Lesson 1: Proposal quality

**Overall: good quality of proposals in this funding window**

- Shorter, **more focused** application packages
- Building on **strong programs** from last cycle
- **Lower** rate of iterations
- Better **key population awareness** across 3 diseases
- TRP appreciated **support of country teams** to clarify questions
- Uncoordinated timing of **RSSH submissions** makes it difficult to evaluate evidence

**Recommendations for Applicants, Partners**

Areas where improvement still needed in programs:

- Disaggregation of data around age and gender and at sub-national level, cascade analysis and then using this for better program design
- Deeper analysis linked to reasons behind poor outcomes: not default to business as usual
- Sustainability planning
- All countries should think more about populations at greater risk and less access to services – beyond traditional key populations

TRP requests that submission timing is aligned across components if possible
Lesson 2: Differentiated applications

Differentiated application process positively received by TRP

- Program continuation was **broadly successful** as an application approach.
  - Amount of information (self-assessment + SBN) normally sufficient to make decisions although TRP missed having modular-level budget, especially when allocation was significantly reduced
  - PC most appropriate for those countries where implementation had just started
  - PC more challenging when significant reduction in GF allocation
  - PC not as conducive for innovative ideas vs. full application (e.g. missing cases in TB)
- Higher expectation that **reprogramming will be required** (and more material reprogramming will need to come back to TRP mid-cycle) once new data is available. Many reviews/studies/NSP revisions in the pipeline.
- Relatively small sample size of tailored reviews but well received.

Recommendations for Secretariat, Applicants, Partners

- TRP suggests that PC is not used for applicants with significant GF funding reduction, unless government takeover of activities is ongoing: otherwise reprogramming and new budgeting will be required and TRP will need to see what will be cut. Tailored material change suggested instead.
- Applicants/Partners should anticipate need for TA to translate new data into reprogramming choices
- Secretariat should plan for great increase in reprogramming and ensure it’s a simple process so as not to distract from implementation
Lesson 3: Matching funds

<table>
<thead>
<tr>
<th>More boldness needed with matching funds applications</th>
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<tbody>
<tr>
<td>• Significant <strong>opportunity</strong> that should be maximized for both catalytic effect and innovation</td>
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<tr>
<td>• Reasons for asking for <strong>iteration</strong> on matching funds:</td>
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<tr>
<td>• Not evidence-based (or not evident it’s innovative)</td>
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<tr>
<td>• Matching funds not identified, or in PAAR instead of allocation request</td>
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<tr>
<td>• TRP recommends applicants submit matching funds <strong>as soon as possible</strong> to maximize opportunity for impact</td>
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<tr>
<td>• TRP recommends applicants identify <strong>larger investments in fewer activities</strong> vs. many small activities to enable better quality evaluation and potential for impact.</td>
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<table>
<thead>
<tr>
<th>Recommendations for Applicants, Partners</th>
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<tr>
<td>• Use evidence based approach or pilot designed to scale-up based on findings</td>
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<tr>
<td>• Match should be in allocation request; if unable to match countries should provide justification and/or identify other non-Global Fund funding sources</td>
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<tr>
<td>• Plan for simple evaluation</td>
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</table>
Lesson 4: Sustainability

**Sustainability not yet sufficiently addressed**

- Desire is for impact to be sustainable.
- Sustainability should encompass programmatic, systems, equity and financing considerations.
- Applicants not yet considering sustainability in all program approaches.
- Biggest risks: large scale programs such as treatment of MDRTB, ARVs, bednets.
- Link disease control to Universal Health Coverage and national governance and economic development strategies.

**Recommendations for Applicants, Partners, Secretariat**

- Systematic inclusion in analysis and reviews.
- Better guidance needed on all dimensions of sustainability.
- Need for narrative and indicators that cover all critical elements.
Lesson 5: Malaria concern

Central and Eastern Africa malaria resurgence concerning: requires change in approach

- TRP observed poor outcomes in malaria in the Central and Eastern Africa region and was very concerned that the countries involved had not yet understood the reason for the significant change in the epi situation. Urgent attention is needed to understand the underlying causes and develop the appropriate response.
- TRP noted that several countries reported that the usage of bed nets is declining. This is observed also in low transmission settings.

Recommendations for partners and applicants

- Urgent operational investigation needed to understand root causes of lack of success in region and propose new way forward. A concerted effort may be needed, in addition to a national response.
Outline

1. Window 1 Overview
2. General Lessons Learned
3. Technical Lessons Learned
4. Information Resources Available
Lessons learned

- **Expansion of Xpert continuing but optimization still needed**: Existing machines are under-utilized, diagnostic algorithms not clearly specified and applicants have not described where new machines will be placed and the expected outcomes (e.g. progress with percentage of patients tested with a WRD)

- **Digital radiography**: Efforts to expand access to the CXR and to take on board findings of prevalence surveys where up to 50% of confirmed TB patients had no symptoms, however operationalization issues and expected outcomes related to digital x-rays missing.

- **Countries moving slowly on MDR-TB diagnosis**: however most countries are moving to shortened regimen. A few countries holding back on shortened regimens for lack of SLD – DST. TRP encourages prioritizing short-course regimen as capacity for SLD –DST is built for treatment optimization and better patient outcomes.

- **TB prevalence surveys have confirmed large proportion of missing TB cases in many settings**. Funding requests appropriately mention interventions to find these cases, but lack sufficient detail, no bold steps and no significant innovation.

- **Countries with big TB/HIV disease burdens making tremendous progress in bi-directional testing and ART coverage**. IPT: % of PLHIV on IPT is low. Slow progress if at all in low TB/HIV burden countries.

- **Human rights and gender issues**: broadly these issues are not well addressed in TB applications.
Lessons learned

- **Expansion of Xpert** continuing quickly but optimization of use still needed
- **Digital radiography**: Efforts to expand access to the CXR, however operationalization issues and expected outcomes related to digital x-rays missing.
- **Countries moving slowly on MDR-TB diagnosis** (case finding targets not achieved). Most countries are moving to shortened regimen however a few holding back for lack of SLD–DST. TRP encourages prioritizing short-course regimen as capacity for SLD–DST is built for treatment optimization and better patient outcomes.
- TB prevalence surveys have confirmed **large proportion of missing TB cases** in many settings. Funding requests appropriately mention interventions to find these cases, but lack sufficient analysis of who is missing, where and why. Missing bold steps and significant innovation.
- Countries with big TB/HIV disease burdens making **tremendous progress** in bi-directional testing and ART coverage. Slow progress if at all in low TB/HIV burden countries. IPT: % of PLHIV on IPT is low overall.
- **Human rights/gender issues** broadly are not well addressed in TB applications.
Lessons learned

**Use of data**: Better use of surveillance data to target programming, but have not maximized the use of programmatic data for program development, implementation and monitoring. Inappropriate use of prevalence data alone for showing progress and impact.

**Donor collaboration**: The most responsive applications have featured improved donor collaboration narratives (e.g. Pepfar countries).

**Use of international guidelines**: Applications increasingly reflected the adoption of normative guidance and included in NSPs; however the degree to which activities proposed to be implemented in accordance with these guidance varied widely.

**Shifting priorities towards biomedical and 90-90-90**: Emphasis on the treatment cascade and 90-90-90, test and treat, while reasons for stagnating levels of prevention coverage not as well addressed.

**Gaps in coverage across prevention and treatment cascade related to HSS, CSS, HRG**: related to structural political and cultural reticence to address and scale-up KP prevention, and HSS-related challenges for the treatment cascade, especially lack of people-centered service delivery model, health workforce, supply chain and specimen transportation.

**Sustainability and transition**: increasing domestic commitments, not translating into more commitments to KPs. Other aspects of sustainability overlooked. Increasing issues with access to affordable medicines through domestic procurement.
Lessons Learned

HRG

• Increased presentation and use of sex-disaggregated data and data on key populations (gaps remain)
• Interventions for children very limited in 3 diseases
• Missed opportunities for integration with RMNCAH across the 3 diseases
• Under-developed integration of gender in HRH and HSS
• Discussion of gender-specific barriers not included in TB and Malaria
• Limited discussion of harmful practices

• Stigma and discrimination often conflated with human rights
• Lack of data and comprehensive evidence-based or gender-responsive interventions for people in closed settings
• Lack of data and interventions for other vulnerable populations – indigenous, mobile and internally displaced populations, military
• HRG and CBO supported KP interventions tend to be under-resourced
• Transition planning does not adequately address sustainable programmatic and financial support for KP interventions
## Lessons learned

### Many areas of improvement noted in RSSH

- New technologies, such as GeneXpert, introduced with **insufficient attention to system support**
- Insufficient **human resources for health** and excessive workload for CHW
- Challenges in managing **decentralized health systems** to ensure flow of funds, supervision, PSM and HMIS and adherence to national policies
- **Missed opportunities to integrate services** across TB, HIV and malaria, and with RMNCAH.
- **Community system strengthening** hardly addressed despite extensive use of CHWs. CSS often only seen as service delivery.
- Increasing attention to engaging private sector without sufficient attention to ensuring **quality of non-state health sector service delivery**
- **Procurement and supply chain management** requires proactive coordinated support among multiple donors
Lessons learned

- **Co-financing experience.** Global Fund co-financing mechanism not necessarily delivering sustainability especially in higher income, low disease settings.
- **Value for Money:** Work in progress. Need for better guidance what VfM means within the GF so it can be systematically applied. VfM is a narrative rather than a number.
- **Health financing reform:** Countries need to remove financial barriers to accessing disease control services in the context of UHC.
- **Innovative financing mechanisms:** RBF, COD, social impact bonds, buy-downs. TRP would like to further engage with GF on this topic to better explore risks and benefits for impact and sustainability.
- **Social contracting:** Legal and administrative framework missing. Some GF supported services/ interventions not ever going to fall within a UHC system.
Outline

- Window 1 Overview
- General Lessons Learned
- Technical Lessons Learned
- Information Resources Available
Online learning resources

- Available 4 languages
- Grant application and implementation courses
- Disease and health systems courses
- CCM orientation program courses
- Webinar recordings
Questions
Back-up
Technical recommendations detailed

1. HIV
2. Human Rights and Gender
3. Tuberculosis
4. Resilient and Sustainable Systems for Health
5. Strategic Investment and Sustainable Finance
## General lessons learned

<table>
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<tr>
<th>HIV</th>
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<tbody>
<tr>
<td>1. <strong>Use of data:</strong> The programs have made better use of Surveillance data to target programming, but have not maximized the use of programmatic data for program development, implementation and monitoring.</td>
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<td>2. <strong>Donor collaboration:</strong> The most responsive applications have featured improved donor collaboration narratives.</td>
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<tr>
<td>3. <strong>WHO guidelines:</strong> Applications increasingly reflected the adoption of normative guidance; however, the degree to which the applications proposed activities to be implemented in accordance with the guidance varied widely.</td>
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<tr>
<td>4. <strong>Improved quality of applications:</strong> Overall, the quality of the funding requests improved possibly due to simplification.</td>
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Lessons learned

**HIV Prevention**

- **Lack of innovation:** Many of the applicants did not propose any novel prevention activities, but relied on “tried and true methods” despite changes in context, while few recognized the need for differentiated approaches for prevention within groups.

- **Lack of use of data (epidemiological and qualitative) for targeting prevention programs:** This includes both key and general populations, e.g. disaggregation by age for adolescent girls and young women, key populations and economic factors. There is limited data on the cascade starting from prevention, i.e. how prevention outreach helps with finding undiagnosed cases for testing, which should be used more/promoted in some countries.

- **PrEP:** While more proposals sought to implement PrEP, several lacked an understanding of the normative guidance and how it applied to their countries’ epidemic and contexts.

- **Condoms:** In a positive development, programs are again allocating funding for condom programming, however not at the levels needed.

**Recommendations for applicants**

- Find ways to better use epidemiologic and program data and tailor guidance recommendations to local situations to better develop and target prevention.

- Innovative strategies should be developed to reach different segments of the population, considering age, risk, use of new social networking technologies and products, and changes in local country situations.

**Recommendations for partners**

- Partners should provide better support for differentiated approaches for prevention, e.g. PrEP implementation tailored to country context.
**Lessons learned**

### HIV

**Key populations**

**Success:**
More prioritization of key populations in all applications. Compared to the previous funding cycle, all countries working to identify and address these populations.

**Challenges:**
- **Generalization:** Some applications use ‘generalized’ outreach approaches to reach hidden populations, with minimalistic packages.
- **Increasingly restrictive environment for key populations:** Legal, political, cultural barriers in accessing key populations with evidence-based interventions becoming more difficult in many countries across regions, putting programs at risk.
- **Cascade:** Not well presented, gaps in prevention coverage not well addressed, especially linkages to test and start and bottlenecks. More of the same – i.e. trainings to decrease stigma.
- **Sustainability for key population programs:** Lack of national ownership and political commitment for funding and managing CSO-led key population programs (with some exceptions).

### Recommendations for applicants

- More emphasis on cascade analysis for key populations.
- Provide increased domestic contribution and commitments for key population programming.

### Recommendations for partners

- Partners should develop and disseminate best practices of cascade use and sustainability.
- Provide more support to countries with restrictive environments for key populations.
**Lessons learned**

**HIV**

The First 90 – HIV Testing and Linkage to Care and Treatment

- **Differentiated testing strategies needed for better HIV case finding**: concept has been increasingly used in narratives, but lacking implementation detail; countries present low-yield results and need more emphasis on higher risk targeting and case finding
- **Insufficient attention to test quality and lab and supply chain issues**: a key bottleneck in many funding requests, yet not clear well addressed in narrative and funding request.
- **Early infant diagnosis still lags behind**: alarmingly low rates in WA
- **Linkage from testing to treatment**: received insufficient focus

**Recommendations for applicants**

- Applicants should develop innovative strategies to reach hard to reach populations (e.g. community-based testing, self testing) and reach segments with low coverage (infants, men)
- These strategies should use data to develop the appropriate case finding strategies

**Recommendations for partners**

- Partners should support implementation of test and start and other policies that improve case finding and linkage
### Lessons learned

#### The Second 90 – Antiretroviral Treatment

**Success:**
Differentiated service delivery models increasingly reflected in funding proposals

**Challenges:**
- **Program continuation**: difficult to understand the degree of program scale up from the program continuation requests
- **Treatment optimization**: more discussion with Secretariat to ensure rational formulary and prescribing practices to ensure they are getting value for money
- **Access to affordable drugs and procurement challenges in countries**: a major challenge for countries who have over 80-90% domestic coverage of HIV programs - some countries face barriers in access to international markers and procurement mechanisms
- **Pediatric treatment coverage**: remains low in some regions and pediatric formulations

#### Recommendations for applicants

- Provide clear data on treatment scale up plans, including for children
- Rationalize formulary requests to come into line with normative guidelines

#### Recommendations for partners

- Support applicants to maintain scale up to reach 90
- Provide support to government-led ARV procurement
Lessons learned

The Third 90 – Treatment Retention and Viral Load Suppression

- **Insufficient data on 12 month retention:** quality of the third 90 and cohort monitoring variable across continents
- **Adherence and resistance monitoring low:** few funding requests discussed adherence to drugs and interventions to address low adherence rates; some countries plan or are in process with Early Warning Indicators
- **Differentiated care models:** countries have not picked that up yet
- **Viral load availability remains low in several countries:** yet underutilization of existing viral load platforms and GeneXpert machines

Recommendations for applicants

- Include support for data systems for cohort monitoring
- Address PSM and sample transport

Recommendations for partners

- Help applicants to undertake strategic planning of laboratory investments
Agenda

1. HIV
2. HRG
3. Tuberculosis
4. Resilient and Sustainable Systems for Health
5. Strategic Investment and Sustainable Finance
Lessons Learned

**HRG**

**Using data to prioritize people, places and programs**

**Strengths:**
- Increased presentation and use of sex-disaggregated data and data on key populations

**Challenges:**
- Population Size estimates: Lack of population size estimates for key and vulnerable
- Data on geographically delineated populations: Lack of data
- Lack of quantitative indicators and analysis of performance for HRG
- Lack of sex-disaggregated data in critical areas, and also across the HIV treatment cascade.
- Sex/age disaggregated data is largely missing in target setting and in reporting
- RMNCAH data in general is missing outside of PMTCT and ANC to guide understanding of context, and to measure potential of integrated services.

**Recommendations for applicants**
- Conduct populations size estimates
- Include RMNCAH data in funding requests
- Strengthen targets and progress reporting using sex/age disaggregation

**Recommendations for partners**
- Provide TA and support to strengthen collection and reporting of sex/age disaggregation in funding request
- Support countries to strengthen outcome measures for reporting HRG and consider aligning with some of the PEPFAR indicators
## Lessons Learned

### HRG: Gender, Women and Girls

**Strengths:**
- Increased discussion of gender in TB and Malaria funding requests

**Challenges:**
- Gaps in gender analysis across the 3 diseases and understanding of gender v. sex; in HIV little discussion of women and girls particularly in concentrated and low generalized
- Weak linkages with RMNCAH across all three disease programs - PMTCT and IPT in ANC are exceptions but not yet fully developed
- Women's organizations generally not included in descriptions of CCM and consultative processes
- Absence of discussion of gender in Human Resources for Health and HSS – a missed opportunity for improving women’s access to health services. For example, in one country, 80% of MCH workforce is male

### Recommendations for applicants
- Include discussion of gender in HRH and HSS
- Strengthen integration between RMNCAH and disease programs
- Include women’s organizations in governance structures

### Recommendations for Secretariat and partners
- Secretariat: For countries that have conducted a gender analysis, include the Report in Annexes
- Partners: Provide technical assistance on integration of RMNCAH with disease programs and gender in HRH/HSS
Lessons Learned

HRG Women and Girls Empowerment

Gender-based violence:
- Continued increased attention to GBV in HIV funding requests.
- Limited or no discussion of GBV in TB and Malaria funding requests.
- The scale of the response to GBV and to violence against women and children very limited.
- Limited discussion of harmful practices (FGMC, child marriage, widow cleansing etc.) and impact where relevant, including for countries that have conducted a gender assessment that identified these issues. Some funding requests did include discussion of harmful practices, but no discussion of interventions.
- Limited interventions to address critical drivers of gender-equality measures that impact improved long-term outcomes:
  - Social norm change
  - Working with men and boys
  - Economic Empowerment
  - Cash transfers for school retentions

Recommendations for applicants
- Strengthen and fund programming for GBV, integrated with disease programs
- Consider including interventions that focus on social norm change, economic empowerment, especially for matching funds

Recommendations for partners
- Strengthen technical assistance in gender programming and GBV
- Consider stronger GBV indicators such as post-rape care and empowerment (aligned PEPFAR indicators)
## Lessons Learned

### Stigma/ Discrimination and CSS

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<thead>
<tr>
<th>HRG</th>
<th>Recommendations for applicants</th>
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<tbody>
<tr>
<td></td>
<td>Expand community engagement in the response</td>
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<td></td>
<td>Use the UNAIDS Stigma Index for HIV and build on this data to develop appropriate responses</td>
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<tr>
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<tr>
<td>Support countries, especially in TB and Malaria, to incorporate community systems in the response</td>
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<tr>
<td>Build country capacity to use the UNAIDS Stigma Index to identify gaps and inform interventions</td>
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- Funding requests tend to conflated stigma and discrimination with human rights. In many cases, the sole proposed human rights intervention is BCC / training for reducing stigma
- Lack of data on stigma and discrimination
- Funding requests recognize lack of adequate community involvement as one of the reasons for poor case detection and treatment outcomes in TB.
- CSS interventions tend to be conflated with service provision.
- Community rarely engaged as an equal and valued partner in the response, particularly in TB and Malaria
Lessons learned

**Under-identified key and vulnerable populations**

- Lack of data and comprehensive evidence-based interventions for people in closed settings – including jails and pre-trial detention, and for women in closed settings - for all three diseases
- Interventions for transgender women are absent from most funding requests. Some countries, however, provided good-practice examples.
- Very limited discussion of age-appropriate interventions for children in general and OVC in particular, across the 3 diseases

Other vulnerable populations overlooked, and limited understanding of their needs, including:

- People with a disability
- Miners
- Indigenous populations
- Mobile populations: Migrants, IDPs, refugees

**Recommendations for applicants**

- Separate Assessment for TG, and propose TG specific interventions where appropriate
- Other vulnerable populations: develop evidence base, systematically describe and assessed
- Include interventions with Ministry of Justice / Police for PWID and closed settings with budget

**Recommendations for partners**

- Support countries to develop interventions for TG
- Extend technical support to countries to identify vulnerable populations and develop specific interventions in response to their needs.
- Support countries to develop and implement comprehensive evidence-based interventions for people in closed settings
## Lessons learned

### Human Rights, KPs and COE

### Success:
Some funding requests propose strong and equitable interventions for refugees and migrants

### Challenges:
- Funding requests largely do not address needs on both sides of the conflict – in line with International Humanitarian Law
- Funding requests do not propose interventions to provide equal access for residents, as well as displaced persons and refugees
- No interventions for the military proposed in conflict / post-conflict areas
- Some funding requests do not address displaced populations especially outside camps

### Recommendations for applicants
- Partner with humanitarian organizations / UN health cluster to ensure equal access in areas where the government has limited or no control
- Include step by step micro-interventions to provide services to hard to reach populations on both sides

### Recommendations for partners
- Ensure that the UN Health cluster liaises with CCM to support inclusion of IDPs/refugees in funding requests
- Support countries to develop strategies to provide services on both sides of a conflict, including through proxies (NGOs)
Lessons learned

**Finance and Sustainability**

**Success:**
Some funding requests consider mechanisms for sustainable financial and programmatic support for CBOs working with key and vulnerable populations, including social contracting.

**Challenges**
- Where evidence-based interventions supported by CBOs in place, they tend to be under-resourced.
- Cuts in country allocations tend to correlate with cuts in interventions for key and vulnerable populations.
- Difficult to determine budget for HRG or NGOs/CBOs/KPs/gender.
- Sustainability planning for countries nearing transition does not systematically include plans for funding CBOs/NGOs following transition.

**Recommendations for applicants**
- Ensure adequate budget for KP and HRG interventions.
- Sustainability plans for countries nearing transition should ensure sustainable funding for KP and vulnerable population services including through CBOs.

**Recommendations for Secretariat and partners**
- Secretariat: Include country Sustainability Plans in funding request Annexes, and support CBOs to participate in the development of these Plans.
- Partners: Support countries to develop budgets that show how HRG and services for KP and vulnerable populations will be be funded.
Technical recommendations detailed

1. HIV
2. Human Rights and Gender
3. Tuberculosis
4. Resilient and Sustainable Systems for Health
5. Strategic Investment and Sustainable Finance
Lessons learned

Diagnostics: GX + digital radiography

• Positive observation: every country scaling up GX and greater interest in digital radiography
• Issues
  • Optimization still needed: current machines are under-utilized and applicants have not described where/how they will use new machines. Operationalization issues related to digital x-rays missing.
  • Specimen transport systems also need optimization; consider links to other programs with transport systems in place (other health programs/potential of outsourcing service to the private sector)
  • Meeting the diagnostic of populations that hard to reach populations (such as nomadic pops)
  • Descriptions of clinical and diagnostic capacity including diagnostic algorithms often lacking

Recommendations for applicants

• Develop diagnostic capacity plan with clear indications of # machines and link to outcomes (e.g. proportion of patients diagnosed with molecular test).
• Adapt clinical management algorithm to incorporate new diagnostic tests
• Include development of clinical management capacity and in future applications

Recommendations for partners

• Partners to work with countries to understand exact needs of GX machines – workload analysis, requirement, gap analysis. E.g. # machines they have, # tests need to do, # machines needed
Lessons learned

**TB**

**MDRTB Program Expansion**

- Positive: all countries plan to expand diagnosis of MDRTB. All plan to adopt shortened regimen. Increasing proportion of diagnosed patients are starting treatment.
- Observation: little progress on cases diagnosed vs. targets. Countries now have infrastructure (equipment) but not yet reporting stronger results. Significant detection/treatment gap persist.
- Countries moving to shortened regimen at different speeds due to capacity for SLD -DST. TRP encourages prioritizing short-course regimen as quickly as capacity as capacity for SLD -DST is built for treatment optimization and better patient outcomes.

**Recommendations for applicants**

- Accelerate detection of MDRTB cases and ensure all diagnosed patients are treated as soon as possible to meet targets
- Use data from conventional DST to move towards shortened regimen if 2nd line molecular DST is not yet in place

**Recommendations for partners**

- Provide support to countries to build capacity to enable rapid implementation of shortened regimen (2nd line DST capacity)
TB prevalence surveys have confirmed large proportion of missing TB cases in many settings. Funding requests appropriately mention interventions to find these cases, but lack sufficient detail – such as geographic location of the missing cases, specific interventions to diagnose them, and especially, how active TB case finding will be intensified.

Requests do not convey a sense of boldness, innovation or ambition in the setting of targets or in the design of interventions, to quickly “move the needle”.

Key populations are described lightly – not going to close the gap without a more detailed understanding of how to find/reach them.

TRP would encourage all applicants to be bold when learning is appropriate, and use lessons from TB REACH projects that can be adopted. Recommendation to strengthen role of communities and information technology for case finding, retention in care and contact management.

TRP encourages those eligible for matching funds to come early and be willing to try innovative ideas.

### Recommendations for applicants

- Search and reapply positive examples of finding missing cases

### Recommendations for partners

- Support countries to better understand country survey and epi data, identify vulnerable populations and design enhanced and sustainable interventions to find “missed” cases
**Lessons learned**

**TB** Human rights and gender understanding: an area for improvement

- Human rights/gender continue broadly are not well addressed in TB applications.
- Issues of miners, their right to free diagnosis and treatment, migrants and access to care were missing in most funding requests.
- Everyone should have access to health care: examples of TB control programs that avoided slums or claimed there were “no human rights issues” in that country indicating significance of human rights still not well appreciated in driving more successful TB interventions.
- More references to HRG in Program Continuation proposals than in full requests due to specific request on alignment to new GF strategy.
- One strong example of gender-designed program and good progress on not using stigmatizing language.

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<thead>
<tr>
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<th>Recommendations for partners</th>
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<tr>
<td>• Consider HRG in programming prioritization decisions.</td>
<td>• WHO should revise reporting tool to include age/gender disaggregated outcomes</td>
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Lessons learned

TB

Pediatric TB

- Childhood TB was consistently identified as an issue in applications but interventions were often missing. Persisting issue from last cycle.
- Positively - more attention paid to using new formulations but not enough to finding the children to give the formulations to
- Missed opportunities to link to RMNCAH (unlike HIV)

Recommendations for applicants

- Best practice: adoption of WHO guidelines to the country context, training of HCWs, Link to maternal/neonatal health clinics.

Recommendations for partners

- Enhance technical support to countries focused on childhood TB and support/ enhance efforts for a non sputum based TB test.
Lessons learned

**TB/HIV collaboration**

- Countries with big TB/HIV disease burdens making tremendous progress in bi-directional testing and ART coverage.
- Implementation of TB/HIV collaborative activities remain weak in low burden countries.
- Co-morbidities: positively, when burden of TB is driven by other factors (DM for example) seeing integration/collaboration with other health programs.
- IPT: % of PLHIV on IPT is low. How to overcome this persistent resistance to IPT? HIV doctors don’t want to give IPT b/c fears of creating resistance and/or affect on patient. Some countries not following normative guidance.

## Recommendations for applicants

- Continue to drive TB/HIV collaboration activities and offer ‘one stop shop’ for benefit of patient care

## Recommendations for partners

- WHO: time to review guidance? Support countries to overcome implementation challenges and to monitor quality and outcomes of the IPT intervention.
Technical recommendations detailed

1. HIV
2. Human Rights and Gender
3. Tuberculosis
4. Resilient and Sustainable Systems for Health
5. Strategic Investment and Sustainable Finance
### Lessons Learned

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<td>Information systems</td>
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<td>PSM</td>
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<td>Decentralization and governance</td>
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# Lesson 1: Information systems

**Information systems**

- Integrated HIS (3 disease programs data are now widely integrated into DHIS2)
- Data use often delayed until improvement in quality, timeliness and only then utilization of data for decision making at local level
- LMIS widely introduced – but using various software
- Sharing of data across countries not happening but possible with DHIS2
- M&E surveys not capturing loss of patients in Continuum of Care

**Recommendations for applicants/ Secretariat**

- After scaling up integration of data, need evidence that data is being used for management and to benefit disease programs
- M&E framework should be modified to demonstrate flow and losses of patients along Continuum of Care
- Encourage use of information systems for analysis and management decisions which would drive data quality improvement as managers demand better data to enable confident use
Lesson 2: Procurement and Supply Chain Management (PSM)

Supply chain management increasingly unified under single authority: coordination among multiple partners improving

Ensure PSM support at all levels (center to the periphery): center improved but often problems in periphery

LMIS widely introduced – best to integrate with DHIS2

Supply Chain Management and equipment maintenance functions frequently weak

GeneXpert and other medical equipment introduced without attention to system support (maintenance, transport of specimens, capacity development etc.)

Impact on global supply prices resulting from large countries procuring domestically

VFM evaluations needed in context of decentralization and moves towards local procurement

Recommends for applicants/Secretariat

- Technical briefing for TRP from Global Fund Global Sourcing Pharmaceuticals Department on procurement issues
- UNITAID technical briefing to TRP and Country Teams to facilitate effective integration of new technologies
- Do careful readiness assessment before introducing new equipment or decentralizing laboratories
- Global Fund to look at shrinking market share and declining leverage of Pooled Procurement Mechanism
- Consider use of non public sector contracting to handle supply chain and equipment maintenance functions
Lesson 3: Human Resources for Health (HRH)

**HRH**

- Public sector employment: inadequate numbers, management, retention, integration of supportive supervision,
- Occupational health and safety of Community Health Workers (CHWs) not considered in almost all cases (EVD)
- Compensation of Community Health Workers by project funds not sustainable
- Task shifting moving down the chain increasing, may require legal justification
- Few countries take over salary costs e.g. Ethiopia, Sierra Leone
- Workload, multiple responsibilities of CHWs continue to increase with service integration, risk of becoming ineffective with overload – most countries
- Lack of human resources remains a key bottleneck to access to services and sustainability in most places

**Recommendations for applicants/Secretariat**

- Support from the Global Fund should be within HRH Framework/Strategy, if not already existing should be developed
- Secretariat to consider documenting innovative initiatives eg: Bangladesh PPM (Public Private Mix) experience in urban services for TB
Lesson 4: Decentralization and governance

Decentralization and governance

- CCMs do not usually involve RSSH persons– role of KPs often weak, even where members
- Decentralization is spreading across all geographic regions
- Implications of decentralization for disease programs threaten quality and impact unless addressed
- Use of de sub-sub recipients
- Challenges with fund flow and supervision in many decentralized systems
- No reference to democratic oversight of decentralized structures
- Lack of attention to improving quality and standards of private sector delivering key services, e.g. Zimbabwe, Nigeria, Rwanda

Recommendations for applicants/Secretariat

- Strengthening of weak CCM, especially with Government PRs (KPs membership vs participation), integration of CCM within country, wider coordination/linkage with governance bodies, including the composition of the CCM to take into account special considerations such as refugees and migrants
- Countries need to seek advice on the implications of decentralisation with relation to fund flow, potential integration of services, devolution of data responsibility, procurement, accountability etc. or make a case for continuing verticalization (pre-elimination for Malaria)
- Countries and partners are encouraged to recognize role of private sector and reflect importance in improved quality, adherence to standards and reporting in all 3 diseases
Lesson 5: Financial management

Financial management

- Financial procedures to strengthen decentralized movement of funds and control of financial resources often not in place
- Strengthened financial management to enable cost efficiencies (PNG, Togo)
- Great differences between countries in per capita allocations, unit costs per beneficiary (Mauritius vs Bangladesh....)

Recommendations for applicants/Secretariat

- Introduce safeguards to ensure funds are used for designated purpose
- Strengthen financial management procedures and accountability processes before decentralization
- Difference in per capita cost, program costs should be harmonized – VFM assessments
Lesson 6: Community System Strengthening (CSS)

### Community System Strengthening

- Many countries use Community Health Workers – increasingly integrated services – worries about over work and quality of service as tasks increase
- Virtually no reference to CSS to enable the communities to perform as partners in putting in place resilient health systems
- Few countries have social contracting mechanisms to enable taking over support of key CSOs when GF exits

### Recommendations for applicants

- Support CSOs to assure involvement of communities in oversight and support to CHWs
- Develop social contracting mechanisms to enable continuation beyond GF
Lesson 7: Integrating service delivery

Integrating service delivery

- RMNCAH services not mentioned in many countries that talk of integrated services
- TB-HIV: limited integration apart from testing and treating – joint supervision, training, even labs often lacking
- Integration of 3 diseases may be different in generalized epidemic vs concentrated epidemic
- Integration may lead to task overload for community health workers, decreased productivity and quality

Recommendations for applicants

Conduct Service Availability of Readiness Assessment (SARA) type of evaluation or Workload Indicator of Staffing Needs (WISN) to assess existing workload and ability to absorb additional functions as a consequence of integration of services. Use to reduce extraneous workload (registers, reports, stock management...)
General observations - RSSH

**General observations**

- Tension between direct investments in disease components vs the strengthening of the systems to enable these disease programs to function well
- With so many countries successfully integrating services for all 3 diseases at peripheral level (clinics and CHWs) secretariat should consider documenting the elements of integration that make for success and issues to avoid in the process – these lessons for wider dissemination
Technical recommendations detailed

1. HIV
2. Human Rights and Gender
3. Tuberculosis
4. Resilient and Sustainable Systems for Health
5. Strategic Investment and Sustainable Finance
Lessons learned

- **Co-financing experience.** Global Fund co-financing mechanism not necessarily delivering sustainability especially in higher income, low disease settings

- **Value for Money**: Work in progress. Need for better guidance what VfM means within the GF so it can be systematically applied. VfM is a narrative rather than a number.

- **Health financing reform**: Countries need to remove financial barriers to accessing disease control services in the context of UHC

- **Innovative financing mechanisms**: RBF, COD, social impact bonds, buy-downs. TRP would like to further engage with GF on this topic to better explore risks and benefits for impact and sustainability.

- **Social contracting**: Legal and administrative framework missing. Some GF supported services/ interventions not ever going to fall within a UHC system.
## Window 1 funding request by program type

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91 funding requests:
- 21 HIV
- 14 TB
- 14 TB/HIV
- 39 Malaria
- 1 RSSH
- 2 TB/HIV/malaria

*Joint HIV/TB and Malaria request
Window 1 funding request by application approach

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<td><strong>HI Asia:</strong></td>
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<tr>
<td>Bangladesh (HIV, TB, malaria)</td>
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<tr>
<td>Philippines (HIV, TB)</td>
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<tr>
<td>RAI (malaria)</td>
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<td><strong>SE Africa:</strong></td>
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<tr>
<td>Malawi (malaria)</td>
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</tbody>
</table>
Funding Requests: Component by window

Based on country team estimates: does not include projected slippage or iterations

As of 21 April 2017

Window 1: 91 (39 HIV/AIDS, 14 Tuberculosis, 14 Malaria, 12 Standalone RSSH)
Window 2: 58 (14 HIV/AIDS, 12 Tuberculosis, 12 Malaria, 12 Standalone RSSH)
Window 3: 19 (5 HIV/AIDS, 4 Tuberculosis, 3 Malaria, 6 Standalone RSSH)
Window 4: 55 (19 HIV/AIDS, 21 Tuberculosis, 10 Malaria, 4 Standalone RSSH)
Window 5: 5 (3 HIV/AIDS, 2 Tuberculosis, no Malaria, no Standalone RSSH)
Funding Requests: Application approach by window

Based on country team estimates: does not include projected slippage or iterations

<table>
<thead>
<tr>
<th>Window</th>
<th>Program Continuation</th>
<th>Tailored</th>
<th>Full Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Window 1</td>
<td>91</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Window 2</td>
<td>58</td>
<td>26</td>
<td>3</td>
</tr>
<tr>
<td>Window 3</td>
<td>19</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Window 4</td>
<td>55</td>
<td>32</td>
<td>3</td>
</tr>
<tr>
<td>Window 5</td>
<td>5</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

As of 21 April 2017
Funding request submission and allocation request for window 1 by portfolio categorization

**Funding requests submitted**

- Core: 42
- Focused: 25
- High Impact: 24

**Allocation request distribution**

- High Impact: $3,147,207,499
- Focused: $204,131,202
- Core: $1,526,769,284
2017-2019 Allocation by application modality

Based on country team estimates: does not include projected slippage or iterations

- Window 1: $4.8B
- Window 2: $4.4B
- Window 3: $0.4B
- Window 4: $0.7B
- Window 5: $0.011B

- Program continuation
- Tailored
- Full review

As of 21 April 2017
Funding request submission and allocation by application approach

Window 1

Amount of allocation, out of $10.3 billion

- $0.1b
- $1.2B
- $0.9B
- $0.8B
- $1.6B
- $5.5B

Funding requests submitted, out of 228*

- 22
- 40
- 10
- 7
- 12
- 137

*based on current projections, as of 21 April 2017
Matching Funds amount by Priority Area

(US$ millions)

- HIV/AIDS - KP: 49
- HIV/AIDS - HR: 44
- HIV/AIDS - AGYW: 55
- Tuberculosis - Missing Cases: 115
- Malaria - LLINs: 32
- RSSH - HRH: 33
- RSSH - Data: 18
- Requested: 29

Source: Access to Funding database
As of 18 April 2017