioritization process to identify potential areas of complementarities and synergies between the three disease programs and the wider health sector. The TRP welcomes the new RSSH Gaps and Priorities Annex that has demonstrated potential, alongside the funding landscape tables and programmatic gap tables, to foster a participatory approach to joint prioritization of health system interventions for collaborative planning and implementation. The TRP was pleased to see some examples, especially from RSSH priority countries, describing a robust consultative process with a diverse range of stakeholders during the completion of the Annex that should serve as best practice when using the tool. However, the TRP observed that applicants are mostly completing the Annex in disease silos and there is very superficial information on funding of identified health system priority areas. In most funding requests, the Annex was not aligned with the funding landscape tables. This raises questions about the extent of involvement or stewardship by the relevant planning departments in Ministries of Health in completing the Annex within the broader context of health sector planning.

A few funding requests clearly used the Annex as an opportunity to assess system wide gaps, to identify convergent priorities across disease programs, and to ensure synergies and complementarity of RSSH interventions between portfolio components (HIV, TB, malaria) as well as C19RM. It also enabled applicants to prioritize RSSH interventions aligned with national health sector and subsectors policies and strategies, with potential to achieve optimal anchoring and impact of Global Fund investments for strengthening integrated people-centered services. Translation of priorities identified in RSSH Annex to interventions planned in the funding request was evident in a majority of RSSH priority countries and a few non-RSSH priority countries.

There was early evidence of integration of service delivery at primary health care level, notably in countries engaged in health sector reforms to transition to UHC, or those implementing programmatic and financial devolution to lower levels. The TRP observed examples of integration of HIV, TB, and malaria with RMNCAH, SRHR and ANC services, synergies with the triple elimination of vertical transmission of HIV, syphilis and viral

hepatitis, prison health, and drug services. There were fewer examples of integration with service delivery for co-morbidities and non-communicable diseases including mental health, even in the COE settings. 11 applicants submitted integrated funding requests for HIV, TB, and malaria (and RSSH), and 37 submitted joint funding requests for two diseases, which has potential for cross-disease learning and planning to increase people-centeredness of service delivery and RSSH inputs.

The TRP observed an encouraging shift towards expanding and integrating CHWs and other community-based health workers (relays, volunteers, mentors etc.), including representatives from key, vulnerable and underserved populations across a range of countries. The TRP noted a few encouraging country initiatives to transition CHWs into the national health care workforce using domestic funding, though community healthcare programs were mostly externally funded by a range of stakeholders.

Funding requests included a wide range of tailored interventions for community health services delivery to be adapted to various contexts and to ensure outreach and equitable access to people-centered services in underserved populations, including in COEs. There were also examples of integrated service provision and supportive supervision. The TRP observed different modalities for integrated service delivery, e.g., facility based, drop-in centers, outreach clinics, to increase outreach to vulnerable and underserved populations.

The TRP also commends applicants' focus on increasing investments to optimize laboratory systems to expand coverage and access to quality diagnostic, largely complementary to C19RM investments through, e.g., leveraging multi-disease molecular platforms for integrated testing, expansion of specimen referral networks and scale up of external quality assurance activities.

However, the TRP noted that challenges remained to achieve effective progress for implementation of integrated, people centered services, as highlighted below:

- Insufficient attention in funding requests to supporting the governance and policy reforms necessary to drive progress. In its feedback to applicants, the TRP raised several issues mentioning outdated or missing policies, strategies and plans needed to ensure stewardship for the implementation of integrated and people-centered systems (e.g., strategies for the wider health sector: human resources for health, health information and digitalization, community health, supply chain, national laboratory network, etc.) This further questions the involvement and stewardship of the MOH in FR development.
- The quality of the RSSH gaps and priorities analyses was mixed, with some countries conducting the analysis separately for each program without a system approach. Additionally, some applicants limited analysis to the scope of the Global Fund portfolio components (HIV, TB, malaria) as well as C19RM, with no demonstrated alignment with national health sector strategies and priorities, which represented missed opportunities to effectively address cross-cutting RSSH gaps potentially limiting progress towards implementation of integrated people centered care.

- In focused portfolios and COEs, there was a need for careful consideration of trade-offs between integration at PHC level and sustained focus on key and vulnerable populations.
- In some countries, financial and programmatic gaps remained for RSSH modules, underscoring a need for increased coordination among disease programs for joint programming of RSSH interventions, and greater attention to value for money and efficiencies.
- Overall, the TRP observed that RSSH indicators included in the performance framework were still inadequate to measure progress and generate evidence to inform policy making. Notably, qualitative data to assess context was missing.
- The WHO guidance on health policy and system support to optimize community health worker programs<sup>7</sup> defines community healthcare as a range of health services provided by CHWs operating inter-professionally with primary care teams. However, the TRP observed missed opportunities for aligning CHW programs within the broader Human Resources for Health (HRH) policies and budgets.
- With various funding sources supporting various cadres of CHWs and efforts for integration, the TRP noted a need for harmonization and defining a fair compensation package aligned with normative guidance from WHO.
- The TRP also observed in some funding requests that investments were skewed towards expanding recruitment of new CHWs with insufficient attention provided to capacity strengthening for greater quality assurance.

### **3.1.2 Community systems and community-led programming**

Well-functioning and responsive community systems are essential for ending the HIV epidemic, and to enhance responses to TB and malaria, while also building resilient and sustainable systems for health.

The TRP observed a general positive shift in supporting the development and integration of community systems for health. Among funding requests recommended for grant-making in the two windows, 79% had well-articulated roles of community-led and -based organizations (CLOs & CBOs) in service delivery. Applicants requested 12.4% of investments in RSSH-specific modules for community system strengthening (CSS). Additionally, some CSS elements were budgeted in other modules, such as HIV prevention or modules addressing human rights and gender barriers.

The TRP noted increased use of community-led monitoring (CLM) by the applicants, following stronger guidance and the variety of tools from across the Global Fund's Partnership. There were good practices in approaches to establish integrated CLM through e.g., harmonization of CLM indicators and tools across HIV/TB and malaria, a community score card including HIV/TB and malaria, gender, and human rights indicators, or an Observatory on Access to Care, Human Rights and Violence. These efforts will be conducive to ensuring greater accountability, integration, and service quality at the community level.

---

<sup>7</sup> World Health Organization. (2018). WHO guideline on health policy and system support to optimize community health worker programmes. World Health Organization. <https://apps.who.int/iris/handle/10665/275474>

The TRP notes that challenges remain for the full utilization of CSS including CLM:

- Missed opportunities were noted for a holistic and system-building approach (e.g., planning community-led organization capacity building and leadership building to support community-led monitoring). Support for community-led advocacy is often absent, underfunded or in the PAAR only.
- Proposed CLM is of variable quality, with missing feedback mechanisms and limited details on how meaningful community engagement is assured.
- Strengthening of community systems of key, vulnerable and underserved populations is hindered by structural barriers, as detailed further starting with Section 3.1.7.
- Civil society organizations, often with community-based presence and community engagement, continue to be trusted to deliver services and other interventions for key and other underserved populations where CLOs have capacity gaps or are hindered by structural barriers. However, the funding requests missed opportunities for systemic efforts to address capacity and structural issues and enable communities directly lead on those interventions where the revised implementation arrangement with a greater role of CLOs can improve program outcomes.

### **3.1.3 Strengthen generation and use of quality, timely, transparent, and disaggregated digital and secure data at all levels**

With an overall amount of US\$ 371 million requested for the “Monitoring and evaluation systems” module, representing 33% of investments in RSSH modules, the TRP acknowledges the continued emphasis on strengthening national capacity for evidence generation and use, particularly through digitalization operationalization and implementation of the national HIMS at all levels, including primary and community levels. In some funding requests this also included integration of programmatic, laboratory, supply chain systems, HRH data components, as well as promising examples of community digital health applications rollout in some countries (such as, e.g., phone-based applications, CLM App, community dashboard, etc.) to enable better data to capture use and delivery of services, monitor quality and impact. Matching funds accessed through the Digital Health Impact Accelerator Initiative will allow eligible countries to set more ambitious targets for HIMS roll out nationally and to further support interoperability.

Where these were available, the TRP noted the reasonable use of a range of national data (biological-behavioral surveillance surveys, programmatic reviews, cascade analysis of continuum of services, assessments including, e.g., Malaria Matchbox tool and gender and stigma assessments) to guide selection and prioritization of interventions. The TRP additionally observed proposed investments to optimize laboratory systems to expand coverage and access to diagnosis at subnational level were informed by systematic assessments such as diagnostic network assessment (DNA) or diagnostic network optimization (DNO)/geospatial analysis.

However, the TRP noted the following concerns:

- 1) In the frequent absence of a national strategy for digital health, digital health information management systems were developed in parallel, often donor driven and

fragmented, with insufficient attention to inter-operability with the national HMIS, Logistics Management and Information Systems (LMIS), and Human Resource Information Systems (HRIS).

- 2) Gaps in quality and use of data to inform prioritization: data disaggregated by gender, age, sub-populations and geography, and key population data (size estimates) were often missing or underused.
- 3) Ambitious laboratory strategies were not supported by adequate investments in infrastructure, equipment, and human resource capacity. Some funding requests showed limited evidence of having been informed by gap analyses or by detailed strategic plans to ensure prioritization of interventions, value for money and efficiency.
- 4) Instances of assessments such as DNO being allocated to the PAAR whereas they are needed to inform investments budgeted on the main allocation.
- 5) The TRP noted the need to rationalize surveys within budgetary constraints, as exemplified by the planning of “light”-integrated biological-behavioral surveillance surveys by some countries.

### **3.1.4 Strengthen the ecosystem of quality supply chains**

The TRP saw focus on supply chain management systems strengthening, with 63 funding requests including the “RSSH: health products management systems” module in their budget. This amounted to US\$154 million overall, of which 12% was allocated to “Planning and procurement capacity” interventions (included in 41 funding requests) and another 12% was allocated to “Supply chain information systems” interventions (included in 37 funding requests). This investment enabled continuous support to the set up and deployment of an electronic logistics management information system, e.g., M-supply, in synergy with C19RM investments, to accelerate supply chain data access and use.

In COEs, the TRP noted innovative solutions and best practices to ensure last mile delivery and access to health products in difficult to access or conflict zones, such as the warehouse in a box, contracting private and humanitarian aid organizations, multi-month dispensing.

The TRP noted persisting challenges pertaining to:

- Ensuring Value for Money and quality, including if procuring on the local market due to national regulations.
- Need to further strengthen regulatory capacity (e.g., absence of supply chain management plans, absence of national essential diagnostic lists).
- Need to strengthen warehousing capacity at central but also subregional levels.
- Operationalizing last-mile delivery, including to CHWs.

### **3.1.5 NextGen market shaping focus on equitable access to quality health products**

The TRP observed concerning commoditization in grants with applicants facing tough prioritization decision with more people in need of services and availability of newer, more effective, but often more expensive tools. Consequently, the TRP observed uneven uptake

of new pharmaceutical products for prevention, diagnostics, and treatment across funding requests.

Most applicants requested support from the Global Fund to introduce new ITNs (e.g., PBO or Dual AI ITNs) for malaria vector control interventions to address growing insecticide resistance as well as people-centered treatments for TB and HIV (fixed dose combination and shorter regimens such as, e.g., dolutegravir-based regimens for HIV, all-oral BPaL and BPaLM regimens for multi-drug resistant TB). The TRP also noted a strong focus on scaling up access to WHO recommended TB rapid diagnostic tests, notably TrueNat to complement GeneXpert, and to point of care (POC) tests for HIV viral load and early infant diagnosis. On the other hand, the demand was lower for POC diagnostics for advanced HIV disease (only included in around 1/3 of 60 funding requests with an HIV component), POC for STIs/hepatitis (11 funding requests), LAM for TB (8 funding requests), or for introducing new PrEP modalities, including injectables and vaginal rings (9 funding requests).

The TRP noted that most applicants used international sourcing and pooled procurement mechanisms (through, e.g., the GDF or Wambo) to ensure Value for money and quality of procured health products.

The TRP however raised the following concerns:

- Pharmaceutical health products procurement through domestic funding sometimes could not always leverage international sourcing and pooled procurement mechanisms due either to regulations mandating local sourcing to support local market development (without comparable value for money) or to insufficient mechanisms to enable pre-delivery payment modalities. These were missed opportunities for economies to be redirected towards other programmatic interventions.
- While the TRP acknowledges efforts by some applicants to diversify their procurement pipeline as a key to providing people with choice and encourage competition in the market, as exemplified with HIV self-test kits, it also emphasizes the need to ensure quality (prequalification) of health products. This was particularly the case in countries with parallel procurement pipelines.
- The higher prices of new products have put major strains on allocation budgets. Some applicants with smaller allocations or with particularly tight fiscal space had to be selective and do tough prioritization, relying on older but less expensive tools (e.g., isoniazid based TPT, HIV interventions relying only on basic prevention with no PrEP, limited uptake of Seasonal Malaria Chemoprevention and Perennial Malaria Chemoprevention). The TRP was sensitive to tough choices made by applicants, especially in COEs.

### **3.1.6 Better engage and harness the private sector**

The TRP observed a momentum in private sector engagement across three diseases, to ensure scale-up of critical interventions and/or to maintain gains achieved, with 12 funding requests specifically including “supporting private sector engagement” interventions in their budget. Some examples include use of vouchers to enable access to X-rays and incentives

to private practitioners, and involvement of the private health sector to extend the minimum prevention services package.

However, the TRP notes the following issues leading to suboptimal private sector engagement:

- Private sector engagement was often disease focused, with an incomplete mapping of private sector actors and their activities in health.
- Lack of a systematic and robust approach for engagement, such as a private sector engagement strategy or public-private mix plans to provide a platform for increased private sector participation in the fight against HIV, TB and malaria, or insufficient description of the mechanisms for engagement.
- Proposed interventions to strengthen the involvement of the private sector which are not supported by a regulatory framework to ensure compliance with national standards for the provision of quality health care services, with limited attention to performance monitoring and information exchange (routine case notification and reporting).

### **3.1.7 Deepen partnerships between governments and non-public sector actors including public (social) contracting**

The TRP noted an increasing number of applicants propose introducing or strengthening social contracting to enhance service sustainability. Several countries have demonstrated their commitment and made good progress in addressing legal and regulatory barriers to contracting of non-government organizations for provision of services. Some applicants plan accreditation of Civil Society Organizations (CSOs). They have developed mechanisms and guidelines for improved contracting moving towards output and outcome-based contracting. The extent of progress has been varied, with some locations demonstrating greater political will via increased domestic financing. Other countries continue to rely almost exclusively on donor funds for contracting CSOs; contracting with the private sector is very limited. Moreover, most countries are more advanced in contracting for HIV services as compared with TB and malaria. The TRP saw encouraging plans to start or institutionalize social contracting through local governments or programs in more funding requests, or to expand or scale-up existing contracting of CSOs and the private sector. There were diverse funding models for social contracting including health insurance based, through Ministries of Health or local government budgets or through a combination of different funding sources.

The Global Fund recognizes that effective partnerships need to include the full range of key stakeholders, including donors, civil society, and the private sector. However, the TRP noted that evidence in the funding requests suggests further coordination is required to center community-led and key population organizations in programming and implementation and to increase opportunities for effective partnerships:

- The TRP noted examples of countries with a repressive legal environment for key populations whose behavior may be criminalized or for civil society in general, which



could prevent organizations that represent them from registering or applying for funding. This situation can hinder the delivery, impact, and sustainability of interventions.

- The TRP's review of impact of Global Fund investment was often limited by an inadequate or insufficient description of activities and investments from external donors and domestic resources (both public or private) as documented in the funding landscape tables, programmatic gap tables and the RSSH Gaps and Priorities Annex. This lack of visibility, and weaknesses in partnership at country level increase the risk of duplication of interventions and inefficiencies across donors and programs.
- The TRP is concerned that social contracting models are often initiated and funded with a one disease focus, leading to disease specific rather than systemic solutions, and representing missed opportunities for integration of services.

### **Recommendations to applicants on maximizing people-centered integrated systems for health to deliver impact, resilience and sustainability**

1. Within the context of Global Funds investments, CCMs and MoH to take a greater role in coordination of full range of partners and ensure stewardship of national programs. Applicants should maintain an up-to-date mapping of health donors and supported activities.
2. Future applicants provide a complete picture of RSSH investments and activities of in-country partners in existing annexes to funding requests.

#### *Health sector planning, leadership, and governance*

1. Applicants to prioritize activities to catalyze governance and stewardship reforms considering programmatic and country context, making use of normative guidance and support from technical partners, and track actions with accountable and effective outcomes (e.g., addressing personnel gaps, quality of care, etc.)
2. Applicants use key annexes (RSSH Gaps and Priorities Annex, Funding Landscape Table, and Programmatic Gap Tables) to assess system-wide gaps (both programmatic and financial) to inform and prioritize interventions and improve value for money.
3. Applicants to build on coordination established in developing integrated funding requests and use the RSSH Gaps and Priorities Annex to strengthen integrated programming.
4. In addition to using the RSSH critical approaches, applicants should adapt the [WHO Operational Framework for Primary Health Care](#) (mentioned in section 1.5) to prioritize RSSH investments at PHC level and adapt the associated framework of indicators to track implementation progress. Applicants to implement interoperable digital Community Health Information Management Systems to support service delivery, improve quality and monitor impact.
5. As mentioned in section 1.5, applicants should harmonize CHW remuneration and prioritize resourcing for people-centered services delivery within the local context, including providing CHWs with necessary commodities ensuring safer working conditions with a stronger gender lens.
6. As mentioned in section 1.5, applicants should prioritize mobilization of domestic resources to progressively allow integration of CHWs into primary health care systems and government payroll.

#### *Community systems and responses*

7. CCMs should continue to meaningfully engage with the full range of communities and community-led organizations and ensure investment in and utilization of community-led monitoring and community system strengthening interventions.

*Private sector engagement, partnerships, and social (public) contracting.*

8. Applicants should develop robust private sector engagement strategies, aligned with global guidance, including private sector participation into national health information systems (NHMIS) for routine reporting and capacity building. This should be complemented by regulatory frameworks to set standards and allow monitoring of service quality and compliance with national policies.

## **Recommendations to the Secretariat & Partners on maximizing people-centered integrated systems for health to deliver impact, resilience, and sustainability**

*Health sector planning, leadership, and governance*

1. Global Fund Secretariat and technical partners to perform RSSH mapping and funding landscape analysis across all health systems pillars to increase visibility on the gaps and opportunities for complementarity across the entire health system.
2. Global Fund Secretariat to support a continued focus on integrating disease specific interventions into PHC, in line with global commitments for Universal healthcare coverage and Public Health Security, with due consideration to the efficiency and sustainability dimensions.
3. Secretariat to consider adapting the Performance Frameworks and Essential Data Tables, including more RSSH indicators, qualitative assessments and workplan tracking measures to inform the funding request narrative.
4. Secretariat and partners to support countries in reforming health systems governance, through inclusive processes ensuring engagement with civil society and communities, strengthening their ability to capitalize on experience sharing and learning, and to base policymaking on this evidence.

*Community systems and responses*

5. Secretariat and partners to support applicants to holistically address all elements of community systems strengthening and focus on linking programs with health systems as complements and not as replacements.

*Monitoring and evaluation systems*

6. Technical Partners to support countries to accelerate the data integration process for their information management systems and provide enhanced support on using data for evidence-based decision making to inform implementation of innovative strategies to address critical gaps.

*Human resources for health (HRH)*

7. Technical Partners should support applicants in developing comprehensive plans for HRH including conducting labor market analyses and developing human resource management systems to inform future HRH reforms towards programmatic impact and sustainability.

#### *Health products management systems*

8. Technical Partners to support countries on supply chain strengthening. This support should include a focus on last-mile delivery and on using evidence-based prioritization to prevent stock-outs.
9. Secretariat and Technical Partners to provide further structured guidance on supply chain management, to help inform country-level supply chain management plans, including policy guidance on infrastructure investments such as warehouses.
10. Secretariat and Technical Partners should identify ways that investments in health systems strengthening can benefit from the use of country-led and sustainable pooled procurement mechanisms.

#### *Laboratory systems strengthening*

11. Technical Partners to support applicants for performing laboratory system geospatial and gaps analyses to inform strategic plans and to optimize laboratory systems which can better support the disease programs.

#### *Next Gen market shaping*

12. With a strong pipeline of innovations and Global Fund's collaboration with UNITAID and other partners for market shaping and driving local manufacturing, the Global Fund Secretariat and Technical Partners should develop more guidance to inform robust prioritization and implementation for new tools, with special attention to the need to manage trade-offs between cost and effectiveness.

#### *Private sector engagement, partnerships, and social/public contracting*

13. Technical Partners and CCMs to support governments to create an enabling environment and to mobilize a national budgetary allocation for the establishment and implementation of public contracting accessible by civil society organizations (CSOs), community-based organizations (CBOs) and community-led organizations (CLOs)
14. Global Fund Secretariat and Technical Partners to continue community capacity building to better equip community-based and community led organizations to credibly access government funding through public contracting.
15. In-country Technical Partners should build the capacity of government ministries support, guide, and engage with private sector, donors, civil society, and other actors. Global Fund Secretariat and Technical Partners to continue facilitating best practices and experience sharing between implementing countries, with the inclusion of CSOs in such exchanges.

### **3.2 Maximizing the engagement and leadership of most affected communities to leave no one behind**

Well-functioning and responsive community and health systems are essential for ending the HIV epidemic, and to enhance responses to TB and malaria, while also building resilient and sustainable systems for health. The TRP observed a general positive shift in integrating

community systems and responses (12.4% of investments in RSSH-specific modules were in Community System Strengthening).

The TRP observed some improvements and a greater reflection of a stronger role and voice of communities living with and affected by the diseases. These have been highlighted in the various assessments (gender, human rights and legal environment assessments), as well as in the development of funding requests, demonstrated by deliberate introduction of public (social) contracting, and as outlined in the Community and Civil Society Priority Annex.<sup>8</sup> There were more examples in which the engagement of civil society and community-led organizations, with specific improvements in the TB response; with emphasis on the scale up of community-led outreach and prevention interventions, building on the strong collaboration with civil society organizations. These included shift towards integrating differentiated HIV prevention services into government facilities, especially in repressive legal contexts, and using community-led monitoring to support national HIV programs. However, the strategic use of community-led tools for monitoring programs, such as CLM reports and findings, was sporadic. Despite these improvements and evidence of community systems strengthening investments, several structural barriers remain, including continuing challenges in enabling the legal structure for social contracting in some countries.

**The TRP generally does not assess the CCMs**, as this is routinely and systematically done by the Secretariat as part of FR eligibility assessment. That said, nearly all funding requests reported a consultation process involving communities most affected by the three diseases, and other key and vulnerable populations in funding request development.

The TRP observed greater and more active engagement of communities and organizations representing people at higher risk of contracting HIV, TB and malaria, and key populations in planning, resource allocation, implementation, and oversight of the funding request development. Furthermore, elements of community-identified priorities were to some degree integrated into allocation budgets in most reviewed funding requests and annexes. In some highly sensitive environments, creative ways were employed (including out-of-country consultations) to engage voices from communities with stigmatized or criminalized behaviors.

The key role of civil society, community-based and community-led organizations in ensuring continued services during emergency situations, and most importantly inclusive decision-making including in the development of national documents and funding requests, was a notable example of integrated, recognized community leadership, especially in countries facing challenges including CSO Principal Recipients.

The Global Fund's dual track financing mechanism provides an opportunity, especially for funding civil society organizations that strengthen and complement existing efforts. The TRP continued to observe this distinctive and value-added role of civil society organizations as second Principal Recipients, reaching the most hard-to-reach, culturally distinctive, and

---

<sup>8</sup> The Community Annex does not necessarily form part of the Finding Request documents that the TRP reviews, but the TRP requested access to the Community Annex to have a view of the equity, representation, and participation dynamics.

underserved communities, in collaboration with government partners. Examples include bringing and scaling up an innovative Integrated Community Case Management (iCCM) model; consulting with most culturally, socially, and geographically isolated community-led and -based organizations in malaria-endemic areas to inform the development of the community-led and -based interventions for the funding request; organizing TB treatment support and channeling key population community strengthening and adaptive services. However, the TRP noted limited evidence of community-led interventions. Most community-based interventions were still led and managed by the long-term Principal and Sub-Recipients, and rarely led by communities of people affected by the three diseases.

**The Civil Society and Community Priorities Annex (Communities Annex)** was introduced in GC7. In addition to the funding requests package, the TRP drew its review on the community annex in a few cases, to provide context on community engagement and found it to be a useful supplementary tool, especially in COE and hostile environments.

While reviewing the funding request documentation, the TRP found the level of information provided inconsistent, making triangulation of information sometimes difficult around country dialogue. Details around technical assistance to support community engagement were available through summary reports, either submitted alongside the funding request or accessed through separate records, instead of being explicitly mentioned in the funding request.

In cases where the TRP saw the Communities Annex, the TRP observed an uneven breadth of representation across the affected communities and civil society. In some cases, this annex offered constructive input from groups beyond the community and civil society representatives at CCMs. The Communities Annex affirmed and complemented some of the TRP findings: while important information was provided/buried across multiple funding request annexes (allowing insight into the participation of networks and organizations of people living with HIV, TB, and key populations), the critical 'variables' such as gender diversity, age, geography (e.g., women who use drugs, young women living with HIV and others) were missing. In the few instances where a view could be formed on the 'diversity' of community representation, the TRP saw limited examples where all priority community stakeholders were documented as engaged.

More positively, the information from the Communities Annex provided evidence that to date has otherwise gone undocumented as part of 'official' Global Fund processes. It also provides insight into where the Global Fund and partners must focus further investigation to understand the dynamics of community engagement and develop strategies tailored towards key and vulnerable populations that are criminalized in some countries.

The TRP noted that strong leadership of affected community members in program implementation and good partnerships between national programs and community-based organizations were more beneficial when supported through leadership strengthening activities, such as needs assessments, training, capacity development, support for official registration with national regulatory bodies, as well as the institutionalization of community-

led monitoring systems integrated across the disease programs. The TRP noted an increase in applicants planning to integrate community-led monitoring in their programs, but with variable quality, scope, and uncertainty on whether there is meaningful community engagement. Feedback mechanisms are often missing, with limited or absent support for community-led advocacy, as they are often underfunded or in the PAAR.

The TRP noted that even though there was an increase in gender, human rights, and legal environment assessments, the TRP could not always establish the level of involvement and engagement of gender-diverse populations in the assessments due to the documentation of participants, which is not disaggregated beyond constituency or organization in some instances.

### **Recommendations to Applicants on maximizing the engagement and leadership of most affected communities to leave no one behind**

1. Engage communities most affected by the three diseases more meaningfully in the discussions around planning and implementation, for instance, they should form part of country-to-country sharing missions and exercises.
2. As mentioned in section 1.5, CCMs should continue to meaningfully engage with the full range of communities and community-led organizations and ensure investment in and utilization of community-led monitoring and community systems strengthening interventions.
3. Continuously evaluate the impact of different service modalities to ensure that the gains made thus far, especially through the community-led responses will not be reversed.
4. With increased focus towards sustainability and shifting/integrating some project-funded and Global Fund-funded initiatives into government ownership, there is an urgent need for social/public contracting to sustain meaningful community engagement.
5. With the increased focus on using community health workers for integrated, people-centered care, and as a focal point for integrated RSSH investments, monitor and manage the realistic and most efficient use of CHWs. There is a possible risk of overwhelming and overloading them with too many integrated programs, hence the need for continuous support and educational activities, ideally supported through mentoring and coaching.
6. Develop and implement CLM systems in line with normative guidance, ensuring that these are driven by communities most affected by the three diseases, include feedback mechanisms, use data to inform programming and integrate with routine data collection systems.
7. In enhancing inclusivity and community engagement, there must be a balance between the need to understand the diversity of community actors engaged in processes at the country level, and the critical need to protect community members privacy, safety, and security as they engage in national and other processes.

## **Recommendations to the Secretariat & Partners on maximizing the engagement and leadership of most affected communities to leave no one behind**

1. Partners to support meaningful community engagement and actively support diversity of community representation and participation, especially the inclusion of key community stakeholders who are usually left behind in national and other critical processes.
2. While the importance of integrating NCDs and other priorities into HIV, TB and malaria programs, there are some systemic challenges that may delay integration efforts, and there should be a realization that with each grant cycle, the number of new requirements may not always be feasible for the immediate uptake by countries.
3. WHO and UNAIDS to update normative guidance to request gender and sex-disaggregated data in all reporting.
4. Technical partners to include gender and sex disaggregation tools and guidance in the documentation for gender, human rights, and legal assessments as it is currently not possible to establish the involvement and engagement of gender-diverse populations.

### **3.3 Maximizing health equity, gender and human rights**

Overall, the TRP observed more funding requests referencing human rights and gender, recognizing the structural barriers to care, and acknowledging the importance to address human rights and gender barriers to reach the last mile across all three diseases, aligning with the Secretariat's recommendation for applicants to include human rights and gender equality assessments as annexes of funding request packages. However, such acknowledgement does not always translate into investment in concrete programmatic activities and these areas continue to remain vastly under prioritized and underfunded in allocation budgets. The human rights and gender-focused modules and interventions represented an investment of US\$ 103 million in the first two windows. The TRP observed sporadic mention or insertion of the Global Fund Strategy language throughout some funding requests without necessarily linking the language and interventions to differentiated services and budgets in the allocation. This included references to key populations often discussed as 'one' population without consideration of differentiation between and within key populations, including gendered differences. More than 90% funding requests from the applicants participating in Breaking Down Barriers and/or with Human Rights and Gender matching funds provided quality focus on equity, gender, and human rights.

In terms of health equity, GC7 applicants were requested to consider inequities based on various dimensions including place of residence, race/ethnicity, occupation, gender, sex, religion, education, and socioeconomic status among others, and to consider and respond to the underlying social and structural drivers of these inequities. However, as noted above, the TRP saw limited evidence of these considerations in the funding requests, except in some funding requests which referred to sex, gender, and rural/urban peculiarities. Despite this, there was limited prioritization of interventions even by area of residence, expect in

some malaria funding requests, which prioritized interventions based on the socio-economic status and geographical/ residence area of people most affected by malaria. A few TB funding requests referred to socio-economic status, and prioritized interventions in such areas, but mainly linked to curbing catastrophic costs for TB treatment.

### **3.3.1 Scale up comprehensive programs and approaches to remove human rights and gender-related barriers across the portfolio**

The TRP observed increasingly hostile laws, policies, and practices in several countries. These include new or increased enforcement of laws criminalizing same-sex sexual relationships, high levels of stigma, barriers to organizational registrations, and acknowledgement of harmful norms by applicants, which are greatly risking the fragile gains that have been made over the years. In addition, in settings where public health and criminal law are in conflict, some applicants used sensitive and coded language in naming key populations, though they are still prioritized in national strategic frameworks and plans.

However, the TRP has noted greater recognition of punitive legal environments, with funding requests clearly highlighting and acknowledging their impact on access to services. The Program Essentials for removing human rights-related barriers to services were consistently reported by the applicants. The acknowledgement of these barriers in some funding requests has been matched with intensified action to address inequities, human rights, and gender related barriers. For instance, there is more integration of human rights interventions in prevention programs for key populations, especially men who have sex with other men and scaling up of PreP for key populations. Furthermore, countries participating in the *Breaking Down Barriers (BDB)* initiative as well as the human rights Matching Funds tended to include higher quality interventions and, in some cases, higher allocations to removing gender and human rights related barriers. Some of the BDB countries used the human rights matching funds to generate evidence and intensify technical support to support advocacy for law reform.

The TRP has also noted the institutionalization of mechanisms to address human rights related barriers to care, through the development of reporting and appeal mechanisms and tools for handling complaints of HIV-related discrimination and human rights violations, supported by the National Human Rights Commissions and government ministries, in collaboration with community actors and with the participation of key populations. Some of these improvements include community legal assistance for victims of discrimination and other violations of rights related to HIV and TB; increasing support for strategic litigation; alternative and community dispute resolution, including engagement of traditional and religious leaders; enhancing access to justice.

There has been a notable increase in gender and malaria Matchbox assessments conducted, with a considerable number of funding requests using these assessments to guide gender and human rights related interventions, and those aiming to enhance equity in service delivery, access, and utilization, especially in malaria grants or components.



However, the quality of the assessments is varied, with too few participatory processes and community engagement, citing time and budget challenges to enhance community participation, hence weakening the quality and credibility of these assessments. In addition, a considerable number of the assessments which were recommended from GC6 were conducted late in the grant cycle, and therefore did not inform the development of the GC7 funding requests, especially for Window 1.

### **3.3.2 Deploy quantitative and qualitative data to identify drivers of HIV, TB and malaria inequity and inform targeted responses, including by gender, age, geography, income and for KVP**

Many countries indicated gender-based violence (GBV) as one of key gender-related barriers to services, with stronger linkages to GBV services continuing to be proposed but not sufficiently budgeted for in the allocation.

Although assessments were not yet consistently being used to inform programming, monitoring and evaluation and budgets, the TRP observed an increased number of assessments, including Malaria Matchbox, gender assessments, legal environment assessments. There were some deliberate efforts in malaria programming to integrate broader equity, human rights and gender considerations and this notable improvement is an indication of the continued advocacy for the integration of equity, human rights, and gender into malaria programs.

Some funding requests had a strong equity and rights-based approach to HIV prevention services delivery, aligned with the allocation focus requirements as well as with National HIV Strategic Plans, with comprehensive interventions to address legal and other structural barriers.

The TRP also observed funding requests which had a strong integration of the global 10-10-10 societal enablers targets<sup>9</sup>, with clear indicators. These funding requests used evidence-informed interventions, including from the *Gender Analysis and Social Inclusion in Malaria and Immunization* survey, with clear interventions that addressed human rights and gender-related barriers, inequities, and vulnerabilities in access to malaria services for key populations. This led to the addition of a new indicator in the performance framework, as well as the introduction of specific indicators to measure intended gender-related changes in the National TB Program (NTP).

In their multi-sector *Breaking Down Barriers* (BDB) initiative, one applicant planned to develop a national action plan to tackle human rights and gender-related barriers for the TB program and set up TB/HIV BDB committees at provincial and district levels, with a commitment to reach the 10-10-10 targets for TB and to surpass those for HIV. The same funding request made a good effort to integrate comprehensive HIV packages for female

---

<sup>9</sup> UNAIDS (2021) Ending inequalities and getting on track to end AIDS by 2030  
[https://www.unaids.org/sites/default/files/media\\_asset/2021-political-declaration\\_summary-10-targets\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/2021-political-declaration_summary-10-targets_en.pdf)

sex workers and women who use/inject drugs such as the use of women peer outreach workers trained for gender-specific peer education and support; women-only spaces and/or times at drop-in centers; links to SRH; and training CSOs on dealing with mental health and GBV integrated into comprehensive HIV service packages for specific key populations.

However, data being used in several funding requests are still not disaggregated by age and gender, thereby limiting prioritization. In some instances, the data are collected but only referenced in the Essential Data Tables with limited evidence of use in the FR.

### **3.3.3 Leverage the Global Fund’s diplomatic voice to challenge laws, policies and practices that limit impact on HIV, TB and malaria**

Matching Funds have demonstrated utility in elevating and expediting comprehensive efforts to address equity, human rights, and gender-related barriers to accessing services, including achieving reform of the legal environment and punitive laws against key and vulnerable populations, and addressing stigma and discrimination. In the countries with increasingly restrictive legal environments, most funding requests acknowledged these and were able to plan for advocacy for the provision of services in the context of public health, without necessarily focusing on funding advocacy for criminal law and enforcement reforms. There has also been positive influence of the Global Fund where for example, an applicant in a challenging operating environment was able to (for the first time) include programming for men who have sex with men despite the harsh political environment and criminal sanctions in the country.

#### **Recommendations for Applicants maximizing health equity, gender, and human rights**

1. Improve the ongoing efforts to use the findings from the assessments to inform interventions, prioritization, and budgeting for programs to remove human rights and gender-related barriers, as well as human-rights-based and gender-transformative interventions that will also enhance equity.
2. Translate assessments of human rights programs, gender, and legal environment into concrete and transformative interventions, budgeted for within the allocation.
3. Applicants should invest in community-led monitoring (CLM) to ensure a quick response to rights violations in rapidly changing contexts.
4. Applicants should undertake and/or utilize existing equity, human rights, and gender analyses to inform updates to CHW programs.
5. Applicants should allocate adequate budget for removing gender and human rights-related barriers and invest in home-grown structures and systems which will be most effective and have the highest impact to overcome the barriers.
6. The BDB countries and other applicants should increasingly consider longer-term planning for law and regulatory reform (e.g., criminalization, inclusion of key populations in UHC) and regulations that create barriers for prevention of the three diseases and access to services, with a central leadership role of CCMs.

## **Recommendations for Technical Partners and the Secretariat on maximizing health equity, gender, and human rights**

1. Technical Partners should support applicants to strengthen GBV linkages (policy, financing, and service provision) at country level, and actively explore the development of new normative guidance on the intersection of diseases and GBV, particularly in conflict settings.
2. Technical Partners and Secretariat should continue supporting countries with gender and/or human rights assessments and the Malaria Matchbox.
3. The Secretariat should extract learnings from the use of the Annex on Funding Priorities of Civil Society and Communities Most Affected by HIV, TB, and Malaria, continue to strengthen its related processes and consider its inclusion in the funding request packages, especially in challenging political and legal environments.
4. In-country partners should lead in identifying the emerging needs in hostile contexts.
5. Secretariat should consider mobilizing additional resources for the scaling up of the Breaking Down Barriers initiative and Matching Funds to expand the number of participating countries and explore new partnerships with other donors and stakeholders focused on gender, equity, and human rights strengthening.
6. While it is of critical value that human rights and gender have been strategically elevated in the Global Fund's strategy along with the centrality of the role of communities, the Module to remove human rights and gender-related barriers needs to be supplemented with the inclusion of human rights-related interventions such as "law and regulatory reform" in the RSSH Module as well.
7. Secretariat to consider identifying countries with challenging EHRG environments, which are not necessarily classified as challenging operating environments (COE) for special consideration and enhanced support during funding request development and grant implementation.

### **3.4. Mobilizing increased resources**

The TRP noted an overall improvement in how funding requests address sustainability, value for money, and co-financing, especially when comparing requests from GC6. However, improvements are still needed as detailed below.

#### **3.4.1 Catalyze domestic resources for health**

The TRP's assessments and recommendations on countries' efforts towards mobilizing increased resources were made in the context of the current global macro-fiscal crisis, high levels of debt distress and inflation which are expected to severely constrain fiscal space for health in the medium-term. The TRP commends the applicants for noting their commitment to increasing domestic financing for HIV, TB and malaria and health, and for making some progress – albeit at varying degrees – towards sustainable financing of their programs. The TRP noted some funding requests acknowledge the importance of domestic resource mobilization; and that a few countries, despite facing strong macro headwinds, have designed sustainability roadmaps for HIV, TB and malaria, and that implementation is underway.

The TRP, however, noted continued dependence on external funding and low domestic public resources for health in multiple funding requests. The necessity for increased resource mobilization has been highlighted in previous TRP reviews and persists in this grant cycle in a significant proportion of funding requests. Some countries have experienced solid economic growth in the last decade, yet there is an ongoing lack of investment in the health sector. Applicants note the drop in government expenditure in some instances, but do not identify it as a major risk for program implementation or analyze its impact on service provision.

Most applicants do not provide a plan to secure the necessary resources for the HIV, TB and malaria programs and the health sector, which jeopardizes the financial sustainability of investments in HIV, TB, and malaria as well as universal health coverage goals. In other cases, specific activities to increase mobilization have not been clearly described. When sustainability plans have been developed, they are often not implemented. Some funding requests are candid about poor public financial management (PFM) as one of the barriers to ensuring timely disbursements to facilitate service delivery.

### **Recommendations for Applicants on mobilizing increased resources**

1. Applicants are advised to conduct fiscal space analyses, aligned with partners, to enable evidence-based advocacy to increase or at least sustain domestic resources allocation to health, and refine their health sector financing strategy, including feasible mechanisms for domestic resource mobilization (e.g., “sin” tax, improvement of tax base, optimization of the tax collection and tax compliance, development of national insurance schemes).
2. To address the very slow movement on sustainability and transition planning in several countries, including High Impact portfolios, such applicants should conduct analysis and start planning early for transition towards domestic ownership.
3. In several instances, the TRP acknowledged the significant shortfalls in funding were beyond the applicant’s control, e.g., due to natural disasters or a bleak macro-economic outlook. In such cases, applicants should explore alternative external sources of funds, and continue taking small yet decisive steps on sustainability planning and implementing roadmaps.
4. For countries that are nearing elimination of malaria, the TRP emphasizes the urgent investment in long term sustainability and sufficient domestic financial resources being allocated to prevent disease re-introduction and resurgence.
5. Applicants invest in systems to track public expenditure on HIV, TB, and malaria, especially in UHC settings and to use more direct process indicators of the quality of PFM, such as timely disbursement of requested funding. When spending is at sub-national levels, those entities should also be accountable for meeting spending/co-financing requirements.

### **Recommendations for Technical Partners and Secretariat on mobilizing increased resources**

1. The Secretariat should encourage applicants to report PFM indicators such as expenditure on HIV, TB, and malaria as part of performance framework and help design and invest in robust systems to track progress on financial management concerns.
2. As countries devolve spending decisions to the lowest administrative structures, these systems should especially track budgets and spending at sub-national levels. Related to this, governments should be encouraged to hold the sub-national entities also accountable for contributing to the countries' spending/co-financing requirements.
3. The TRP strongly recommends that the Global Fund asks countries to track and report IMF-recommended indicators on external financing dependency and PFM integration including Global Fund grants moving to on-budget and in-budget status.

### **3.4.2 Strengthen focus on value-for-money to enhance economy, efficiency, effectiveness, equity and sustainability**

The TRP noted that several activities and budget items in some funding requests do not reflect good value for money and are not poised for sustainability. These include high human resource costs in program management, numerous daily allowances, “performance” premiums and other salary top-ups, travel related costs, and external technical assistance.

The TRP notes instances of skewed prioritization when program management costs increased compared with GC6 even as key interventions were radically downsized and face major funding gaps. There were instances when applicants are reporting increased domestic financing for the programs, but those funds are largely earmarked for infrastructure support, despite significant gaps in funding for critical commodities and human resources for health.

In a few cases, there was a missed opportunity to improve value for money by modifying the payments mechanism in social health insurance which incentivizes tertiary care rather than in lower-cost, more effective primary care settings.

The TRP also noted the continued problem of high out-of-pocket expenditures and underfunding of public health insurance systems, a fact acknowledged in several of the funding requests. The TRP raised concerns about the equity impact of an applicant's proposal to develop a resource mobilization initiative by instituting user charges.

### **Recommendations to Applicants on Value for Money**

1. Applicants should ensure efficient and lean program management budgets.
2. Applicants to track their progress on reducing household out-of-pocket health expenditures more systematically and regularly.

### **Recommendations to the Secretariat & Partners on Value for Money**

1. Technical partners to support applicants in conducting allocative and technical efficiency analyses for their programs and to incorporate the findings in their funding requests.
2. To ensure evidence-generation on the equity impact of the program's investments and domestic financial protection mechanisms such as social health insurance, partners should support applicants to conduct periodic surveys and studies on out-of-pocket spending.
3. The Secretariat and Health Finance Department should provide clear and practical guidance, and expert advice to countries on how to make value for money-based decisions including trade-offs between the 5 dimensions of value for money. The current guidance outlines the principles clearly; the Secretariat should provide practical examples that will help countries apply these principles while designing their programs. Moreover, countries need more practical support with decision-making and weighing trade-offs between the 5 principles.

#### **3.4.3 Leverage blended finance and debt swaps**

The TRP was encouraged to note some funding requests utilizing blended finance mechanisms (with multilateral banks) to leverage greater HIV, TB and malaria impact. The TRP considers that the blended finance projects, often with a focus on Universal Health Coverage expansion, offer an opportunity to push forward the necessary reforms to move towards more integrated strategic purchasing of health services. In addition, the TRP noted and welcomed so-called virtual pooling of Global Fund investments with World Bank loans in several COE countries, ensuring alignment and integration with larger primary level programs.

Several of these programs, however, have an associated element of provider-level performance-based financing (PBF); success of PBF programs is heavily dependent on context, design and robust monitoring and evaluation mechanisms. The funding requests did not provide sufficient information on the value-for-money of the PBF schemes attached to the blended finance programs.

### **Recommendations to Applicants on blended finance**

1. The TRP notes that according to evidence from similar contexts, provider-level PBF might not be the most efficient modality and cannot, on its own, resolve health system bottlenecks. If the applicant cannot provide robust evidence on the value for money of its PBF program and if its efficiency is not demonstrated, the TRP recommend they reconsider their approach.
2. As PBF is institutionalized, systematic monitoring of lessons learned from implementation of pilots is required to continue to inform and consolidate the design of the PBF schemes.

### **Recommendations to the Secretariat on blended finance**

1. The TRP would like to draw the attention of the Global Fund Secretariat, especially the Country Teams and Health Finance Department, to the importance of closely monitoring blended finance projects; the provider-level PBF modality, which is often associated with the blended finance applications, is a complex intervention which encompasses several intertwined components, which require institutional reforms.
2. Both academic evidence and the recent impact evaluation of provider-level PBF conducted by the World Bank conclude that financial incentives have mixed results and are not always as efficient as other programs such as direct facility financing and demand-side financing. Furthermore, evidence shows that PBF schemes do not guarantee that countries will implement the necessary health financing reforms towards more strategic purchasing.

### **3.4.4 Support country health financing systems**

The TRP also noted that while integration of HIV, TB and malaria services in social health insurance (SHI) offers a promising path to sustainable financing, progress on SHI development has been slow and uneven. The TRP noted the impact of SHI funding gaps and bottlenecks on a stable supply of health products as well as co-payment requirements. These bottlenecks hinder the continuity of services.

### **Recommendations to Applicants on health financing systems**

1. The TRP encourages applicants to expedite the use of domestic financing from national and subnational budgets and use national procurement systems to contract CSOs and the private sector for delivery of health systems. Systematic monitoring of lessons learned from the implementation of the social contracting pilots is required to continue to inform and consolidate the design of the model.
2. In the case of SHIs, when the legal framework allows, the TRP recommends that malaria, HIV and TB services are costed and integrated into the benefits package of care and that there are clear plans to ensure equity and social protection for the poor. However, countries should ensure financing public health activities not covered by SHI.
3. The TRP encourages applicants to continue refining their SHI policies by addressing areas of inefficiency such as the provider payment mechanism, hospital-centered service delivery, and pharmaceutical spending.

### **Recommendations to the Secretariat & Partners**

1. The TRP finds the proposed public contracting and social health insurance mechanisms promising complementary strategies for domestic resource mobilization and ownership of programs. Countries, however, struggle with the complex political, legal, financing, and regulatory reforms necessary to institutionalize these mechanisms. The Global Fund is understandably cautious in its support for these reforms, given the perceived programmatic and financial risk they present. The TRP is encouraged to find evidence in its reviews of countries where the Global Fund played a strong catalytic role in advancing these reforms through financing and institutional support. The TRP would encourage the Secretariat to share lessons from such countries and incentivize other countries (and Country Teams) to consider such approaches.