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

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 we divided it into two parts: Part I covered the thematic findings and recommendations, and was published in our special Board issue 431 on 13 May; and this is Part II, covering the technical observations and recommendations by disease and RSSH.

TRP Funding Request Quality Survey: Technical observations and recommendations

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 maximizing 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.

The previous article covered the thematic observations and recommendations and can be downloaded here. Now we move on to the technical ones.

Resilient and Sustainable Systems for Health (RSSH)

Lesson 1: Mixed RSSH progress including in RSSH Priority Countries

The TRP made the following observations:

- Integrated FRs provided greater visibility into integration opportunities (regarding service provision, M&E, training, supervision, quality improvement and supply chain) with notable improvements in broader community systems strengthening and laboratory optimization.
- Momentum in private sector engagement including contracting across three diseases, often catalyzed by COVID-19 innovations. However, proposed interventions are often focused on advocacy, with limited attention to reporting, performance monitoring and regulation.
- Some funding requests and Secretariat Briefing Notes provided increased visibility to current and planned COVID-19 Response Mechanism (C19RM) RSSH investments. However, the TRP noted possible risk of duplication between W1 grants and the upcoming second wave of C19RM portfolio optimization.
- There was a mixed quality of the RSSH analyses (some countries conducted the analysis separately by each program) without taking a systems lens and missing opportunities to address cross-cutting RSSH gaps.
- RSSH investments are insufficiently prioritized in allocation budgets especially for primary health care (PHC) level in focused portfolio and challenging operating environment countries. Most investments are in community health workers (CHW), lab systems, and data management systems.

The TRP produced a set of recommendations:

Table 3. Recommendations to country applicants, partners and Secretariat

For Applicants	For Partners and the Secretariat

· Build on the coordination established in developing integrated FRs and mapping investments in the RSSH Gaps and Priorities Annex to strengthen integrated programming. In addition to using the RSSH critical approaches, applicants are encouraged to adapt the WHO Operational Framework for Primary Health Care to prioritize RSSH investments at PHC level. · Applicants planning private sector engagement should develop robust private sector engagement strategies including opportunities for integrated supportive supervision, reporting into NHMIS and capacity building as part of quality assurance/ regulatory framework. · Applicants encouraged to continue to build community systems for health and pay more attention to addressing the broader aspects of CSS as well as increasing and optimizing investments in community health workers (CHWs). Applicants should conduct thorough mapping of RSSH elements in the approved W1 grants and planned C19RM PO Wave 2 as well as future GC7 components that are yet to come for TRP review, and make sure RSSH is really supporting the strengthening of the overall health system (including reforms in terms of governance, decentralized HRH management and financing), and not just providing one-shot or program-specific health system support.	· RSSH mapping and funding landscape analysis across all health systems pillars (beyond the current critical approaches guidance to focus on only three priorities per disease program). This will increase visibility on the gaps and opportunities for complementarity across the entire level of the health system. · Secretariat to consider adapting the program and funding landscape template to help capture RSSH gaps and priorities consistently. · Provide more detailed guidance to applicants on Private Sector Engagement including definitions, best practices and examples of program design, regulatory framework and outcomes. · Secretariat and partners to intensify support on CSS, in line with the existing Global Fund guidance on CSS. Secretariat and TRP to maintain greater engagement on TRP's involvement in C19RM reviews to foster improved visibility across C19RM and GC7 Window 2 reviews to optimize integration and mitigate risk of duplication of investments.

Lesson 2: Progress observed, with effort still needed across several areas

The TRP made the following observations:

- More human rights and gender (HRG) assessments, including the Malaria Matchbox Tool , are being conducted. However, their quality varies, with too few participatory processes and meaningful community engagement. Many assessments were conducted late in the grant cycle, and findings were not used to inform programming and budgeting for GC7 FRs.
- Essential HRG activities continue to be relegated to the Prioritized Above Allocation Request (PAAR).
- There are a lack of coverage targets and interventions for specific populations (e.g., refugees, migrant populations). Key populations (KPs) are often discussed as being 'one' homogenous group without consideration of differentiation between and within KPs including gendered differences.
- The impact of social determinants leading to vulnerablity was often not well articulated.
- Only a few applicants attempted to address the risks to program impact related to the worsening human rights environment, with repressive legislation planned in several countries across regions; and only a few applicants have developed interventions to address the imminent threats to program effectiveness as a result of these worsening human rights.

- The new guidance on adolescent girls and young women (AGYW) released during Window 1 was appreciated and should inform programming. Few AGYW FRs considered intersectionality of risk and the overlapping of AGYW from KPs.
- Data are still not gender-and age-disaggregated (even in HIV) which limits effective prioritization. Some applicants collect this data but do not use or report it at the national level, and it is not referenced in most FRs.
- There was more community-led monitoring (CLM), but with variable quality, and it was unclear if there is meaningful community engagement. Feedback mechanisms are often missing and support for community-led advocacy is absent, under-funded or only found in the PAAR.
- Where differentiated services for KPs are included, some FRs overlook the need to ensure safety and protection for these populations, their clients and civil society organization (CSO) staff (e.g., people who use drugs may need protection when they pick up opioid substitution therapy (OST); peer educators working with men who have sex with men (MSM) need protection where there is regressive legislation).

The TRP's recommendations to both applicants and partners/Secretariat are in Table 4 below.

Table 4. Recommendations to country applicants, partners and Secretariat

Applicants	Partners and Secretariat
· Ensure that HRG assessments (including Malaria Matchbox) are conducted in a participatory manner, early in the grant cycle and that the findings inform programming and budgeting. · Budget HRG interventions in the allocation, as separate modules and/or integrated within HIV, TB and malaria (HTM) and RSSH modules. Avoid placing essential HRG activities in the PAAR. · KP programming should include activities and a budget to protect members of KPs and CSO staff against violence, legal persecution and exploitation. · Consider interventions to address emerging legislative challenges. · Follow recently issued AGYW guidance and differentiate services according to intersections, e.g., for young women selling sex and/or using drugs. · Develop and implement CLM systems in line with normative guidance, ensuring that these are driven by communities, include feedback mechanisms, use data to inform programming and integrate with routine data collection systems	· Ensure that sex disaggregation is mandatory in the Performance Framework, across all diseases in both high and core countries. The lack of these data impacts prioritization, strategic focus, the development of technically sound FRs and weakens value for money. · WHO and UNAIDS need to update normative guidance to request gender and sex disaggregated sex data in all reporting.

Malaria

Lesson 1: Lack of data-informed prioritization in some resource-constrained settings

Observations

An effective strategy for prioritization, which involves sub national tailoring of malaria interventions informed by data-driven geographic stratification, was not completed in all countries.

Recommendations for Applicants:

- All countries' FRs should stive to include a formal risk stratification to be used to inform sub-national tailoring and prioritization of malaria interventions.
- Follow WHO normative guidance and provide accompanying rationale for the scale, type and mix of effective vector control based on the best available data on disease burden, transmission potential, insecticide resistance and trends in intervention coverage.
- Ensure that all at risk populations have access to quality malaria case management.
- Fundings from Malaria Matchbox and other Gender and Equity Assessments should also be deployed where they assist in identifying sub-populations that require additional focus where warranted.
- In resource-constrained contexts where not all at risk populations can be covered by core malaria interventions, it is recommended to prioritize effective vector control and access to effective case management at full coverage in the highest-burden areas to maximize impact on malaria mortality first, and then expand interventions based on sub-national tailoring to lower burden areas with available funding.
- In resource-constrained contexts, the FRs should include a plan to mobilize additional resources to fill gaps so that all at risk populations can be covered by effective vector control and case management at a minimum, followed by expansion of sub- nationally tailored interventions.

For Technical Partners and the Secretariat, the TRP recommended support to all countries to use data-informed risk stratification, sub national y=tailoring and prioritization in their FRs.

Lesson 2: Stagnation and resurgence of malaria cases and deaths in some countries

Observations

Despite continuous investments in malaria control, cases and deaths have been on the rise for the past two funding cycles in many countries. Some countries' FRs have not provided an updated data-driven strategy to reverse these trends – Business as usual in these contexts is unlikely to achieve impact, strategic focus or value for money.

Recommendations

For Applicants:

- All countries with stagnation/resurgence should undertake a situation analysis to better understand the underlying factors, asking for technical assistance where needed. In addition, applicants should better utilize program reviews/mid-term reviews to identify factors associated with sub-optimal progress regularly and systematically.
- The following factors should be considered in the situation analysis at a minimum: changing malaria epidemiology, funding gaps and lags in program performance, trends in core intervention coverage/access, intervention failures, health system and community barriers, as well as natural, human and economic disasters that have impacted malaria program performance, at-risk populations and malaria transmission.
- Results of the situation analyses should be used to inform an updated strategy presented in the FR to reverse these trends and maximize impact in preventing malaria deaths.
- Where resources are insufficient to carry out the full updated strategy, use the principles of intervention prioritization based on data-informed risk microstratification and sub-national tailoring, maximizing reductions in malaria death.

Tuberculosis

Lesson 1: Gaps in more systemic detection of people with DS- and DR-TB, despite investments and expanded strategies

Observations

- Most FRs presented past and planned investments in expanding access to mWRD (molecular WHO-recommended rapid diagnostic tests for TB), diagnostic, digital chest X-ray, TB-HIV collaboration, strong community TB care, active case finding interventions, and private sector engagement.
- However, progress and ambition for the detection of people with TB are lagging. Many applicants provided scant information on TB detection at health facilities.
- More consistent implementation of community TB case finding and active case finding among KPs (children, people in prisons, internally displaced people, migrants, miners, etc.). However, context-specific screening algorithms were weakly presented. While most FRs plan to find children with TB, they present no information on contact investigation cascade including TB preventive treatment.
- FRs rarely described the use of sputum/presumptive TB registers and data use and how data from various strategies of finding ‘missing’ people with TB will be integrated in the analysis of diagnostic cascades and TB information systems. There was missing data on and strategies to address pre-treatment loss to follow-up (LTFU).
- Most applicants plan for HIV-TB collaboration but do not cover other TB comorbidities and social determinants, such as malnutrition, diabetes, smoking, silicosis, etc.

The TRP’s recommendations are:

Table 5. Recommendations to country applicants, partners and Secretariat

Applicants	Partners and Secretariat
· Apply cascade analysis to identify and reduce gaps in various case finding strategies, including TB detection in facilities and sub-national levels to ensure better continuum of care, including: o Where relevant, establish registers of people with presumptive TB integrating data from various entry points and approaches, o Use rates for presumptive TB rate/100,000 population and sputum positivity rates (ie the proportion of people with bacteriologically confirmed TB out of all people with sputum examination results) to better understand quality of TB case finding services by facility and sub-national levels, and; o Establish estimates of pre-treatment LTFU. · Optimize the use of new technologies for better detection. · Adopt data-driven monitoring and supportive interventions for facilities, districts, etc. that are 'falling behind.' · Consider operational research to facilitate a selection of the most appropriate algorithm for screening and linkage to diagnosis and care.	· Support integrated data flow from the community and population-focused interventions of finding 'missing' people with TB to general TB information management system (in health settings). · Support TA and operational research to produce the cascades and define the optimal algorithms to link the community-level and population-focused approaches with TB care. · Advance shaping the market to reduce the cost of all diagnostic technologies and new treatment regimens since the applicants face tough prioritization in the limited budget.

HIV

Lesson 1: Limited programming among KPs with the highest incidence and vulnerabilities

Observations

- There was a positive trend of more attention to KPs across FRs.
- Still, KP programming often lacked:
- Ambition for impact (e.g., low targets of pre-exposure prophylaxis (PrE)P among MSM, PrEP often in PAAR, low scale or pilot OST),
- Differentiation to diverse (sub)populations (e.g., trans and gender diverse populations, sub-groups of people who use drugs [PUD]); and insufficient attention to the inter-sections between (sub)populations (including AGYW),
- Adaptations to complex policy environments and major gender inequalities, alignment with guidance for evidence-based opioid substitution therapy, strategies to address viral hepatitis among PUD and other populations.
- Limited precision of programming among AGYW using HIV incidence data and weak prioritization of those from KPs and with intersectional vulnerabilities.
- Some countries planned approaches to address barriers to PrEP uptake and diversify PrEP options, though missed opportunities to include vaginal Dapivirine and PrEP for pregnant and breastfeeding women remain.
- Several applicants delay adoption of key documents to inform strategic programming, establish packages of combination prevention and increase their sustainability.

Lesson 2: Uneven progress to address gaps in HIV cascades and care, despite improved data

Observations

- Most countries adopted or plan adopting the UNAIDS targets of 95-95-95. Some countries with generalized epidemics show improving cascades. However, some other applicants continue to struggle with particularly poor cascades and insufficient plans to address challenges at each stage of the cascade.
- Some applicants continue to delay normative guidance such as WHO-recommended testing and diagnostic algorithms, decentralizing antiretroviral therapy from tertiary or secondary care and insufficient planning for higher-scale viral load testing.
- Countries continue progressive use of multi-month dispensing and other differentiated service delivery approaches. However, few set up effective systems for preventing loss or reaching LTFU and measuring/addressing treatment adherence.
- Several FRs lacked strategies for addressing HIV care gaps among children, KPs and/or prevention of mother-to-child transmission including through greater integration with reproductive, maternal, neonatal, child and adolescent health, sexual and reproductive health and rights, TB and primary care.
- Applicants–even those close to 95-95-95-often missed opportunities to address advanced HIV disease (AHD), including co-infections and non-communicable disease integration.

The TRP's recommendations are:

Table 6. Recommendations to country applicants, partners and Secretariat

Applicants	Partners and Secretariat

· Increase focus on quality of KP programming, notably for PUD, engaging them to adapt to complex environments and gender inequalities. · Update AGYW programming prioritization and packages using HIV incidence data in line with the new guidance from the Global HIV Prevention Coalition. · Follow national strategic plans and national guidelines in developing FRs, ensuring sustainability and visibility of country-owned national priorities to external partners including the Global Fund. · Reinvigorate focus on quality of care, treatment adherence, reaching those lost-to-follow up, and longevity, in addition to 95- 95-95 targets.	· Provide TA to countries to address challenges preventing progress towards 95-95-95 targets, especially in countries with weak points in their cascades, some concentrated epidemics and among underserved populations; · Support visibility and provide TA to address treatment adherence, and longevity. · For the Global Fund, technical partners and other major donors align messages, and funding policies on diversified PrEP delivery options, AHD, CD4 and management of coinfections/comorbidities in restrictive funding environment. · Support countries to update HIV diagnostic algorithm especially in the context of the changing epidemic.

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