The 49th Global Fund Board Meeting

# Technical Review Panel's observations and recommendations on Window 1 funding applications: Part I

On 8 May the Technical Review Panel (TRP) debriefed technical partners, including technical assistance providers and others, on its findings from the funding requests (FRs) submitted under Window 1. Highlights of the findings were also presented to a pre-Board meeting on 9 May.

Countries applying under Windows 2 and 3 still have time to be able to take the lessons learned and recommendations into account in their draft documents.

This article is based on the presentation and because of its length is in two parts: Part I covers the thematic findings and recommendations; and Part II covers the technical observations and recommendations by disease and RSSH and will be published in GFO 432 on 24 May.

Funding requests in 2023

Approximately 205 FRs are expected in the 2023-2025 allocation period. The majority of FRs for this allocation period will go through TRP review in the first half of 2023.

Figure 1. Funding requests in the 2023 application cycle
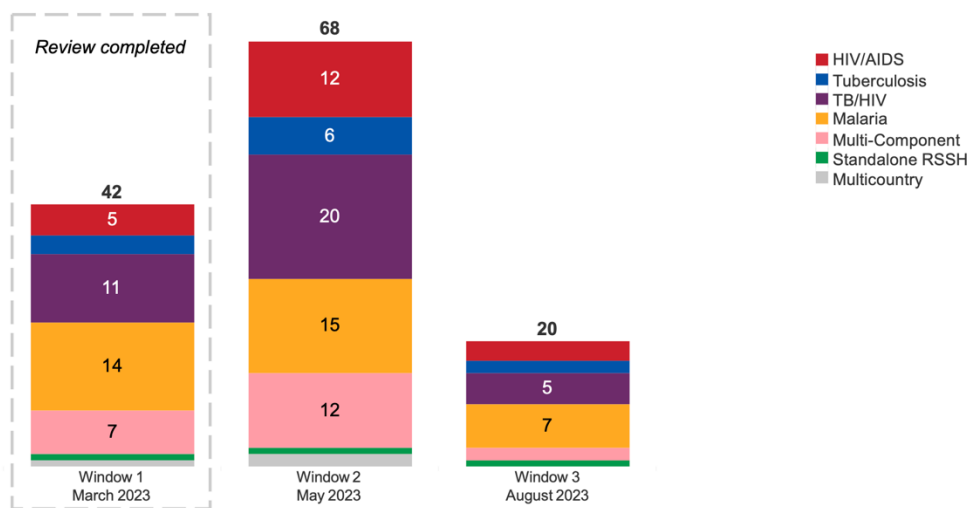
Source: The Global Fund, 3 May 2023

- 39 out of 42 FRs from 26 countries and one multicounty application  have been recommended for grant-making. This represents a 7% iteration rate, consistent with the last funding cycle at 6%.
12 FRs were from Challenging Operating Environment countries (nearly half of all countries in W1).
36% of FRs were under the Program Continuation modality, most often used for malaria – 43% of FRs with a malaria component.
- 11 out of 42 (26%) came as Tailored for NSP, with more TB components coming through this NSP modality (37% of all TB components).

Figure 2. Overall TRP review outcome, Window 1
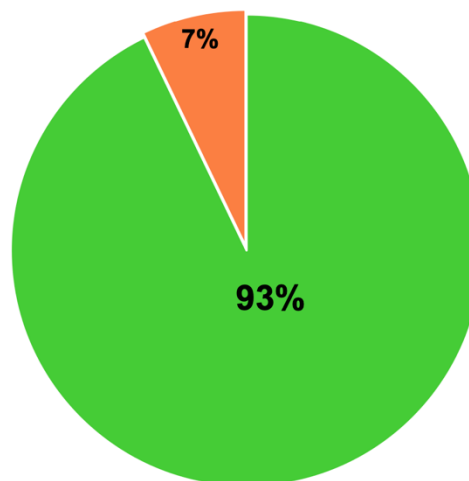


THE GLOBAL FUND

TRP recommended $4.9 billion in allocation funding for grant-making. This represents over a third of the funding for Grant Cycle 7 (GC7).

Table 1. Recommended Window 1 funding amounts

| | Recommended Amount (US$) | % total communicated |
|---|---|---|
| Allocation | 4,906,353,063 | 37% |
| Matching Funds | 98,250,000 | 36% |
| Catalytic Multicountry | 50,000,000 | 44% |
| **Total** | **5,054,603,063** | |

Matching fund priority areas recommended for grant-making are shown below.

Table 2. Requested versus recommended amounts, by component

| | Requested Amount (US$) | Recommended Amount (US$) | % total communicated |
|---|---|---|---|
| HIV Prevention | 18,800,000 | 17,800,000 | 36% |
| TB: Find & successfully treat the missing people with DS-TB and DR-TB | 34,000,000 | 34,000,000 | 41% |
| Incentivizing RSSH quality and scale | 24,000,000 | 24,000,000 | 34% |
| Effective community systems & responses | 12,000,000 | 12,000,000 | 28% |
| Scaling up programs to remove human rights and gender related barriers | 11,900,000 | 10,450,000 | 33% |
| Total | 100,700,000 | 98,250,000 | 36% |

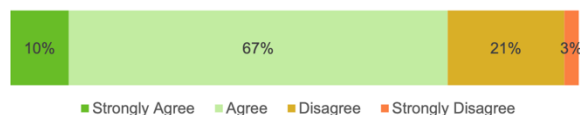TRP Funding Request Quality Survey

Overall, according to the TRP Funding Request Quality Survey on Window 1 FRs Recommended for Grant-making (N=39) 72% of TRP members agreed that the Window 1 FRs delivered strategically focused and technically sound responses aligned with the epidemiological context and maximising the potential for impact. 23% of TRP members even went as far as to say they "strongly agreed" that this was the case. However, 5% disagreed.

Early problems with resilient and sustainable systems for health were on the whole addressed

Peer reviews of early drafts of Window 1 FRs had observed excellent examples of Integration across diseases with all three diseases and RSSH in one joint application; labs; Community Health Workers, (CHWs), HIV/TB and Human Rights and Gender (HRG). There was a step change in CHW programmes with stronger focus on people centred services and greater focus on community-led monitoring (CLM); but many countries were struggling with their RSSH components, especially integrating RSSH across all three diseases and avoiding repetition and a siloed approach. Evidently many countries had managed to address this problem in subsequent drafts since the TRP found that 77% of FRs recommended for grant-making demonstrated a "strategic focus" on RSSH which is higher than in the previous funding cycle, NFM3. It assessed that 36% of FRs were more focused on system strengthening than system support.

Figure 3. Window 1 funding request RSSH focus

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

| Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|
| 10% | 67% | 21% | 3% |

■ Strongly Agree  ■ Agree  ■ Disagree  ■ Strongly Disagree

**Focus on RSSH:** To what extent does the funding request demonstrate focus on systems strengthening or systems support.

| | | | |
|---|---|---|---|
| 5% | 31% | 51% | 13% |

■ Entirely focused on system strengthening
■ More focused on system strengthening than system support
■ More focused on system support than strengthening
■ Entirely focused on system support
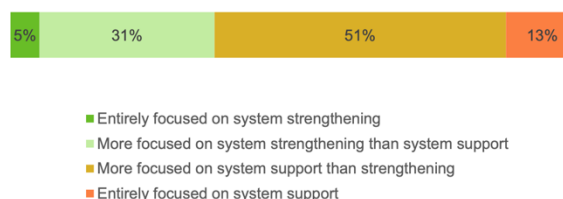
Community systems and responses strongly iterated

The TRP reviewed FRs in terms of six areas where they wanted to see better focus: Sustainability, Gender, Human Rights, Equity, Community Stems and Responses, and Pandemic Preparedness.

Figure 4. Funding request focus areas

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

| | | | |
|---|---|---|---|
| 5% | 74% | 15% | |
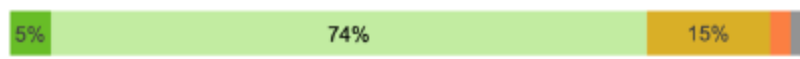
**Focus on Gender:** The funding request maximizes gender equality by considering and addressing gender inequalities and gender-related barriers that impact on health outcomes.

| | | | |
|---|---|---|---|
| 3% | 67% | 26% | 5% |
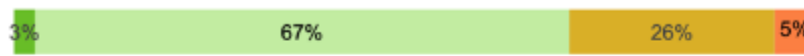
**Focus on Human Rights:** The funding request ensures that human rights-related barriers to accessing services are adequately analyzed and addressed to achieve the set targets.

| | | | |
|---|---|---|---|
| 5% | 59% | 28% | 8% |
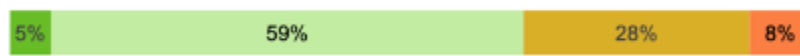
**Focus on Equity:** The funding request demonstrates investment in equitable health outcomes with proposals to address structural barriers and improve access.

| | | | |
|---|---|---|---|
| 5% | 72% | 15% | 8% |
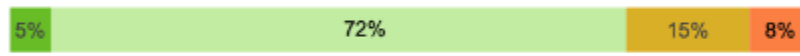
**Community Systems & Reponses:** To what extent are the roles of community-led and -based organizations in service delivery articulated in the funding request? (Scale of Not Articulated to Extremely Well Articulated)

| | | |
|---|---|---|
| 8% | 79% | 13% |
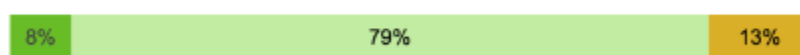
**Pandemic Preparedness:** The funding request demonstrates appropriate investments to strengthen pandemic preparedness and response.

| | | | | |
|---|---|---|---|---|
| 3% | 64% | 15% | 3% | 15% |
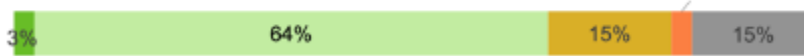
■ Strongly Agree  ■ Agree  ■ Disagree  ■ Strongly Disagree  ■ N/A

The TRP found the strongest focus on community systems and responses with an 87% positive rating. Addressing human rights barriers has the lowest relative rating, but at 64% positive is still an improvement over NFM3.

Thematic observations and recommendations

Lesson 1: Tough prioritization needed

The TRP noted that, while resources are limited, needs are increasing with severely limited fiscal space. Yet countries cannot dilute their focus to be everywhere and do everything. It was clear from the 42 FRs that the Global Fund allocation is insufficient for countries' aspirational 'wish lists' of priorities and the TRP saw many "thinly spread" or "frontloaded" budgets. Countries also submitted large Prioritized Above Allocation Requests (PAAR), e.g., much larger than 30% with some over 100%, with commodities split across the core allocation and PAAR. In particular, the TRP noted:

- Malaria: Some applicants don't have enough funds to cover vector control and case management and Year 3 in many FRs has gaps in the malaria allocation.
- Malaria: Not all countries followed the explicit stratification guidance on where resources should go and results were mixed. So that, while all high burden to high impact (HBHI) countries

followed the guidance, more challenges were observed in non-HBHI countries.

- TB: Increasing diagnoses means increasing treatment costs, with some treatment being underfunded.
- HIV: Improving prioritization attempts were limited by poor disaggregated data. Advanced HIV disease was not prioritized for funding..

The TRP noted two concerning scenarios: some applicants had split essential investments across the core allocation and PAAR because the funding was insufficient. It also observed that some applicants put "less essential" investments in the core allocation yet key interventions were relegated to PAAR.

In financially-constrained environments with increasing disease burden, countries continued to do "business as usual". The TRP had seen a few examples of high-level indicators going backwards yet had failed to change their approach.

The TRP raised concerns over gaps in quality and use of data to inform prioritization: data disaggregated by gender, age, sub-populations and geography and key population (KP) data (especially population size estimates [PSE]) were often missing or underused.

On to human rights and gender: HRG assessments had been done but the corresponding interventions were not always budgeted in core allocations. There is a real risk that equity, human rights and gender investments "fall out" in prioritization discussions – again, the TRP saw cases where such investments were found in the PAAR instead of the core allocation.

The TRP observed high management costs in the FRs (e.g., high travel costs (one country had, in its first draft, allocated 70% of its budget to training and travel-related costs!), human resources and management costs). Indeed, some of the management costs were hidden in other interventions' budgets.

Finally, the Program Essentials framework has clearly caused some confusion for Window 1 applicants, not helping applicants to prioritize.

Tough prioritization needed: recommendations for applicants

Countries were told to address the basics first and focus on impact to save lives based on country context and data:

- Data for tailoring: Tailored interventions for priority and underserved populations using geographic prioritization and KP/gender/age-disaggregated data to target investments more precisely. If precision data weren't available countries were advised to use qualitative data, e.g., HRG assessments, with a reality check on context and social factors.
- Malaria: countries need to use stratification and/or available data to inform prioritization and sub-national tailoring of interventions to maximize coverage and impact.
- HIV generalized epidemic: If KP PSEs are missing, countries should use modelling and available data.
- TB: KVP assessments can support the prioritization of integrated people-centred services.
- Optimize available tools and data for assessing progress/impact. Rationalize surveys within budget constraints.

The TRP said that countries should focus investments on prioritized populations and/or geographical urgencies in line with national strategic plans (NSPs) and normative guidance to achieve Performance Framework coverage targets and avoiding putting priority investments in PAAR. FRs should focus on country priorities rather than just including what they think the Global Fund and TRP want to see. Applicants should explain how they have made trade-offs to ensure value for money.

TRP members felt that there is an ethical concern that not all diagnosed are being treated. Treatment should be prioritized within allocation and progressively funded by domestic resources, avoiding the use of PAAR.

Finally, the TRP urged applicants to focus budgets on programs and avoid excessive program management costs.

Translating grants into impact will not be easy. It will require all hands-on deck across the Global Fund Partnership. There will be an even more acute focus on finding efficiencies and deploying them to the most critical gaps in country programs to achieve impact, including through integrated, more harmonized and joined up implementation arrangements with absolute accountability.

Lesson 1 recommendations for Secretariat and technical partners

Technical partners were told that they should strengthen core technical teams that advise on FRs and program development to ensure fundamentals are adequately prioritized, costed and planned. Partners should assist applicants to manage trade-offs and more rigorously focus resources on appropriately tailored interventions in line with country context and normative guidance.

Technical partners should ensure guidelines are more explicit on what to do when burden and needs are increasing against a backdrop of diminishing resources and share useful tools to help applicants avoid funding being thinly spread (not just say "prioritize").

The Secretariat should review the Program Essentials role in prioritization and guide applicants on how these sit within the context of global normative guidance, NSPs and programs.

The TRP appreciated the Global HIV Prevention Coalition & UNAIDS Decision-Making Aide for Investments into HIV Prevention among Adolescent Girls and Young Women, just published in April 2023, which is a useful prioritization tool; and recommended that this be shared with future applicants.

Lesson 2: Positive shifts in integration but opportunities for improvement

While acknowledging that progress could be seen in several areas, the TRP also saw areas where countries could do better.

Table 3. TRP assessment of positive findings versus missed opportunities

| Positive Findings | Missed Opportunities |
|---|---|
| • Progress seen: FRs better reflecting integration emphasis..<br><br>• The new RSSH annex has potential as a good tool to foster integrated people-centred services, if used well. | • Program Level: More coordination and synergies needed among programs. |
| • Integrated FRs or multiple FRs from same country coming to the same TRP review window are well-received by TRP as they help to visualize where integration is happening or should happen. | • Disease service delivery: Further integration is desirable across three diseases, reproductive maternal neonatal child and adolescent health (RMNCAH), sexual and reproductive health and Primary Health Care (PHC). |

| | |
|---|---|
| • TRP saw positive examples of integration in the following areas: labs optimization, Community Health Workers (CHWs), community-led monitoring for the three diseases, HRG with TB/HIV etc. | • System Level: Supply chain; Data/data management systems. |
| | • Focused portfolios: challenge for integration of HIV/TB programs into PHC while retaining the tight KP focus. |
| | • Missed opportunities for partner harmonization and coordination at country level. Unclear whether/how technical partners are supporting countries on integration. |

Lesson 2: Recommendations for Secretariat and technical partners

Table 4. TRP recommendations for improvement regarding integration

| Applicants | Secretariat & Partners |
|---|---|
| • Ensure services are people-centred: community systems strengthening components (such as CLM) need to be resourced and driven by local communities.<br><br>• Continue presenting integrated FRs. Multiple FRs from the same country should be submitted in one window.<br><br>• Integration presented at FR stage should translate into implementation. CCM must oversee this, liaising closely with MOH and other relevant Ministries and stakeholders, including communities, to develop and sustain integration opportunities. | • Meaningful harmonization and coordination is needed to foster integration within country programs.<br><br>• Further guidance is needed on (i) what to integrate, (ii) where to integrate, and (iii) why (with a focus on outcomes noting integration is not an end in itself). |

Lesson 3: Sustainability concerns and domestic financing for health (DFH)

Table 5. Observations regarding sustainability and DFH

| Observations |
|---|
| |

- Broadly positive commitment to increasing health financing, although this is not consistent across portfolios.

- Inadequate detail in the Funding Landscape Table, with limited visibility of government and external commitments.

- Some encouraging examples of government contracting of civil society organizations (CSOs) and private sector, with room to scale up.

- Examples of planned or concluded blended (joint) financing arrangements, although without timely TRP engagement.

| Recommendations | |
| --- | --- |
| Applicants | Secretariat & Partners |
| <ul><li>Increase focus on domestic resource mobilization.</li><li>In addition, remove regulatory barriers that prevent public funding of local CSOs.</li><li>Specify where government uptake is expected over the next implementation period.</li></ul> | <ul><li>Closely track and provide greater visibility on domestic co-financing commitments and implementation to improve accountability.</li><li>Global Fund to evaluate its existing blended joint financing initiatives and share lessons across the Partnership.</li><li>Secretariat and TRP to urgently agree on the arrangements for the TRP's early engagement on Global Fund's blended financing.</li></ul> |

Lesson 4: Community health workers: positive steps and opportunities

The TRP has seen a significant change in terms of interest and investments in expanding use of CHWs across a range of countries. Some CHW programs addressed people-centred services within and across programs. However, more is needed to improve the harmonization of different CHW cadres.

There have been missed opportunities for aligning CHW programs within the broader Human Resources for Health (HRH) policies and budgets. CHWs continue to fill critical HRH gaps, especially at primary health care (PHC) level. The TRP did see some examples of CHWs being assimilated into national health workforces; however, most CHWs programs are still externally funded.

There were promising examples of health information systems digitalization for CHWs in some countries–enabling better delivery of services and better data to capture service usage. There were also encouraging examples of safer programming for female CHW, considering the risks of gender-based violence and insecurity (consistent with Protection from Sexual Abuse and Harassment principles).

Table 6. CHWs: Positive steps and opportunities

| Recommendations |
| --- |
| Applicants |

- Prioritize resourcing for CHWs to deliver people-centred services within the local context, applying a stronger gender lens and in line with the national HRH policies.

- Adapt CHW programming in line with the WHO Primary Health Care Operational Framework, and other normative guidance. Harmonize CHW remuneration, prioritize integrated training, and supportive supervision where applicable, and provide necessary commodities and ensure safer working conditions.

- Progressively assimilate CHWs into primary health care systems and government payroll.

- Provide mapping of CHWs across all programs and funding sources including the COVID-19 Response Mechanism (C19RM).

- Implement interoperable digitalization of Community Health Information Management Systems to support service delivery, improve quality and monitor impact.

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