Advisory Report

Grant implementation in Western and Central Africa (WCA)

Overcoming barriers and enhancing performance in a challenging region

GF-OIG-19-013
May 2019
Geneva, Switzerland

The Global Fund
Office of the Inspector General

Chapter Contents

1. Executive Summary

Background

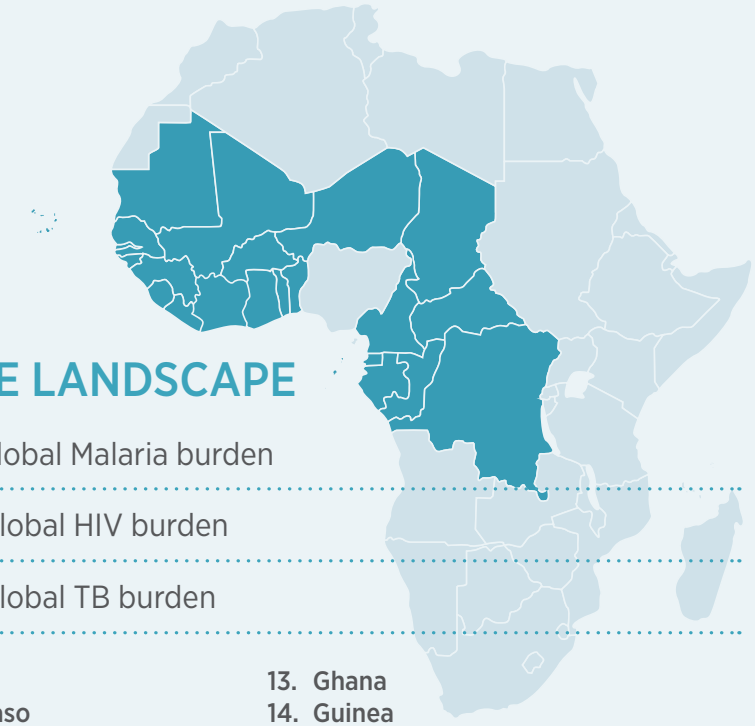
70% of countries in the region have a low utilization of past allocations

In May 2018, Program Finance assessed corporate absorption rates across the Global Fund portfolio. Against the target Key Performance Indicator of 90%, the assessment highlighted that the Western and Central African (WCA) countries are below target. While some countries were very close to meeting the KPI, many of the countries in WCA were far off:

- Eleven Countries are between 70-90%; and
- Six countries are below 70% (Mali, Chad, Liberia, Congo, Mauritania, Gabon)

The assessment suggested that there are potential opportunities to improve portfolio performance and therefore grant absorption of countries within the Western and Central Africa region. It also pointed out that some of the reasons for the low absorption are specific to the region and not sufficiently understood to enable the development of effective solutions.

At the request of the Executive Director, the Office of the Inspector General completed an advisory review for a more in-depth analysis around key implementation bottlenecks and drivers of successful program implementation in the region, looking beyond financial management.



DISEASE LANDSCAPE

- 40% - Global Malaria burden
- 9.2% - Global HIV burden
- 5.8% - Global TB burden

1. Benin
2. Burkina Faso
3. Cameroon
4. Cape Verde
5. Central African Republic
6. Chad
7. Congo
8. Congo (Democratic Republic)
9. Côte d'Ivoire
10. Equatorial Guinea
11. Gabon
12. Gambia
13. Ghana
14. Guinea
15. Guinea-Bissau
16. Liberia
17. Mali
18. Mauritania
19. Niger
20. Sao Tome and Principe
21. Senegal
22. Sierra Leone
23. Togo

Nigeria has been excluded from the scope of this advisory due to the unique context and challenges faced in the country as well as significant transformations in progress.
The Global Fund has no current investments in Equatorial Guinea.

1. Executive Summary

Good performance in a challenging region

Western and Central Africa is a challenging environment

The region has a number of inherent challenges for implementing grants and achieving optimal portfolio performance.

- **High Fragility and Instability:** 18 countries have experienced major crises in the last decade. The Ebola epidemic in West Africa killed over 11,000 people and significantly damaged the health sector.
- **Weak Health Systems:** Human resources for health are three times lower than in the Rest of Africa.
- **Limited Fiscal Space:** GDP is 6.5 times smaller than in the Rest of Africa. 5 countries have experienced significant economic recessions in the last 5 years. 13 countries have experienced reductions in real government expenditure.
- **Low Health Financing:** Government health expenditure per capita is 3 times lower than the Rest of Africa. Out-of-pocket payments on health are proportionately 36% higher than the Rest of Africa.
- **Funding Gap:** The region has an overall funding gap of 50% across the three diseases. The Global Fund is the largest funder in the region, representing 55% of TB, 45% of Malaria and 32% of HIV funding

Global Fund Investments

- **Financial:** Since 2002, the Global Fund has invested US$6.9bn for Western and Central Africa across all three diseases (18% of total Global Fund investments). 53% of total Global Fund investments have been directed at Malaria due to its 40% contribution to Global Disease Burden. US$$1.2bn has been invested in Health System Strengthening since 2014.
- **Human Resources:** The Global Fund has 85 FTE for the region (five FTE per $100m invested, compared to two FTE per $100m in the Rest of Africa). 16 WCA countries have a dedicated Fund Portfolio Manager.
- **Strategic Initiatives:** Since 2014, the Global Fund has conducted a number of initiatives addressing grant implementation, including projects on Financial Management, Monitoring and Evaluation, Procurement and Supply Chain, and Human Rights.

Performance against the three diseases

31% reduction in Malaria deaths between 2010-2016

The Malaria incidence rate has also decreased by 23%, case management in 2017 was 87% against target, and LLIN coverage was 72% in 2016, with 215 million having access to bed nets.

27% reduction in AIDS deaths between 2010–2017

New HIV infections fell by 12% between 2010 and 2017. While the region is behind the Rest of Africa on all targets in the HIV (90-90-90) treatment cascade, significant improvement has been noted since 2015. ART coverage increased by 29.2% between 2010 and 2017.

5% increase in TB deaths between 2010-2016

The region is significantly lagging behind in the fight against TB. Its global contribution to total TB deaths rose from 7% in 2010 to 9% in 2016. TB incidence rates have increased by 10%, and TB missing cases have risen by 8% since 2010, representing 48% of total estimated cases in the region.

Multiple factors influence the performance of Global Fund programs. Some of these are out of the organization's control (State fragility and stability, In-Country Governance and Leadership), some are within it (Global Fund internal processes) and some fall in between (Partner and Donor coordination, Health Systems Strengthening and Implementation Arrangements). The advisory review focused on areas where the organization had partial or full control.

Source: UNAIDS 2018 HIV Data, WHO 2017 TB & Malaria Data

1. Executive Summary

The Global Fund Processes

CHALLENGES

A fine balance between risk mitigation measures and simple, flexible processes that can be tailored to the specific country context is a critical enabler to successful program implementation. A number of challenges impact Global Fund performance in the WCA region:

- The **Challenging Operating Environment Policy is not effectively operationalized** - standard GF policies and processes still drive how grant management is performed.
- Additional safeguards have led to an **imbalance between financial and fiduciary risk mitigation measures and grant implementation:** (i) conflicted role for the fiscal agent, (ii) zero cash policy not differentiated, and (iii) lack of regular assessments and exit plans.
- **Absence of a regional approach to grant management** limits the Global Fund's ability to engage in and leverage external regional reviews/initiatives, and to share regional knowledge internally,
- **Limited granular data available from support functions** (TAP, RSSH, CRG, etc.) to support decision making at regional level.

RECOMMENDATIONS

Simplify interventions for COEs, define flexibilities in grant implementation and ensure the right balance between financial safeguards and program implementation

- Identify and focus on a targeted set of **key strategic priorities for COEs** in WCA
- **Implement flexibilities** for challenging operating environments in WCA
- **Perform a baseline assessment** for each WCA country with additional safeguards
- Apply a **differentiated approach** to the implementation of Zero/Restricted/ Limited cash policy
- **Focus Fiscal Agents as a control function and shift the capacity building function** to longer term Technical Assistance providers.

Adopt a regional approach to Grant Management, elevate the role of support functions in assisting GMD with relevant data and thematic strategies and improve on-ground monitoring and donor coordination by appointing a long term in-country technical assistance resource. The Secretariat could improve regional coherence either by organizing GMD departments along relevant regional portfolios that may include a mix of High Impact, Core and Focused portfolios or by:

- **Designating focal points for all key initiatives and partners** to ensure a more structured harnessing of regional partnerships and initiatives.
- **Developing approaches to address regional programmatic needs,** including a sub-regional approach where appropriate, e.g. how to better deliver impact on Malaria in the Sahel 5 countries.
- **Improving knowledge sharing,** both on grant management and programmatically.

1. Executive Summary

Implementation Arrangements

CHALLENGES

Multiple implementation arrangements are utilized across Western and Central Africa, presenting three main challenges:

- Implementation at **central level** by Principal Recipients with **limited mandate in delivering health services** and no hierarchical, functional or financial relationship with service delivery entities.
- The Global Fund Implementers (National Programs and National Aids Council) do not have a mandate to implement healthcare delivery services. They are in charge of policy making, adoption of global treatment guidelines, monitoring and evaluation, program supervision, training, and overall coordination of the disease response.
- **Vertical implementation** and lack of integration among the three diseases are **not conducive to efficiency at central level,** and **increasing the burden on service delivery** functions at lower levels.

  Fragmented management arrangements at the central level between the three disease programs create an increased burden on health service delivery functions at the regional, district and facility levels, due to uncoordinated requests for financial reporting and data, as well as multiple M&E and other oversight activities.
- **INGOs and UN Agencies can fill significant gaps** and have a strong track record in targeted service delivery roles such as executing key populations and community activities and managing supply chain and LLIN campaigns. When INGOs or UN agencies are **used as 'pass-through' PRs** for financial management purposes, the grant ratings for INGOs are generally in line with those achieved by MOH PRs. However, **for the same level of performance, INGOs are typically more costly,** with much higher management costs than government PRs.

RECOMMENDATIONS

Integrate implementation using entities in charge of service delivery in a decentralized manner. Notwithstanding the limited country capacity and high financial and fiduciary risk in many of the countries in the region, there are still opportunities to:

- **Integrate the three disease programs at central level by creating a structure** that will regroup the key support functions: Finance, M&E, PSM, Administration, etc.
- Maintain MOH central role in the implementation and reinforce the accountability at lower levels by having **triparty contracts** between the PMU, General Health Directorate and Regional Health Directorates who are in charge of service delivery at regional level.
- **Ensure the implementation arrangements leverage the mandate and core competencies of various type of implementers** to balance programmatic needs and fiduciary responsibilities:

  (i) Maintain the **National Programs and National AIDS Councils as Sub-Recipients** to develop policies, advocacy and coordination of the disease response – in line with their mandate.

  (ii) Where country capacity is limited or financial and fiduciary risks remain high, use INGOs as pass-through PRs as a temporary solution, ensuring specific **time bound capacity building plans** are in place for national entities.

  (iii) Use the INGOs for their service-delivery mandate, based on their specific competencies, to fill critical gaps in areas such as mass campaign distribution, key populations activities, community health systems and supply chain.

1. Executive Summary

Access to Health

CHALLENGES

Although HIV incidence is lower than in the rest of Africa, there is less progress on improving the 90-90-90 cascade. Less people living with HIV have access to treatment and mortality is higher. Missing tuberculosis cases are increasing, as are the number of deaths. Barriers to accessing health services contribute to the lagging performance on HIV and TB.

- **Financial barriers:** Gratuity policy is different from country to country with **significant costs to patients in accessing health care.** In an environment that is under-funded, health workers are under paid or not paid at all.
- **Geographical barriers:** Population is rural based and there is limited health infrastructure and human resources. Community activities are designed in silos (TB, malaria etc) and are not integrated.
- **Social barriers:** Stigma and discrimination are high, with 19 WCA countries having HIV criminalization laws. Civil society is less mature and organized than Rest of Africa.

RECOMMENDATIONS

- The Global Fund should be **more prescriptive/strategic in the co-financing requirements** to ensure that it strikes the right balance between the financial sustainability of the health system and the gratuity of services for patients.
- **Direct counterparty financing to finance the health workforce and to support health facilities with gratuity.**
- **Enhance mechanism to monitor the use of counterparty financing** in order to ensure visibility on the utilization of funds.
- **Integrate community activities for the three diseases to ensure common package of services is defined** (e.g. case management for malaria, TB active case finding and lost to follow up activities, etc.).
- **Building on current ongoing Thematic Reviews on user fees** being implemented for selected countries, clarify an organizational approach to user fees and implement country by country, working with partners.

1. Executive Summary

Technical Assistance (TA)

CHALLENGES

The Global Fund provides approximately US$10m annually in technical assistance for the region, and a number of partners provide technical assistance to support disease programs and transversal investments in Resilient and Sustainable Systems for Health (RSSH). Some bilateral donors do so as part of their pledged contribution during the Global Fund replenishment, such as France through the 5% initiative and Germany through the BACKUP Health initiative. Managing such contributions is inherently difficult for the Global Fund due to lower control and influence in leveraging technical assistance for in-country programs. National systems to manage coordination, assessment and evaluation are often weak. Key challenges for technical assistance include:

- **Limited TA coordination** between key partners at country level (Expertise France, GIZ Backup and The Global Fund) to ensure assistance is targeted and tailored.
- **Expertise France operating model:** significant component based on ad hoc, country requests.
- **Global Fund financed technical assistance** not based on needs assessment, not specific nor monitored regularly against KPIs.
- **Lack of effective coordination and implementation mechanisms** at country level limit the effectiveness of RSSH investments.

RECOMMENDATIONS

- Perform **a consolidated needs assessment for technical assistance** to inform TA approach and interventions in short to medium term (grant cycle) and over longer term (strategy cycle).
- Engage with countries and partners (France, GIZ, UNAIDS, WHO, etc.) and **identify a lead agency to coordinate and lead joint programmatic technical assistance.**
- **Develop TA framework agreements** with partners who are key providers or supporters of technical assistance in WCA, with the objective of prioritizing long term TA conducive to capacity building rather than ad hoc interventions to fill short term gaps.
- **Develop clear terms of reference to guide each TA intervention,** including specific objectives, clear milestones, KPIs to track progress, and annual evaluation process.

2. Objectives and Methodology

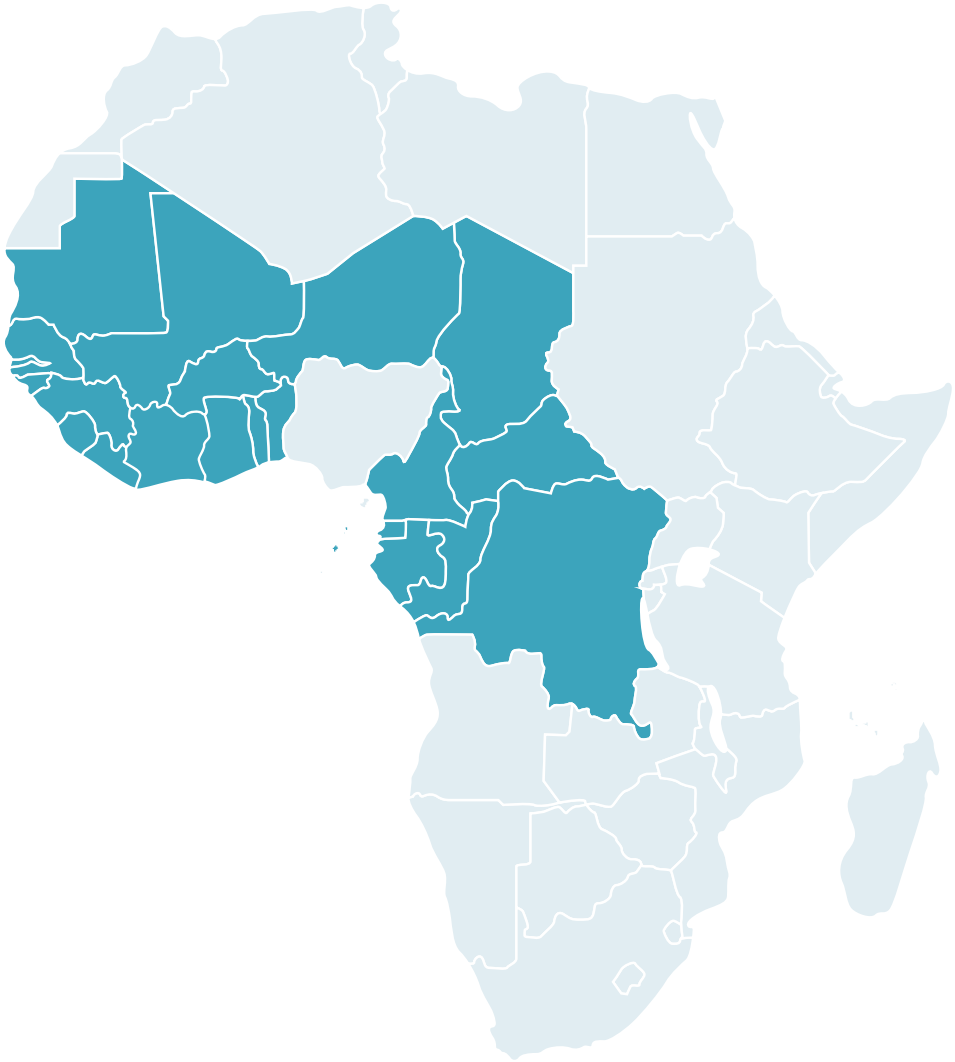
Advising the Global Fund on Grant implementation in West and Central Africa

To advise the Secretariat on identifying and addressing implementation bottlenecks in Global Fund grants to Western and Central Africa (WCA). Key focus areas include:

- Current effectiveness of Global Fund programs in WCA;
- Key drivers of success and lessons learnt behind successful programs;
- Root causes of program implementation challenges and bottlenecks;
- Potential opportunities to improve on the current performance of the organization's investments for countries in the WCA Region.

The countries in scope were as follows[1]:

1. Benin
2. Burkina Faso
3. Cameroon
4. Cape Verde
5. Central African Republic
6. Chad
7. Congo
8. Congo (Democratic Republic)
9. Côte d'Ivoire
10. Equatorial Guinea
11. Gabon
12. Gambia
13. Ghana
14. Guinea
15. Guinea-Bissau
16. Liberia
17. Mali
18. Mauritania
19. Niger
20. Sao Tome and Principe
21. Senegal
22. Sierra Leone
23. Togo



[1] Nigeria has been excluded from the scope of this advisory due to the unique context and challenges faced in the country as well as significant transformations in progress.

The Global Fund has no current investments in Equatorial Guinea.

2. Objectives and Methodology

Advising the Global Fund on Grant implementation in West and Central Africa

Objectives and methodology

QUANTITATIVE ANALYSIS

- Country and regional demographics
- Disease and allocation
- Macro economics
- Health financing and Funding landscape
- HSS data
- Performance data

QUALITATIVE ANALYSIS

- OIG audit and investigation reports
- Risk reports
- Partner reports
- Global Fund policies and procedures
- Technical review panel reports
- TERG reports

STAKEHOLDER CONSULTATIONS

	HEADQUARTERS	IN COUNTRIES	
Donors	• France: Ministry of Foreign Affairs • France: Expertise France • France: Agence Française de Développement • Germany: GIZ	• DFID • European Union • France, government of	• IrishAid • JICA • USAID/PEPFAR
United Nations	• WHO	• UNAIDS • UNDP • UNICEF	• WHO • World Bank
Civil society	• Catholic Relief Services • Coalition Plus • Croix Rouge Francaise • Friends of the Fund Europe • Médecins Sans Frontières • SOLTHIS	• Catholic Church • LIBNEP+ • LIPRIDE • Lutheran Church	• Médecins Sans Frontières • PHIL • TNOL

12 COUNTRIES VISITED

Country	OIG Audit Countries 2018	In-Country Visits
Burkina Faso		●
Senegal		●
Mali		●
Niger	●	
Guinea Republic		●
Benin	●	
Mauritania		●
Ghana	●	
Sierra Leone	●	
Liberia		●
Chad	●	
Democratic Republic of the Congo	●	

- ☐ 6 audited in 2018 – Niger, Chad, Benin, Ghana, DRC, Sierra Leone
- ☐ 6 WCA-specific workshops – Mauritania, Mali, Senegal, Guinea, Burkina Faso, Liberia
- ☐ 55% of countries in the region
  71% of allocation in region
  74% of Malaria burden
  100% Sahel Countries

Chapter Contents

Disease Burden and other key demographics

A malaria burden region representing 25% of Africa's population

3. CHALLENGING REGION

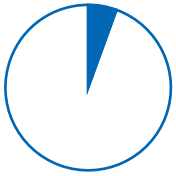
HIV

9.2%
OF GLOBAL DISEASE burden

14%
OF GLOBAL DEATHS

9.2%
OF GLOBAL NEW INFECTIONS

TB



5.8%
OF GLOBAL DISEASE burden

9%
OF GLOBAL DEATHS

Malaria

40%
OF GLOBAL DISEASE burden

12.5%
OF GLOBAL POPULATION AT RISK

45%
OF GLOBAL DEATHS

Demographics

- Total population is 297.3m – 25% of the population of Africa.
- 44% of the WCA population is under 15 years old (2015)
- Official languages in WCA:
  - 15 Countries are Francophone
  - 4 Countries are Anglophone
  - 4 Countries are Lusophone

Sources: World Population Prospects: The 2017 Revision, UN Department of Economic and Social Affairs
Global Fund Disease Burden Share of Global Fund Portfolio - updated with 2017 data releases, Allocation Team - SIID
Global Fund Data on HIV Impact Indicators based on UNAIDS 2018 data sets, Strategic Information Team - SIID
Global Fund Data on TB & Malaria Impact Indicators based on WHO 2017 data sets, Strategic Information Team - SIID

3.1. Limited Fiscal Space

Gross domestic product and Government expenditures

Gross Domestic Product in absolute and per capita

Overall the total GDP of the WCA countries is 6.5 times smaller than the Rest of Africa (2017).

The Average GDP per Capita in the WCA region is also 33% lower than in the Rest of Africa (2017 - unweighted average).

The wider macroeconomic context feeds into the domestic financing of the wider RSSH landscape, as well as medical/clinical resourcing that impacts Global Fund programs. It also increases pressure on funding coming from external donors (including the Global Fund) to drive impact in the region.

There are large disparities in GDP per capita for the WCA countries. The highest GDP per capita in the region is over 32 times larger than the lowest, and 13 of the 23 countries are classified as Lower Income countries, with GDP per capita of under US$1,000.

Government expenditure

Taking inflation into account, several countries have experienced significant reductions in government expenditure, and the decline in real government expenditure is projected to continue into the next allocation cycle in 9 out of the 23 WCA countries.

This results in an overall decrease in real government spending that also impacts investment into health care provision and RSSH affecting GF programs in country.

Western and Central Africa has 33% lower GDP per capita than Rest of Africa

Country	Income status (2017)	GDP per capita	Real increase in gov. exp. 2012-2014	2015-2017	2018-2020
Central African Republic	LI	387	-18.6%	8.5%	10.6%
Niger	LI	440	26.5%	-0.7%	-2.3%
Congo (Democratic Republic)	LI	478	17.2%	-7.5%	-7.5%
Gambia	LI	480	6.4%	10.5%	12.9%
Sierra Leone	LI	491	6.1%	6.4%	6.8%
Togo	LI	611	8.9%	-3.7%	-4.2%
Burkina Faso	LI	664	6.4%	14.1%	12.6%
Liberia	LI	729	9.4%	3.1%	3.6%
Guinea	LI	749	12.8%	0.0%	-0.9%
Guinea-Bissau	LI	794	11.6%	-3.4%	2.7%
Chad	LI	810	6.5%	-14.3%	-19.3%
Mali	LI	811	1.8%	10.8%	11.2%
Benin	LI	830	4.9%	12.1%	9.0%
Senegal	Lower-LMI	1'038	5.3%	5.3%	4.7%
Mauritania	Lower-LMI	1'318	16.1%	-0.9%	-4.2%
Cameroon	Lower-LMI	1'401	9.2%	1.7%	0.8%
Côte d'Ivoire	Lower-LMI	1'617	14.7%	12.2%	12.6%
Ghana	Lower-LMI	1'663	10.4%	-3.6%	2.4%
Sao Tome and Principe	Lower-LMI	1'785	-12.8%	7.0%	8.0%
Congo	Upper-LMI	1'958	35.3%	-20.0%	-28.5%
Cape Verde	Upper-LMI	3'238	-2.1%	3.9%	2.6%
Gabon	UMI	7'972	8.2%	-4.7%	-8.5%
Equatorial Guinea	UMI	12'727	6.3%	-17.7%	-27.5%

Source: World Development Indicators, World Bank

Source: Global Fund Health Financing Dashboard on Macroeconomic Indicators based on IMF WEO data sets, Health Financing Team - SIID

3.2. Low Health Financing

Western and Central Africa average health expenditure is three times less than Rest of Africa

3. CHALLENGING REGION

Average Government Health Expenditure

As per the Abuja declaration (April 2001), heads of state of African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector. The average for WCA countries is 5.34% (unweighted average) versus 7.55% for the Rest of Africa.

Average Government Health Expenditure per capita health spend for the WCA region (unweighted average) has been historically lower than the rest of Africa.

WCA	VS	ROA
25.19 USD		73.61 USD

This means that per capita a citizen in WCA was historically receiving only a third of the Govt. financial support of an African citizen outside the region.

This limits investments into broader health care, weakening the impact of Global Fund grants that rely on the wider health sector infrastructure.

Average Out Of Pocket Expenditures (OOPS)

For Western Central Africa the OOPS average stands at 45.02% compared to 33.67% (unweighted average) in the Rest of Africa. This means that on average people in the region pay almost 36% more in health care costs than citizens in the Rest of Africa.

NB: this represents OOPS for all health care as opposed to HIV/TB/Malaria specific services, where disaggregated data does not exist.

WCA	VS	ROA
45.02%		33.67%

Country	Average Out-of-pocket (OOPS) as % of Current Health Expenditure (2010-2015)	Average per Capita Govt. Health Spend (2010-2015) - US$
Democratic Republic of the Congo	38.5	2.20
Central African Republic	42.9	2.72
Guinea	60.9	3.48
Mali	57.6	5.73
Sierra Leone	53.6	6.35
Niger	56.9	6.38
Liberia	28.5	6.44
Benin	42.1	8.05
Togo	57.4	8.91
Guinea-Bissau	44.8	9.05
Burkina Faso	33.6	10.30
Chad	58.5	10.40
Cameroon	67.6	10.48
Gambia	20.6	11.06
Senegal	44.4	12.84
Côte d'Ivoire	52.9	13.22
Mauritania	54.6	16.88
Congo	41.1	28.12
Ghana	41.0	38.34
Sao Tome and Principe	17.0	41.62
Equatorial Guinea	68.3	73.81
Cabo Verde Republic of	25.6	104.22
Gabon	27.3	148.77

Source: Global Fund Health Financing Dashboard on Macroeconomic Indicators based on WHO GHED data sets, Health Financing Team - SIID

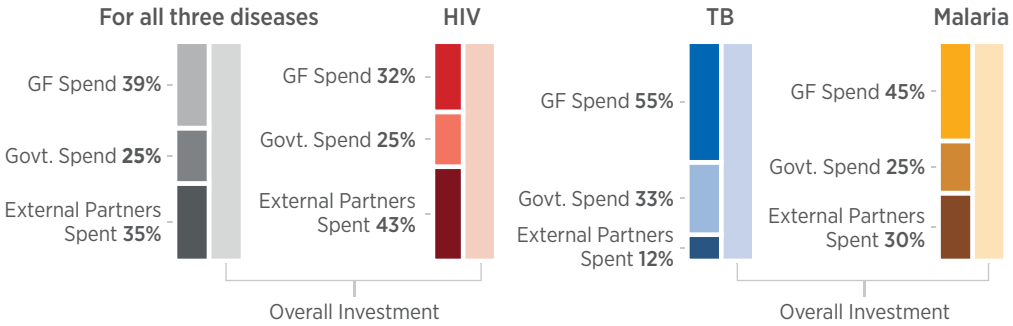
3.3. Large Funding Gap

Partners are complementing limited government investments in health, but gaps remain

Global Fund investments to WCA countries

Investments to date in the WCA countries from the Global Fund total US$6.9bn across all three diseases.

Between 2012–2017, Global Fund Investments in the region equated to US$3.6bn (US$6.9bn since 2002) which represented 39% of the total investment (Government, External Funding and Global Fund) in the three diseases. The Global Fund is the largest funder of the three diseases in the region with 55% in TB, 45% in Malaria and 32% in HIV.



WCA Funding Gap – Regional View

Per the HIV/TB/Malaria National Strategic Plans for the three diseases, the funding requirements for 2015-2017 WCA countries were unmet by 50%. This amounts to a funding gap of US$4.65bn. Between the three diseases this looks as follows:

- HIV had a 63% unmet funding need (US$3.1bn)
- TB had a 55% unmet funding need (US$0.4bn)
- Malaria had a 31% unmet funding need (US$$1.1bn gap)

NB: several countries in the region have funding gaps much higher than the WCA Aggregated average. Congo, CAR and DRC had significant recent funding gaps of up to 74% of total need.

Country	Total GF Investment 2012-2017 %	Total Govt. Investment 2012-2017 %	Total Ext. Investment 2012-2017 %
Sierra Leone	83%	9%	8%
Gambia	78%	12%	10%
Guinea-Bissau	72%	12%	16%
Togo	66%	18%	16%
Sao Tome and Principe	55%	18%	28%
Chad	53%	25%	22%
Congo (Democratic Republic)	53%	5%	42%
Benin	52%	15%	33%
Guinea	51%	18%	31%
Liberia	43%	21%	36%
Niger	43%	33%	24%
Senegal	43%	15%	42%
Burkina Faso	41%	30%	29%
Cape Verde	38%	48%	14%
Cameroon	36%	34%	31%
Mauritania	35%	46%	19%
Mali	32%	11%	57%
Côte d'Ivoire	24%	18%	58%
Ghana	24%	55%	20%
Congo	21%	65%	14%
Gabon	7%	90%	3%
Central African Republic*			

Sources: Global Fund Disbursement Data, Global Fund External Website (Dec 2018)
Global Fund Financing Shares 2015-2017 derived from landscape tables in funding requests & NSP need as reported by Countries, Health Financing Team - SIID

* No data available

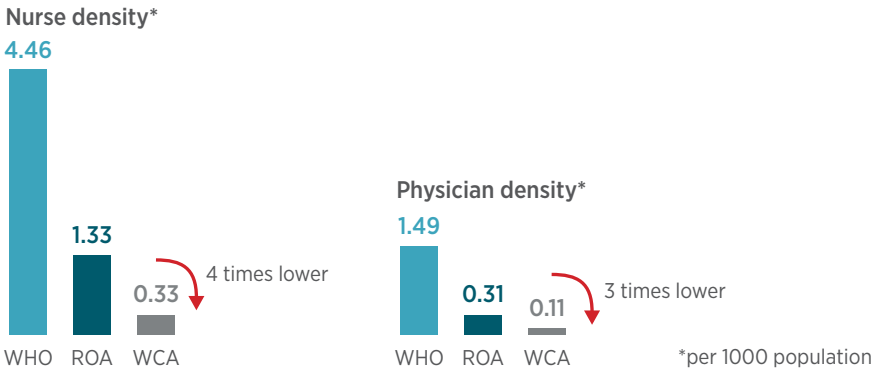
3.4. Weak Health Systems

Western and Central Africa has 3 times less doctors than the Rest of Africa

3. CHALLENGING REGION

Human Resources for Health

A significant gap in RSSH in the WCA countries is in Human Resourcing for Health.



The above indicators (unweighted average) highlight a concentrated HRH gap in the WCA region that impacts the resources available in country to implement Global Fund and other donor programs. However significant data gaps on these indicators were noted across WCA and ROA.

RSSH – Infrastructure & Equipment

The GF RSSH dashboard benchmarks key RSSH components against established targets set by WHO and other agencies.

The infrastructure indicator focuses on provision of facilities, clinics, and hospital beds for patients. There is very low scoring on this metric across the region with the average unweighted scoring being 20.1% - with only countries like Cape Verde, Gabon and Sao Tome having stronger scores.

RSSH – Governance and Leadership

The World Bank ranks countries globally on their Government Effectiveness. Countries are given a score from 0-100, with the higher the score the better the effectiveness.

17 of the 23 countries in the WCA region are in the bottom quartile (worst performing). This highlights a significant concentration of weak Government Effectiveness in the WCA region.

Source: Global Fund RSSH Dashboards data derived from WHO/World Bank Data Sets, RSSH Team - SIID

Country	Government Effectiveness
Cape Verde	59.13
Ghana	49.04
Senegal	40.38
Burkina Faso	30.77
Benin	26.44
Gambia, The	25.96
Niger	24.04
Mauritania	22.60
Côte d'Ivoire	21.63
São Tomé and Principe	20.67
Cameroon	19.71
Mali	17.31
Gabon	16.83
Guinea	13.94
Togo	12.50
Congo, Rep.	11.06
Sierra Leone	10.58
Liberia	8.17
Equatorial Guinea	6.73
Chad	6.25
Congo, Dem. Rep.	4.81
Guinea-Bissau	3.37
Central African Republic	2.88

2nd Quartile 3rd Quartile 4th Quartile (Bottom)

Source: World Bank Governance Data 2017, World Bank website

3.5. Fragile Environments

A fragile and risky environment

Fragile State Index

The FSI score is a composite of 12 conflict risk indicators used to measure the condition of a state at any given moment. The Fragile States Index is based on a conflict assessment framework that was developed nearly a quarter-century ago for assessing the vulnerability of states to collapse. It uses a scale of 0 to 178 (the lower the number, the weaker the state).

15 of the 23 countries in the WCA region are in the weakest quartile. They represent a significant concentration of weakened states in a region where the Global Fund is operating.

Corruption Perception Index

The CPI index ranks 180 countries and territories by their perceived levels of public sector corruption, using a scale of 0-100 (0 is highly corrupt, 100 is very clean).

7 out of the 23 countries in the WCA region are in the lowest quartile (the top 25% worst) on the CPI based on their 2017 scoring.

> 65% of Western and Central African Countries are among the world's most fragile states

	Fragility Index				Corruption Index		
Country	2015	2016	2017	2018	2015	2016	2017
Central African Republic	3	3	3	5	24	20	23
Congo Democratic Republic	5	8	7	6	22	21	21
Chad	6	7	8	8	22	20	20
Guinea	10	12	12	13	25	27	27
Guinea Bissau	17	17	16	16	17	16	17
Niger	19	19	20	21	34	35	33
Cameroon	28	22	26	23	55	59	55
Côte d'Ivoire	15	21	21	25	32	34	36
Mali	30	29	31	27	35	32	31
Congo Republic	33	31	29	29	23	20	21
Liberia	21	27	27	30	37	37	31
Mauritania	26	28	28	31	31	27	28
Sierra Leone	31	34	38	35	29	30	30
Gambia	51	48	37	42	28	26	30
Burkina Faso	39	41	44	45	38	42	42
Togo	47	51	56	49	32	32	32
Equatorial Guinea	54	53	51	55			17
Senegal	60	59	60	62	44	45	45
Benin	73	72	73	74	37	36	39
Gabon	104	98	91	88	34	35	32
Sao Tome and Principe	93	94	97	92	42	46	46
Ghana	100	102	108	108	47	43	40
Cape Verde	94	101	106	110	27	26	25

Source: Fund for Peace's Fragile State Index 2018, Fund for Peace Website

Source: Transparency International CPI data 2017, Transparency International Website

3.5. Fragile Environments

Multiple enduring conflicts and crises impacting health development in WCA

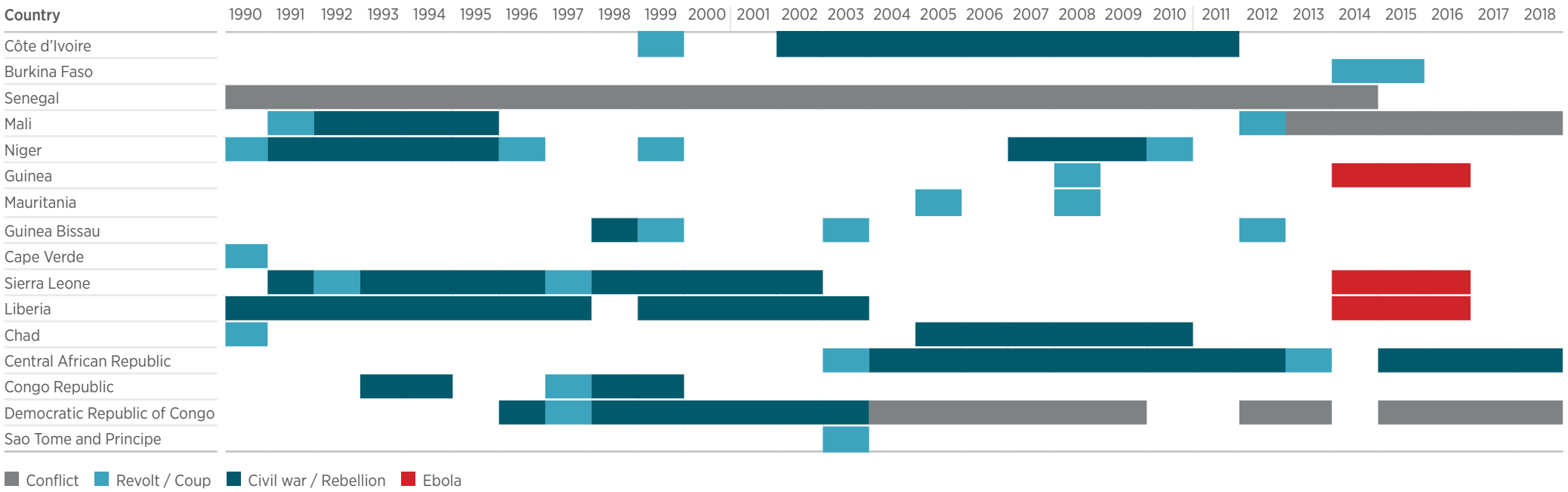
Conflicts

The WCA region has been heavily impacted by numerous revolts, coups, regional conflicts and full scale civil wars. 18 out of the 23 countries have experienced one of these events. Since 1990 there have been at least 21 coups, over a dozen civil wars and localized conflicts. As of 2018 there are still 3 fully fledged active conflicts in the region. All have had a negative impact on health care and service provision relating to the three diseases either through disruption of supply chains, fleeing populations or killings in general.

Ebola

The WCA region has been impacted by multiple outbreaks of Ebola since the first outbreak in 1976. These outbreaks have heavily impacted Health Systems, directly affecting performance on combating the three diseases.

The West African Ebola epidemic in Liberia, Sierra Leone and Guinea was the largest in history. Starting in March 2014, the virus killed over 11,000 people and was only declared over in June 2016. The epidemic had severely negative impacts on health systems in the countries impacted. With the Ebola outbreak in DRC still ongoing, the impact of Ebola is not just a historic concern.



Source: WHO & CDC factsheets on Ebola Outbreaks in West Africa, WHO/CDC website

Chapter Contents

3. Challenging Region

PAGES 12 - 18

3.1. LIMITED FISCAL SPACE

- GDP per capita is 33% lower than Rest of Africa

3.2. LOW HEALTH FINANCING

- Average government health spend per capita is 3 times lower than Rest of Africa

3.3. LARGE FUNDING GAP

- An overall funding gap of 50% with 31% unmet funding need for Malaria

3.4. WEAK HEALTH SYSTEMS

- Human resources for health are 3 times lower than Rest of Africa

3.5. FRAGILE ENVIRONMENT

- 65% of countries in the region are among the world's most fragile states consistently since 2012

4. Global Fund Investments

PAGES 20 - 24

4.1. FINANCIAL RESOURCES

4.2. HUMAN CAPITAL

4.3. STRATEGIC INITIATIVES

4.1. Financial Resources

Significant financial investments provided to the WCA region

Since 2002, The Global Fund has invested significantly in the WCA region. Total investments amount to US$6.9bn across all three diseases including health systems strengthening. This represents 18% of total Global Fund investments of US$39.4bn.

The three diseases

US$3.3bn of investments have been directed towards malaria, representing 30% of total malaria investments. WCA's malaria burden is 40% of the global total.

In contrast the WCA region has received 14% of the total Global Fund standalone HIV investments although the current WCA HIV burden is 9.2% of the global burden. WCA has received 9% of total funding in TB in comparison to a 5.8% global burden.

The region has received over US$0.6bn of Global Fund investment since 2002 through standalone TB grants which account for 9% of total Global Fund investments in TB. There was also a further US$0.1bn in HIV/TB grants, accounting for 9% of total Global Fund investment in HIV/TB.

RSSH

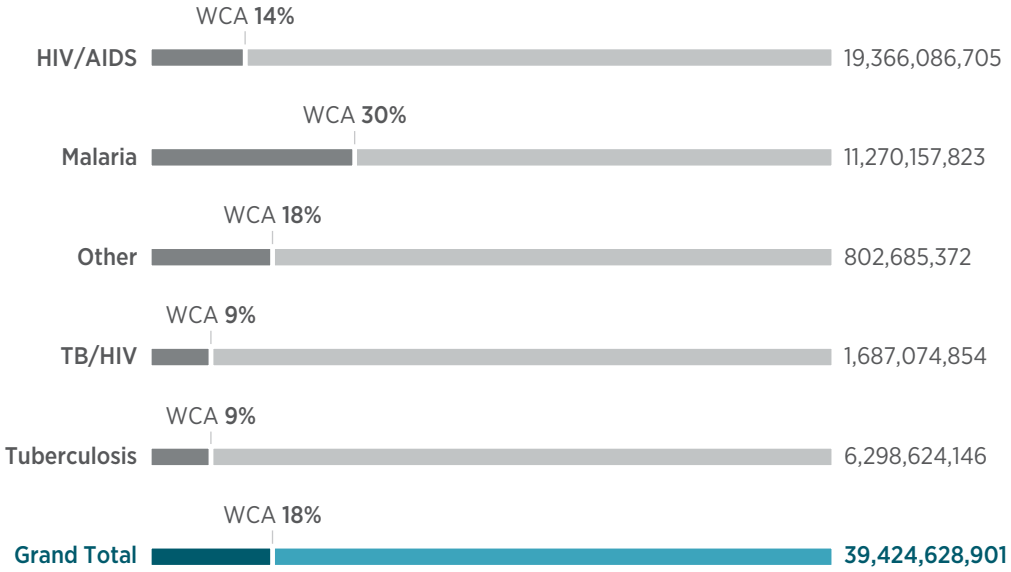
Since 2014, US$1.1bn has been invested in health system strengthening for WCA countries out of a total of US$5.3bn. This is funding from both standalone RSSH grants and also funding incorporated into disease specific grants. This represents 36% of all funding invested since 2014.

Annual operational expenditures

In addition, the Global Fund contributes approximately US$25 million of its annual operational expenditure towards Local Fund Agents, Fiscal Agents and Country Coordinating Mechanisms in the region.

Financial Investment

Total GF investment since Inception



US$6.9bn invested in the region, including US$1.1bn in health system strengthening

Source: Global Fund Disbursement Data, Global Fund External Website (Dec 2018)

4.1. Financial Resources

Significant financial investments provided to the WCA region

The three diseases

When looking at grant budgets between 2015-2021 for the WCA countries, the bulk of Global Fund investment has been focused on specific interventions for each disease.

HIV

The bulk of Global Fund budgeted spend in the region is on treatment (72%) with prevention accounting for a further 20%.

Malaria

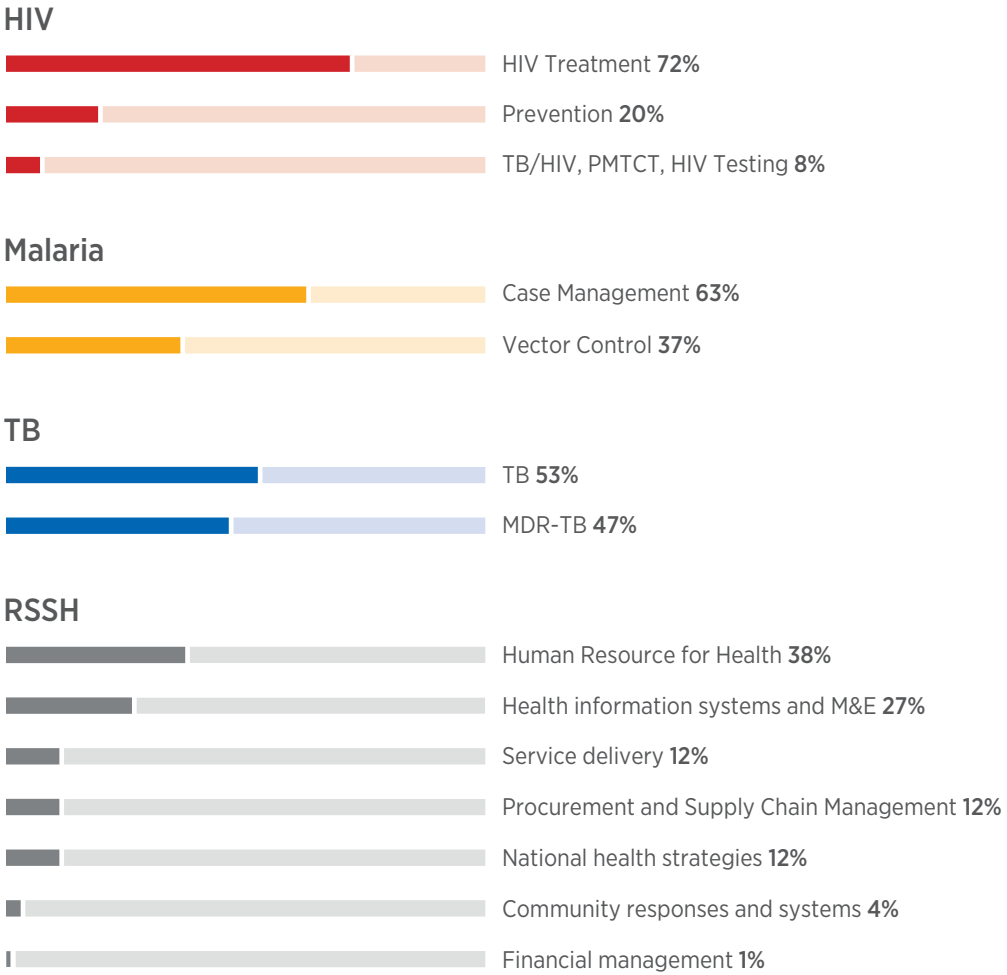
The bulk of Global Fund budgeted spend in the region is on case management (63%).

TB

TB budgeted spend is equally split between first line TB testing and treatment and MDR-TB.

RSSH Investments

RSSH investments have been aligned to where the need is greatest in the region with 38% of the spend in Human Resources for Health. Investment in information systems is the second largest investment with the implementation of DHIS2 in several countries in the region.

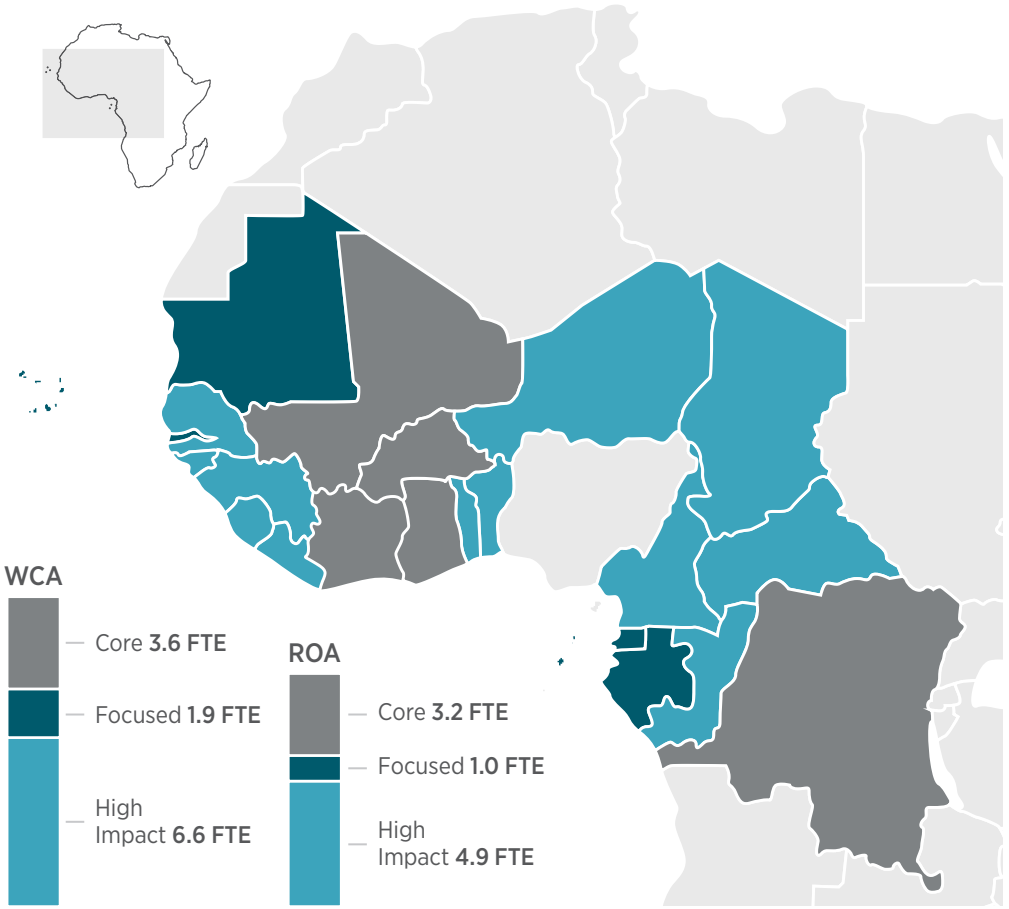


Source: Global Fund Budget Data 2015-2021, DASH Team - GMD

4.2. Human Capital

Significant Secretariat human resource investments provided to the WCA region

- Currently the Global Fund has allocated 85 Full Time Equivalents (FTE) for the WCA region. This amounts to 5 FTE per US$100m based on 2017-2019 Global Fund allocation invested in WCA vs 2 FTE per US$100m in ROA.
- 16 out of 22 countries in the region have a dedicated Fund Portfolio Manager.
- Some countries in Challenging Operating Environments have benefited from 2 program officers and the remainder are currently in the process of moving additional program officers into COE portfolios.



Country	D4I Classification	COE	Dedicated FPM	Country Team FTE
Benin	Core		●	3.46
Burkina Faso*	High Impact		●	3.69
Cameroon	Core		●	3.87
Cape Verde	Focused			1.75
Central African Republic	Core	●	●	3.15
Chad	Core	●	●	3.64
Congo	Core	●	●	3.75
Congo (Democratic Republic)	High Impact	●	●	14.54
Côte d'Ivoire	High Impact		●	5.09
Gabon	Focused			1.17
Gambia	Focused			2.53
Ghana	High Impact		●	4.86
Guinea	Core	●	●	3.69
Guinea-Bissau	Core	●	●	2.91
Liberia	Core	●	●	4.16
Mali*	High Impact	●	●	4.92
Mauritania	Focused	●		1.7
Niger	Core	●	●	3.06
Sao Tome and Principe	Focused			2.32
Senegal	Core		●	5.01
Sierra Leone	Core	●	●	3.1
Togo	Core			3.41

* In May 2018 Burkina Faso and Mali were reclassified from Core to High Impact portfolios. However no resource changes have been made at December 2018.

Source: Global Fund Grant Management Country Team Distribution List

4.2. Human Capital

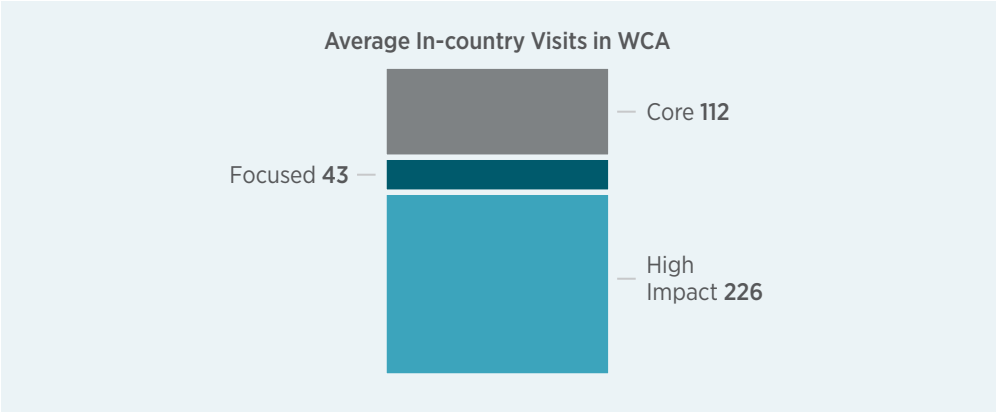
Significant human resource investment provided to the WCA region

Number of In-Country Visits in WCA

Global Fund staff spent 2,610 days on visits within WCA between 2015 and 2018. This amounted to an average of 5 days spent in each country, per trip.

When split between type of portfolio the average number of in-country visits varies with High Impact having more than double the visits for Core and focus having less than half the visits in comparison to Core portfolios.

The number of in-country visits also varies significantly within each portfolio. In the Core portfolio, Senegal was the most visited over the period with 250 visits in comparison to Central African Republic having only 38 visits.



Quality of engagement with Global Fund Secretariat

Survey results from over 195 respondents in 6 WCA countries noted overall satisfaction with the quality of engagement between country teams and in-country stakeholders. Country teams are communicating better than previously, listening to implementers and providing guidance, which is appreciated.

Perspectives from the Country

91%

of in-country stakeholders felt there were no language barriers between country teams and the actors implementing programs.

80%

agreed that the Global Fund's Country Team responds promptly to questions / concerns from those responsible for implementing programs in the country.

77%

agreed the Country Team provides adequate advice and assistance to the country according to the needs expressed.

65%

agreed that the Country Team approves the requests (e.g. request for no objection) from the Principal Recipients within a reasonable period of time.

Continuous quality engagement between the Global Fund Country teams and in-country implementers and stakeholders

Source: Global Fund Travel Records 2015 - 2018

4.3. Strategic initiatives

Key initiatives to address WCA bottlenecks

Since 2014, the Secretariat has conducted a number of strategic initiatives to identify and address challenges across the Global Fund portfolio. Many of these have included countries in WCA.

10 WCA COUNTRIES

Implementation Through Partnerships

- Project coordinated with partners to address implementation bottlenecks and financial absorption in **10 WCA countries**

11 WCA COUNTRIES

Challenging Operating Environments

- Adoption of the COE policy to enable grant management in challenging environments impacting **11 WCA countries**
- Building a network of partners to support COE countries and enable performance improvements and financial absorption in **8 WCA countries**

18 WCA COUNTRIES

Financial Management

- Co-Link Project to accelerate in-country financial management capability building in **18 WCA countries**

10 WCA COUNTRIES

Procurement and Supply Chain

- Pooled procurement mechanism/Wambo utilized in **18 WCA countries**
- Supply chain diagnostics and transformations in **10 WCA countries**

18 WCA COUNTRIES

Monitoring and Evaluation

- Support deployment and functionality of HMIS and Improve integration of HMIS and LMIS and improve in-country data quality in **18 WCA countries**

15 WCA COUNTRIES

Human Rights

- Enable comprehensive human rights programs in priority countries and provide differentiated support to key affected populations in **15 WCA countries**

Financial Management, Human Rights Monitoring and Evaluation, Procurement and Supply Chain Initiatives were ongoing at the time of the advisory review.

Source: Global Fund Strategy Implementation Plan 2018

Chapter Contents

3. Challenging Region

PAGES 12 - 18

3.1. LIMITED FISCAL SPACE

3.2. LOW HEALTH FINANCING

3.3. LARGE FUNDING GAP

3.4. WEAK HEALTH SYSTEMS

3.5. FRAGILE ENVIRONMENT

4. Global Fund Investments

PAGES 20 - 24

4.1. FINANCIAL RESOURCES

- Since 2002, investments to date in the WCA countries from the Global Fund total US$6.9bn across all three diseases.

4.2. HUMAN CAPITAL

- 85 FTE for WCA - 5 FTE per $100m invested in WCA vs 2 FTE per $100m invested in ROA.

4.3. STRATEGIC INITIATIVES

- Multiple Global Fund Secretariat-led initiatives impacting WCA countries including PPM, Wambo and CCM Evolution.

5. Performance

PAGES 26 - 41

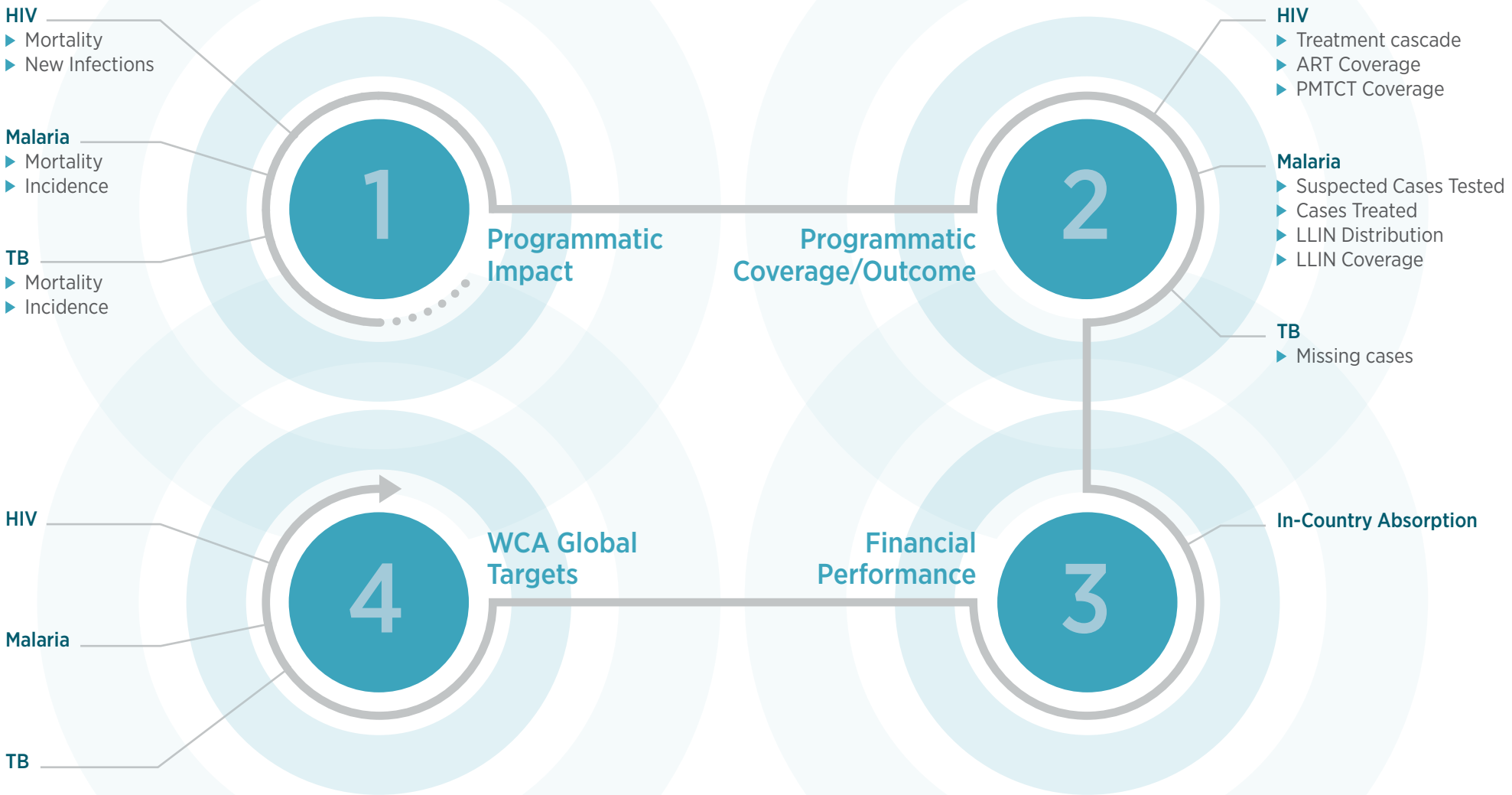
5.1. MALARIA

5.2. AIDS

5.3. TB

Performance Overview

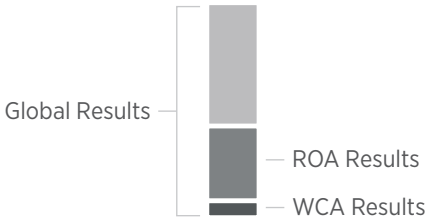
Key metrics to assess performance

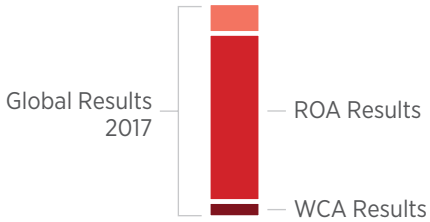


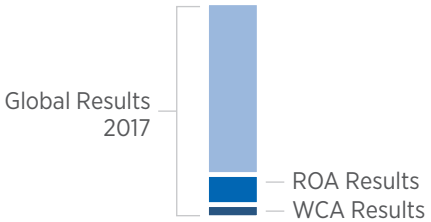
Global Fund 2018 results

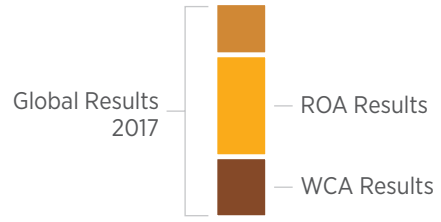
Western and Central Africa contribution to global targets

	CUMULATIVE LIVES SAVED BY THE GLOBAL FUND PARTNERSHIP	PEOPLE RECEIVED ANTIRETROVIRAL THERAPY FOR HIV	PEOPLE TESTED AND TREATED FOR TB	MOSQUITO NETS DISTRIBUTED TO PREVENT MALARIA
Global Results	27 MILLION	17.5 MILLION	5 MILLION	197 MILLION
ROA Results	9.4 MILLION	13.7 MILLION	0.7 MILLION	93.5 MILLION
WCA Results	2.1 MILLION	1.3 MILLION	0.3 MILLION	55.7 MILLION









Source: Global Fund Results Report 2018 & Global Fund disaggregated analysis, Strategic Information Team - SIID

5.1. Malaria Performance - Impact

Malaria Deaths

Malaria Deaths

Between 2010 and 2016, malaria deaths in WCA countries decreased by 31%.

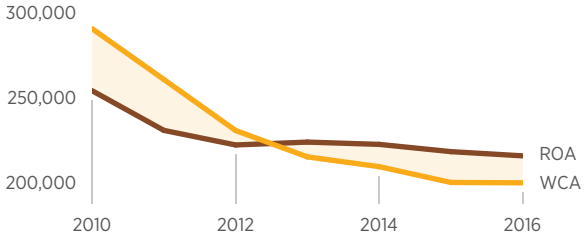
This decrease is double than that experienced by the Rest of Africa in the same period, which had a decrease of 15%. It is also a larger decline than the Global decrease which was 25% in the same period.

WCA	VS	ROA
-31%		-15%

This has led to the WCA countries reducing their global contribution to total Malaria deaths from 49% in 2010 to 45% in 2016.

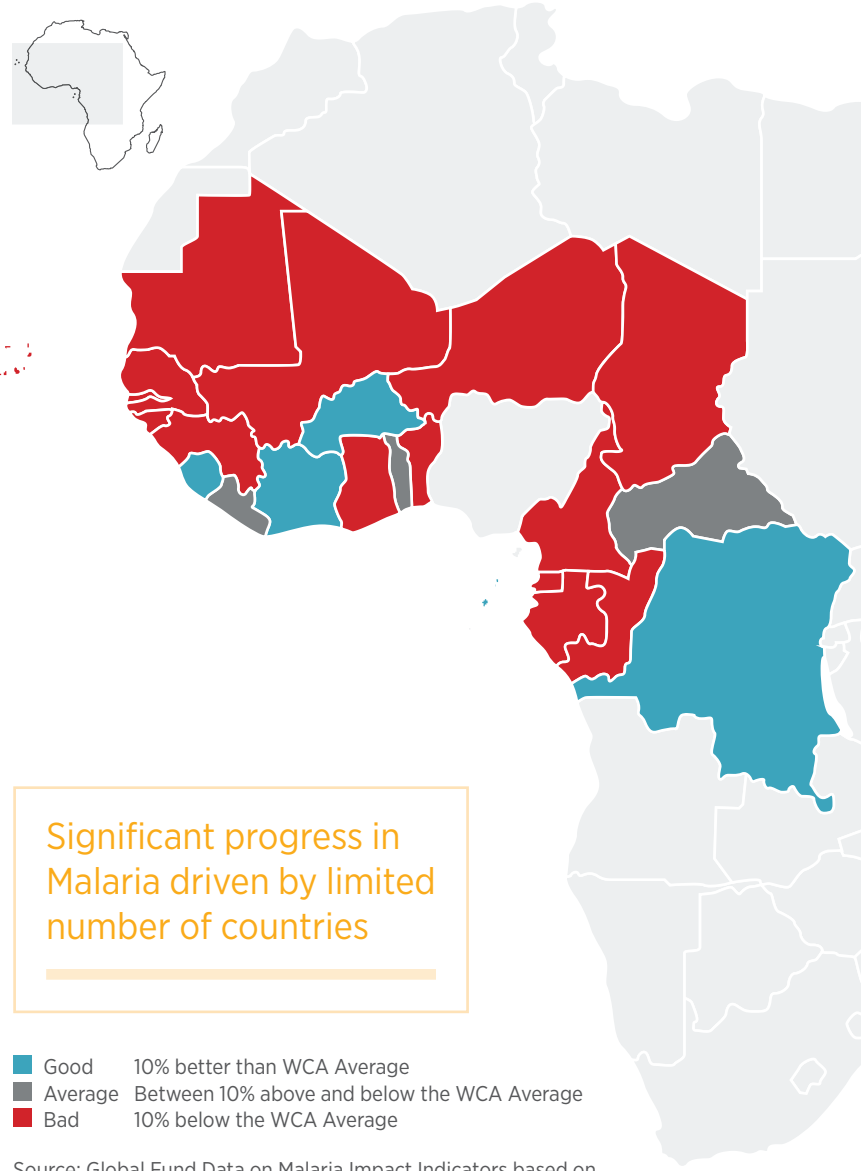
The huge decline in the number of total annual Malaria deaths in the WCA is driven by extremely impressive declines in Burkina Faso, Côte d'Ivoire and DRC.

The WCA region has received over US$3.3bn of total Global Fund investment since 2002 through Malaria grants which accounts for 30% of total Global Fund investment in Malaria across all portfolios.



% Change in Malaria deaths between 2010-2016 in the General Population

Country	Change (abs)	Change (%)
Democratic Republic of the Congo	-43,623	-42%
Côte d'Ivoire	-18,884	-73%
Burkina Faso	-15,737	-42%
Sierra Leone	-6,443	-48%
Sao Tome and Principe	-14	-100%
Central African Republic	-2,239	-38%
Togo	-1,174	-21%
Liberia	-565	-23%
Niger	-3,373	-16%
Ghana	-3,175	-20%
Guinea	-1,809	-16%
Cameroon	-1,633	-17%
Benin	-114	-2%
Cabo Verde	-	0%
Guinea-Bissau	26	4%
Gambia	63	11%
Gabon	118	36%
Mauritania	154	14%
Senegal	218	5%
Congo	228	13%
Equatorial Guinea	310	67%
Chad	347	5%
Mali	6,479	45%
WCA	**-90,840**	**-31%**
ROA	**-38,385**	**-15%**



Significant progress in Malaria driven by limited number of countries

Good	10% better than WCA Average
Average	Between 10% above and below the WCA Average
Bad	10% below the WCA Average

Source: Global Fund Data on Malaria Impact Indicators based on WHO 2017 data sets, Strategic Information Team - SIID

5.1. Malaria Performance - Impact

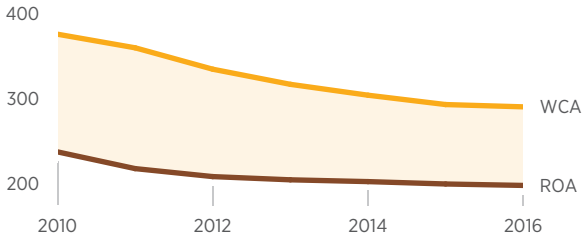
Malaria Incidence

Malaria Incidence

Between 2010 and 2016, the annual Malaria Incidence rate in WCA countries decreased by 23%. This decline is more than that in Rest of Africa at -17%. Incidence rates are still 47% higher in WCA when compared to ROA. However performance has been variable across the region.

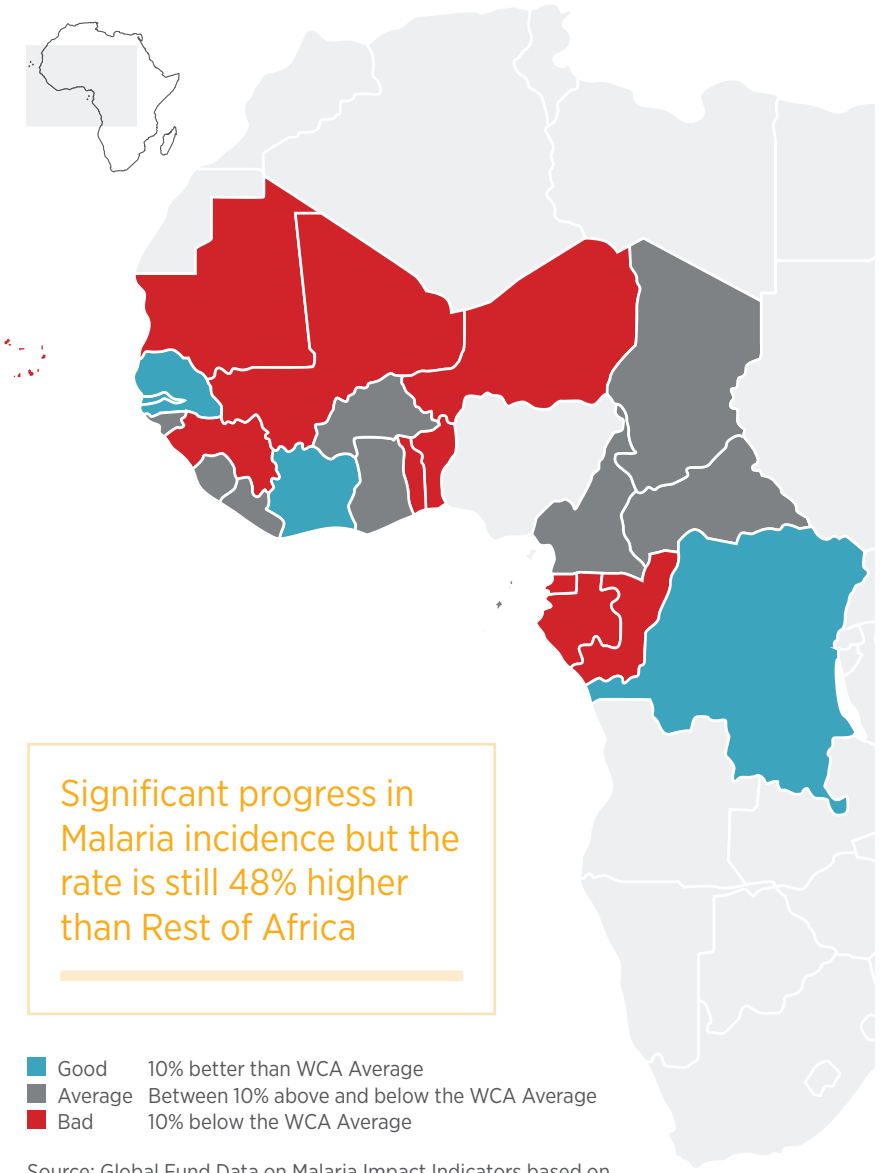
WCA	VS	ROA
-23%		-17%

Despite the significant improvement in incidence rates since 2010, in 2016 the WCA countries still had an incidence rate higher than that of the Rest of Africa and the Globe.



% Change in Malaria incidence between 2010-2016 in the General Population

Country	Change (abs)	Change (%)
Côte d'Ivoire	-243.87	-52%
Democratic Republic of the Congo	-154.81	-35%
Gambia	-127.09	-50%
Senegal	-52.53	-52%
Burkina Faso	-121.89	-22%
Sierra Leone	-97.01	-24%
Liberia	-90.66	-28%
Ghana	-70.52	-20%
Cameroon	-53.53	-16%
Central African Republic	-49.17	-14%
Chad	-23.61	-12%
Guinea-Bissau	-20.45	-22%
Sao Tome and Principe	-4.48	-29%
Niger	-34.74	-8%
Togo	-34.60	-9%
Benin	-25.95	-8%
Guinea	-22.82	-6%
Cabo Verde	-0.04	-5%
Congo	11.56	6%
Equatorial Guinea	36.89	18%
Mauritania	42.64	93%
Gabon	72.07	54%
Mali	87.77	24%
WCA Region	-85.54	-23%
ROA Incidence	-39.57	-17%



Significant progress in Malaria incidence but the rate is still 48% higher than Rest of Africa

Source: Global Fund Data on Malaria Impact Indicators based on WHO 2017 data sets, Strategic Information Team - SIID

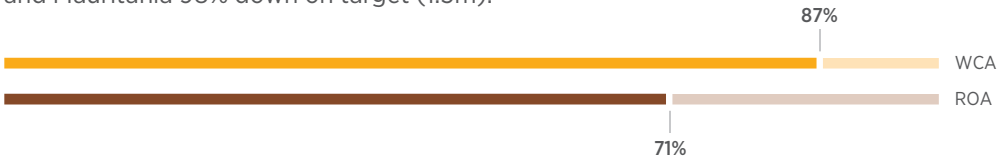
5.1. Malaria Performance – Case Management

Malaria – Testing and Treatment

Malaria Cases Tested

The WCA countries were 13% down (9.8m) on their targets in 2017 in regard to the number of suspected Malaria cases tested. This was however better than the performance in ROA which missed its target by 29% (51m).

The WCA performance was largely driven by three countries that significantly missed their targets; DRC 32% down on target (7.5m), Sierra Leone 33% down on target (1.8m) and Mauritania 98% down on target (1.5m).



Malaria Cases Treated

The WCA countries were 12% down (4.7m) on their targets in 2017 in regard to the number of Malaria cases treated. This was however better than the performance in ROA which missed its target by 27% (30.5m).

WCA	VS	ROA
88%		73%

The WCA performance was largely driven by three countries that significantly missed their targets; DRC 19% down on target (2.3m), Cameroon 78% down on target (1.7m) and Guinea 41% down on target (0.9m).

Test and Treatment below targets in WCA but the gap in targets is lower than ROA

	Malaria Suspected Cases Tested		Malaria Cases Treated	
Country	Result	vs Target (%)	Result	vs Target (%)
Benin	171,963	39%	179,780	48%
Burkina Faso	8,798,054	145%	21,643	4%
Cameroon	2,128,082	65%	476,806	22%
Cape Verde	16,573	279%	446	1174%
Central African Republic	1,375,337	100%	345,897	100%
Chad	1,881,312	108%	1,286,899	77%
Côte d'Ivoire	6,791,674	89%	4,642,614	144%
Democratic Republic of the Congo	15,844,984	68%	10,197,961	81%
Gambia	649,764	100%	69,128	50%
Ghana	8,902,711	105%	5,213,714	100%
Guinea	2,134,910	73%	1,327,203	59%
Guinea-Bissau	462,567	100%	121,371	100%
Liberia	1,794,810	100%	1,500,247	100%
Mali	3,481,271	115%	1,485,690	77%
Mauritania	28,197	2%	501	100%
Niger	4,036,066	117%	2,547,161	123%
Sao Tome and Principe	99,023	270%	2,466	342%
Senegal	1,488,852	175%	424,029	405%
Sierra Leone	3,536,020	67%	2,080,225	78%
Togo	2,709,255	72%	1,642,238	110%
WCA Region Total	**66,331,425**	**87%**	**33,566,019**	**88%**
ROA Region Total	**126,793,039**	**71%**	**83,843,575**	**73%**

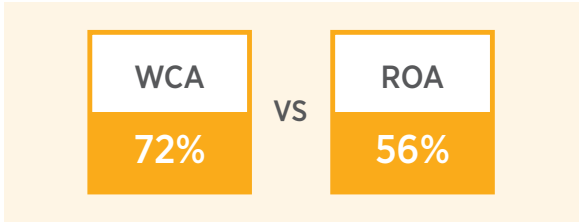
Source: Global Fund Programmatic Results Data 2017, Strategic Information Team

5.1. Malaria Performance – Vector Control

LLIN Distribution & Coverage

LLIN Coverage

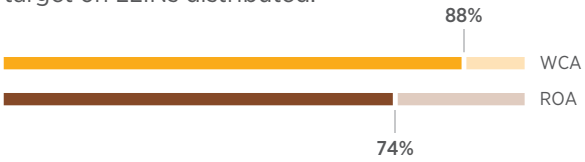
In 2016 WCA countries had a total LLIN coverage of 72%, resulting in over 215m people having access to a bed net. This was significantly higher than 56% in the ROA.



WCA coverage has also rapidly increased over time from 29% in 2010 to 72% in 2016. However as of 2016 there were still 85m people without access.

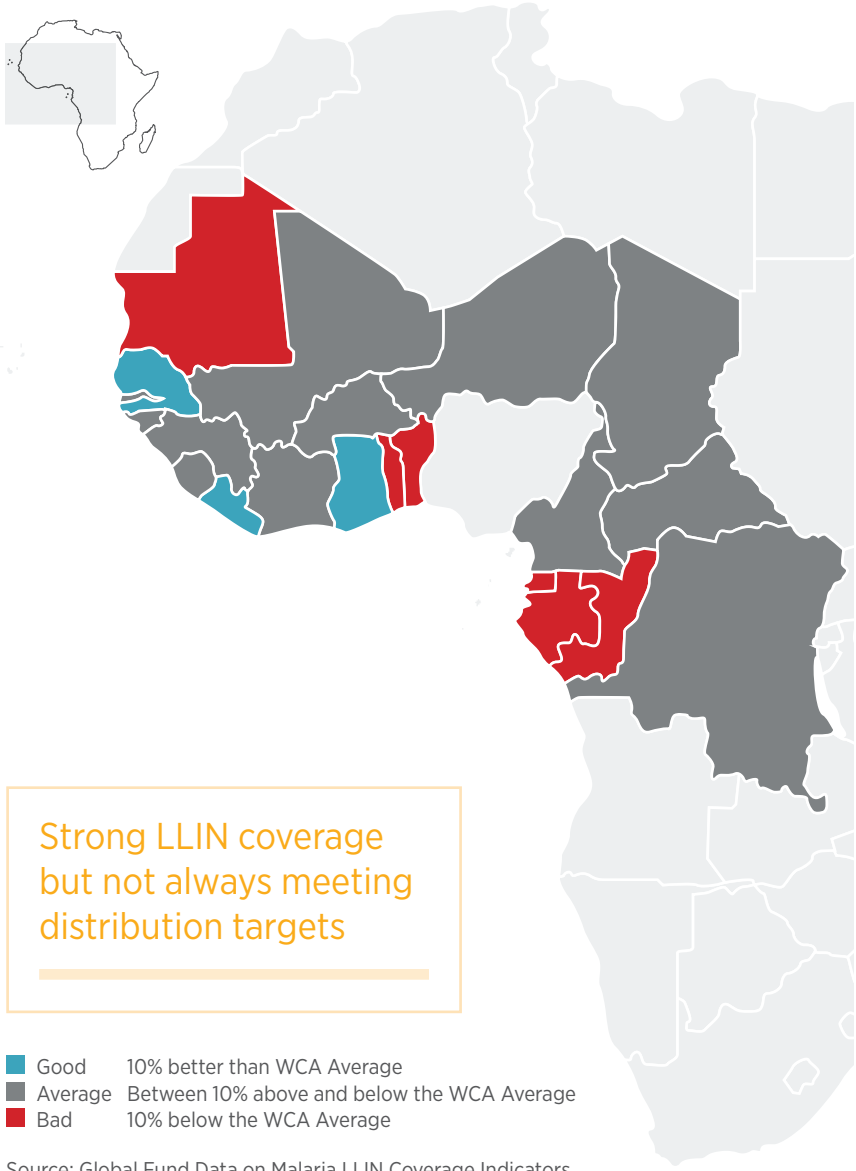
LLIN Distribution

WCA countries distributed over 55.8m LLINs in 2017. This was 12% below the targets set in Global Fund agreements leading to a gap of over 7.5m bed nets. However the gap against target for ROA was even bigger as the region was 26% below its target on LLINs distributed.



Source: Global Fund Programmatic Results Data 2017, Strategic Information Team

Population at risk with access to LLINS in 2016		
Country	People with access to LLINs	Coverage- For population at risk
Ghana	23,240,980	83%
Senegal	13,060,003	83%
Liberia	4,026,368	87%
Democratic Republic of the Congo	59,362,188	77%
Côte d'Ivoire	16,837,180	73%
Cameroon	14,890,720	63%
Burkina Faso	14,746,478	79%
Mali	14,261,669	80%
Niger	13,186,184	65%
Chad	9,559,043	68%
Guinea	8,203,080	64%
Sierra Leone	4,953,889	75%
Central African Republic	3,653,067	73%
Guinea-Bissau	1,497,349	79%
Gambia	1,411,141	69%
Benin	5,674,295	51%
Togo	4,641,651	61%
Congo	1,716,972	34%
Mauritania	338,049	11%
Equatorial Guinea	216,564	26%
Gabon	161,503	9%
WCA	**215,638,372**	**72%**
ROA	**347,242,666**	**56%**



Source: Global Fund Data on Malaria LLIN Coverage Indicators based on WHO 2017 data sets, Strategic Information Team - SIID

5.2. HIV Performance - Impact

AIDS Deaths

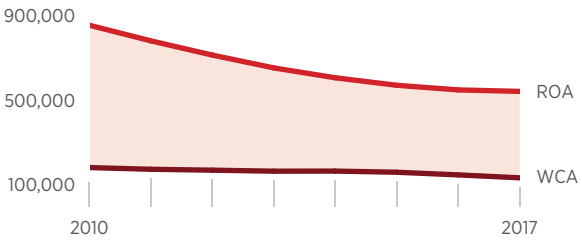
AIDS Deaths

The WCA region experienced a decrease of 27% in the annual number of AIDS deaths when comparing latest reports to 2010.

WCA	VS	ROA
-27%		-37%

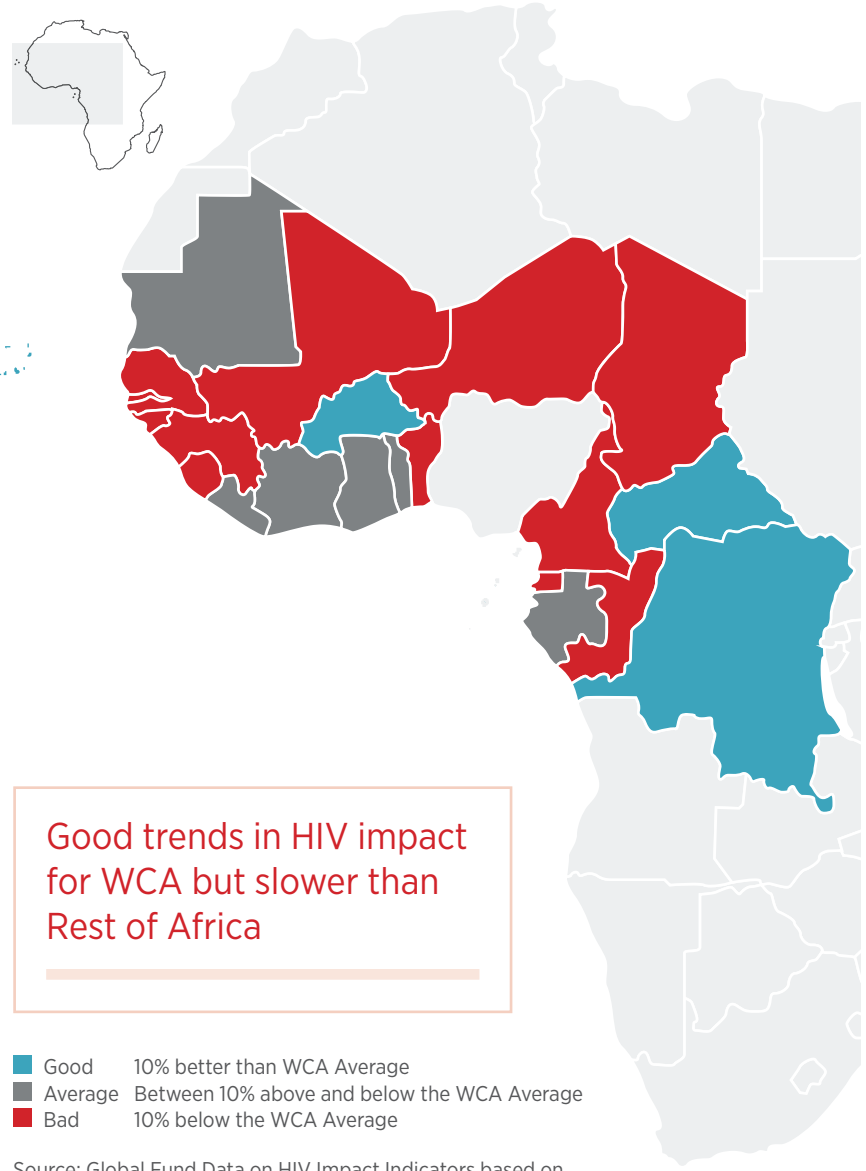
However, this decline is smaller than that in Rest of Africa of -37% for the same period. This has led to the WCA countries contributing 14% of global AIDS deaths in 2017, up from 12.7% in 2010.

The WCA region has received over US$2.7bn of Global Fund investment since 2002 through standalone HIV grants accounting for 14% of total Global Fund investment in HIV across all portfolios. There was also a further US$0.1bn in HIV/TB grants accounting for 9% of total Global Fund investment in HIV/TB.



% Change in AIDS deaths between 2010-2017 in the General Population

Country	Change (abs)	Change (%)
Democratic Republic of the Congo	-22,393	-56%
Central African Republic	-3,952	-43%
Burkina Faso	-2,471	-46%
Cape Verde	-58	-53%
Côte d'Ivoire	-10,613	-30%
Ghana	-4,910	-24%
Togo	-2,248	-32%
Liberia	-1,304	-34%
Gabon	-304	-19%
Mauritania	-154	-18%
Cameroon	-1,277	-5%
Chad	-605	-16%
Sierra Leone	-322	-11%
Niger	-289	-14%
Gambia	-110	-9%
Guinea-Bissau	-91	-5%
Benin	-85	-3%
Senegal	253	14%
Congo	308	7%
Guinea	357	7%
Equatorial Guinea	479	33%
Mali	1,320	26%
WCA Total	**-48,468**	**-27%**
ROA Total	**-312,138**	**-37%**



Good trends in HIV impact for WCA but slower than Rest of Africa

Good	10% better than WCA Average
Average	Between 10% above and below the WCA Average
Bad	10% below the WCA Average

Source: Global Fund Data on HIV Impact Indicators based on UNAIDS 2018 data sets, Strategic Information Team - SIID

5.2. HIV Performance - Impact

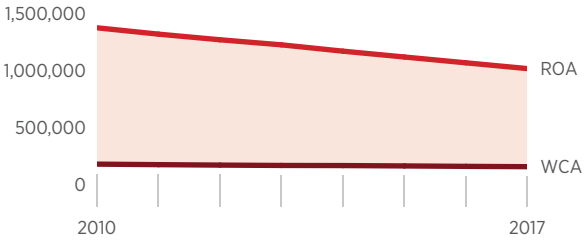
New Infections

New Infections

Between 2010 and 2017, new HIV infections in WCA fell by 12%.

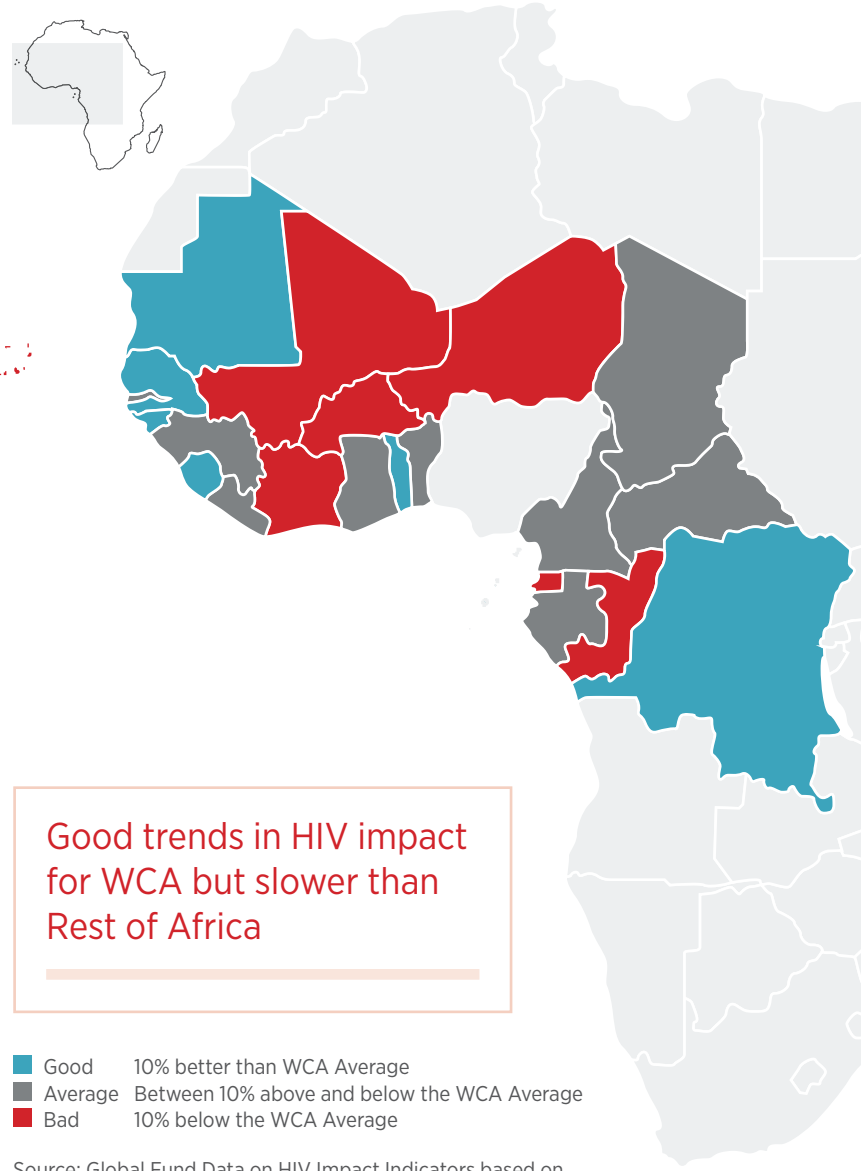
WCA	VS	ROA
-12%		-26%

This decline is less than half of that in the Rest of Africa at -26% for the same period. As a result the WCA countries accounted for 9.2% of global new infections in 2017 compared to 8.5% in 2010.



% Change in New HIV Infections between 2010-2017 in the General Population

Country	Change (abs)	Change (%)
Democratic Republic of the Congo	-8,156	-35%
Togo	-1,811	-27%
Sierra Leone	-1,646	-34%
Guinea-Bissau	-866	-27%
Senegal	-654	-30%
Mauritania	-162	-37%
Cameroon	-6,419	-19%
Central African Republic	-1,830	-19%
Ghana	-1,579	-8%
Chad	-478	-8%
Guinea	-387	-5%
Benin	-326	-8%
Gambia	-268	-16%
Liberia	-207	-8%
Gabon	-120	-4%
Cape Verde	12	11%
Burkina Faso	44	1%
Niger	63	4%
Equatorial Guinea	364	10%
Mali	580	6%
Congo	719	10%
Côte d'Ivoire	752	3%
WCA	**-22,375**	**-12%**
ROA	**-357,297**	**-26%**



Good trends in HIV impact for WCA but slower than Rest of Africa

Good	10% better than WCA Average
Average	Between 10% above and below the WCA Average
Bad	10% below the WCA Average

Source: Global Fund Data on HIV Impact Indicators based on UNAIDS 2018 data sets, Strategic Information Team - SIID

5.2. HIV Performance – Treatment Cascade

HIV – Treatment Cascade

Treatment Cascade overview of the region

Since the launch of the 90-90-90 cascade targets, the WCA countries have been behind the Rest of Africa on all three main targets in the HIV treatment cascade.

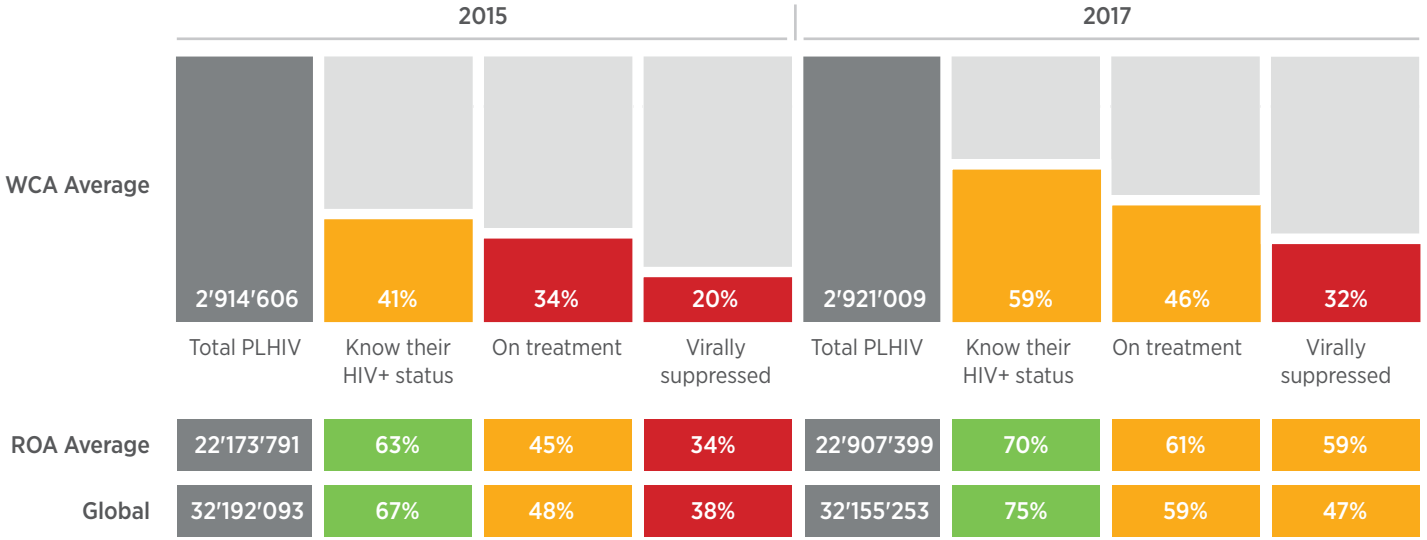
The WCA countries started at a significantly lower base with only 41-34-20 in 2015. All components were double digits lower than the average attained by ROA at 63-45-34 and the global value at 67-48-38.

However between 2015 and 2017, the WCA countries made significant strides in improving the first 90 pillar reaching 59% coverage in 2017, an increase of 18% in two years and closing the gap on ROA.

The second pillar showed stable improvement for the WCA with an increase of 12% in two years reaching 46% in 2017. This was in line with the improvement noted in ROA with an increase of 10% in coverage reaching 61%.

However the third pillar for the WCA is significantly behind that for ROA. The third pillar for the WCA reached 32% in 2017, an increase of 12% compared to 59% for the ROA, an increase of 15% in coverage.

Please note however there are significant data gaps for the 1st and 3rd pillars. For example only 12 and 7 countries reported data respectively for each pillar in 2017, with Sao Tome not reporting on any.



These numbers are “unweighted averages”.

Impressive progress in Treatment Cascade for WCA but still behind Rest of Africa

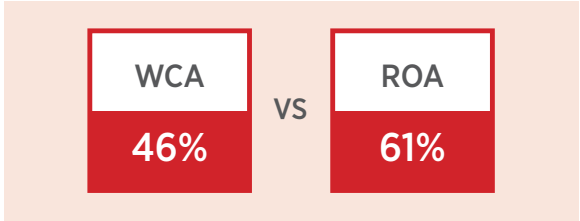
Source: UNAIDS Data on HIV Treatment Cascade 2015-2017, UNAIDS Website

5.2. HIV Performance – ART Coverage

ART Coverage

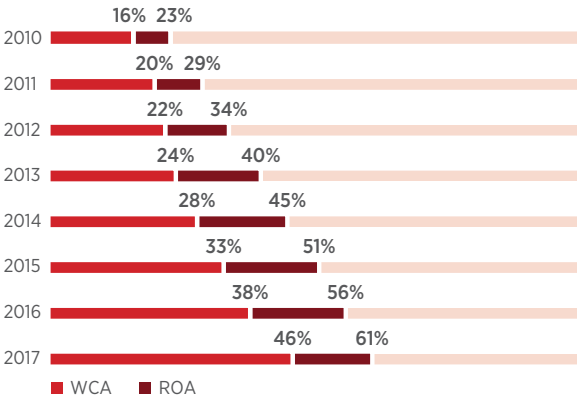
ART Coverage

In 2017, in WCA countries 45.7% of PLHIV were receiving ARTs. This is significantly behind the UNAIDS target of 90 and that in the Rest of Africa at 61.3%.



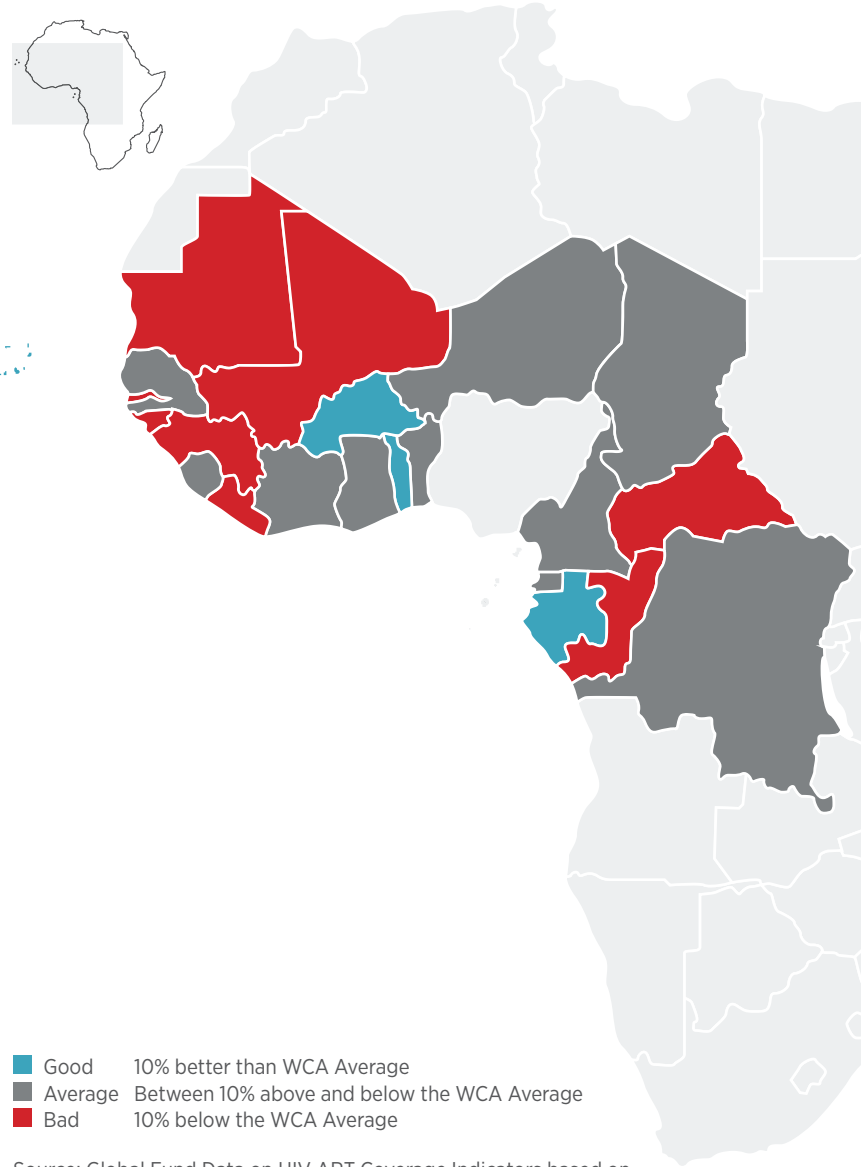
The WCA countries show a large increase in ART coverage when comparing 2010 to 2017 with an increase of 29.2%. However this increase is smaller than that experienced by the Rest of Africa in the same period which had an increase of 37.9%.

Within the WCA region there are significant differences in ART coverage between countries. The highest coverage is in Cape Verde at 75% and Burkina Faso at 65%, however Liberia and Congo lag far behind at 29%.



People receiving ART as % of HIV population between 2010-2017

Country	Latest ART Coverage (%) in 2017	Increase in % coverage from 2010
Cape Verde	74.97	48.76
Burkina Faso	65.07	32.97
Gabon	58.92	32.74
Togo	56.60	37.30
Benin	55.25	22.27
Democratic Republic of the Congo	54.64	45.67
Senegal	54.07	28.63
Niger	51.77	32.52
Cameroon	49.35	32.09
Côte d'Ivoire	45.61	28.98
Chad	45.36	15.01
Ghana	40.14	27.09
Sierra Leone	39.09	28.75
Equatorial Guinea	38.48	31.73
Guinea	35.16	15.76
Mauritania	33.47	20.90
Central African Republic	32.42	20.76
Gambia	32.25	21.93
Mali	32.17	10.57
Guinea-Bissau	30.24	20.03
Congo	29.09	11.45
Liberia	28.94	19.19
Grand Total	45.68	29.20



Source: Global Fund Data on HIV ART Coverage Indicators based on UNAIDS 2018 data sets, Strategic Information Team - SIID

5.2. HIV Performance – PMTCT Coverage

PMTCT Coverage

PMTCT Coverage

In 2017, in WCA countries 64% of pregnant women are receiving ARVs to prevent Mother to Child Transmission. This is significantly behind the Rest of Africa at 84%.

WCA	VS	ROA
64%		84%

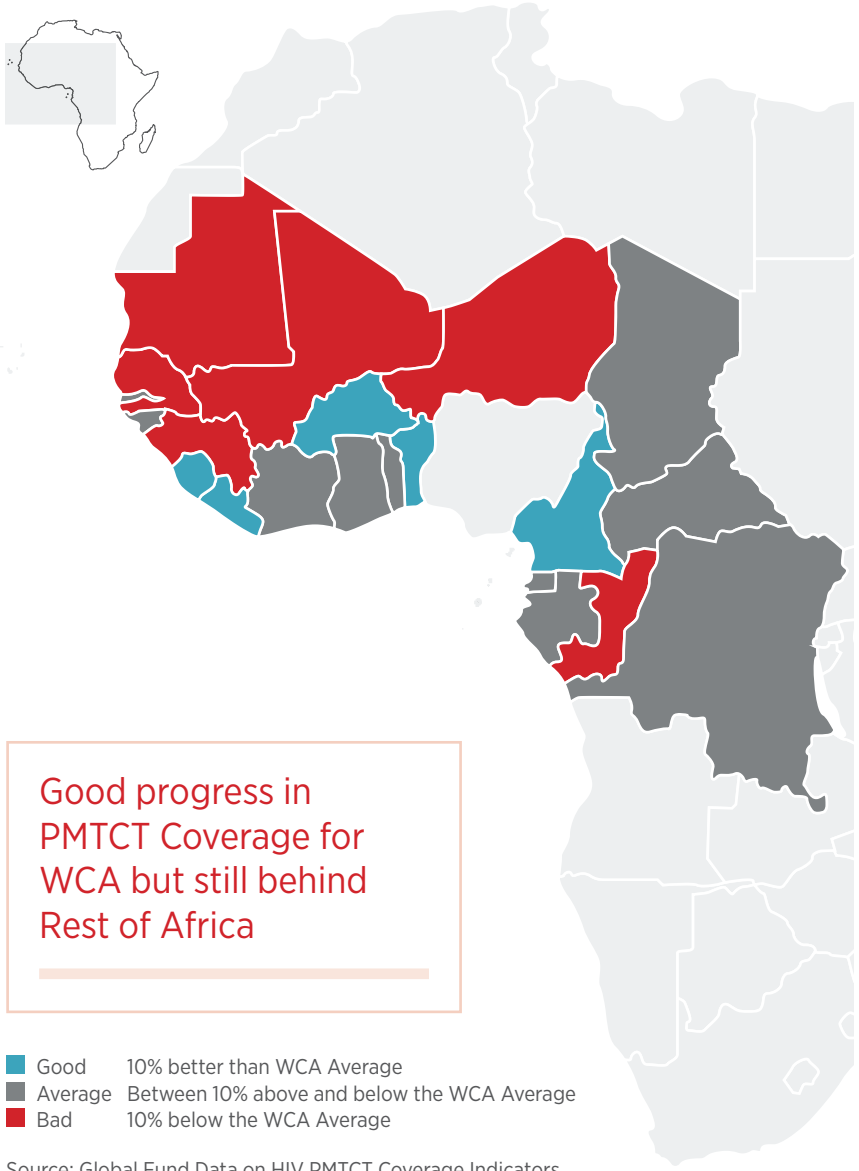
The WCA countries show a large increase in PMTCT coverage when comparing 2010 to 2017 with an increase of 35%. This increase is larger than that experienced by the Rest of Africa in the same period which had an increase of 29%.

Within the WCA region there are significant differences in PMTCT coverage between countries. The highest coverage is in Burkina Faso at 92% and Sierra Leone at 89%, however Mauritania and Congo are lagging behind at 12% and 11% respectively.

% of pregnant women receiving ARVs to prevent HIV transmission

Country	Latest PMTCT Coverage (%) in 2017	Increase in % coverage from 2010
Burkina Faso	92%	46%
Sierra Leone	89%	54%
Liberia	86%	59%
Benin	83%	67%
Cameroon	77%	35%
Côte d'Ivoire	70%	29%
Chad	68%	47%
Ghana	66%	34%
Togo	66%	33%
Gambia	65%	10%
Guinea-Bissau	65%	49%
Equatorial Guinea	64%	47%
Gabon	64%	35%
Democratic Republic of the Congo	59%	53%
Central African Republic	56%	22%
Senegal	53%	30%
Niger	43%	3%
Guinea	38%	20%
Mali	31%	-4%
Mauritania	12%	4%
Congo	11%	0%
WCA Region	64%	35%
ROA Region	84%	29%

Cape Verde not shown due to errors in data.



Source: Global Fund Data on HIV PMTCT Coverage Indicators based on UNAIDS 2018 data sets, Strategic Information Team - SIID

5.3. TB Performance - Impact

TB Deaths (All forms)

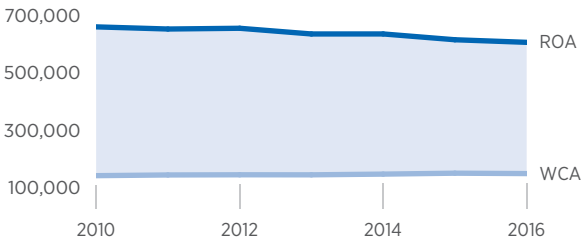
TB Deaths (All forms)

The WCA experienced an increase of 5% in the annual number of TB deaths (all forms) when comparing latest reports to 2010. This is in direct contrast to ROA that experienced a -8% decline.

WCA	VS	ROA
+5%		-8%

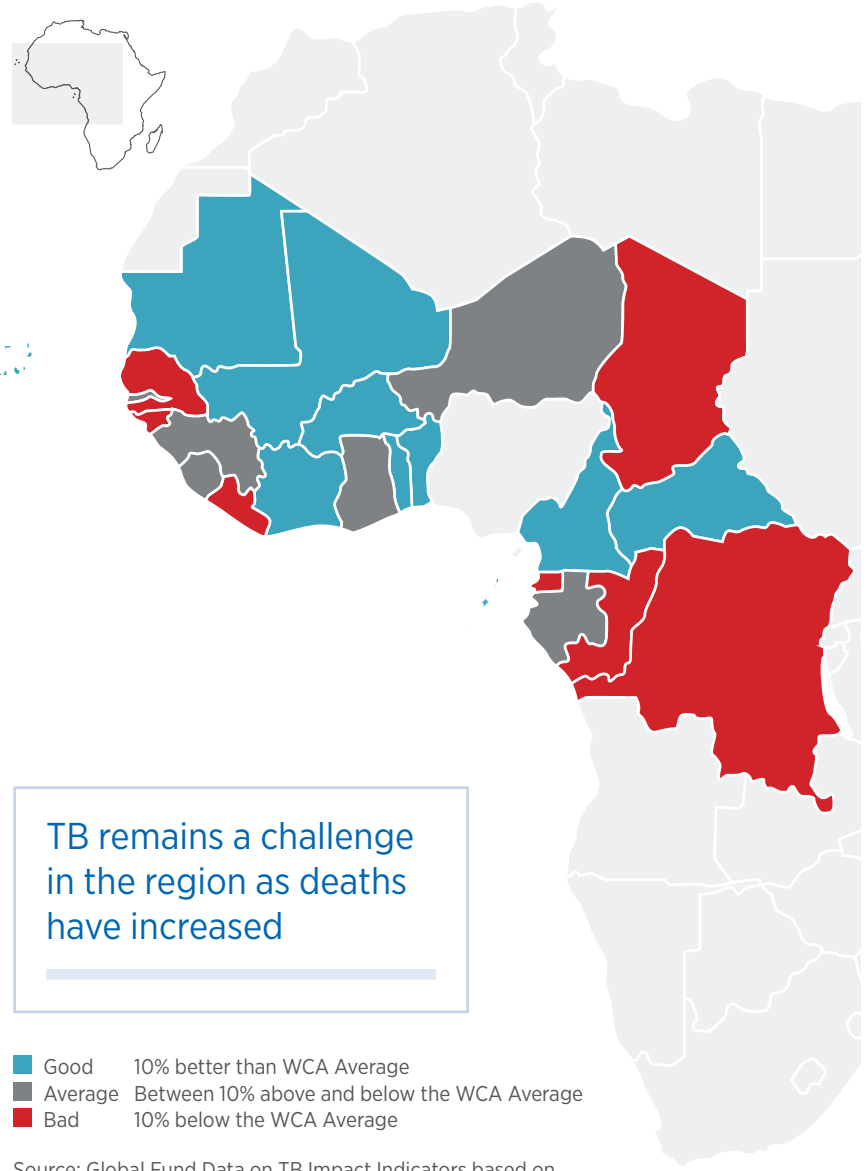
This has led to the WCA countries increasing their global contribution to total TB deaths (all forms) from 7% in 2010 to 9% in 2016.

The WCA region has received over US$0.6bn of Global Fund investment since 2002 through standalone TB grants accounting for 9% of total Global Fund investment in TB across all portfolios. There was also a further US$0.1bn in HIV/TB grants accounting for 9% of total Global Fund investment in HIV/TB.



% Change in TB deaths (all forms) 2010-2016 in the General Population

Country	Change (abs)	Change (%)
Cameroon	-4,000	-24
Central African Republic	-2,300	-31
Côte d'Ivoire	-1,600	-16
Togo	-720	-60
Mali	-400	-18
Burkina Faso	-400	-17
Mauritania	-220	-18
Cabo Verde	-27	-34
Sao Tome and Principe	-15	-58
Benin	-100	-7
Ghana	0	0
Gambia	30	5
Niger	100	2
Gabon	100	5
Guinea	200	4
Sierra Leone	500	13
Equatorial Guinea	310	124
Guinea-Bissau	400	18
Senegal	900	26
Congo	1,000	24
Liberia	1,200	48
Chad	1,300	29
Democratic Republic of the Congo	11,000	22
WCA Total	7,258	5
ROA total	-54,049	-8



TB remains a challenge in the region as deaths have increased

Good 10% better than WCA Average
Average Between 10% above and below the WCA Average
Bad 10% below the WCA Average

Source: Global Fund Data on TB Impact Indicators based on WHO 2017 data sets, Strategic Information Team - SIID

5.3. TB Performance - Impact

TB incidence (All forms)

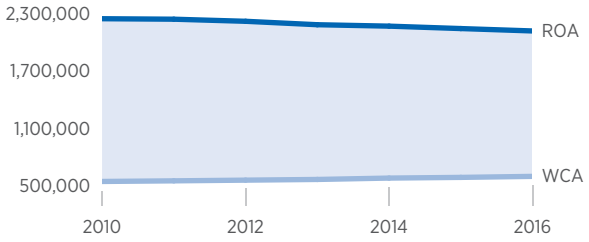
TB incidence (All forms)

Between 2010 and 2016, the annual TB incidence rate in WCA increased by 10%. This is in direct contrast to ROA, which experienced a -6% decline. However performance has been variable across the region.

WCA	VS	ROA
+10%		-6%

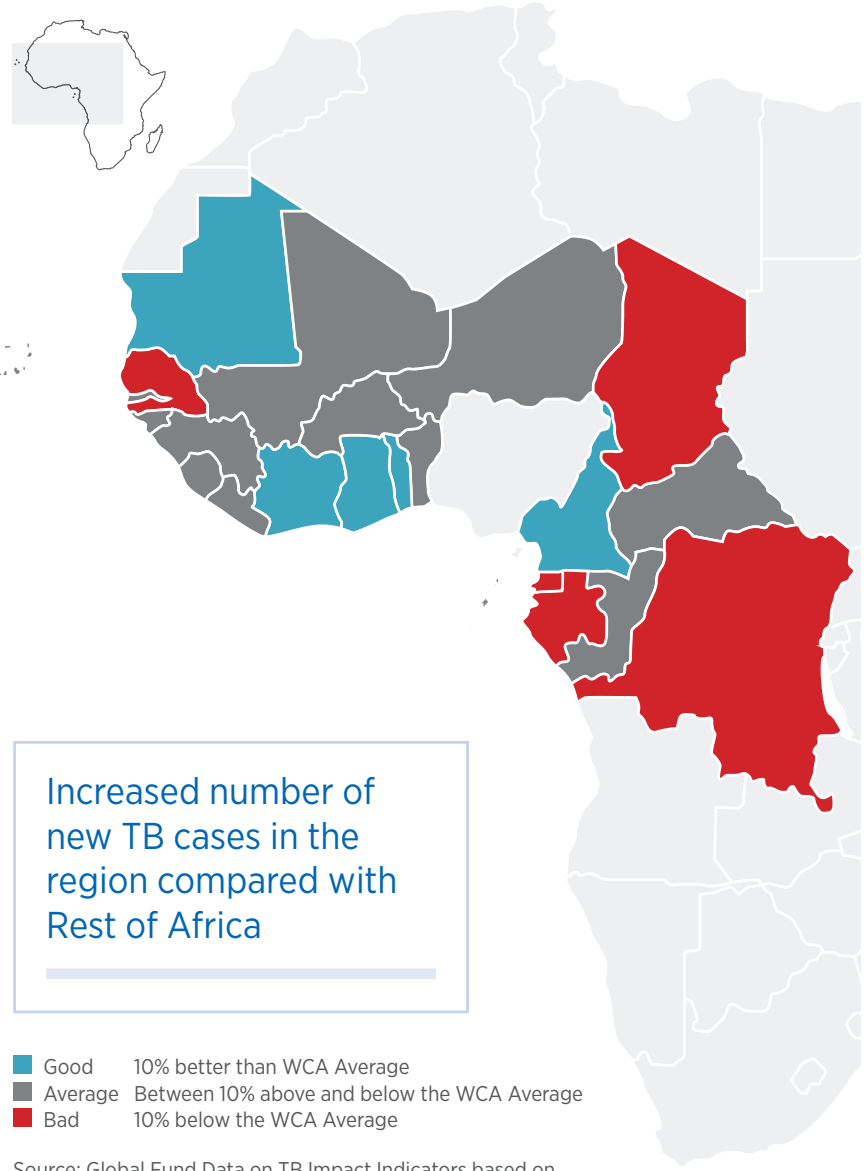
This has led to the WCA countries increasing their global contribution to total TB incidence from 5% in 2010 to 6% in 2016.

While there has been an increase in the number of total annual TB incidence in the WCA countries, most of this has been driven by the DRC with a 43,000 increase.



% Change in TB (all incidents) 2010-2016 in the General Population

Country	Change (abs)	Change (%)
Côte d'Ivoire	-4,000	-10
Cameroon	-4,000	-8
Togo	-1,400	-29
Ghana	-1,000	-2
Mauritania	-500	-10
Cabo Verde	0	0
Central African Republic	0	0
Niger	0	0
Sao Tome and Principe	30	18
Benin	100	2
Burkina Faso	300	3
Mali	500	5
Gambia	500	17
Guinea-Bissau	1,000	17
Guinea	2,000	10
Sierra Leone	2,000	10
Congo	2,000	12
Liberia	2,000	17
Equatorial Guinea	1,000	83
Gabon	1,800	23
Chad	4,000	22
Senegal	4,000	22
Democratic Republic of the Congo	43,000	20
WCA	**53,330**	**10**
ROA	**-128,340**	**-6**



Increased number of new TB cases in the region compared with Rest of Africa

Good 10% better than WCA Average
Average Between 10% above and below the WCA Average
Bad 10% below the WCA Average

Source: Global Fund Data on TB Impact Indicators based on WHO 2017 data sets, Strategic Information Team - SIID

5.3. TB Performance – Missing Cases

TB Missing Cases

TB Missing cases – evolution

Between 2010 and 2016, the annual number of TB Missing Cases in WCA increased by 8%. This is in direct contrast to ROA that experienced a 0% change. However performance has been variable across the region. In total there were 284,000 TB missing cases in 2016 from the WCA countries. These are most concentrated in DRC 123,000, Ghana 30,000 and Cameroon 22,000.

WCA	VS	ROA
+8%		0%

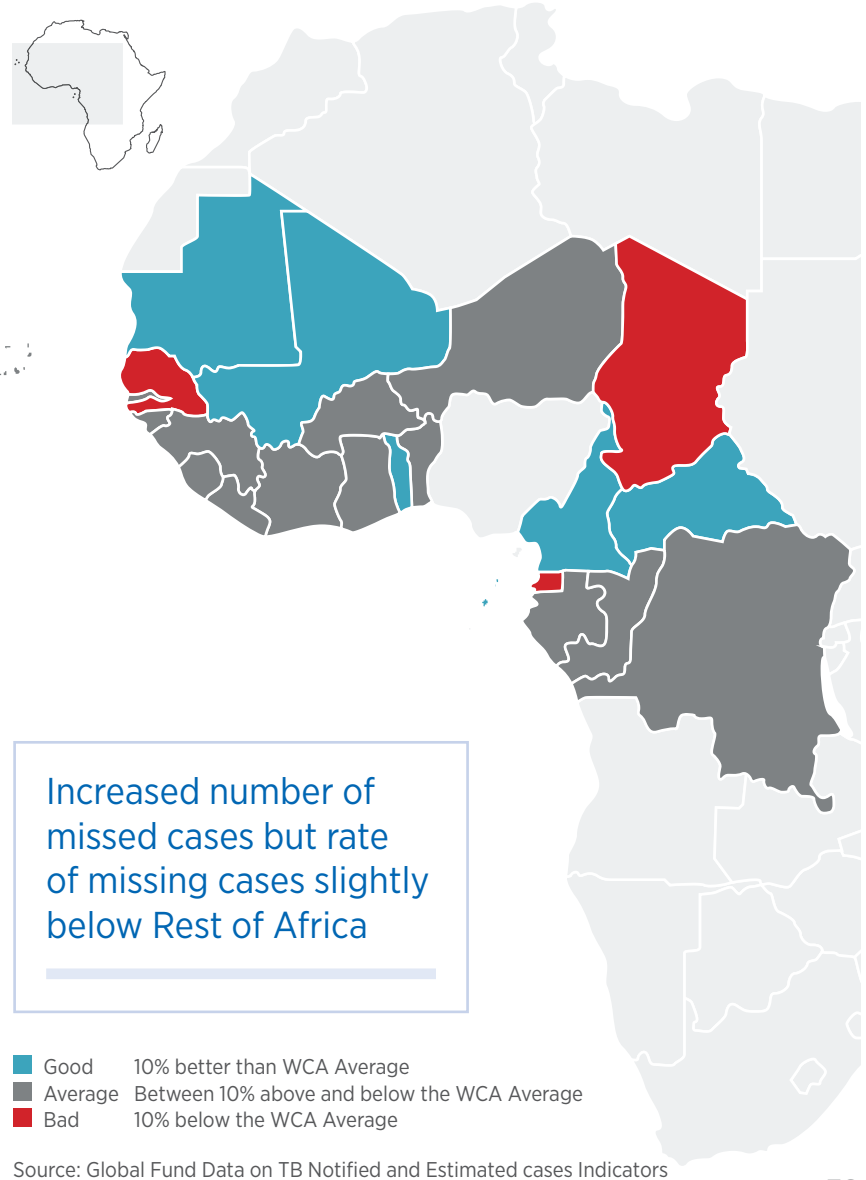
TB missing cases as % of estimated cases

The 284,000 missing cases represent 48% of the total number of estimated TB cases in 2016. This is a lower proportion than the ROA which has over 1.1m missing cases in 2016, representing 51% of estimated TB cases. However several countries in the WCA region have a higher rate of missing cases as a % of total estimated cases including Ghana at 68%.

WCA	VS	ROA
48%		51%

TB Missing Cases between 2010-2016

Country	Change (%)	as % of estimated cases
Sao Tome and Principe	-76%	6%
Togo	-65%	21%
Central African Republic	-30%	29%
Mali	-23%	32%
Cameroon	-20%	35%
Mauritania	-16%	36%
Côte d'Ivoire	-15%	39%
Burkina Faso	-13%	40%
Ghana	-2%	41%
Benin	-1%	41%
Gambia	-1%	42%
Gabon	1%	43%
Niger	2%	45%
Guinea	4%	45%
Sierra Leone	10%	46%
Congo	25%	47%
Guinea-Bissau	26%	48%
Democratic Republic of the Congo	27%	49%
Liberia	28%	49%
Cabo Verde	28%	51%
Chad	31%	67%
Senegal	31%	67%
Equatorial Guinea	103%	68%
WCA Region	8%	48%
ROA Region	0%	51%



Source: Global Fund Data on TB Notified and Estimated cases Indicators based on WHO 2017 data sets, Strategic Information Team - SIID

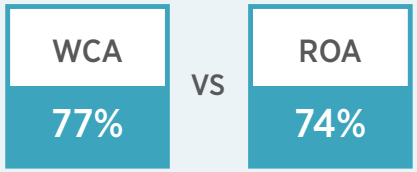
Financial Performance

In-country absorption

Absorption (based on 2014-2017 data)	
Global In-Country Absorption	71%
ROA In-Country Absorption	74%
WCA In-Country Absorption	77%

In-Country Absorption:

WCA as a whole has performed better than both the rest of Africa and the global average, with 77% In-Country Absorption compared with 74% for Rest of Africa and 71% Global average.



However WCA countries have extremely varied performance and there are several outliers from the WCA Average. While countries like Senegal, Ghana, Burkina Faso and Côte d'Ivoire have shown good absorption rates, others like Guinea, Mauritania and Liberia have performed poorly.

Financial Absorption in the region is higher than Rest of Africa and global average

	Calculated in-country absorption 2014-2017
Côte d'Ivoire	97%
Senegal	94%
Burkina Faso	93%
Ghana	92%
Sao Tome and Principe	92%
Congo (Democratic Republic)	87%
Central African Republic	85%
Cape Verde	84%
Guinea-Bissau	83%
Cameroon	80%
Togo	79%
Congo	74%
Gambia	74%
Niger	69%
Benin	61%
Chad	61%
Mali	59%
Sierra Leone	54%
Liberia	42%
Guinea	33%
Mauritania	28%
Equatorial Guinea	
Gabon	

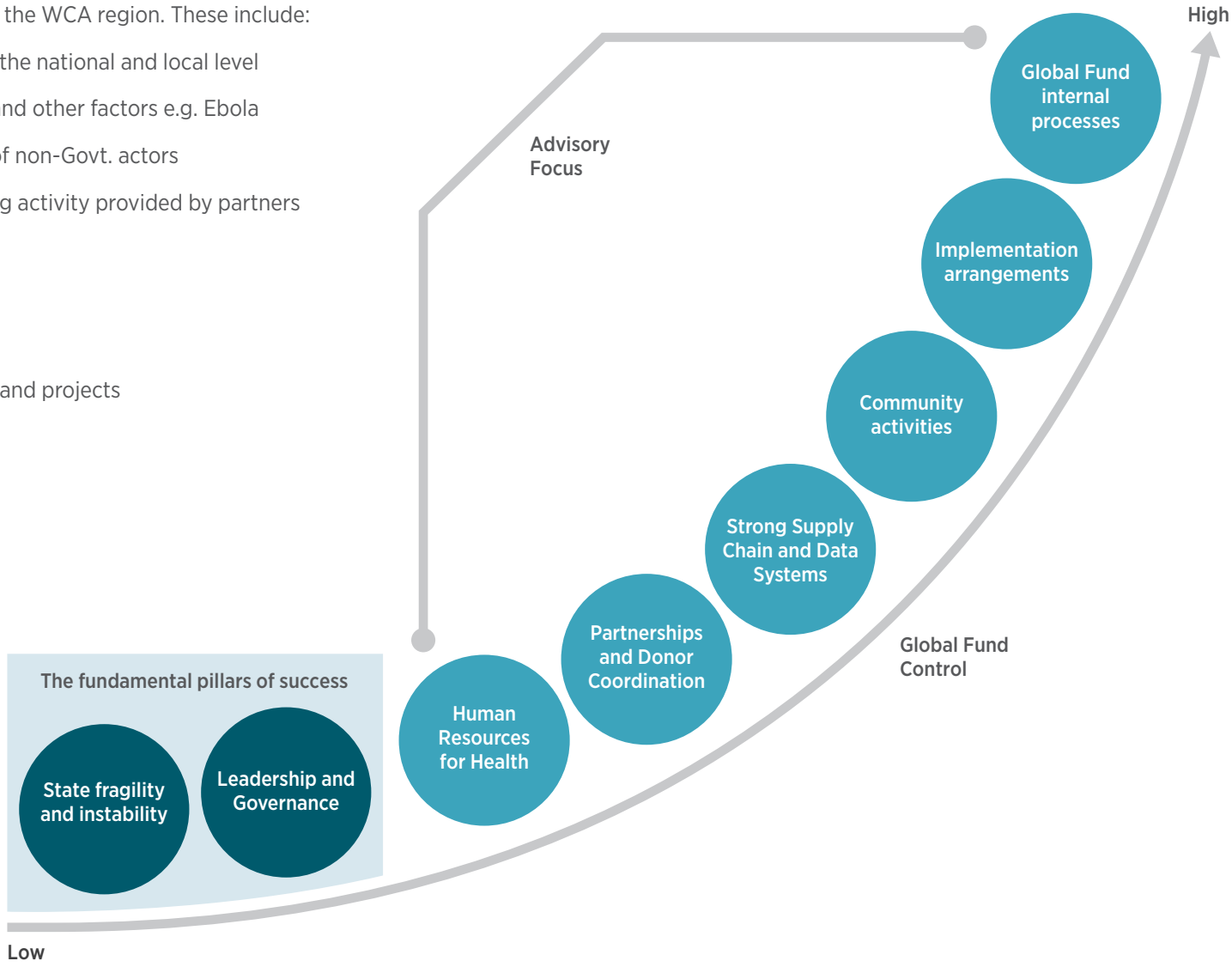
Source: Global Fund Data on In-Country Absorption 2014-2017 per July 2018, Finance Team - FISA

Regional Performance

Key factors to enable high performance in WCA

Multiple factors influence performance in the context of the WCA region. These include:

- Collaboration and coordination amongst partners at the national and local level
- Instability of the government and presence of conflict and other factors e.g. Ebola
- Stigma and discrimination acting as a social barrier of non-Govt. actors
- Short and long term TA support and capacity building activity provided by partners
- Strength of health systems to support programs
- Choice of implementer and funds flow
- Impact of GF investments, policies and processes
- GF Support provided in the form of strategic initiatives and projects



Chapter Contents

6.1. Global Fund Processes

Introduction:

As a financing institution, the Global Fund has established various policies and processes to support the funding of its grants. These are designed to ensure effective implementation of disease programs while safeguarding its financial investments. Both aspects are critical to Global Fund success and are interlinked. Simple, flexible and yet robust processes that can be tailored to the specific country context are a critical enabler to successful program implementation. This is especially relevant for the Global Fund's chosen operating model of having no in-country presence and therefore being heavily reliant on local implementers, who often have limited capacity and resources.

Western and Central Africa (WCA) is a high risk environment characterized by political instability, institutional weaknesses and low capacity of the implementers. **Almost 70% of the countries in the region have been in the top 25% most fragile states consistently since 2012.***

Successful program implementation in the high risk countries of WCA is critical for the Global Fund to achieve overall impact, as 22% of the world's malaria burden comes from these environments. The organization has two key policies, the Additional Safeguards Policy (2014) and the Challenging Operating Environment Policy (2016), to safeguard Global Fund financial investments and to support flexible grant management in high risk environments.

In addition, from 2015 onwards, the organization has been active in the region to respond to ongoing challenges around grant implementation and financial absorption.

2015

- **WCA regional workshop in Abidjan tackling root causes for low financial absorption**
- **Launch of Implementation Through Partnerships initiative impacting 10 WCA countries**
- **WCA regional workshop in Dakar to address programmatic bottlenecks**

2016

- Adoption of COE policy impacting 10 WCA countries. 1 additional resource made available for some COE countries
- Secretariat differentiates internal resources between High Impact, Core and Focused portfolios based on disease burden and country context
- Launch of WCA Support Strategy including disease specific strategies
- NFM budget reprogramming based on 2016 for efficiencies and alignment with WCA disease strategy
- Board approves catalytic investments of which US$58m for 10 WCA countries

2017

- **Creation of COE support team**
- **Launch of Co-Link to strengthen in-country Financial Management for 18 WCA Countries**

2018

- Launch of CCM evolution project to build capacity in governance and oversight of GF programs in 5 WCA countries
- Burkina Faso and Mali reclassified from Core to High Impact portfolios
- Supply Chain Diagnostic Reviews for 11 WCA countries

* Fragile States Index 2017

6.1. Global Fund Processes

Challenges:

6.1.1. Due to limited operationalization of the Challenging Operating Environment Policy, standard GF policies and procedures still drive grant implementation in challenging WCA countries.

The Challenging Operating Environment (COE) Policy was adopted by the Board in April 2016 and operationalized through an Operational Policy Note in 2017. These documents define which countries are classified as COE countries; their objectives are to improve grant implementation effectiveness in COEs through innovation, increased flexibility, partnership, and better oversight. **Half of the 22 countries in WCA are classified as Challenging Operating Environments** (see visual 4, page 48). They represent approximately 40% of all the countries in the Global Fund portfolio classified as COEs. While the policy has been in place for two years now, the expected flexibilities are yet to be effectively leveraged, either during grant making or grant implementation.

6.1.1. - 1. Grant Making

(a) Funding requests insufficiently leverage available COE flexibilities

The Global Fund tailored the funding application process for challenging environments for the 2017 – 2019 funding cycle. The tailored approach simplified many aspects of the process:

- Replacement of the standard detailed concept note with a simplified CCM request to access funding.
- Specific review criteria to guide the TRP review and focus on specific priority areas for COEs.
- One Grant Approval Committee review instead of two.

However, only 40% of grants in the COE countries have made use of these flexibilities. This is primarily due to countries being uncomfortable with the significant changes to the application process between the two allocation cycles, and not fully understanding the implications and flexibilities granted under the simplified application process for COEs. While countries are aware of their COE status with the Global Fund, they are not clear on how this should be factored into the preparation of the funding request.

31% of survey respondents felt Global Fund programs do not sufficiently take into account a country's complexities.

Guidance on the review of funding requests for COE countries is in its infancy, with a wide spectrum of TRP review comments. While there is an overall appreciation for the flexibilities in the application process, the TRP acknowledges limitations in the review process under this approach. Specifically, it has noted that the diverse types and capacities of COEs are not catered for in the current review template.

> "I'm not sure how COE has worked as a different modality. I think we instead could go with more instruction to the TRP about what sorts of lens to put on. So, for a country in conflict, we don't ask for complete sustainability."
>
> TRP Member

6.1. Global Fund Processes

(b) Need to tailor country dialogue to COE context and challenges

The country dialogue process is yet to effectively factor local context and challenges into the program design. The TRP observed that, often applicants do not clearly describe the context and specific challenges they face in their challenging operating environment and how they will respond. As a result, a number of applicants had to revisit their funding requests, which had a direct impact on their ability to access funding in a timely manner:

- The average time taken from funding request submission to board approval for the Global Fund portfolio: 7.7 months
- COE countries in WCA take much longer: 15.1 months for Chad, 10.8 months for Congo, 9.9 months for Central African Republic and Guinea, 8.5 months for DRC, Liberia and Niger.

These delays have a knock-on impact on grant implementation, such as selection of grant sub-recipients and signing of contracts. Contracting SRs ranges between 4 months to as much as 21 months. For example in Sierra Leone sub recipients were signed 8 months after the grant commenced, in Mauritania 14 months and in Mali 21 months. As a result, in a standard 3-year grant cycle, one-third of the implementation period can be lost. In these cases, the organization mitigates the risk of disruption of key services by providing grant extensions. However, these extensions have limitations as the country's ability to scale up programmatic interventions is itself limited.

> "Programme design is significantly impacted by Global Fund rules and principles. As a result, the supported programmes are designed to meet GF rules and expectations rather than the actual needs and expectation of the country."
>
> Implementer in Mali

(c) Program Design and Priorities for COE countries

Two years after the introduction of the COE policy, specific guidance needs to be developed to simplify related Global Fund processes to enable the program to focus on key priorities for COE countries.

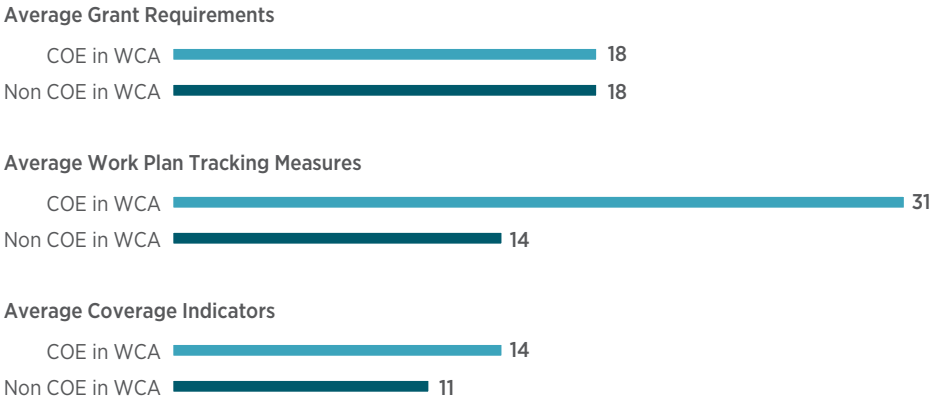
The Program Description, Performance Framework and Program Budget sections form part of the overall Grant Agreement between the Global Fund and the Principal Recipient (PR) and set the foundation for measuring and monitoring grant performance. It is critical that these core elements reflect the challenges in the country and focus on priority areas. Opportunities for improvement include:

- Prioritizing and simplifying how Program Objectives and Performance Framework are set for COE countries.
- Reducing the number of interventions measured through the Performance Framework's coverage indicators; these remain exhaustive and often more numerous than for non-COE countries. For example, the average number of coverage indicators for COE countries in WCA is 14, compared to 11 for non-COE countries in the region. Mali has 36 coverage indicators in a single grant.
- Reducing the number of work plan tracking measures, which are incorporated into the Performance Framework to track implementation deliverables not covered by standard performance indicators. The average number of work plan tracking measures is 31 for COE countries, with Mali and Chad having as many as 65. In comparison, non-COE countries in the region have an average of 14 work plan tracking measures.

Source: Global Fund Grant Management Documents

6.1. Global Fund Processes

VISUAL 1:
Limited difference in Grant Design between COE and non-COE countries



The combination of limited prioritization of interventions, lack of focus in the performance framework, and fragmented tracking of multiple deliverables results in significant complexity. This, in turn, creates potentially burdensome responsibilities for implementers, and allows limited opportunities to focus on priority areas which are likely to yield the biggest programmatic impact. It has a potentially adverse impact on the quality of the Country Teams' portfolio oversight, and their ability to focus attention and resources on core deliverables and the most critical challenges.

6.1.1. - 2. During implementation

(a) Cumbersome reporting framework and tools

The Global Fund uses a number of reports and tools to monitor grant implementation. However, these procedures are exactly the same for COE and non-COE countries. While efforts have been made to simplify the grant monitoring process, it remains complex and cumbersome. This was highlighted in the OIG's audits of Grant Monitoring Processes in 2017 and of Grant Oversight in Focused Portfolios in 2018. This presents an additional bottleneck to implementation for countries in challenging environments with low capacity. These countries have to deal with a significant number of reports and activities to meet Global Fund requirements, as shown in the figure below.

VISUAL 2:
Number and frequency of reports and tools used for grant monitoring applicable to COE countries

Frequency	Report	
Annually	Donor External Audits MOH and MOF External Audits Data Quality Assessment	Tax Report GF External Audits Health Facility Assessment
Semi Annually	Programmatic and Financial Progress Update LFA Review of Progress Update Conditions Precedent Monitoring	
Quarterly	GF Country Missions Supervision visits	Cash Balance Reporting Internal Audits
Once Off	PR Capacity Assessment	
Ad hoc	Budget Reprogramming Risk and Assurance Reviews	LFA Spot Checks GF Strategic Initiatives

Source: Global Fund Grant Performance Frameworks

6.1. Global Fund Processes

These tools are both numerous and complex for a challenging operating environment where capacity is often limited. For example:

- A Progress Update contains 12 worksheets with more than 400 data points to be collected and populated.
- The Annual Financial Report requires input for 224 data points and the Quarterly Cash Balance Report has on average 30 data points that need to be populated with supporting bank statements.

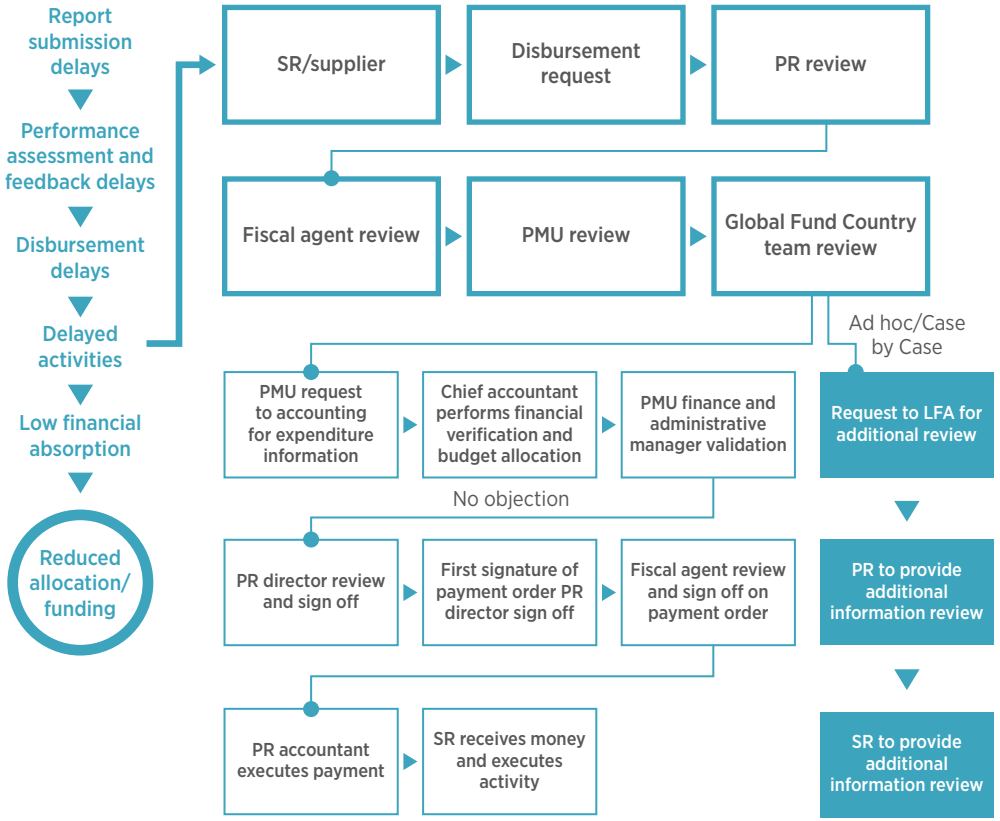
The reports take significant time to complete. A number of iterations are required between the implementers, the Local Fund Agent and the Country Team before performance assessments on grant implementation can be concluded. On average, it takes two months or longer past the expected date for COE countries in WCA to submit the required reports, in comparison to an average of 15 to 30 days for non-COE countries. The downstream impact of these complex reporting requirements includes delays in implementing grant activities, performance assessments and disbursements, as well as poor financial absorption.

> "GF procedures are cumbersome; as a result, implementers prefer to dedicate their efforts and time in implementing grants from other donors who don't apply such rigid procedures."
>
> Implementer in Guinea

(b) Reprogramming:

In order to improve absorption, the Global Fund has enhanced its grant revision process allowing countries to reprogram funds more easily. While the Global Fund only requires budget revisions if they exceed 15% of the total grant budget or 5% of a discretionary cost category, countries still apply for the approval processes for all reprogramming of activities. In 2017 and 2018, Country Teams received 5 to 10 reprogramming requests per grant that did not require approval by the Global Fund. Guinea, Mali, Mauritania, and Niger each submitted more than 10 reprogramming requests that did not require approval. The time it takes for the Country Team to review these requests and issue a "non-objection" opinion to the country can vary from a few weeks to as long as six months. The review process requires significant feedback and various checks between the implementer, fiscal agent, Local Fund Agent and the Country Team.

VISUAL 3:
Effect of complex and non tailored grant monitoring reports and tools to challenging operating environments

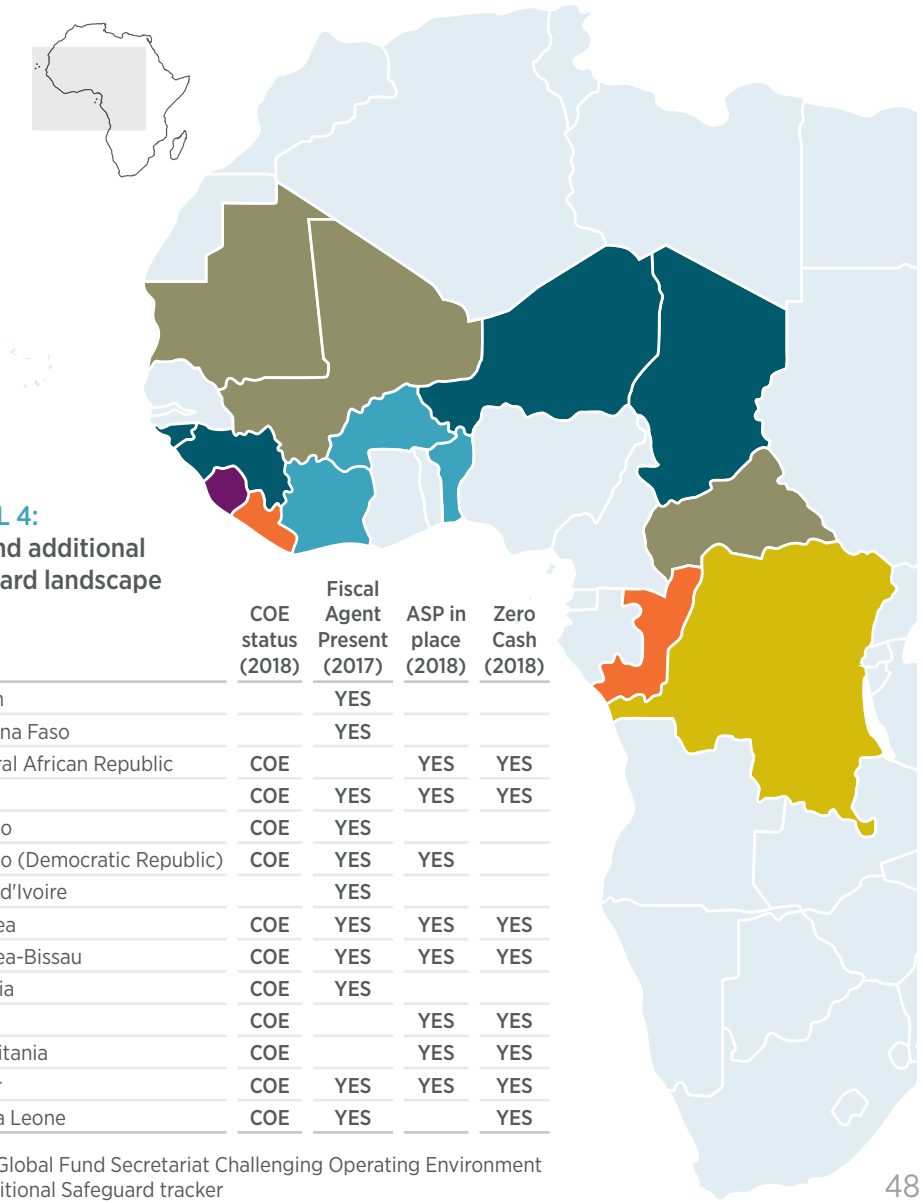


6.1. Global Fund Processes

6.1.2. Additional safeguards have led to an imbalance between financial risk mitigation and grant implementation.

In addition to fragility and political instability, 30% of the countries in WCA are included in the top quartile of corrupt countries based on Transparency Internationals Corruption Perceptions Index*. Global Fund grants have faced significant fraud and misuse of funds in the region: between 2009 and 2018, US$99.3m of funding to WCA countries were classified as either misappropriated, unsupported or ineligible expenditures, representing approximately 44% of the Global Fund's total misused funds.

In response to this risky environment, the Global Fund has invoked the Additional Safeguard Policy in eight of the 22 WCA countries. In addition 3 other countries have financial safeguards although not under the policy. This measure is designed to be temporary and used whenever the existing systems in a country suggest that Global Fund money could be in jeopardy without the use of additional measures. These additional measures are not meant to be a "one-size-fits-all". Instead, they are expected to be tailored to each portfolio, based on the relevant context. They can include various safeguards, such as: Global Fund selection of implementers, imposition of financial management intermediaries such as fiduciary or fiscal agents, zero-cash policy, mandatory procurement arrangements, etc.



VISUAL 4:
COE and additional safeguard landscape

Country	COE status (2018)	Fiscal Agent Present (2017)	ASP in place (2018)	Zero Cash (2018)
Benin		YES		
Burkina Faso		YES		
Central African Republic	COE		YES	YES
Chad	COE	YES	YES	YES
Congo	COE	YES		
Congo (Democratic Republic)	COE	YES	YES	
Côte d'Ivoire		YES		
Guinea	COE	YES	YES	YES
Guinea-Bissau	COE	YES	YES	YES
Liberia	COE	YES		
Mali	COE		YES	YES
Mauritania	COE		YES	YES
Niger	COE	YES	YES	YES
Sierra Leone	COE	YES		YES

Source: Global Fund Secretariat Challenging Operating Environment and Additional Safeguard tracker

* Corruption Perception Index 2017

6.1. Global Fund Processes

6.1.2. - 1. Significant prevalence of Fiscal Agents in WCA...

Fiscal Agents act as an embedded control function to provide enhanced oversight and verification of grant expenditures. They are appointed to build the financial management capacity of the Principal or sub-recipients. For the WCA portfolio:

- 50% of countries (11 out of 22) have Fiscal Agents for grants with government implementers
- About 60% of all Global Fund fiscal agents are deployed in WCA
- Annual cost: approximately US$9 million for the WCA region.

... but with potentially conflicting mandates

Fiscal agents have been put in place in the region to fulfill two potentially conflicting mandates: financial control and capacity building.

Financial control: With a few exceptions such as Chad, DRC and Sierra Leone, the control function role of fiscal agents in the region has generally been effective in reducing financial risk. As an indication, the region's assigned Global Fund grant risk ratings on financial and fiduciary management have improved over the years from "Very High" to "Moderate".

Capacity building: Fiscal Agents have not consistently developed and implemented the required capacity-building activities in WCA countries. In cases where a plan has been developed, there is no mechanism to track its implementation, resulting in delays. While Fiscal Agents undergo an annual formal review, there is no assessment of their ability to build implementers' financial and fiduciary capacity. As a result, financial capacity in the region remains low and there is very limited evidence of effective capacity building to enable transition out of a country. These issues were highlighted in the OIG audit of Grant Management in High Risk Environments (published in January 20 17).

A combination of factors account for the weak capacity building, including limited governance and political leadership (8 out of 22 countries in WCA are ranked in the worst quartile for governance and leadership for Africa*) and significant operational challenges in country. However there is a clear conflict of interest in the Fiscal Agents' mandate: building strong capacity in a country would make the role of fiscal agent redundant.

6.1.2. - 2. Zero Cash Policy

Due to the high inherent risk associated with cash transactions, this policy is designed to limit the use of cash at the sub-recipient level and to improve accountability over grant funds. For example, it includes a requirement to provide supporting documentation for 80% of payments before a new disbursement is made. Seven countries in WCA have a zero cash policy in place.

While this is a strong mitigant of financial risk, the zero cash policy can present significant bottlenecks in terms of program implementation. WCA countries under zero cash policy account for 9.1% of the global Malaria burden, with vector control – mass campaign distribution and case management at community level. Program activities to treat and prevent malaria generally happen at the lower service delivery levels. However, as banking and mobile payment systems are not well developed at this level, Principal Recipients don't have a decentralized structure to perform payments on the sub-recipient's behalf. Compliance with a zero cash policy is therefore extremely challenging.

> "Zero cash policy is one of the major causes contributing to low absorption."
>
> Implementer Guinea

* Mo Ibrahim Governance -recipients and community based interventions. Countries in Index 2017

Source: Global Fund Additional Safeguard Report July 2018

6.1. Global Fund Processes

While generally justified by the high financial risk in the region, these additional safeguards and internal controls over financial investments have affected implementation.

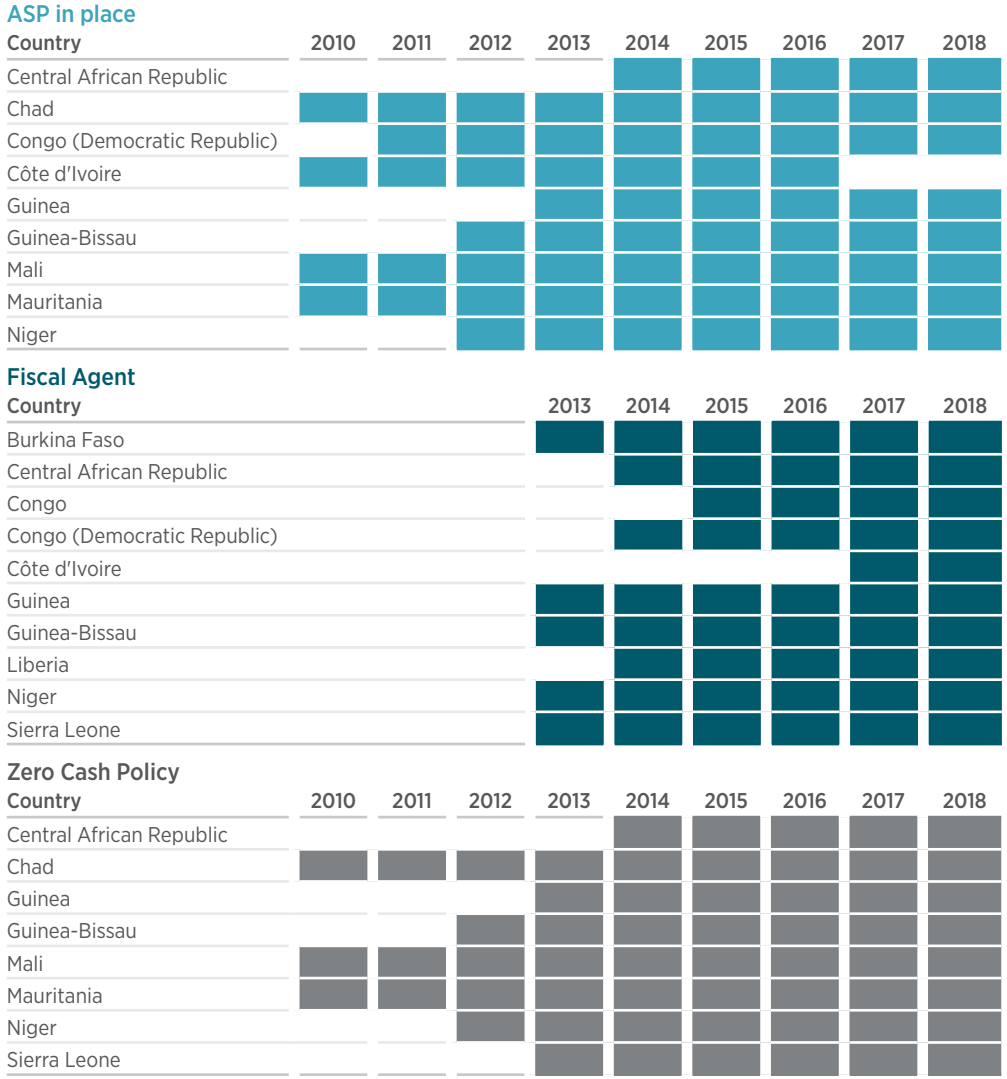
41% of survey respondents believed that the financial control system deployed by the Global Fund was a top contributor to low absorption.

Mauritania and Guinea have extremely low financial absorption levels (28% and 33% respectively), with Sierra Leone, Niger, Chad and Mali also experiencing suboptimal absorption ranging between 50% and 69%. All of these countries are under ASP, using both Fiscal agents and the zero cash policy.

The historical absence of a defined risk appetite for both Challenging Operating Environments and countries with high financial risk has led to an imbalance between program implementation and additional safeguard measures. Clear strategies, responsibilities and timelines do not exist to strengthen capacity over time and to phase out what should be short term or exceptional risk mitigation measures. Since 2004, only one country in the region (Côte d'Ivoire) has transitioned out of the Additional Safeguard policy. These issues were highlighted in the OIG's report on High Risk Environments.

There is insufficient monitoring of the effectiveness of the risk mitigation measures deployed. For the eleven countries under ASP, all with fiscal agents and seven under the zero cash policy, no formal reassessment has been conducted to determine whether the measures remain appropriate. For example, Chad has been under ASP measures for six years and Guinea for five years, yet no assessment of the effectiveness of the measures or their programmatic impact has been conducted.

VISUAL 5:
Evolution of Fiscal Agent, Additional Safeguards and Zero Cash



Source: Global Fund Secretariat Challenging Operating Environment and Additional Safeguard tracker

6.1. Global Fund Processes

6.1.2. - 3. Low financial absorption has a downward impact on funding allocations to WCA countries

A heavy focus on financial and fiduciary risk mitigation measures in Global Fund programs has resulted in improved risk ratings, however this has been at the expense of low implementation and poor absorption, with a knock on effect on country allocations.

Impact of low financial absorption on country allocation

The final 2017-19 Country allocation to the WCA countries in the scope of this review is USD$2.2bn. However this final allocation was reached after qualitative adjustments[1] reduced the formula-derived amounts by US$115m (5.0%). The key driver of the reduction was the potential for absorption and impact resulting in a downward adjustment of USD$228m (9.9%) although it was offset by other upward adjustments.

Globally, the downward adjustment due to lower potential for absorption/impact was USD$541m, meaning WCA countries accounted for 42% of this qualitative adjustment while only representing 21% of the total global allocation. This highlights the concentration of issues identified by the Secretariat and Board impacting absorption in this region in comparison to the Rest of Africa (ROA) and the Rest of World.

Despite the overall downward adjustments for absorption, the final 2017-2019 allocations for WCA countries increased by 9% compared to the 3-year equivalent spend from their 2014-2016 allocations.

VISUAL 6:
Impact of low absorption on country allocations

Country	Adjustment for potential for absorption/risk and impact (US$m)	Other Qualitative Adjustments (US$m)*	Total Change from Formula-Derived Amount (US$m)**
Benin	3.1	4.3	7.4
Burkina Faso	▼ -40.1	9.7	-30.3
Cameroon	▼ -45.1	-8.5	-53.7
Central African Republic	▼ -12.3	-2.1	-14.4
Chad	▼ -7.0	-2.5	-9.6
Congo (Democratic Republic)	▼ -11.3	29.3	17.8
Côte d'Ivoire	▼ -10.1	1.5	-8.6
Gabon	▼ -2.6	-1.7	-4.2
Gambia	1.1	1.1	2.2
Ghana	▼ -10.1	26.7	16.6
Guinea	▼ -15.0	5.2	-9.7
Guinea-Bissau	▼ -5.0	-0.8	-5.8
Mali	▼ -26.5	13.9	-12.6
Niger	▼ -17.9	5.0	-12.9
Sierra Leone	▼ -4.6	11.6	6.9
Togo	▼ -15.0	-2.0	-17.0
Other WCA countries: Cape Verde, Congo, Equatorial Guinea***, Liberia, Mauritania, Sao Tome and Principe, Senegal	0.0	12.5	12.4
Total	▼ -218.4	103.2	-115.5

The allocations are complemented in part by catalytic funding to ensure delivery against the 2017-2022 Global Fund Strategy through matching funds, multi-country grants and strategic initiatives. Matching funds of US$60m (as of May 2019) have been approved for WCA countries to incentivize the programming of allocations towards key strategic priorities, such as key populations and gender-based programs. This amount represents 98% of the total approved amounts for the region and 19% of the total amount across the Global Fund portfolio. Strategic initiatives are centrally managed projects designed to achieve the Global Fund strategic objectives for selected countries that cannot be addressed through country allocations. Ten out of the 16 strategic initiatives have a direct or indirect impact on countries in WCA. The total cost of these initiatives amount to $104m.[2]

[1] Qualitative adjustment were done holistically, with potential for absorption being one of many factors considered. What is reported is the primary rationale for the adjustment of the formula-derived amounts

[2] The amount directly attributed to WCA cannot be quantified as these are centrally managed projects that incur costs that cut across all countries in the scope of the project

* Other factors include cost of essential programming, higher potential for impact/coverage gaps, populations disproportionately affected by HIV, risk of malaria resurgence and low endemicity malaria

** Due to rounding, the sum of "Adjustment for potential for absorption/risk and impact" and "Other Qualitative Adjustments" may not exactly match the "Total Change from Formula-Derived Amount"

*** Equatorial Guinea did not receive an allocation in 2017-2019 period

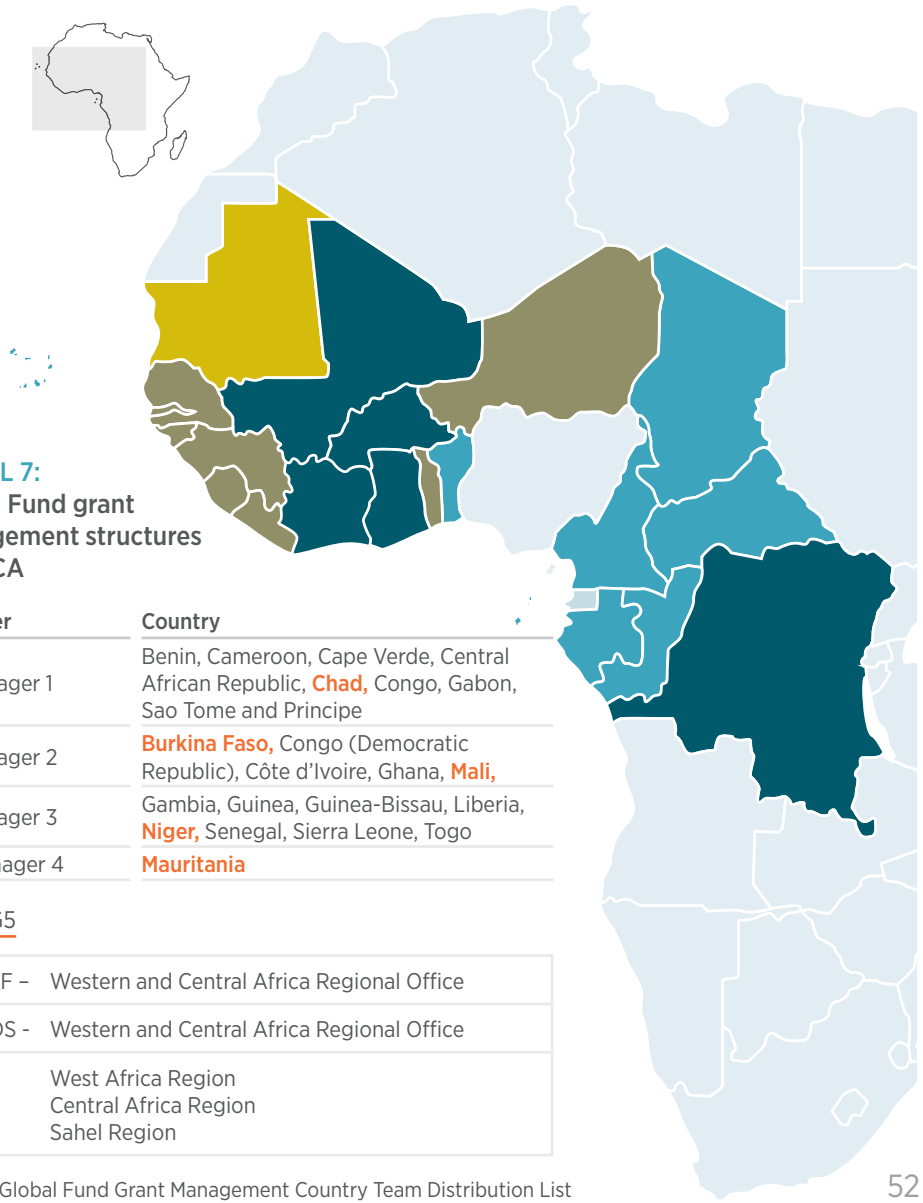
Source: SC report GF/SC02/ER05: "Allocation 2017-2019: Report on Qualitative Adjustments - Annex 1" and Allocation Team, SIID

6.1. Global Fund Processes

6.1.3. Lack of regional approach to grant management to leverage regional initiatives, share knowledge internally and effectively engage with regional partners.

The current Grant Management structure based on disease burden (High, Core, Low) has enabled the organization to dedicate time and resources to key Global Fund portfolios but it has not always helped in tackling regional challenges.

The Global Fund strategy in its current form considers broad objectives relevant to ending the three diseases globally. However, while the broad objectives are generally applicable across the portfolio, significant specificities exist at regional level that require a tailored implementation approach. There are currently no regional strategic implementation plans that consider regional specificities such as disease burden and other key contextual factors such as Human Rights barriers or the maturity of Health Systems. This limits the ability to effectively cascade the organization's strategy to regions and countries, with key objectives that can be prioritized over the long term (the six year strategy cycle) and short term (three year grant periods). Only 30% of the countries in WCA currently have a national strategy implementation plan that is broken down into annual work plans with priority activities, roles and responsibilities, and timelines.



VISUAL 7:
Global Fund grant management structures for WCA

Manager	Country
Manager 1	Benin, Cameroon, Cape Verde, Central African Republic, **Chad,** Congo, Gabon, Sao Tome and Principe
Manager 2	**Burkina Faso,** Congo (Democratic Republic), Côte d'Ivoire, Ghana, **Mali,**
Manager 3	Gambia, Guinea, Guinea-Bissau, Liberia, **Niger,** Senegal, Sierra Leone, Togo
Manager 4	**Mauritania**

Sahel G5

UNICEF –	Western and Central Africa Regional Office
UNAIDS -	Western and Central Africa Regional Office
AFD –	West Africa Region Central Africa Region Sahel Region

Source: Global Fund Grant Management Country Team Distribution List

6.1. Global Fund Processes

6.1.3. - 1. Regional partners and structures as a platform to build political will and support

Collaboration and coordination with partners is a critical enabler for successful program implementation of Global Fund grants in this region. Although the Global Fund is the main donor for the three diseases in WCA, other partners play vital roles, meaning the Global Fund needs to leverage partner strategies and oversight mechanisms to achieve effective program implementation. For example:

- Donors such as France, through the Agence Française de Développement and Expertise France, and Germany, through Gesellschaft für Internationale Zusammenarbeit (GIZ) provide Health System Strengthening support and technical assistance;
- UNICEF, with its significant focus on community-led interventions, is a critical implementing and technical partner in the region;
- Technical partners such as WHO and UNAIDS are critical for Global Fund success in the region;
- The USA's Presidents Malaria Initiative, PMI, is our main partner in the region in the fight against Malaria.

In addition to their local country offices, most partners are structured regionally and have regional strategies. As the Global Fund does not have a regional dimension to its structure, there is a natural misalignment in how we collaborate and coordinate with key partners.

As a result, there are often missed opportunities to collaborate with partners on key regional and country challenges. For example, in Chad, the country's President meets with all health donors on a quarterly basis, however the Global Fund is not present at these meetings. In 2017, France, Germany and the European Union launched the Sahel Alliance and were joined by key partners such as the World Bank, United Nations and WHO. However the Global Fund, despite a significant portfolio with approximately US$440million of investments between 2012 and 2017 (20% total investments in the region) in Sahel countries, did not participate.

> "The Global Fund is not present at the Annual Health Sector Review meetings. Last year Global Fund contribution was not mentioned at all, and neither were the three diseases. This was not a good sign of coordination with other development partners' contributions including Germany, World Bank, the UN and USAID. The scoping of work being done by other partners is important to leverage their contributions towards the targets for the three diseases."
>
> CCM in Burkina Faso

6.1. Global Fund Processes

The lack of a regional approach has also affected the way the organization deals with internal knowledge and its ability to leverage various regional reviews and insights

6.1.3. - 2. Sharing Internal Knowledge to scale up successful approaches

While some of the challenges are common across the region, each Country Team operates independently. This creates a siloed approach in how grants are managed in the region and does not promote internal knowledge sharing, including lessons learned and good practices. There are currently a variety of approaches to implementing and monitoring grants: although some Country Teams have managed to find innovative ways to deal with systemic challenges, the siloed structures within Grant Management make it difficult to scale up these successes to the regional level while taking into account country specificities.

Burkina Faso is a good example of how implementation arrangements can be adapted to:

- create accountability between national programs and the Ministry of Health
- drive innovation in the implementation of community activities
- develop and monitor the technical assistance plan

DRC is a good example for integration among the three diseases, while Senegal and Côte d'Ivoire are successful examples of donor coordination for HSS activities.

However, these good practices are not shared amongst Country Teams within the region. In most cases, Country Teams are unaware of the different approaches and key insights applied to grant management within the region.

6.1.3. - 3. Leveraging regional reviews to tackle common challenges

Various partners as well as the TERG have completed regional reviews tackling the challenges facing WCA countries. For example, the UNAIDS "Western and Central Africa Catch-up Plan: Putting HIV treatment on the fast track by 2018" and other progress reports highlight critical observations and recommendations on Health System Strengthening. Similarly the Solthis Risk Management report on optimizing the efficiency of the Global Fund's Grants, "Managing Risk in Fragile States: Putting Health First!" highlights challenges to implementation and provides useful recommendations. However, in the absence of a regional approach or structure, there is no opportunity to leverage these regional reviews and to tailor the grant management approach accordingly.

VISUAL 8:

List of research and recommendations performed in WCA

6.1.3. - 4. Global Fund engagement with in-country implementers

Global Fund Country Teams regularly visit countries to engage in a Country Dialogue at the time of funding requests and throughout grant implementation; this is to ensure progress against program objectives and that key implementation challenges are being tackled. However, there is a significant degree of inconsistency in how country visits are conducted. Some countries enjoy regular and well-timed visits from the Global Fund, along with strong engagement from senior management, while others experience very little in-person engagement.

The average number of grant management in-country visits over a five year period for countries in the Core Portfolios is 55. However, countries like Senegal (198 trips) and Cameroon (70 trips) experience visits well over this average while others like Central African Republic (6 trips), Congo (22 trips) or Mali (25 trips) are significantly under this average despite those countries facing significant challenges in program implementation and financial absorption. Furthermore, countries like Central African Republic, Niger, Sierra Leone, Chad, Liberia and Congo have not been visited by any senior management in the last five years, despite significant challenges on performance, weak health systems and human right barriers.

Systematic and well planned country missions by Grant Management in itself will not compensate for the lack of in-country presence. As WCA is a challenging environment, there is a need for the Global Fund to have a more hands-on approach to Grant Management. Key partners such as UNAIDS, UNDP, UNICEF and PMI have all highlighted that, in Challenging Environments, country presence is more critical to implementation success than in less fragile states.

VISUAL 9:

Grant Management related in-country missions between 2015 and September 2018

Grant Management In-Country Visits		Country Team	Regional Manager (West Africa, Central Africa and Middle East and North Africa)	Head of Department (High Impact Africa 1 and Africa and Middle East)	Head of Grant Management	Total
Benin		43	0	0	1	44
Burkina Faso	HIGH IMPACT	27	0	1	1	29
Cameroon	CORE	65	3	2	0	70
Cape Verde	FOCUS	14	0	0	0	14
Central African Republic	CORE	6	0	0	0	6
Chad	CORE	28	3	0	0	31
Congo	CORE	22	0	0	0	22
Congo (Democratic Republic)	HIGH IMPACT	106	N/A	6	2	114
Côte d'Ivoire	HIGH IMPACT	99	N/A	4	2	105
Gabon	FOCUS	21	0	0	3	24
Gambia	FOCUS	23	0	0	0	23
Ghana	HIGH IMPACT	37	N/A	3	2	42
Guinea	CORE	41	0	2	3	46
Guinea-Bissau	CORE	30	0	0	0	30
Liberia	CORE	34	0	0	0	34
Mali	HIGH IMPACT	23	1	0	1	25
Mauritania	FOCUS	27	0	0	0	27
Niger	CORE	41	0	0	0	41
Sao Tome and Principe	FOCUS	26	0	0	0	26
Senegal	CORE	187	7	2	2	198
Sierra Leone	CORE	76	0	0	0	76
Togo	FOCUS	38	0	0	0	38

Source: Global Fund Travel Records 2015 - 2018 for Grant Management department

6.1. Global Fund Processes

Recommendations

Although rigorous financial safeguards are required for many of the countries in the region, the Secretariat needs to have a balanced approach to managing risk. Risk management processes in place should be reviewed country by country aiming to simplify interventions for Challenging Operating Environments, leveraging flexibilities in grant implementation, and ensuring the right balance between the financial safeguards and program implementation.

- **Identify and focus on a targeted set of key strategic priorities for COEs –** Define priority interventions to accelerate the fight and be more prescriptive to ensure the countries are following them as part of the funding request
- Operationalize the COE principles by **effectively implementing flexibilities for challenging operating environments.** These should be wide ranging for the different types of challenging environments and must be across the grant lifecycle. Review, at the beginning of each implementation period, the flexibilities granted and their effect on implementation to inform decision making.
- **For WCA countries, perform a baseline assessment for each country under ASP** with a rigorous evaluation of the reasons why the country is under ASP, and objectives/criteria to be met to exit ASP. Assess the progress at the beginning of each implementation period to inform decision making.
- **Apply a differentiated approach to the implementation of Zero/Restricted cash policy** (e.g. by type of implementer, type of activities, regions, etc.). Establish a tool to have a consolidated view and track the evolution and performance of the policy in each country where it applies.
- **Focus Fiscal Agents as a control function and shift the capacity building function** to longer term Technical Assistance providers.

Ensure support functions (TAP, RSSH, CRG, etc.) provide GMD with relevant analysis and **data to support decision making at regional level** (e.g. maturity of community activities, mapping of the gratuity policy, regional disease and demographic data at a granular level). Where budget limitations apply, this analysis could be driven by the support functions using partners on the ground (e.g. mapping gratuity policy requirements in the region using MSF).

Adopt a regional approach to Grant Management, elevate the role of support functions in assisting GMD with relevant data and thematic strategies, and strengthen the Fund presence in countries.

Secretariat Level

Option 1:

- **Organize GMD departments along relevant regional portfolios** that may include a mix of High Impact, Core and Focused portfolios. If WCA as a region is too big and heterogeneous, sub-regional structures should be added (e.g. Sahel sub-region).

Option 2:

- Define internal GMD processes and tools to ensure effective regional management in order to **(i) break internal siloes and share knowledge across region, (ii) better leverage external regional initiatives/reviews, and (iii) improve regional coordination with key partners.** The Secretariat could improve regional coherence by:
  - **Designating focal points for all key initiatives and partners** to ensure a more structured harnessing of regional partnerships and initiatives.
  - **Developing approaches to address regional programmatic needs,** including a sub-regional approach where appropriate, e.g. how to better deliver impact on Malaria in the Sahel 5 countries.
  - **Improving knowledge sharing,** both on grant management and programmatically.

Country Level

Option 1:

- **Appoint a long term in-country technical assistance resource** reporting to the Fund Portfolio Manager with a clear mandate regarding (i) on-the ground follow up on implementation of grant programs and (ii) donor coordination. Unlike the LFA, who has primarily a control and assurance mandate, the long term TA's mandate would primarily be one of operational support, coordination and on-the-ground monitoring.

Option 2:

- **At the PMU level and based on the grant performance, appoint a long term in-country technical assistance resource** reporting to the Fund Portfolio Manager with a clear mandate regarding on-the-ground follow up on implementation of grant programs.
- **Enhance CCM role in terms of donor coordination** through CCM Evolution project and create specific requirements in the funding request to strengthen coordination for RSSH and TA (e.g. a map of donor's interventions in RSSH and TA).

6.2. Implementation Arrangements

6.2.1. Importance to Grants

Strong implementation arrangements are critical to ensuring programmatic success, and in mitigating wider health sector and country wide challenges.

Implementation arrangements refer to grant governance and program delivery processes from receipt of funds to beneficiary-level activity, defining Who is doing What with grant funds. The "Who" is important: utilizing the right implementers and leveraging their distinct capabilities is crucial in ensuring strong performance in Global Fund grants.

One common key feature of some of the best performing portfolios in the region in terms of financial absorption – Burkina Faso, Senegal, DRC, and CIV - is strong implementation arrangements that are adapted for the country context and available capacity. While country stability and strong political leadership are critical pillars for strong performance, implementation arrangements are a major contributing factor to programmatic performance, absorption and sustainability.

Even in fragile states with weaker health systems, choosing the right implementers and leveraging their key competencies can mitigate the impact of wider external challenges faced by the broader health sector.

6.2.2. Regional View

Multiple implementation arrangements utilized across West and Central Africa (WCA), but similarities in the approaches developed.

Implementation arrangements vary both across different WCA countries and within countries, and from one disease component to another. As part of the Global Fund's commitment to strengthening the role of civil society and the private sector in Global Fund processes, CCMs are encouraged to pursue a "dual-track financing" (combination of government and civil society PRs) approach in nominating Principal Recipients (PRs). This has led to a large number of implementers and multiple PRs for each disease.

- **Large number of implementers:** for the 2014 – 2016 allocation (also referred as New Funding model – NFM 1), 88 grants were signed in the WCA region. These were implemented by a variety of Principal Recipients: Local and International NGOs (37%), Ministries of Health (27%), other National Institutions outside the MOH such as National AIDS bodies and Presidential offices (29%).
- **Multiple PRs arrangements:** Disease components often have multiple PRs, particularly for HIV (10 countries have multiple PR implementers providing HIV services) and Malaria (6 countries have multiple PR implementers providing Malaria services).

VISUAL 1:
Distribution by type of implementer

PR types	NFM 1	%
Local NGO	11	13%
Ministry of Health, excluding National Disease Programs	24	27%
International NGO	21	24%
Other National Institutions	19	22%
National Disease programme	6	7%
United Nations Agencies	6	7%
Private Sector	1	1%
Total	**88**	

Source: Global Fund Data on Implementation Arrangements in WCA, Country Teams in WCA

6.2. Implementation Arrangements

The following implementation arrangements were in place under NFM 1 with respect to Principal Recipient selection:

Malaria program:

- 37% of the 27 grants had INGO Principal Recipients.
- Six countries had grants implemented through a dual track approach involving both government and civil society organizations managing different malaria activities. Non-Government PRs were primarily tasked with LLIN campaign planning and execution, with case management and treatment implemented by the government PRs.
- In 14 countries, there was a single PR. Government bodies (Government Agencies, MOH & national disease programs) were the sole implementer in six of these countries."

HIV program:

- 38% of the 32 grants had a national entity that was not a part of the Ministry of Health, such as the National Aids Council, as PR.
- 22% of the grants had Local NGO PRs linked to key population and prevention activities.
- In 10 countries, HIV implementation was split between multiple implementers. Procurement and treatment was generally allocated to Government PRs while prevention and specific key population activities were allocated to local and international NGOs. This type of implementation arrangement is often more appropriate in countries where the activities of key affected populations are criminalized.

TB program:

- 37% of the 27 grants had INGO Principal Recipients.
- Six countries had grants implemented through a dual track approach involving both government and civil society organizations managing different malaria activities. Non-Government PRs were primarily tasked with LLIN campaign planning and execution, with case management and treatment implemented by the government PRs. In 14 countries, there was a single PR. Government bodies (Government Agencies, MOH & national disease programs) were the sole implementer in six of these countries.

VISUAL 2:
Number of implementers by disease

	NFM 1			
Countries in scope	**HIV**	**TB**	**Malaria**	**TB/HIV**
Côte d'Ivoire	2	2	2	
Burkina Faso	1	1	1	1
Senegal	2	2	2	
Mali	2	1	1	
Togo	1	1	1	
Niger	1		1	
Guinea Republic	2	1	1	
Benin	2	1	1	
Mauritania	1	1	1	
Guinea Bissau	1	1	1	
Cape Verde			1	1
Ghana	4	1	2	
Sierra Leone	1		1	
Liberia	1		2	1
Gambia	2		2	
Cameroon	2	1	1	
Chad	1	1	1	
Central African Republic			1	1
Gabon		1		
Congo Republic	2	1		
Democratic Republic of Congo	3	2	3	
Equatorial Guinea				
Sao Tome and Principe	1	1	1	

Source: Global Fund Data on Implementation Arrangements in WCA, Country Teams in WCA

6.2. Implementation Arrangements

Evolution of implementation arrangements in WCA Region:

The Global Fund and CCMs in the region have refined implementation arrangements over time by:

- reducing the number of grants and increasing the number of combined grants;
- implementing Project Management Units (PMUs) to better coordinate grants and improve program management capability;
- using NGOs on their key areas of expertise – community activities, key and vulnerable populations, supply chain.

From funding cycle 2014 – 2016 (NFM 1) to the new funding cycle 2017 – 2019 (NFM 2), grant implementers in WCA were streamlined by 23%, from 88 to 68 PRs. For example:

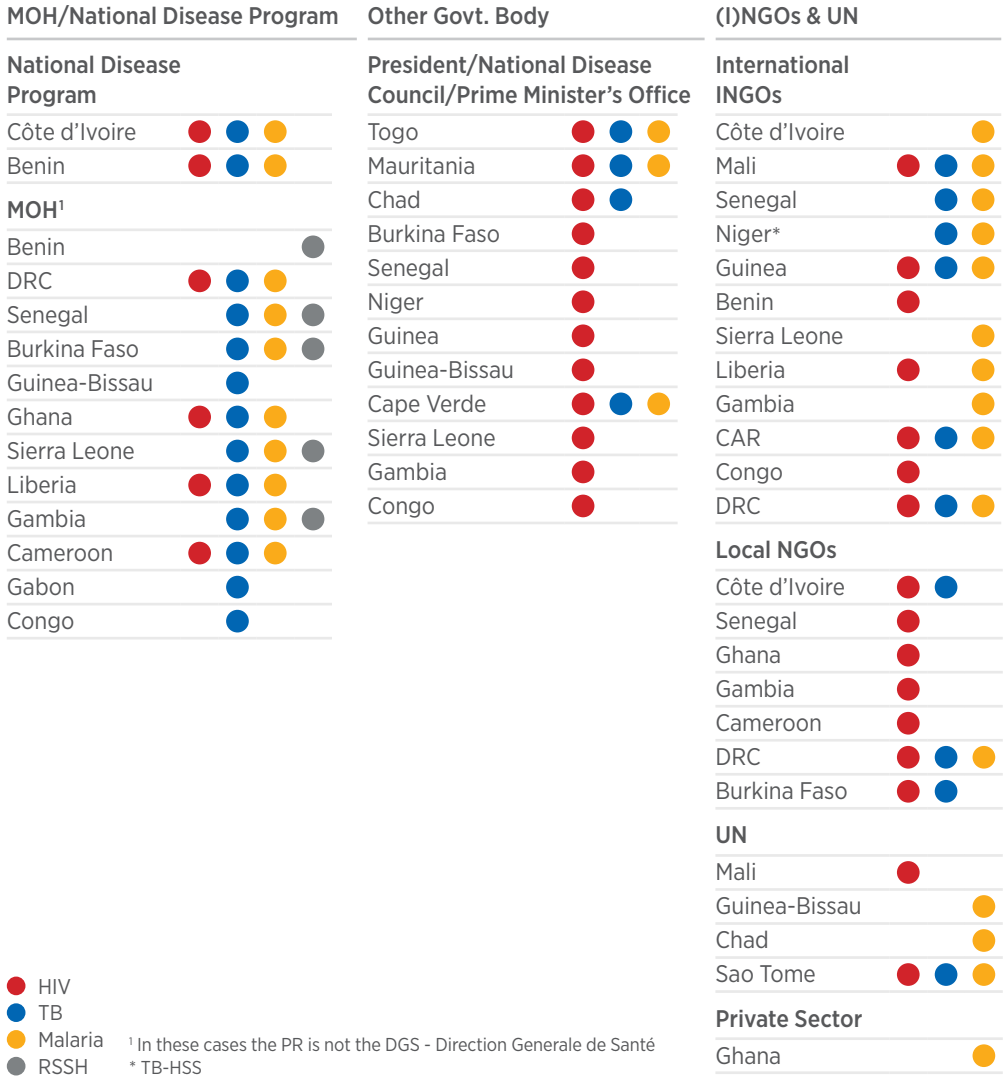
- in Ghana, seven grants were merged into four in 2018.
- in DRC, there is now one PR each in charge of HIV and Malaria supply chain, instead of two for each disease during NFM 1.

In addition, the proportion of combined grants has increased from 8% to 21% of grants in the region, with an increase in the number of HIV/TB grants, and disease grants being merged into RSSH grants.

In five countries, Global Fund programs are implemented either through PMUs or through other mutualized support functions. 15 different NGO organizations operated as PRs in the region under NFM 1: these have been used to help countries develop their community activities (Burkina Faso and Benin), work with key populations (Ghana, Liberia, Guinea, Cameroon) or to support planning, procurement and distribution of health commodities (Liberia, Chad, Niger and Ghana).

Implementation arrangements are specific to every country based on the grant objectives, implementers' capacity to execute specific activities, and local leadership and governance. While arrangements vary across the region, they follow a similar general pattern, using three types of PRs.

VISUAL 3:
Mapping the Principal Recipient implementation arrangements (NFM 1):



Source: Global Fund Data on Implementation Arrangements in WCA, Country Teams in WCA

6.2. Implementation Arrangements

6.2.2. - 1. Implementation is performed at the central level by Principal Recipients with limited mandate in delivering health services and no hierarchical, functional or financial relationships with service delivery entities.

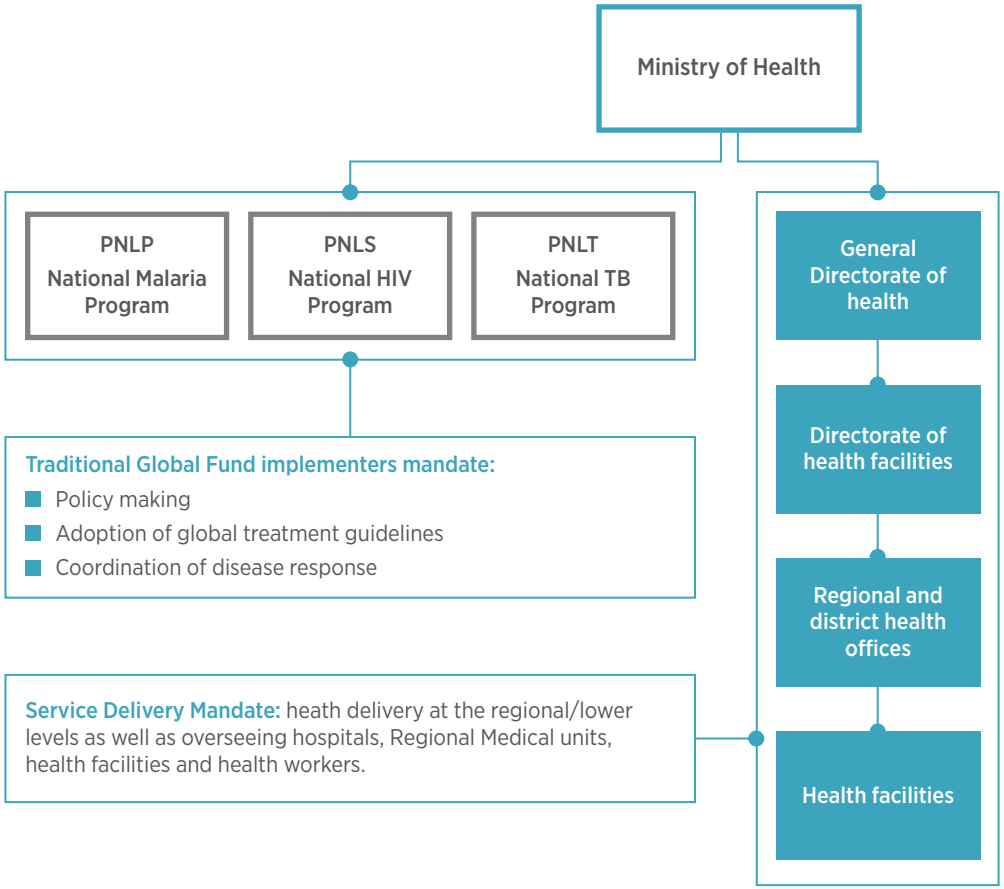
6.2.2. - 1.1. Implementation through National Programs

In the 1990s and 2000s, vertical national programs were created to fight against HIV, Malaria and TB. Today, every WCA country has established national disease programs for the three diseases. These programs are often embedded as standalone units within the Ministry of Health, reporting directly either to the Minister or the General Secretary. These national disease programs are always PRs or SRs for Global Fund supported grants: they have two primary mandates:

- **'Traditional' mandate:** policy making, adoption of global treatment guidelines and translation into national guidelines, monitoring and evaluation, program supervision, training, and overall coordination of the disease response (although this mandate is often limited for HIV if a National AIDS Council exists).
- **Service delivery mandate:** this operational role typically rests with other MOH departments, such as the Directorate of health facilities (part of the General Health Directorate), which is responsible for service delivery at the regional/lower levels as well as overseeing hospitals, Regional Medical units, health facilities and health workers.

National programs play an important role in Global Fund-supported programs due to their coordination ability and concentration of disease-specific expertise. **They do not, however, have a mandate to implement healthcare delivery services.** In most WCA Countries, the National Programs engaged as PRs or SRs have no administrative authority or contractual relationship (such as a sub-recipient agreement); the Directorate of health facilities alone has direct authority and oversight over service delivery.

VISUAL 4:
Typical national program implementation arrangements in the region



6.2. Implementation Arrangements

Consequences:

- Limited ability of National Disease Programs to directly influence roll out implementation of Global Fund Grants, enforce guidelines, safeguard quality of service, and effectively supervise work with beneficiaries.
- Limited leverage to follow up on supervision visit findings, data collection, and diminished accountability of health service delivery structures to Global Fund programs.
- Sharing reporting lines to the Minister of Health has not ensured alignment and coordination of resources, activities and approaches, due to National Programs being too far from operational/tactical implementation matters.

A few countries have mitigated the limitations posed by such arrangements through various approaches:

- Principal Recipients in Burkina Faso and National Programs in Benin have signed annual contracts based on work plans and budgets with Regional Health Directorates or districts in charge of service delivery.
- Senegal's Ministry of Health has created joint positions that oversee both the national disease programs and the DGS, with common senior management stakeholders to ensure better coordination and alignment.

These implementation arrangements have significantly contributed to good financial absorption in these countries compared to the rest of WCA: 94% for Senegal and 93% for Burkina Faso. This is higher than the average absorption in the region (77%).

6.2.2. - 1.2. Implementation through National implementers outside MOH

In 12 WCA countries, national implementers outside the Ministry of Health were used for one or more grants during NFM 1. These non-MOH government PRs included Presidential/Prime Ministers offices (2 countries), Ministries other than MOH (1 country), and autonomous National Disease Councils (9 countries). These implementation arrangements were most prevalent with HIV grants: nine of the 19 countries with a standalone HIV grant were led by the National AIDS response agency PRs due to their mandate.

National AIDS response agencies, often called *Conseil National de Lutte contre Sida* (CNLS) in francophone countries, were created from the 1990s onwards in response to the threat posed to national security by the growing HIV burden. They often undertake an advocacy role for resource mobilization, national communications to increase public awareness, and coordination of multi-sectoral plans to combat HIV/AIDs.

In all WCA countries, these entities are not accountable to the MOH, sitting either under the President's Office, the Prime Minister's Office, or as a standalone autonomous body.

- **Mandate limitations:** as with the national programs, these non-MOH government PRs have no mandate in implementing health, and do not have authority or contractual relationships with service delivery structures. This lack of mandate impacts their ability to effectively drive program implementation.
- **Coordination and communication challenges:** There is often complex and ineffective coordination and communication between Principal Recipients and the MOH via National Disease Programs that are often sub-recipients. Information sharing between these entities is a long, multiple-layered process. Communications often require the validation of the entire MOH hierarchy if requests come from an external body and the MOH does not have a signed agreement with the Global Fund. These bureaucratic challenges hinder addressing bottlenecks and executing planned grant activities.

Sources: Global Fund Data on In-Country Absorption 2014-2017 per July 2018, Finance Team - FISA
Source: Global Fund Data on Implementation Arrangements in WCA, Country Teams in WCA

6.2. Implementation Arrangements

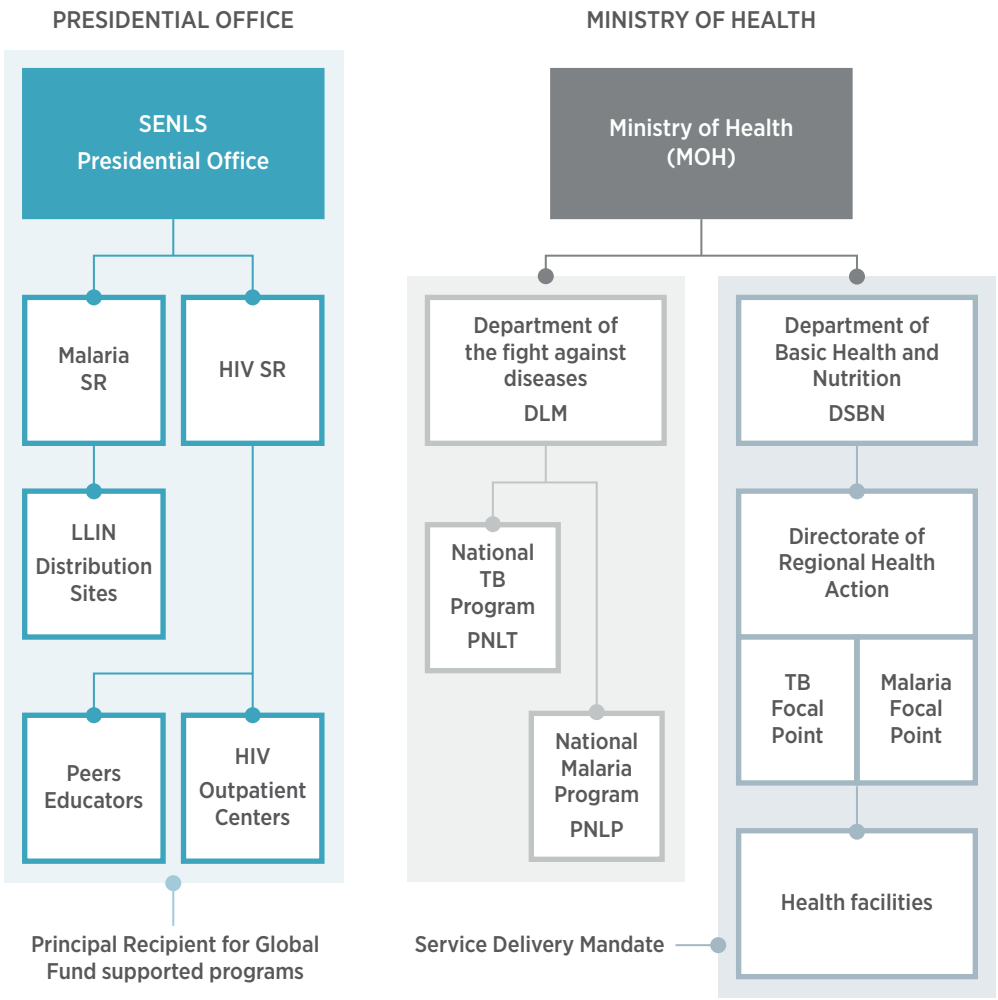
Overall, this approach to implementing grants contributes to low absorption and poor performance:

Mauritania is a good example of a complex set of implementation arrangements with a non-MOH PR. All three disease grants were signed with the Secretariat Exécutif National de Lutte Contre le SIDA (SENLS). However SENLS must operate via three separate Ministry of Health departments before it can engage with the underlying National Disease Programs for Malaria and TB. In addition, it then must work through another layer in a separate MOH department before engaging with TB and Malaria Focal points at the service delivery level. This complex structure highlights the distance and limited control and oversight that a non-MOH PR has with the service delivery level. These inefficient arrangements have contributed to extremely low absorption in the country (only 28%, the lowest in the WCA region).

While Mauritania is an extreme case, it does underscore the general pattern that grants with a non-MOH government PR tend to achieve lower financial performance, with an average absorption of 66% compared to 77% for WCA grants with a PR within the Ministry of Health.

Countries such as Burkina Faso and Senegal have achieved improved results by altering the model, with the adjustments highlighted in the previous section.

VISUAL 5:
Presidential Office implementation – Mauritania example



Source: Global Fund Data on In-Country Absorption 2014-2017 per July 2018, Finance Team - FISA

Source: Global Fund Data on Implementation Arrangements in WCA, Country Teams in WCA

6.2. Implementation Arrangements

6.2.2. - 1.3. Implementing through International Non-Governmental Organizations (INGOs) & UN agencies

INGOs are important actors in the development world, playing a critical role in implementing health programs. The Global Fund also relies on UN agencies to serve as PRs in challenging environments. Implementing Global Fund programs through INGOs and UN agencies often mitigates the risks of operating in a difficult environment.

INGOs and UN Agencies can fill significant gaps: In various challenging operating environments, the Global Fund has leveraged multiple (I)NGO & UN agencies, utilizing their skills and strengths to implement grants that would otherwise have been negatively impacted by contextual challenges:

- In the Democratic Republic of Congo (DRC), two local and International NGOs are used as implementers to help fill gaps in planning and distribution of health commodities, as well as for community activities.
- In Niger, INGOs (CRS and Plan International) are used as implementers to help address deficiencies in planning and distribution capacity. The Malaria grant benefits from their budgeting, planning and supply chain expertise to ensure grant objectives are achieved.
- In the Central Africa Republic, INGOs (IFRC and World Vision) are used as PRs to assist with procurement and supply chain management as well as financial management for all Global Fund grants in country; this arrangement was implemented in 2013 to better manage grant risks.

Extensive presence in the region: The Global Fund has extensively used INGOs and UN agencies to implement health programs in WCA. They have been used as PRs to mitigate significant financial risks, following a number of high profile fraud and misuse cases in the early 2010s. They are also used as SRs or PRs for delivering specific activities where local capacity is low. In total, 21 (or 24%) of 88 NFM 1 grants in the WCA region were led by 8 different INGO organizations. A further 7% of NFM 1 grants were led by UN agencies.

Typical areas of focus: The use of (I)NGOs is most prominent in HIV and Malaria: this is partly because unlike TB, these two diseases entail components other than case management, and NGOs working on these diseases have a strong presence in the region. For HIV in Liberia, Mali, Guinea, Benin, Congo and DRC, INGOs are primarily used to undertake prevention activities or to deal with key populations. For Malaria, in Côte d'Ivoire, Senegal, Mali, Niger, Guinea, Sierra Leone, Liberia, Gambia, CAR and DRC, INGOs primarily assist with planning and execution of LLIN mass campaigns, and to distribute test kits and treatments through their supply chains.

Different value propositions for different roles: The INGOs and UN agencies offer different value propositions depending on the specific roles they are assigned in implementing Global Fund grants

- **Strong track record in targeted service delivery role:** INGOs and UN agencies bring strong experience and capabilities in delivering services to key populations, executing community activities and managing supply chain and LLIN campaigns.
- **Mixed cost/benefit value proposition in 'pass-through' role:** The situation is different when INGOs or UN agencies are used as 'pass-through' PRs for financial management and risk mitigation purposes, meaning they are awarded grants but they are just custodians of the funds, passing those funds on to either MOH or other implementers who are implementing the program. From a grant performance perspective, grant ratings for INGOs are generally in line with those achieved by MOH PRs. However, for the same level of performance, INGOs are typically more costly, with much higher management costs than government PRs. On average in the WCA Countries, program management costs for INGO & UN agency PRs accounted for 22.7% of the total grant value, more than double the figure for MOH PRs (10.9%). Several INGO grants recorded even higher management costs, the highest being 54% of the total grant. Multiple TRP reviews of WCA grants have highlighted high management costs and the need to re-examine and minimize these costs where possible (this was specifically noted in the reviews of Mali and Niger, where management costs are between 32%-47%).

Source: Global Fund Data on In-Country Absorption 2014-2017 per July 2018, Finance Team - FISA

6.2. Implementation Arrangements

Potential misalignment in incentives: As with all PRs, INGOs are responsible for ensuring the correct use of grant funds, and have to repay the Global Fund for any ineligible expenditures. When operating only as pass-through PRs, they implement activities through national entities. There is no legal framework which would allow INGOs to be reimbursed by the national entities in case of ineligible expenditures. This strongly incentivizes the INGOs to be extremely prudent in disbursing money to lower levels, which in turn can affect program implementation and absorption (highlighted in the lower absorption values).

Lower absorption rates: Across the region, average absorption rates for INGO/UN PRs was 72%, compared to 77% for MOH PRs. Nine countries had average absorption higher for MOH/Government PRs than for UN/NGO PRs. For INGO/UN PRs that are partial or full pass-through PRs (i.e. heavily reliant on national institutions for service implementation), average absorption drops to 69%. Guinea, Mali and Niger all experience low absorption rates, high management costs, and weak programmatic performance. Secretariat assessments of INGO PRs have highlighted issues with SR management and PSM that impact grant performance.

Balancing short term performance needs and longer term national capacity goals: While INGOs/UN Agencies are used to mitigate temporary capacity gaps and to improve programmatic results in the short to medium term, longer term exit plans are generally not designed and capacity building activities are not budgeted for. This often leads to INGOs/UN being in place for many years, or PR roles being passed between different INGOs between grants as the significant risks of fraud and corruption often remain high. Out of 15 countries under NFM 1 that utilized INGO and UN agencies as PRs, only two countries had transitioned to government PRs under NFM 2. In Chad, UNDP has been the PR for the last 10 years and both the capacity of national entities and the overall performance of the portfolio remain low.

Sources: Global Fund Data on In-Country Absorption 2014-2017 per July 2018, Finance Team - FISA
Global Fund Data on Implementation Arrangements in WCA, Country Teams in WCA

6.2. Implementation Arrangements

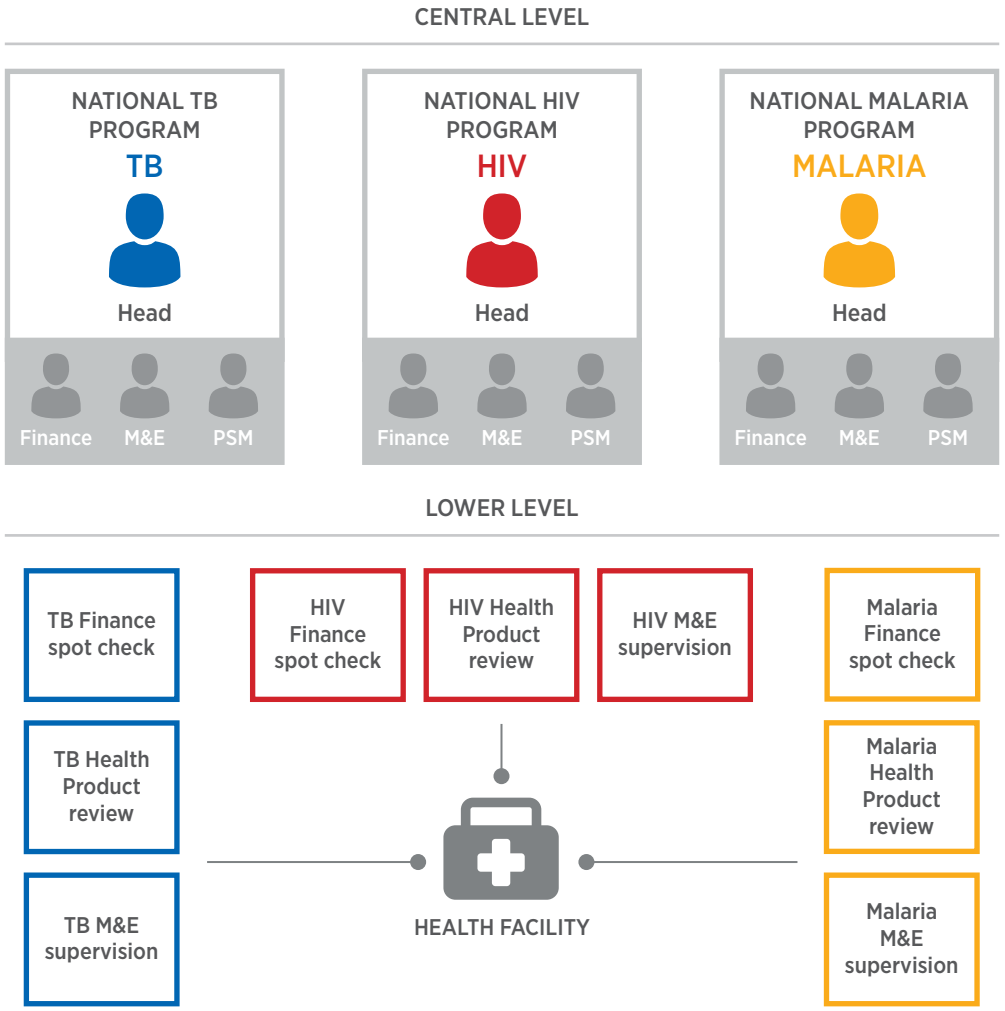
6.2.2. - 2. Vertical implementation and lack of integration among the three diseases leads to inefficiencies at the central level, lack of ownership and overburdening of service delivery providers at lower levels.

Implementation through vertical programs has brought great success to the fight against the three diseases. While this has worked historically in reducing the deaths in the region, it is less and less efficient and effective today.

Central Level: Due to the siloed nature of national disease programs within the MOH, cross-cutting functional responsibilities around sourcing, financial management, supervision and oversight are often duplicated across the three disease programs. Under NFM 1, this operating model was present in all countries without a PMU or similar coordination function (18 of the 23 countries). This siloed approach at central level is fundamentally inefficient, as every program has its own support functions – finance, procurement, M&E, administration.

Lower Level: While this impacts efficiency and value for money at the central level, the negative impact in the WCA countries is more acute at the service implementation level. Despite there being three central program management teams, service delivery work is often carried out by the same staff in the same health facilities at the lower levels. Fragmented management arrangements at the center between the three disease programs create an increased burden on health service delivery functions at the regional, district and facility levels, due to uncoordinated requests for financial reporting and data, as well as multiple M&E and other oversight activities. This impacts WCA countries more than other regions because of their lower levels of human resources for healthcare.

VISUAL 6:
Effect of vertical implementation over health delivery



6.2. Implementation Arrangements

The Global Fund is working towards increased integration of vertical programs, especially for HIV and TB. For example, while Cameroon, Mali, Burkina Faso had a joint TB/HIV concept note for both NFM 1 and 2, three grants were created, splitting TB and HIV implementation.

79% of NFM 2 grants in WCA remain as stand-alone grants, in comparison to the rest of Africa where 70% of grants are integrated for HIV and TB. Benin, Burkina Faso, Mauritania, Niger, Côte d'Ivoire, Senegal and Sierra Leone have disease-specific grants for all three diseases, noteworthy in a region where allocations for HIV and TB are smaller, due to the disease burden being under 10% of global burden for both diseases. These non-integrated grants have contributed to poor programmatic performance in relation to TB.

A number of countries have managed to better integrate support functions at the central level with service delivery at lower levels:

- In DRC, a PMU has been created at the MOH level regrouping the procurement, accounting and program management functions for the three national programs. This is also the case for two disease programs (TB and Malaria) in Burkina Faso.
- In Senegal, in the absence of a PMU, support functions for three diseases are under the responsibility of one national program (accounting under malaria, procurement under HIV, etc.).
- In DRC, there is one SR per province in charge of supply chain activities for all the three diseases.

Overall, for the WCA countries with PMUs or integrated support functions, in-country absorption was significantly higher (an average of 83% compared to 69% for other WCA countries).

6.2. Implementation Arrangements

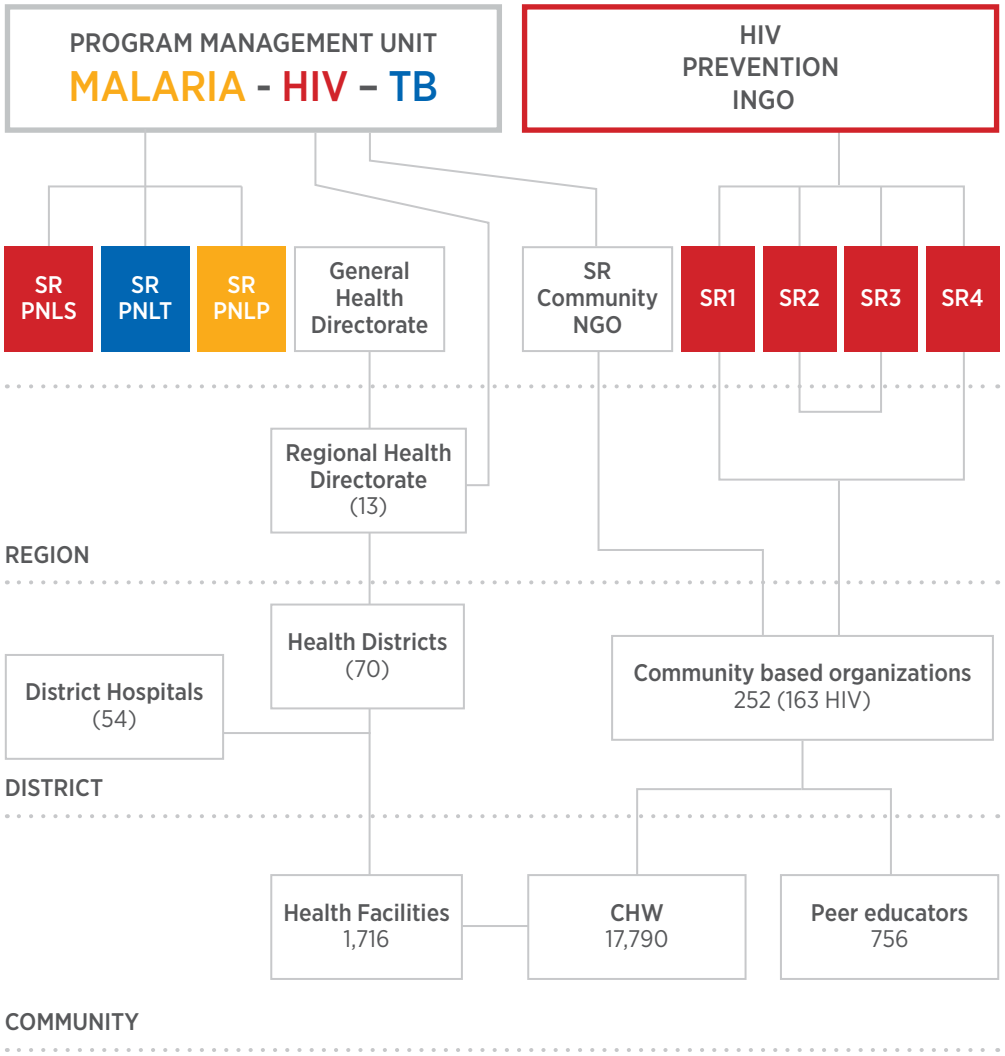
Recommendations

Review the country portfolios in a phased manner during the current implementation period. Assess the potential for an integrated implementation using entities in charge of service delivery in a decentralized manner.

Notwithstanding the limited country capacity and high financial and fiduciary risk in many of the countries in the region, there are still opportunities to:

- **Integrate the three disease programs at central level by creating a structure** that will regroup the key support functions: Finance, M&E, PSM, Administration, etc. This may include setting up or reinforcing an existing PMU within MoH, preferably one that serves all donors.
- Maintain MOH central role in the implementation and reinforce the accountability at lower levels by having **triparty contracts,** including work plans and budgets, between the PMU, General Health Directorate and Regional Health Directorates – in charge of service delivery at regional level.
- **Ensure the implementation arrangements leverage the mandate and core competencies of various type of implementers** to balance programmatic needs and fiduciary responsibilities:
  - **(i)** Maintain the **National Programs and National AIDS Councils as Sub-Recipients** to develop policies, advocacy and coordination of the disease response – in line with their mandate.
  - **(ii)** Where country capacity is limited or financial and fiduciary risks remain high, use INGOs as pass-through PRs as a temporary solution, ensuring specific **time bound capacity building plans** are in place for national entities.
  - **(iii) Use the INGOs for their service-delivery mandate,** based on their specific competencies, to fill critical gaps in areas such as mass campaign distribution, key populations activities, community health systems and supply chain.

VISUAL 7:
Implementation map – leveraging key competencies of every type of implementer



6.2. Implementation Arrangements

Downsides:

- Limited capacity at central level (PMU) to deliver the mandate – regrouping the support functions and ensuring follow-up of program implementation.
- Capacity at lower level to follow up on implementation and account for Global Fund funds. Ability to plan activities in an integrated manner, follow the work plans, collect and validate data and follow up on financial advances.
- Political difficulties to take over the implementation role from traditional well established entities in country such as National AIDS Council and National Programs.
- A potentially higher financial risks profile if INGOs won't be used as pass-through implementers.

Pre-requisites:

- Accompanying the country at the time of the creation of the PMU, ensuring good governance principles are respected, recruitment of staff follows a competitive process, and capacity building plans are in place. A temporary Fiscal Agent to ensure funds are properly managed both at central and lower levels.
- At lower levels, as part of RSSH investments provide regions with infrastructure (e.g. accounting systems, simple tools and guidelines), staff (accountants, data clerks and pharmacists). Develop specific capacity building plans and assess them regularly. Where capacity is limited take a gradual/pilot approach in terms of decentralization.
- Where the traditional implementers have to be maintained, ensure program delivery is decentralized.

6.3. Technical Assistance and RSSH

6.3.1. Resilient and Sustainable Systems for Health

Strategic, relevant and effective investments in resilient and sustainable systems for health critical to achieve long term disease impact

Functioning health systems are critical for the effective delivery of disease programs. From its inception, the Global Fund has recognized this linkage, embedding cross-cutting support for health systems in its Framework Document, and incorporating it in various policy and strategy frameworks that have guided Global Fund investments over the years. This culminated with the 2017-22 Strategy, "Investing to End the Epidemics", which establishes "Resilient and Sustainable Systems for Health" (RSSH) as one of the Global Fund's four strategic objectives. At the global level, partners have acknowledged that the achievement of Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages)[1] is contingent on strengthening health systems.

As shown in the first part of the report, health systems are weaker in Western and Central Africa than in the rest of the world. In order to achieve long term impact in the region, strategic, relevant and systematic investments in resilient and sustainable systems for health are critical.

6.3.1. - 1.1. The Global Fund has made significant RSSH investments in Western and Central Africa during the last two funding cycles

Global Fund investments in RSSH in the Western and Central Africa region include both direct investments (through standalone RSSH grants or specific RSSH components included within disease grants) and contributory investments (interventions in disease grants that have cross-cutting impact beyond an individual disease). Since the introduction of the New Funding Model (NFM) in 2014, the Global Fund has invested more than US$1.1bn in RSSH-related interventions in the region.

As illustrated in the table, the proportion of RSSH investments (direct and contributory) has proportionally decreased in the WCA region (from 27% in 2014-2016 to 21% in 2017-2019)[2]. This was impacted by the general reduction in funding allocation for the region in the 2017-2019 grant cycle (as detailed in 2.3. of the Global Fund processes section of the report).

VISUAL 1:

RSSH and disease investments in WCA during NFM 1 (2014-2016) and NFM 2 (2017-2019) funding cycles

	2014 - 2016 (US$)		2017 - 2019 (US$)		Consolidated 2014 - 2019	
Investment Categories	**Amount**	**%**	**Investment amounts ($)**	**Proportions (%)**	**Investment amounts ($)**	**Proportions (%)**
Direct RSSH Investment	386,759,190		256,455,268		643,214,458	
Contributory RSSH Investments through disease	320,355,017		171,322,310		491,677,326	
Total RSSH investment in WCA	**707,114,206**	**27%**	**427,777,578**	**21%**	**1,134,891,784**	**25%**
Investment in disease interventions	1,902,291,234	73%	1,584,414,505	79%	3,486,705,739	75%
Overall investment in WCA	**2,609,405,440**	**100%**	**2,012,192,083**	**100%**	**4,621,597,523**	**100%**

Global Fund grant data

[1] SDG 3: https://sustainabledevelopment.un.org/sdg3

[2] Data for 2017-2019 does not include Eq. Guinea, Gabon, Mauritania and Guinea-Bissau, whose grant making processes were not finalized at the time of data extraction (20 October 2018)

Source: Global Fund Grant Management data for the allocation periods 2014-2016 and 2017-2019

6.3. Technical Assistance and RSSH

6.3.1. - 1.2. RSSH investments in the region are generally well aligned with needs

During the NFM 1 funding cycle (2014-2016), the top investment categories were **human resources for health, health management information systems,** and **service delivery.** These priorities were maintained during NFM 2, although **procurement and supply chain** surpassed service delivery as the third most important category of investments.

These areas of focus are generally well aligned with the capacity gaps that this review identified in the WCA region, although several challenges limit the effectiveness of these investments.

VISUAL 2:
2014-2016 RSSH funding distribution

Sum of Budget amounts (US$)	2014-2016 Direct RSSH Investment	Contributory RSSH Investments through disease	2014-2016 Total
Community responses and systems	36,149,170		36,149,170
Service delivery	32,618,729	60,429,965	93,048,693
Procurement and Supply Chain Management	68,101,659	8,365,021	76,466,680
Human Resources for Health	39,283,486	214,153,578	253,437,064
Health Management Information Systems and M&E	195,011,895		195,011,895
National health strategies	2,827,716	37,406,453	40,234,168
Financial management	7,691,561		7,691,561
"Others"	5,074,974		5,074,974
Total	**386,759,190**	**320,355,017**	**707,114,206**

The highest spend category, human resources for health, accounts for 36% or US$253 million of the total investment, and is mostly funded through contributory RSSH investments; these include salaries, top-ups and indemnities. Health management and information systems, accounting for 28% or US$195 million, is exclusively funded through direct RSSH investments and is primarily made up of DHIS2[3] implementation activities in the WCA region.

[3] District Health Information System 2

Source: Global Fund Grant Management data for the allocation periods 2014-2016 and 2017-2019

VISUAL 3:
2017-2019 RSSH funding distribution

Sum of Budget amounts (US$)	2017-2019 Direct RSSH Investment	Contributory RSSH Investments through disease	2017-2019 Total
Community responses and systems	9,819,568		9,819,568
Service delivery	20,918,964	25,801,878	46,720,842
Procurement and Supply Chain Management	49,328,617	7,636,856	56,965,473
Human Resources for Health	51,641,898	121,099,952	172,741,851
Health Management Information Systems and M&E	111,018,890		111,018,890
National health strategies	5,961,652	16,783,623	22,745,275
Financial management	7,765,679		7,765,679
Total	**256,455,268**	**171,322,310**	**427,777,578**

For the NFM 2 funding cycle, the highest spend category for the region remains human resources for health, with in total almost US$173 million of spend (representing 40% of RSSH investments). Health management and information systems continue to be the second highest category of spend, with over US$111 million (all funded as direct RSSH investments, as in the previous funding cycle).

Six countries in the region have implemented RSSH-specific grants (either standalone RSSH grants or combined with one or more disease components), while the remainder of countries channel RSSH investments through disease grants.

6.3. Technical Assistance and RSSH

6.3.2. Challenges

6.3.2. - 1. Lack of human resources for health creates challenges throughout the health system

6.3.2. - 1.1. Shortage of human resources for health in the region

For 2017-19, the primary area of focus for Global Fund RSSH investments in WCA remains human resources for health, equating to over 40% of total spend. As noted in the background section of this report, lack of adequate human resources remains a significant challenge in the region's health system: WCA countries have among the **lowest density of human resources for health in the world.** The region's overall coverage on human resources for health is **three times lower than the rest of Africa.** The distribution of health workers throughout each country is also uneven, with rural areas being severely under-served. In a region with 57%[4] of the population living in rural areas, this significantly impairs their access to services.

The labour market shortage in human resources for health reflects both demand and supply side challenges:

- Demand: willingness and ability of the government, private sector and/or donors to financially support health workers in clinics, hospitals or other parts of the health system;
- Supply: amount of healthcare workers available at any given moment.

These challenges have an impact on all aspects of the health labour market, including health worker education; the capacity of the health system to absorb available human resources; workforce distribution between urban and rural areas and between primary and secondary/tertiary care; continuous training and on the job coaching; retention of health workers; and supervision and performance management.

Global Fund programs in WCA face significant challenges due to the limited number and capacity of staff, especially at district and health facility levels.

Due to resource limitations, staff often need to assume multiple responsibilities. For example, a nurse with a basic educational background performs a broad range of both clinical and administrative tasks, including service delivery to patients, management of the facility, collection and reporting of data, etc. With limited bandwidth and an overwhelming volume of tasks, both the quality of services provided and the accuracy of related data reported are often compromised.

6.3.2. - 1.2. Root causes are often cross-cutting and system wide

Root causes are interlinked with other parts of the health system. Lack of human resources for health availability, capacity, skills and training at all levels in the health system have been identified as key root causes of challenges related to both health information management systems and procurement and supply chain management. Both of these are major challenges in the Western and Central Africa region.

The Global Fund has invested US$133 million over the last two funding cycles to strengthen procurement and supply chain processes in Western and Central Africa. Despite these investments, these areas remain significantly challenging. During recent OIG country audits in the region, 48% of findings related to weaknesses in procurement and supply chain. These included poor inventory management, sub-standard product quality, misuse and diversion, and stock-outs leading to treatment disruptions.

The Global Fund has invested over US$306 million in strengthening health management information systems in the region over the last two funding cycles. This has primarily been done through supporting roll out of the information system DHIS2 – a web-based, open source, tailored information management software developed by the University of Oslo. Despite the roll out of the system, significant challenges remain in terms of data reporting and management. The 2016 HMIS baseline study conducted by the Global Fund highlighted challenges related to data coverage, completeness and quality, including:

- 27% of countries had a national health information system that did not have significant coverage over public health facilities;
- 50% of countries had a national health information system that did not include private sector data;
- 59% of countries had a national health information system that did not include community level data;
- 45% of countries did not have data quality assurance procedures in place to ensure data were of good quality.

[4] World Bank data 2017

6.3. Technical Assistance and RSSH

6.3.2. - 2. Need for more effective RSSH coordination mechanisms at country level

Achieving impact requires a collaborative approach between national governments, the Global Fund, donors and partners, and civil society. This is especially critical with RSSH investments: while vertical programs have had a tremendous impact on the three diseases (particularly HIV and TB), resilient and sustainable systems for health interventions are best developed in a horizontal and transversal manner and require the collaboration of a large number of actors.

With the exception of Senegal (where a donor coordination platform is in place) and Burkina Faso (where a Ministry of Health project management unit acts as Principal Recipient for RSSH funding from several donors), the region generally does not have country-level platforms that bring together various donors investing in RSSH. Instead, donor investments, including the Global Fund, are fragmented across different areas of the health system.

6.3.2. - 3. Cross-cutting challenges of particular relevance in the Western and Central Africa region

Concurrent with this review of grant implementation in Western and Central Africa, specific reviews related to RSSH are ongoing by several Global Fund stakeholders. The OIG is conducting an RSSH audit, the TERG is conducting an RSSH Thematic Review and the TRP has produced a report on RSSH investments in the 2017-2019 funding cycle. This Western and Central Africa review does not seek to duplicate work and findings from these reviews, but refers to them for identified challenges and recommendations.

The OIG audit of Global Fund management of RSSH found that:

- Structures, systems, processes and skill sets, both at the Global Fund Secretariat level and in-country implementation mechanisms (including the structure of the CCMs) are mainly designed for disease-specific interventions rather than transversal RSSH programs.
- Limited coverage indicators for RSSH activities exist in the performance indicator framework. This makes it difficult to measure progress of RSSH activities on strategic and grant levels. Since RSSH interventions tend to be longer term by nature, the three year grant cycle may be too short to achieve the intended results.
- There are limited sustainability measures built in to RSSH activities. Not all operational objectives under the Strategic Objective 2 to build resilient and sustainable systems for health have performance indicators attached to them. This makes it difficult to measure progress for these areas.

The issues highlighted in the OIG RSSH audit are cross-cutting across the entire Global Fund portfolio, and are in line with the RSSH-related challenges discussed in this Western and Central Africa review. Since health systems are generally weak in the region, achieving impact from RSSH interventions is particularly dependent on a strong Global Fund approach that is tailored to RSSH-specific challenges.

The operational objectives under the Strategic Objective 2 that do not have indicators attached to them are particularly critical for the Western and Central Africa region. These include: to *leverage critical investments in human resources for health,* one of the main challenges in the region; to *strengthen community responses and systems,* which have a strong role in bringing health services to populations where the formal health system is weak and does not have sufficient coverage across the population; and to *support reproductive, women's, children's and adolescent health, and platforms for integrated service delivery,* which has a strong potential to bring down maternal and child mortality in the region (which is among the highest in the world).

6.3. Technical Assistance and RSSH

6.3.3. Technical Assistance

Global Fund definition of Technical assistance:

"The engagement of people with specific and relevant technical expertise to support inclusive country dialogue, preparatory activities, grant-making processes or implementation of Global Fund-supported programs."

Several of the challenges identified in WCA relate to the general lack of capacity in the region. Health systems and institutions are comparatively weaker and there is a severe shortage of qualified human resources for health (see background section of the report). Therefore, technical assistance support from Global Fund and other partners and donors in terms of both long-term capacity building and short-term targeted support are critical for effective grant implementation in the region and for achieving impact.

6.3.4. Technical assistance provided through partners

A number of partners provide technical assistance to support disease programs and transversal investments in RSSH (including those supported by the Global Fund) at a global, regional and country level. These include bilateral technical assistance providers, as well as multilateral technical partners such as WHO, UNAIDS, Roll Back Malaria and the Stop TB Partnership.

Most partners providing technical assistance do so as part of their bilateral or multilateral commitment to a country or region. Some bilateral donors to the Global Fund however include provision of technical assistance as part of their pledged contribution during the Global Fund replenishment. These include the United States government, the Government of Germany through the BACKUP Health[5] initiative and the Government of France through the 5% initiative. Managing these types of contributions through a modality where the Global Fund has less influence and leverage than through regular pledged contributions involves challenges.

In the WCA region, the Expertise France 5% initiative is the largest partner in terms of pledged technical assistance contributions to the Global Fund.

The Expertise France 5% initiative provides both short and long term technical assistance and capacity building during grant making processes and grant implementation, supporting general capacity building projects on national and regional levels.

5% initiative funding for technical assistance and capacity building is channelled through the following mechanisms:

- **CHANNEL 1:** Short-term technical assistance support for access to funding and grant making processes, as well as program implementation. This includes support to CCMs and in-country grant making processes, conducting evaluations and diagnostics, as well as targeted technical assistance to, for example, improve quality assistance processes at national laboratories and conducting pharmacovigilance diagnostics.

- **CHANNEL 2:** Financing of long term (around two to four years) projects focusing on capacity building. These activities include capacity building support in projects to one or more countries related to, for example, building training networks, improving access to services, monitoring and evaluation, improving logistics and supply chain capacity, and disease-specific interventions.

- **CHANNEL 3:** A third channel was temporarily established to support capacity building during and after the Ebola crisis in West Africa.

[5] Initiated and funded by the German Federal Ministry for Economic Cooperation and Development. Since 2013, the Swiss Agency for Development and Cooperation has co-funded the program.

6.3. Technical Assistance and RSSH

VISUAL 4:
Overview of total and WCA support provided by Expertise France 5% initiative in 2017

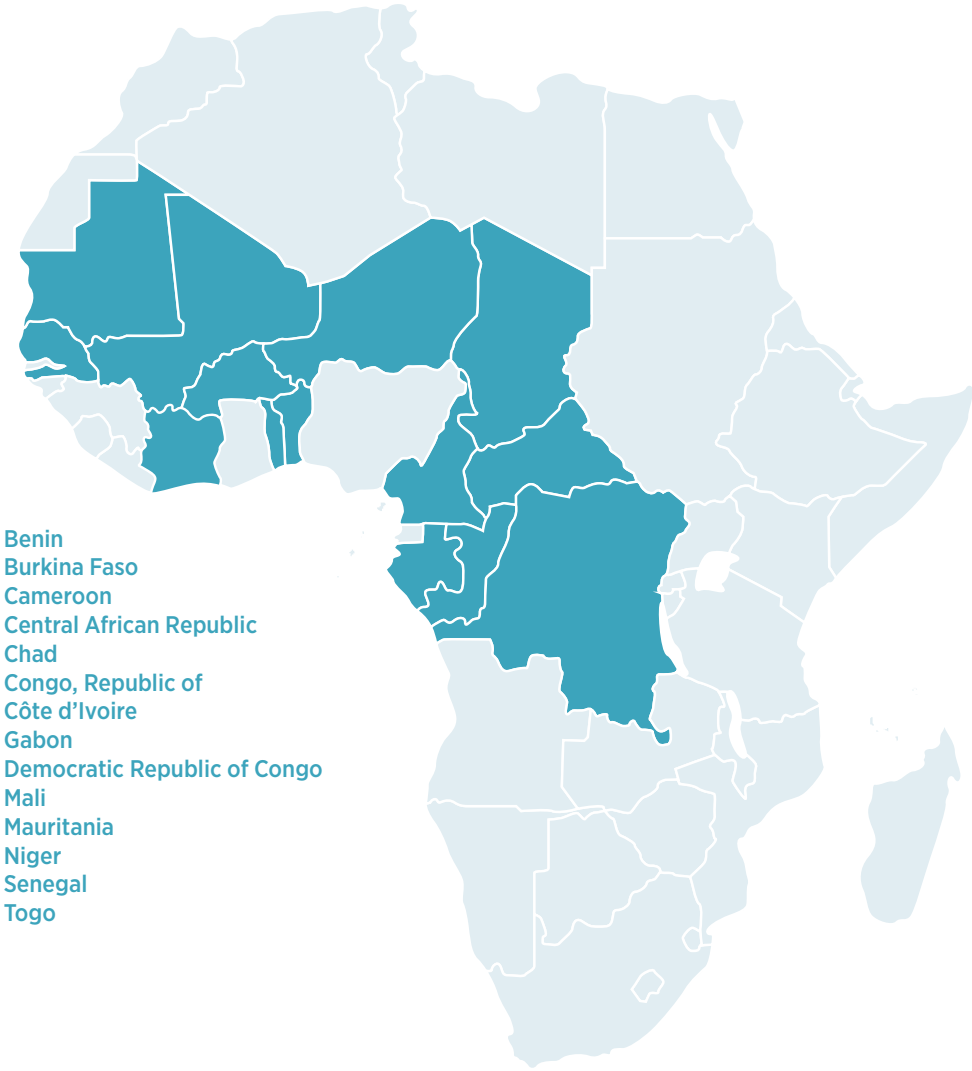
	HIV	TB	Malaria	RSSH/ transversal	Total Expenditure	Expenditure in WCA	Expenditure in WCA as % of total
Channel 1 (expert missions) - short term	20.1%	6.2%	11.1%	62.6%	3,459,508.00	2,815,614	81%
Channel 2 (project funding) - long term	52.8%	6.5%	12.7%	28%	7,665,130.00	6,750,016	88%
Grand total					11,124,638.00	9,565,630.00	86%

86% of Expertise France 5% initiative total investments go to the Western and Central Africa Region.

Most of the funding for short term expert missions is geared towards RSSH/transversal components, while long term project funding is dedicated approximately equally between HIV and RSSH related projects.

Source: Expertise France Initiative 5%, Rapport d'activité 2017

VISUAL 5:
Overview of support provided by Expertise France 5% initiative in 2017



Benin
Burkina Faso
Cameroon
Central African Republic
Chad
Congo, Republic of
Côte d'Ivoire
Gabon
Democratic Republic of Congo
Mali
Mauritania
Niger
Senegal
Togo

Source: Expertise France Initiative 5%, Rapport d'activité 2017

6.3. Technical Assistance and RSSH

6.3.4. - 1. Challenges

Limited mechanisms for leveraging technical assistance to Global Fund programs provided by key partners

The Global Fund lacks a well-defined and comprehensive framework to manage technical assistance through pledged contributions in order to: ensure maximum synergies; match technical assistance and capacity building to Global Fund needs; provide good visibility of contributions.

6.3.4. - 1.1. Enhancing visibility into technical assistance investments by partners

The Global Fund does not have a structured process to sign Memorandums of Understanding with partners to ensure visibility over contributions. The Global Fund has limited visibility regarding the investments in technical assistance provided by the 5% initiative, and information is not regularly shared.

A 5% initiative 2017 annual report was shared with the Global Fund in December 2018. While it provides high level investments and overviews of individual projects in Channel 2, it does not include annual disbursements made or implementation status. Prior to the 2017 Annual Report, the Global Fund had limited information on Channel 1, including details on investments per country, disease component or health systems.

The limited flow of information may result in missed opportunities to build additionality and synergies between the capacity-building efforts of the Global Fund and the 5% initiative. Enhanced coordination would allow the Global Fund to factor planned technical assistance by the 5% initiative into grant design and better target available technical assistance resources towards critical capacity gaps that inhibit effective grant implementation.

6.3.4. - 1.2. Improving opportunities to capitalize on investments made by partners

The Global Fund operates on a three-year grant cycle. A grant can commence any time during the allocation cycle. Yet for technical assistance through Channel 1, the countries address technical assistance needs directly to the 5% initiative, bypassing the Global Fund. Short term technical assistance is approved on a more regular basis. The lack of alignment between the Global Fund's cycle-based approach and the 5% initiative model of continuous allocation of technical assistance makes it difficult to effectively coordinate technical assistance and leverage available resources at the time of grant making, and to plan grant budgets accordingly.

For projects financed through the longer term Channel 2, the process of deciding project themes is more inclusive. The Global Fund is consulted to ensure there are no duplications and that projects are generally aligned with Global Fund needs. However, there is no process in place to ensure that coordination with the Global Fund is maintained throughout the implementation of the approved projects. This prevents the Global Fund from coordinating and synergizing with the projects, and if relevant taking over projects upon their expiration.

6.3.5. Technical Assistance through Global Fund grants

The Global Fund provides funding for short or long term technical assistance to Country Coordination Mechanisms, implementers or civil society organizations. Funding can be requested directly from the country or can be recommended by the Global Fund. Requests for technical assistance can be made at any stage of the grant cycle, although the majority of requests are made during the country dialogue and grant making process.

The Global Fund has allocated over US$61 million for technical assistance for the Western and Central Africa region during the NFM 1 and NFM 2 funding cycles.[6] This has contributed to improvements in the design and implementation of Global Fund grants and long term capacity building in country. However, there are cross-cutting challenges in the Global Fund's approach to technical assistance, which affect the Western and Central Africa region disproportionately as their national systems to manage coordination, assessment and evaluation are often weaker.

[6] As classified under budget lines 2.2 Technical Assistance related per diems/transport/other costs and 3.1 Technical Assistance Fees/Consultants. Please see section 3.1.2. on limitations in the calculation of technical assistance spend.

6.3. Technical Assistance and RSSH

6.3.5. - 1. Challenges

6.3.5. - 1.1. Need for comprehensive approach to coordinating technical assistance

At the Global Fund Secretariat, the Technical Assistance and Partnerships department manages overall technical assistance coordination among partners, but has limited staff dedicated to this task. There is a lack of defined roles and responsibilities within the Secretariat on focal point roles, coordination across partners, and development of policies, guidance and tools. As a result, coordination efforts with partners are dispersed across the Secretariat:

- The Technical Assistance and Partnership department is responsible for coordinating technical assistance across bilateral and multilateral partners and convenes partner forums for technical assistance, such as the Technical Partners Group;
- The External Relations Division keeps track of technical assistance provided through bilateral donors and can act as informal focal points for specific portfolios;
- Country Teams in grant management coordinate technical assistance within their individual portfolios.

There is currently no consolidated overview of technical assistance funded by the Global Fund, including regional, country, disease-specific, or cross-cutting investments related to, for example, RSSH. This fragmentation hinders the organization's ability to make long-term strategic decisions regarding technical assistance needs and interventions.

6.3.5. - 1.2. Lack of visibility on amounts invested in technical assistance

Funding for technical assistance (both short and long term) is captured in the grant budget. The grant budget contains standard cost categories for technical assistance. However, this is used by countries and Country Teams inconsistently. While additional technical assistance may be funded as the need arises, original budgets are not updated accordingly. Technical assistance funded at the sub-recipient level is not always included in the overall grant budget. There is no distinction between short and long term technical assistance, nor between studies/diagnostics/surveys and activities aimed at strengthening the country's capacity. This limits the Global Fund's ability to design impactful technical assistance and ensure proper monitoring and follow up of technical assistance investments.

6.3.5. - 1.3. Need for improved processes around designing, implementing and evaluating long term technical assistance

Countries can make requests for long-term technical assistance without clear needs assessments and capacity building plans, since there is no mechanism to check that this has been done. There is no consolidated view on total country needs for technical assistance, the funded status, and the remaining gaps.

At the country level, there is no requirement to have a formalized technical assistance work plan: only one of the 12 countries sampled in WCA had a technical assistance plan with short- and long-term key deliverables and timelines.

Technical assistance is being put in place without clear terms of references and without key performance indicators to measure progress and results. There is no process for regular monitoring by the Global Fund Secretariat to ensure objectives are achieved. Five countries (Guinea, Mauritania, Chad, Niger and Mali) were sampled for review of their long term technical assistance. All of them experienced the above challenges, which limit the effectiveness of Global Fund technical assistance investments.

6.3. Technical Assistance and RSSH

Case study: Challenges in establishing, evaluating and building capacity through technical assistance in Chad

In Chad, a country classified as a Challenging Operating Environment, the Global Fund has invested significantly in technical assistance as part of the implementation of the Additional Safeguards Policy. However, long term and meaningful improvements have not been demonstrated as a result of the assistance.

Between 2013 and 2017, the Global Fund disbursed almost **2.1 million euros** to eight international technical assistance providers, most of it through the coordination mechanism FOSAP (*Fonds de Soutien aux activities en matiere de population et de lutte contre le SIDA*).

The challenges:

An OIG audit in 2018 of the Global Fund grants to Chad noted the following challenges in the design, implementation and monitoring of technical assistance:

1. there was a lack of clear assessment to determine the needs for technical assistance;
2. the assistance was not based on any capacity-building plan for PRs or any timed schedule for execution and hand-over;
3. the high turnover of staff at the PRs was not taken into consideration when the technical assistance was planned.
4. there were no defined KPIs to allow for objective evaluation of results to monitor progress, and some technical assistance providers had operational roles which could have been held by local staff.
5. there was no exit strategy or roadmap for completion of the support interventions.

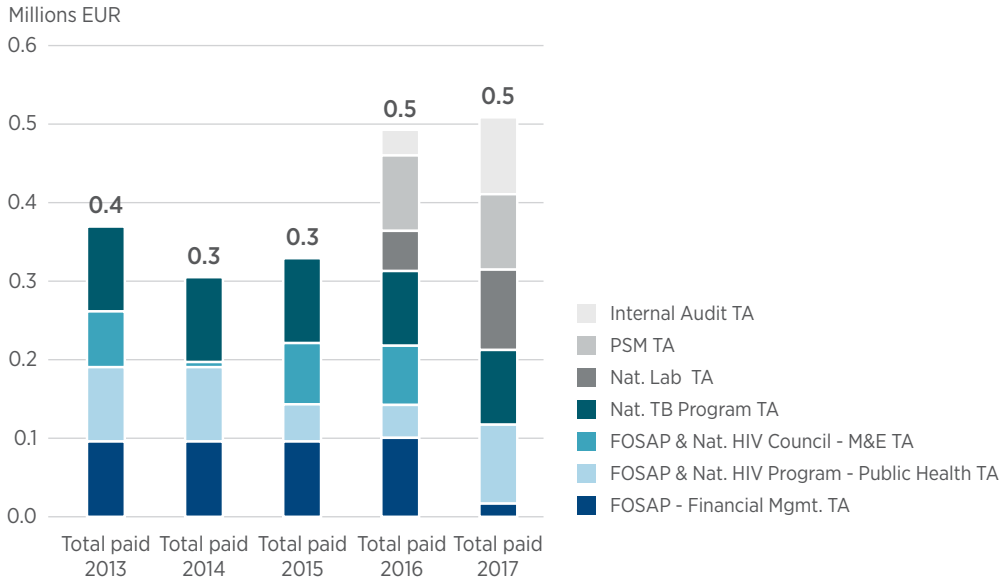
The consequences:

This resulted in inefficient technical assistance that did not contribute to long-term capacity building or systems strengthening. In the absence of clear evaluation mechanisms, the Global Fund could not ensure it received value for money from the interventions.

Inefficiencies in the technical assistance provided contributed to:

- Stagnating grant performance;
- stock-outs of essential health products and drugs which impacted services to patients
- limited effectiveness of supervisions, with supervisions not being conducted according to plan;
- inadequate financial management: despite several years of financial management technical assistance being in place, grants received qualified opinions from external auditors and the Local Fund Agent continuously found inadequate supporting documents for payments;
- lack of incentives for technical assistance providers to provide capacity building, as this would mean making themselves redundant.

VISUAL 6:
Chad 2013-2017 Technical Assistance costs



Source: Global Fund Grant Management data

6.3. Technical Assistance and RSSH

Recommendations

RSSH investments:

- Require countries to provide **a mapping of donor's investments in RSSH** as part of the concept note submission.
- Support countries in the **establishment or strengthening of country-level donor coordination platforms** to coordinate RSSH interventions by different donors.

Technical Assistance:

- As part of the country dialogue, **a consolidated needs assessment for technical assistance** should be performed to inform TA approach and interventions in short to medium term (grant cycle) and over longer term (strategy cycle).
- Engage with countries and partners (France, GIZ, UNAIDS, WHO, etc.) and **identify a lead agency to coordinate and lead joint programmatic technical assistance** planning to ensure that there is a clear identification of needs and avoid gaps and overlaps in the implementation of TA.
- **Develop TA framework agreements** with partners who are key providers or supporters of technical assistance in WCA, primarily AFD and Expertise France. These framework agreements should harmonize the funding and interventions, based on the consolidated needs assessment, with the objective of prioritizing long term TA conducive to capacity building rather than ad hoc interventions to fill short term gaps.
- **Develop clear terms of reference to guide each TA intervention,** including specific objectives, clear milestones, KPIs to track progress, and annual evaluation process.

6.4. Access to Health

6.4.1. Introduction

A cornerstone of Sustainable Development Goal 3 is the commitment to achieve universal health coverage by 2030, including "financial risk protection, access to quality essential health care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all."[1]

In the Western and Central Africa region, there are significant barriers for the population to access health services.

Although the HIV incidence is lower than in the rest of Africa, there has been less progress on improving the 90-90-90 cascade, less people living with HIV have access to treatment, and mortality is higher. Missing tuberculosis cases are increasing, as are the number of deaths. Malaria deaths are proportionally higher than the disease burden (see Performance section of the report). These are all indicators of barriers for the population to access adequate health services

Main barriers to accessing services in the region include:

- **Financial barriers** with high out-of-pocket expenditures and fees charged for services that are supposed to be provided for free
- **Geographical barriers** to accessing health facilities. The population is primarily located in rural areas, health facilities are ill-equipped or under-staffed, and community health response systems are not fully functional
- **Social barriers** that limit access to services for members of key populations due to stigma, discrimination and lack of civil society organizations which can provide services and conduct advocacy

6.4.2. Challenges linked to financial barriers

6.4.2. - 1. User fees are higher than in the rest of Africa

User fees in the Western and Central Africa region are almost 40% higher than in the rest of Africa. In Western and Central Africa, an average of 45% of the cost of health care is borne by the individual at the time of receiving care, compared with 34% in the rest of Africa.

High user fees increase barriers to accessing health care and lead to reduced health-seeking behaviour, delaying or preventing access to healthcare. Direct consequences are lower diagnostics and treatment initiation, increased treatment drop-out, and excess mortality and morbidity. These barriers often push already poor people into further financial distress and debt. Vulnerable populations, including women (who often have the least money), are hardest hit.

User fees are made up of payments made to healthcare providers at the time of use, as well as other out-of-pocket costs associated with using healthcare services, such as transportation and food costs. They can include the cost of procuring medicines from private pharmacies if public health facilities have stock-outs of free medicines[2]. Health systems with weaker financing structures often rely more on users covering a larger part of the cost themselves.

Health spending by WCA governments is only one third of that of the rest of Africa, and countries are significantly poorer. This creates a double burden for patients in the region – despite being poorer, they are expected to contribute more from their pocket to access healthcare.

UNAIDS' Western and Central Africa Catch Up plan recognizes high user fees as one of the top barriers to accessing healthcare (primarily HIV services) in the region.[3]

MSF state in their report **"Taxing the ill"** that: **"user fees end up being a taxation of the ill rather than a contribution to better health, with severe consequences for the most vulnerable."**

[1] Target 3.8 of the SDG 3 on Health: http://www.globalgoals.org/globalgoals/good-health/
[2] Excludes contributions to health care services through, for example, taxes and health insurance premiums.
[3] UNAIDS: Western and Central Africa Catch-up plan

6.4. Access to Health

6.4.2. - 2. Gratuity policy in the region

For most countries in the region, Global Fund-financed drugs are included in the basket of essential medicines that are provided free of charge to the population as part of a gratuity scheme. Exceptions include Ghana, where malaria drugs are not free, and Côte d'Ivoire, where malaria drugs are provided free of charge only to pregnant women and children under five years old.

Even where countries provide drugs free of charge, other costs related to accessing healthcare are not always provided for free. For example, while antiretroviral treatment (ART) is free, critical services such as CD4 and viral load tests, and other laboratory diagnostics are often not free. High user fees are especially deterring for patients needing long-term (e.g, tuberculosis) or life-long treatment (e.g., HIV).

For example in Cameroon, tuberculosis drugs are provided free of charge, but it can cost up to US$42 for a patient to be diagnosed. The combined cost of sustaining HIV treatment can be up to US$140 per year, including costs for lab tests, viral load tests and CD4 tests. Malaria rapid diagnostic testing is free, but the drugs are not. While these amounts may seem immaterial, they can represent a significant financial burden and barrier to accessing services and sustaining treatment.

> "The drug gratuity policy for the three diseases is effective, but the fees for exams, other essential medicines and other indirect costs (transport costs, hospitalization costs...) limit the access to health services."
>
> CCM survey respondent in Guinea

> "The majority of the services are free, but the patients do not know it."
>
> CCM survey respondent in Mauritania

Gratuity policies are not systematically formalized, enforced and monitored by governments throughout the region, which can lead to lack of compliance. In-country actors all say that patients lack information on the gratuity policy and on which drugs and services are supposed to be provided free of charge. This makes it difficult for patients to be empowered to request healthcare that they have the right to obtain.

According to the OIG survey results, **66% of respondents consider money to be a top barrier to accessing services.**

Increasing gratuity coverage is challenging in an environment where investments in health are limited. In the region, health workers are not always paid a living wage or in a timely manner and investments in health infrastructure do not keep up with demand, especially in rural areas. Primary point of care health facilities are often underfunded and raise part of their funding through charging user fees for services. Gratuity policies can therefore take away from well-needed funding for health facilities, as this is not always replaced by increased government funding allocations.

Given the potential trade-off between complying with gratuity policies and earning income for the facility, the challenges related to patient out-of-pocket costs cannot be evaluated in isolation. Addressing them will require consideration of each country's broader health financing context, particularly in relation to compensation of health workers and support to health facilities at the community level.

6.4. Access to Health

VISUAL 1:
Gratuity policies and their adherence in a sample of countries

	Burkina Faso	Central African Republic	Democratic Republic of Congo	Guinea	Guinea Bissau	Senegal
Out Of Pocket Expenses	33.6%	42.9%	38.5%	60.9%	44.8%	44.4%
Malaria diagnostics	Free for under 5 years old and pregnant women, but not respected in private clinics	RDTs are free, but confirmatory lab tests are not. There is a tendency for facilities to also perform a lab test even when this is not necessary.	Free in policy Most patients pay consultation fee, some pay for drugs	Free in policy Most patients pay consultation fee (US$0.5), some pay for drugs	Free in policy	No gratuity policy in place
Malaria treatment (ACTs)	Free for under 5 years old and pregnant women, but not respected in private clinics	Free in policy. When public ACTs are out of stock, providers sell private sector ACTs.	Free in policy	Free in policy	Free in policy	No gratuity policy in place
TB drugs	Free in policy	Free in policy	Free in policy	Free in policy	Free in policy	Free in policy
TB consultation and treatment	Free in policy	Only the first consultation is free. PLHIV benefit from free consultation throughout the treatment. Hospitalization is free in public hospitals.			Free in policy	Diagnostic is free since 2013. Global Fund funds hospitalization for MDR-TB patients, but apart from that, these services are payable.
HIV/AIDS diagnostics and drugs	Free in policy	Free for Global Fund-funded drugs	Free in policy	Free in policy	Free in policy	Free in policy
HIV/AIDS tests and consultation during treatment (CD4 test, viral load tests etc)	Free in policy, apart from complementary bio tests	Free for Global Fund-funded treatment	CD4 and viral load free in policy, but often not adhered to. Patients often have to pay for consultations, laboratory tests and drugs for opportunistic infections before ARV treatment initiation.	CD4 and viral load free in policy, but often not adhered to. Lab tests and CD4 test before ARV treatment initiation can cost up to US$16. Consultation can cost up to US$5.	Free in policy	Free in policy

Source: Global Fund Grant Management Country Teams

6.4. Access to Health

6.4.3. Challenges linked to geographical barriers

6.4.3. - 1. Rural-based population makes accessing health care challenging

Over half of the population in the Western and Central Africa region lives in rural areas. The distribution of health workers is uneven and rural areas experience severe shortages of health workers. In a region that is already experiencing a shortage of healthcare personnel in general, the few healthcare staff available are concentrated in urban areas.

The number of health centers per 100,000 population is 3 for Central Africa and 3.52 for West Africa, about half of the global WHO target of 7 centers per 100,000 population.[4] In addition, population density in WCA is about half of that in the rest of Africa.[5] This combination of low health facility coverage and low population density leads to a large number of inhabitants without access to a health facility within a reasonable distance.

Poor infrastructure and road conditions, together with underdeveloped public transportation systems in many parts of rural Western and Central Africa, represent geographical barriers to accessing health services. Even travelling short distances can be costly and time consuming, and some roads are inaccessible during rainy seasons. These factors can prevent patients from seeking care at health facilities.

According to the OIG survey, **65% of respondents considered that geography was one of the top three barrier to accessing health services in the region.** Together with financial barriers, this was the top-scoring category.

> "Despite efforts to address geographical barriers, roads and infrastructure in Guinea remain very weak, preventing or hindering the movement of people to health services."
>
> HIV Implementer survey respondent in Guinea

6.4.3. - 2. Task shifting to bring care closer to patient still in roll-out

Task shifting involves re-assigning health care tasks from highly qualified medical professionals to healthcare workers with lower qualifications and less training, but with appropriate knowledge and support tailored to those tasks. This is a way of improving the efficiency of human resources for health, and can be a cost-effective way to break down geographical barriers to accessing healthcare.

Several countries in Western and Central Africa have initiated task shifting programs, including delegating clinical tasks to community health workers. UNAIDS views this as representing progress in the region. Task shifting guidelines for HIV treatment and services have been implemented in 12 countries in the region.[6]

Task shifting guidelines[7]

Physician to nurse	Burkina Faso, Chad, Côte d'Ivoire, Gabon, Mauritania, Senegal
Nurse to community lay workers	Cameroon, Central African Republic, the Democratic Republic of the Congo, Guinea, Sierra Leone, Togo

Although implementation guidelines have been initiated, complete roll-out requires extensive training of trainers and establishing effective monitoring and evaluation systems. Countries are in different stages of maturity, and the model is not yet fully functional.

> "Health services are located far from the people most in need, which limits the health-seeking behaviour of patients. There is a lack of appropriate health structures in many of the insecure zones [of the country]."
>
> Implementer survey respondent in Mali

[4] Global Fund: Best practices on TB case finding and treatment: Reflections and lessons from West and Central Africa and beyond

[5] WCA: 67.7 persons per square km ROA: 134.8 persons per square km. Source: UN-DESA Population Division

[6] UNAIDS: The Western and Central Africa Catch-up plan

[7] ibid

6.4. Access to Health

6.4.4. Challenges linked to social barriers

Stigma, discrimination and other social or cultural barriers act as important barriers to accessing services, especially for HIV and tuberculosis.

6.4.4. - 1. Stigmatization of key population groups

Same-sex relationships are illegal in nine countries in the Western and Central Africa region[8] and 19 countries have HIV criminalization laws.[9] While HIV prevalence is lower than in other parts of Africa, stigma and discrimination remain high. The LGBTQ community is facing an increasingly hostile environment in Western Africa,[10] and an MSF study[11] finds that an increasing proportion of key populations who seek care in the MSF clinics do so because they face stigma and discrimination in the public health system. Stigma and discrimination are faced by other key affected population groups such as female sex workers and people who inject drugs.

> "Cultural issues and stigmatization prevent key populations (MSM) from using health services and some of them prefer to turn to medical care associations that unfortunately are not equipped."
>
> CCM respondent in Burkina Faso

6.4.4. - 2. Civil society is less organized

Civil society can play an important role in mobilizing communities, conducting advocacy, reducing stigma and discrimination, and providing prevention and treatment services, especially for HIV. In countries where HIV prevalence is relatively low, civil society groups are often dispersed and not as organized as in countries where prevalence is high.[12] This limits their advocacy influence on governments and other national authorities, as well as their ability to provide services.

Civil society organizations for tuberculosis and malaria are less organized than those for HIV.

Language is also seen as a barrier, especially in terms of exchanging and learning lessons on a regional level between civil society organizations in different countries. The *"We exist"* report concludes that: "[...] a weak civil society infrastructure, especially in Francophone countries, discourages funders and has made donor engagement and organizing around LGBTQ rights uncoordinated, uneven, and linguistically divided."[13] The MSF report "Taxing the ill"[14] states that [...] the fragmentation of civil society organizations into distinct language-speaking groups (primarily English and French) leads to constraints in exchanging experiences and support between countries).

6.4.5. Community health systems as a way to reduce barriers

Community health services are a critical part of health care provision and are essential for ensuring access to both prevention and treatment services. This is especially true in the Western and Central Africa region, where populations are largely based in rural areas and the formal health system is poorly staffed with weak infrastructure. Community-based health programs, when implemented well, complement the public health care provision and fill important gaps. They can be an effective way of breaking down geographical, social and financial barriers to accessing services.

6.4.5. - 1. Overview of community health systems in the region

Most countries (19 out of 23) in the Western and Central Africa region have taken steps towards implementing a community health response system.

[8] ILGA.org: State-sponsored homophobia: A world survey of sexual orientation laws – criminalization, protection and recognition. 12th Edition
[9] HIV Justice Network: Advancing HIV Justice 2 Building Momentum in Global Advocacy Against HIV Criminalization
[10] We exist: Mapping LGBTQ organization in Western Africa
[11] MSF: Out of Focus (2016)
[12] ibid
[13] We exist: Mapping LGBTQ organization in Western Africa
[14] MSF: Taxing the ill

6.4. Access to Health

VISUAL 2:
Overview of community health systems in the region

Policy has been defined, which includes a care package of at least malaria and childhood diseases	**Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Mauritania, Niger, Senegal, Sierra Leone, The Gambia, Togo.**
Package of services also includes HIV services	**Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Mauritania, Senegal, Sierra Leone, The Gambia, Togo.**
Package of services also includes tuberculosis services	**Benin, Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of Congo, Ghana, Guinea, Guinea Bissau, Liberia, Mauritania, Senegal, Sierra Leone, The Gambia, Togo.**
Plans for national coverage of CHW	**Benin, Burkina Faso, Central African Republic, Congo, DRC, Gambia, Guinea Bissau, Mauritania, Sierra Leone**
Policy is supported by government funding	**Burkina Faso, Gambia, Guinea, Sierra Leone**
Fully functional system with equipped CHWs offering a full package of services and remunerated on a regular basis	None

Community health worker scheme policies include a basic package of services of antenatal and newborn care, as well as integrated community case management for malaria and the top childhood killers. Most of them also include HIV and (to a lesser extent) tuberculosis in their package of services.

Although policies have been established and are of varying degrees of implementation, this review did not find any country in the region with a community health response that has national coverage of community health workers providing a comprehensive package of service and who are remunerated regularly for their work, according to a costed and funded national strategy. Challenges include payment systems and securing funding for salary and motivation payments; recruiting, training and retaining community health workers; ensuring a relevant package of services and supplying health workers to carry out those services; as well as supervision and reporting mechanisms for community health workers. These challenges were observed and reported by the OIG in previous audits of Sierra Leone, Benin and Burkina Faso.

Community health services related to malaria are more mature than for tuberculosis services.

All of the countries in the region that have community health worker systems rely on UNICEF and The Global Fund as main donors for their community health programs. Thus, the Global Fund is a key partner in the community health landscape.

The Global Fund is investing over US$174.4 million in activities related to community health during the NFM 1 and NFM 2 funding cycles. This includes investments in integrated case management, community-based advocacy, capacity building and retention, and scale up of community health workers.[15]

Global Fund grants to the region finance activities related to community health responses, such as remuneration and training to community health workers. However, there is no requirement to integrate sustainability aspects into the grants to ensure that community systems continue to function beyond the end of Global Fund support.

> "The community system is not sufficiently integrated into the health system."
>
> TB Program Implementer, Mauritania

6.4.5. - 2. Challenges linked to progress not being tracked

While community represents an important element of our grants, the progress of our investments in community activities is not systematically tracked. There are no corporate level key performance indicators to track progress in this area, and the modular framework does not include any cost grouping or input specific to community health systems.

Data on malaria cases treated within communities were not reported till 2017. Data on access to health facilities (more than 5 km) is not consolidated on a collective level to inform decision about financing community activities.

[15] This category also includes retention and scale up of health workers in the formal health system (category: "Retention and scale-up of health workers, including for community health workers")

6.4. Access to Health

Recommendations

The Global Fund should refine its co-financing mechanism and enhance community activities to ensure financial and geographical barriers are reduced.

- The Global Fund should be **more prescriptive/strategic in its co-financing requirements** to ensure they strike the right balance between the financial sustainability of the health system and the gratuity of services for patients.
- **Direct counterparty financing to finance the health work-force and to support health facilities with gratuity** (e.g. consultation fees for specific populations and HIV/TB services are reimbursed, etc.).
- **Enhance mechanism to monitor the use of counterparty financing** in order to ensure visibility on the utilization of funds.
- **Integrate community activities for the three diseases to ensure common package of services is defined** (e.g. case management for malaria, TB active case finding and lost to follow up activities, etc.). This will reduce the missing cases for TB, increase retention on treatment and improve malaria indicators.
- **Building on current ongoing Thematic Reviews on user fees** being implemented for selected countries, clarify an organizational approach to user fees and implement country by country, working with partners.

6.5. Summary of Key Advisory Recommendations

1. GLOBAL FUND PROCESSES

1.1 Identify and focus on a **targeted set of key strategic priorities for COEs**

1.2 Effectively **implement flexibilities for COE countries**

1.3 Perform a **baseline assessment for each country under ASP**

1.4 Apply **differentiated approach to implementation of Zero cash policy**

1.5 **Focus Fiscal Agents on control function and shift capacity building** to longer term Technical Assistance providers

1.6 **Organize GMD departments along relevant regional portfolios or define internal GMD processes** and tools to ensure efficient regional management

1.7 Improve Secretariat **analysis and data to support decision making at regional level**

1.8 Appoint a **long term TA in-country** to support coordination and operational monitoring of grant programs

2. IMPLEMENTATION ARRANGEMENTS

2.1 **Integrate the three disease programs at central level,** maintaining MoH central role

2.2 Establish **triparty contracts** between PMU, General and Regional Health Directorates

2.3 Maintain the **National Programs and National AIDS Councils as Sub-Recipients** to develop policies, advocacy and coordination of the disease response – in line with their mandate

2.4 Where country capacity is limited or financial and fiduciary risks remain high, use INGOs as pass-through PRs as a temporary solution, ensuring specific **time bound capacity building plans** are in place for national entities

2.5 **Use the INGOs for their service-delivery mandate,** based on their specific competencies, to fill critical gaps in areas such as mass campaign distribution, key populations activities, community health systems and supply chain

3. TECHNICAL ASSISTANCE AND RSSH

3.1 Develop more **prescriptive/strategic co-financing requirements**

3.2 Direct **counterparty financing** to finance the health workforce and to support health facilities with gratuity

3.3 Enhance **mechanism to monitor the use of counterparty financing**

3.4 **Integrate community activities** for the three diseases

4. ACCESS TO HEALTH

4.1 Perform **consolidated needs assessments for technical assistance**

4.2 Engage with countries and partners (France, GIZ, UNAIDS, WHO, etc.) and **identify a lead agency to coordinate and lead joint programmatic technical assistance**

4.3 Develop **framework agreements** with key partners who fund or provide TA in WCA countries

4.4 Develop **clear terms of reference** to guide TA interventions

Final message...

In a CHALLENGING REGION...

- LIMITED FISCAL SPACE
- LOW HEALTH FINANCING
- LARGE FUNDING GAP
- WEAK HEALTH SYSTEMS
- FRAGILE ENVIRONMENT

...the Global Fund HAS INVESTED A LOT OVER TIME...

- FINANCIAL RESOURCES
- HUMAN CAPITAL
- STRATEGIC INITIATIVES

...to IMPROVE PERFORMANCE over time for malaria and HIV with challenges in TB

- 31% REDUCTION IN MALARIA DEATHS BETWEEN 2010-2016
- 27% REDUCTION IN AIDS DEATHS BETWEEN 2010-2017
- 5 % INCREASE IN TB DEATHS BETWEEN 2010-2016

To SCALE UP REGIONAL PERFORMANCE AND END THE THREE EPIDEMICS, the Fund has to rethink its approach in four key areas:

- GLOBAL FUND PROCESSES
- IMPLEMENTATION ARRANGEMENTS
- TECHNICAL ASSISTANCE AND RSSH
- ACCESS TO HEALTH