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COMMUNITY-BASED, RIGHTS AND GENDER INTERVENTIONS FAIL TO FEATURE STRONGLY IN GLOBAL FUND COVID-19 MITIGATION PROPOSALS

Background

The Joint United Nations Programme for HIV/AIDS (UNAIDS) has supported countries in the preparation of COVID-19 Response Mechanism (C19RM) applications. A review of the funding shows that countries are still falling short on community, rights and gender (CRG) interventions, as well as innovations in service delivery, although requested by the Global Fund in its C19RM funding request instructions. Several other weaknesses mean that countries may have a lot of work to do when it comes to grant-making and implementation.

This support is part of the innovative technical assistance model established earlier this year by UNAIDS to support countries preparing applications for the second C19RM phase. It comprises in-country support to proposal development, an online Virtual Support Desk Mechanism and a helpdesk to provide countries with tailored technical support on request, as well as virtual peer reviews of draft applications

The first article in this series Innovative technical support to strengthen countries' COVID-19 mitigation proposals to the Global Fund) described the details of the virtual support. In this article, our third in the series on C19RM experiences, the UNAIDS-supported peer review team and UN Joint Programme experts share lessons learnt from assessing C19RM applications, identifying common strengths and weaknesses, and providing suggestions for further strengthening these types of funding requests (FRs).

The Global Fund had invited eligible countries to request their C19RM Full Funding Request during four submission windows in May and June 2021, and two more windows in July and September.

There are key differences between the usual funding requests and the C19RM applications

As mentioned in our previous article, approaches and materials for developing C19RM FRs are very similar to those required for regular Global Fund HIV, tuberculosis (TB), malaria and health systems strengthening (HSS) applications, e.g., meaningful stakeholder engagement (especially of civil society and key and vulnerable populations/KVPs), and submission of a FR Form and major annexes such as the Funding Landscape and Detailed Budget.

However, there are also some new aspects. It is expected that countries have prepared their National Strategic Preparedness and Response Plan (NSPRP) and their proposed C19RM activities must be in line with the Plan's pillars. Other differences include endorsement of the C19RM application by the national COVID-19 response coordinating body as well as the Country Coordinating Mechanism. There is a new C19RM-specific Modular Framework that is very different from the usual Modular Framework; and C19RM applications require neither Programmatic Gap Tables nor Performance Frameworks. The proposals do not go to the Global Fund's independent Technical Review Panel but to the C19 Investment Committee for recommendation for funding and to proceed to grant-making. All C19RM applications must show that there has been significant consideration of the pandemic's impact on CRG, including gender-based violence (GBV), and corresponding mitigating activities have been developed in response.

One other major factor impacts the development and submission of C19RM funding applications. The turnaround time, from receipt of the Allocation Letter to proposal submission, is between four to eight weeks although, with the announcement of the September date, some countries may now have longer.

UNAIDS C19RM technical support for applications' peer reviews

In a similar way as the reviews conducted for regular grant FRs last year, remote peer reviews of draft C19RM Full Funding applications in English or French were conducted by a team of peer reviewers. In total, 17 countries submitted draft applications for peer review and of these four resubmitted their proposals for a second round. Applications came from Botswana, Central African Republic, Chad, Congo, Cote d'Ivoire, Gambia, Kenya, Liberia, Madagascar, Namibia, Nigeria, Senegal, Tanzania, Uganda, Zambia, Zanzibar and Zimbabwe. To date, these have all been approved and the corresponding Base Allocation amounts to over $624 million.

Lessons learnt: what components can be seen in a successful application?

Certain commonalities contribute towards a robust FR.

Table 1. Elements of a successful application

Draft arrives early enough to review properly	Proposals that allowed a longer turnaround time (usually 48 hours or more) facilitated a more in-depth review.
The proposal is well-balanced	Applications contained an adequate split of resources between "pure COVID" activities, mitigating impact on responses to the three diseases and health system strengthening.
Draft includes key annexes	Reviewers were able to provide more comprehensive feedback for applications that attached critical annexes such as the budget.

Does what instructions say to do	The Global Fund’s detailed instructions were followed to the letter.
Well written text, with a logical flow and clear rationale	The identified gaps and challenges resulted in activities to address them, with measurable time-bound outcomes.
Attention paid to grammar, punctuation, spelling, table numbers, etc.	While this may sound like a relatively unimportant factor, attention to detail ? including consecutively numbered tables and figures ? made a difference to the proposal’s quality.
Inclusive, consultative, well-described approach for FR process	The Global Fund’s emphasis on inclusive consultations for proposal development was reflected by detailed descriptions of approach and participants involved.
Approach used for prioritization of interventions very well presented and clearly complies with Global Fund instructions	The prioritization approach was outlined in full, including how interventions were assessed, ranked and selected for Base or Above Base Allocation. Critical interventions are included under Base Allocations, not Above Base.
Good synthesis of pre-COVID context with baseline data and additional surveys	Proposals described a comprehensive situation analysis backed up with an evidence base of referenced data, surveys, etc.
Description of key role of community-based organizations, community health workers, civil society to deliver services to KVPs	Applications paid particular attention to community-based/led initiatives, especially those led by and/or offered to PLHIV/KVPs and targeted at hard to reach/under-served groups such as internally displaced populations, prison inmates, miners, fisherfolk, truckers, etc.
Consideration of HIV differentiated service delivery (DSD)	Countries mitigating the impact of the pandemic on HIV programs expanded their service delivery mechanisms to include DSD, or ramped up existing DSD modalities.
CRG specialist/expertise apparent	FR teams that included CRG specialists were better able to address Global Fund C19RM requirements

Unfortunately, very few countries were able to demonstrate all or even some of these components.

Lessons learnt: red flags
Most of the draft proposals reviewed suffered from all or some of the following weaknesses at the peer review stage:

- Very little time allowed for turnaround, implying insufficient planning.
- This short processing time does not allow countries to draft quality proposals nor the Peer Reviews to issue in-depth, extensive feedback, which can then be addressed by the writing team prior to submission.

- Surprisingly high incidence of inadequate/incorrect use of the detailed Global Fund templates and instructions.

- Lack of information about program disruptions due to the pandemic (and associated measures) and how this C19RM application would get the programs back on track.

- As well as insufficient identification of the pandemic's impact on diseases and health system components, disease adaptations were poorly covered.

- Consideration of length was often lacking: weak attention to detail was a common failing BUT, conversely, sometimes too much unnecessary detail was provided.

- Text was frequently wordy when use of histograms, graphs, tables, and bullet points would have done a better job and been more visually appealing.

- Failure to provide all annexes/attachments for peer review ? especially funding landscape and budget.

- Weak prioritization section did not adequately explain how the interventions were assessed, selected and ranked (as seen last year with Global Fund applications).

- Failure to link context (e.g., socio-economic) to corresponding interventions and to the appropriate NSPRP pillars; sometimes, failure to reference the NSPRP.

- No activities outlined beyond those under Base Allocation meant that significant opportunities for extra funding were missed (or not shared for peer review).

- Lack of costing elements included in the modules.

- Limited understanding of COVID-related good practices and options for interventions and resource allocation. Despite COVID-19 restrictions, very high travel-related costs, e.g., meetings, workshops, training (one country had allocated 49% of its budget to this) instead of using virtual platforms/other new technologies.

- Lack of systematic, reliable and community-generated data (for example, countries could have undertaken a rapid assessment of KVP/people living with HIV (PLHIV) needs, whose findings could inform gaps and needed interventions).

- Lack of private sector involvement (who may provide more than 50% of health care services, especially in urban areas)

- Global Fund grants are a performance-based funding mechanism so the anticipated results should be included but, in the few applications that did so, the expected results were mostly unquantifiable and very poorly outlined across all countries. Outcomes should be SMART (Specific, Measurable, Measurable, Attainable, Realistic and Time-bound)

Communities did not stand out sufficiently

It remained unclear to what extent the constituencies/communities would be engaged in proposal implementation. In fact, this section was largely left empty in the drafts that came to the peer reviewers. The importance of civil society, including communities' engagement and involvement in FR development, implementation and monitoring, was frequently underestimated. For example, civil society was often not broken down by its constituents and there was an apparent lack of engagement of KVPs and PLHIV networks. It was unclear how funding prioritisation/re-prioritisation decisions were conveyed back to the constituencies or whether stakeholders were able to provide more inputs other than during the first consultations. No proposal noted if the constituencies' costs were covered where appropriate (e.g., transport, etc.) or if consultations were held virtually and how this worked in communities without access to e-based platforms.

Many proposals displayed common thematic weaknesses

Additionally, several proposals' technical components needed further work

- Lack of quantified data/information on COVID-19's impact on diseases/health system components made it harder for countries to propose evidence-based and measurable disease adaptations.

- Despite the significant impact on disease programmes, some countries only prioritized pure COVID support, but with no or insufficient investment in HSS (such as waste disposal) despite the focus on C19 commodities and equipment.

- HIV impact and mitigation: scant consideration of condom programming, pre- and post-exposure prophylaxis and mother-to-child-transmission (MTCT) through antenatal care (ANC).
- ANC and MTCT status needed to be better described to ensure the coherence of the context with the proposed modules.

- Lack of detail in proposed actions: many modules' interventions read like shopping lists, not a clear description of effective activities.

- Applicants rarely considered how they could link C19RM activities to interventions under the existing Global Fund grants and those of the United States President's Fund for AIDS Relief (PEPFAR).

- Overall, HIV adaptations were weak: applicants needed to address all affected services including voluntary medical male circumcision.

- Lack of data on GBV and even more so on human rights violations.
- In countries with nomadic populations or refugee camps, there was a lack of consideration of the impact of GBV not only on women but on boys.

- There were missed opportunities to link services for adolescent girls and young women (AGYW) to ANC, GBV, sexual and reproductive health and rights (SRHR) and STIs, including HIV.

- Urban slums, 'hotspots', underserved communities such as migrants and others, were largely neglected.

- Community-led responses displayed missed opportunities and a lack of innovation. What makes the C19RM different from the usual Global Fund FRs is the even higher importance placed on the role of the community. This is especially imperative given that service mitigation and adaptations also imply enhanced use of DSD, which can mean greater use of community structures.

- Collaboration with opinion leaders and social influencers (politicians, mayors, artists, singers, footballers) were insufficiently exploited.

- Even if applications mentioned rights violations and increased stigma and discrimination, they rarely include appropriate interventions to address these issues aimed at police, parliamentarians and legislative bodies.

- In spite of the Global Fund's encouragement to consider 'innovations', use of new technologies, social media and eHealth was weak, as were alternative and new ways to provide essential services that are currently unable to function normally because of COVID.

- TB activities were poorly developed in most applications, including joint HIV/TB activities.

Interventions aimed at addressing women, GBV, SRHR and rights need to be prominent

The C19RM allows for a 'new' aspect of support to HIV impact mitigation: SRHR integrated with HIV services to address a diverse range of issues including GBV. Yet, despite the evident gaps, interventions to respond to these were largely missing.

There were other interventions that applicants could have considered; for example, covering provision of contraceptives; ensuring that women's centres/shelters remain open/expanded to new clients; providing domestic violence helplines and legal aid; leveraging online virtual support networks; for post-GBV cases, expanded community paralegal programmes; temporary shelters; community awareness activities of potential rights violations in the context of COVID-19; and prevention interventions aimed at police and judiciary. For survivors of intimate partner violence, programs needed to ensure that peer counsellors and communities (including KVPs) were readily able to access PrEP and PEP, emergency contraception and other crisis services, including psychosocial support. Mental health support for young people in particular

has been highlighted as critical in latest studies on the impact of the pandemic.

Finally, our findings indicate that applications rarely mentioned the extra barriers related to rights violations and increased stigma and discrimination in the COVID context, despite the overuse of criminal laws and punitive approaches. This is an area that has to be better addressed for HIV adaptations to mitigate the impact of COVID-19 on vulnerable populations. Interventions that applicants could have considered include:

- Support community and civil society efforts to prevent the introduction of new legislation or the application of existing legislation to criminalize exposure, non-disclosure or transmission of viruses and communicable diseases.
- Support efforts that refocus law-enforcement measures on ensuring public safety and referring marginalized groups to health and social services, and fund efforts to train law enforcement to ensure protection of rights in implementing law enforcement actions.

Conclusion

Many peer review comments could also be applied to the usual Global Fund grant applications for HIV and TB. Nonetheless, the reviews provide a wealth of information that should be built on and leveraged for future applications for both types of grants (regular FRs and C19RM). Moreover, countries can still build on some of these lessons at the grant-making and implementation phases.

With this in mind, the fourth article in this series looks at country experience of C19RM application using Ethiopia as an example (Global Fund's COVID-19 Response Mechanism grants to Ethiopia yield challenges and lessons), and the fifth article in the next GFO issue #403 examines the implications and opportunities presented by the virtual technical assistance and helpdesk mechanism for prospective grant development.

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