Technical Review Panel's observations and recommendations on Window 2 funding applications: Part II

On 17 July 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 2 (W2).

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 was published in GFO 435; you can read it here; and Part II, the focus of this article, covers the technical observations and recommendations by disease and resilient and sustainable systems for health (RSSH)

Countries applying under Window 3 have just submitted their FRs, on 21 August. It will be interesting to see if the TRP feedback on the first two Windows has been observed in this latest round of applications.

TRP Funding Request Quality Survey: Technical Observations and Recommendations

Equity, Human Rights and Gender (HRG)

Observations	Recommendations

- Overall, the TRP observed more FR narratives recognizing structural barriers to care and acknowledging that it is critical to address HRG barriers in order to reach the last mile across all three diseases.
    - Increased number of assessments (including Malaria Matchbox, gender assessments) although assessments are not yet consistently being used to inform programming, M&E and budgets. Deliberate effort in malaria programming to integrate equity/HRG considerations.
- Hostile legal environments observed in an increasing number of countries (includes conflict, new or increased enforcement of laws criminalizing lesbian, gay, bi, trans, and queer (LGBTQ) populations, stigma, barriers to registration, harmful norms) – risking fragile gains made.
    - The TRP drew on the community annex to provide context on community engagement and found it to be a useful supplementary tool.
    - Legal response mechanisms in several countries were key to mitigating the impact of stigma and hostile environments.
- Many countries indicated gender-based violence (GBV) as one of key gender-related barriers to services. Stronger linkages to GBV services continue to be proposed but not sufficiently budgeted for in allocation.
    - Normative guidance is lacking related to intersection of disease and GBV, particularly in conflict.
- Many countries showed strategic focus on key populations (KPs), yet intersectionality among key and vulnerable populations (e.g., young KPs, male sex workers, women who use drugs, KPs among refugees or in prison) is poorly addressed with tailored interventions. Many TB programs strengthened access to services for incarcerated people.
- Several countries with momentum around updating and harmonizing their community health worker (CHW) program; but untapped potential to further mainstream equity, HRG perspectives (e.g., equitable compensation for CHWs, better gender balance among cadres to reach more women, and empowerment of KP CHWs) which add to the sustainability and impact of the community health programs.

- Overall: Technical Partners and Secretariat should continue supporting countries with gend and/or human rights assessments and the Mala Matchbox. Applicants should ensure findings of these assessments inform their FRs, budgets a program implementation.
- Hostile Environments: Technical partners and Secretariat should support advocacy to mitigate the impact of hostile environments. Secretariat should consider emergency funding for civil society advocacy and community-led interventi in hostile environments (taking into account participation in Country Coordinating Mechanis and other processes might not be possible).
- The Secretariat should continue to strengthen t community annex tool and process, and consid its inclusion in FR packages. In-country partner should lead on identifying the emerging needs hostile contexts.
- Applicants should invest in community-led monitoring (CLM) to ensure a quick response to rights violations in rapidly- changing contexts.
- GBV: Partners should support applicants to strengthen GBV linkages (policy, financing, and service provision) at country level; and actively explore the development of new normative guidance at the intersection of diseases and GI particularly in conflict.
- Intersectionality and differentiated programming Applicants should ensure tailored interventions address such critical interventions for maximizi impact. Secretariat and technical partners need foster further support for intersectional programming and budgeting.
- CHWs: Applicants should undertake and/or util existing equity, human rights and gender analys to inform updates to CHWs programs.
- Budget allocation: the Secretariat should suppo Applicants to allocate adequate budget for removing gender and human rights-related barriers and invest in structures and systems which support larger budget allocations to this critical area of funding. The BDB Strategic Initiative and Matching Funds should be further scaled-up.

Malaria

Observations	Recommendations
• Funding gaps: Significant challenges in funding core treatment and prevention. • Data use: Better use of country data for prioritization and targeting of interventions, such as conducting a detailed sub-national analysis of the epidemiological trends in malaria and intervention coverage, used to inform the FR. • Allocation misalignment: Large increases in malaria burden in some countries due to natural and man- made disasters which will take time to reverse. Country allocation amounts did not appear to account for these situations. • Pre-referral rectal artesunate suppositories (RAS): Positive examples of countries including pre-referral RAS, but some FRs did not demonstrate a strong referral system for severe malaria, as per WHO recommendations. • Indoor residual spraying (IRS): High burden countries with gaps in vector control shifting from IRS to effective insecticide treated nets (ITNs) to cover more of their high-risk populations. Yet some high-burden countries continue to use IRS over next- generation ITNs even where large gaps of vector control coverage exist. • Elimination: In some elimination settings, inadequate timely foci response in case-based surveillance implementation, which is not aligned with WHO elimination guidance	• Applicants should follow the latest WHO guidelines for management of severe malaria, including establish / supporting a strong referra system for severe malaria in remote settings where pre-referral RAS is used. To be clearly articulated in FRs. • In resource constrained settings in high-burden countries where large gaps exist for vector control, countries may consider replacing IRS w effective ITNs, with a focus on maximizing coverage and use among the highest risk populations. TRP recommends applicants inclu a strong justification in their FRs for their use of IRS in these contexts. • Applicants should work with technical partners focus on building sufficient capacity and humar resources to implement complete foci response in countries that are in the elimination phase, following WHO recommendations. • Secretariat and Partners should review their allocation methodology to include factoring in more recent epidemiological contexts. • The Secretariat should consider coordinated regional funding approaches to help address th increasing malaria burden as a result of natural and man-made disasters, including accounting population movement across borders.

HIV

Lesson 1: Epi analysis

Observations	Recommendations

• Inconsistent information on distributions of HIV by population and geography. • Epidemiological, integrated, and biobehavioural surveys often not current or inclusive of all populations, resulting in inaccurate population size estimates (PSEs). • Cascades which were not sufficiently disaggregated to cover relevant populations (e.g., finer age disaggregation). • HIV prevention cascades were often missing. • Lack of data on main co-morbidities (non-communicable diseases including mental health, co-infections).	• Applicants should ensure that biobehavioral surveys and PSEs are current and cover all populations and that these data are used to gui program implementation. • Applicants should analyze the distribution of HI by population and geography, looking especiall at the burden of disease and coverage of interventions. • In cases where data is missing from the pre-fille Essential Data Tables, Applicants are requeste to provide the missing data. • Partners should support better cascade analys ensuring that HIV prevention cascades are performed and that cascades are sufficiently disaggregated by age.

Lesson 2: Poor performance on paediatric and adolescent HIV management

Observations	Recommendations
• Insufficient understanding and progress in closing the paediatric cascade, especially in the use of finer-age disaggregation to better tailor interventions. • Inadequate attention to adolescent HIV, insufficiently considering the complexities of treatment and adherence in these populations.	Applicants: • Renew a focus on children and adolescents livi with HIV: from testing, to treatment, adherence viral load testing and suppression. These shoul be linked to PMTCT and maternal and child hea services. • More quickly adopt new normative guidance on paediatric treatment. Consider the new dosing recommendations in forthcoming guidelines to facilitate faster adoption of recommended dolutegravir (DTG) regimens. • Partners and Secretariat should work with applicants to accelerate uptake of normative guidance.

Lesson 3: Exclusion of some KPs in HIV interventions

Observations	Recommendations to Applicants
• Some KP groups were excluded in surveys or from differentiated services funded by the allocation, particularly in countries with repressive legal environments.	• Based on epidemiological context and vulnerability, ensure inclusion of interventions a budgeting for all relevant KPs in line with WHO Consolidated Guidelines for HIV, Hepatitis and Sexually Transmitted Infections for Key Populations. • Enhance the inclusion of all key and vulnerable communities in HIV service delivery, surveys, a evaluation, addressing their unique needs.

Lesson 4: Treatment optimization

Observations	Recommendations
• Variations in regimens being used for second line HIV treatment. • A lack of progress on the introduction of DTG (a cheaper option than protease-inhibitor based regimens) as second line treatment. • Lack of progress on the treatment of some opportunistic infections, such as cryptococcal meningitis.	• Applicants should follow and adopt treatment guidelin aligned to WHO normative guidance using DTG as 2n line, which has a cost benefit. • Partners and Secretariat should work with Applicants t accelerate uptake of normative guidance, with urgency when there is a cost benefit that will allow funding mor interventions now in the Register of Unfunded Quality Demand.

Lesson 5: Challenges in sufficient differentiation and adaptation of HIV interventions

Observations	Recommendations

• Lack of differentiation for Adolescent Girls and Young Women (AGYW): different age groups, different geographies, and different profiles to help target interventions. • Not enough details on how applicants were undertaking differentiated service delivery (DSD). • Interventions like PrEP, and HIV self-testing proposed without details on how they would be adapted based on epidemiological context and populations.	• Adopt normative guidance (e.g., from the Globa HIV Prevention Coalition) to improve targeted interventions for AGYW. • Provide more details in FRs on DSD provision based on population and geography. • Adapt service delivery for interventions, considering, e.g., HIV risk level, vulnerability to HIV, accessibility, and user preferences. Adher to normative guidance, especially for PrEP.

Tuberculosis

Lesson 1: As under Window 1, DS- and DR-TB detection still lagging behind

Observations	Recommendations
All FRs included modules and interventions to expand detection – and demonstrated more action to: • Find more children, adolescents and men with TB. • Enhance TB detection in advanced HIV disease (and more widely in: services to reduce the TB burden in people living with HIV (PLHIV); in intensified TB case finding in HIV care; and in scale-up of TPT among PLHIV). • Ensure strong TB detection in health facilities in addition to community level activities. • Aim towards nation-wide case finding and ensure quality implementation. • Ensure support of community health/TB activities; laboratory and commodity supply; linkage to treatment initiation; and people-centered care. • Reach out to (remote) rural areas; urban slums were frequently covered though not at scale. • Monitor progress and make sure to targets were met.	For Applicants: • Strengthen the introduction and implementation all recommendations of the revised (2022) normative guidance on child and adolescent TB invite technical support when necessary. • Systematically use stools for WHO-recommend rapid diagnostics and urine for TB-LAM (Lipoarabinomannan). • Target interventions to the 'right' geographies a populations to optimize yield. • Consider access-related barriers to case finding (e.g., stigma, discrimination, distance, user fees transport costs, etc.) • Monitoring and evaluation: see W1 Lessons Learned (e.g., on better use of cascade analysi for monitoring continuum of care, support of integrated data flow) For partners: • Consider engagement with the UNICEF agenda for action on childhood TB.

Lesson 2: Need for continuous quality improvement in TB care for better treatment outcomes

Observations	Recommendations
Many FRs recognize need to reduce deaths and loss to follow-up and not evaluated among: • People with DR-TB and PLHIV with TB. • Adolescents with TB. • A limited amount of information was seen about management of adverse drug effects, especially among people with DR-TB.	For Applicants: • Shorten treatment regimens and use child-frien preparations, ensuring that drug-safety is monitored and managed. • Ensure that person-centered care and adheren support is provided. Consider using digital adherence technologies. Recognize the need f 'youth-friendly' services for adolescents with TB • Find out root causes for undesirable outcomes these are not yet known and develop approach to address them. • Expand meaningful interventions to reduce stig and out-of-pocket costs and to increase social a nutritional support, etc. For partners: • Support applicants in their efforts to maximize T cure and treatment completion to prevent development of drug resistance. • Support cascade analyses of case holding.

Resilient and Sustainable Systems for Health (RSSH)

Lesson 1: Limited progress on health sector reforms to promote Integrated People-centred Quality Health services

Observations	Recommendations to Applicants

• RSSH indicators in the performance framework were still inadequate to measure progress; RSSH assessments were limited to quantitative data, making the context difficult to assess. • While noting difficulty of governance reforms, some key governance and stewardship issues were often under-addressed in FRs, except for support for planning and meetings. • Missed opportunities for countries to integrate the various RSSH-related applicant guidance materials into program design and for them to learn from their peers. • Limited information in FRs showing that evidence-based policy making was based on systematic evidence or that health system reforms were addressed. • Need for greater attention to Value for Money (VfM) and efficiencies in the prioritization of interventions.	• Applicants need to prioritize activities to catalyz governance and stewardship reforms consideri programmatic and country context, make use o normative guidance and support from technical partners, and track actions with accountable an effective outcomes (e.g., addressing personnel gaps, quality of care, etc.). • Applicants need to use key annexes (RSSH Ga and Priorities Annex, Funding Landscape Table and Programmatic Gap Tables) as tools to asse system-wide gaps (both programmatic and financial) to inform and prioritize their interventions. This will improve the VfM of their requests. • Applicants are encouraged to refer to case stud from good practices for RSSH interventions and use simple resources which summarize operational guidelines, such as the VfM one-pa • The Secretariat should develop more indicators qualitative assessments, and workplan tracking measures for RSSH (including on critical approaches) which can be included in the fundi request narrative, Performance Frameworks an Essential Data Tables for GC7. • Partners should support countries in reforming health systems governance, strengthening thei ability to capitalize on experience and learning, and basing policy-making on this evidence.

Lesson 2: Encouraging signs to include health financing module, but continued incomplete information on co-financing, funding landscape and social health insurance

Observations	Recommendations

• Incomplete information on Applicants' financial contributions/funding landscape. • National Public Financial Management (PFM) systems were often underperforming, reducing the opportunities for use of domestic systems by donors – further weakening the PFM systems. • Some requests had "Health Financing" modules. Unfortunately, these were often weak and unambitious. • Many countries adopted primary health-care (PHC) or universal health coverage (UHC) objectives, but social health insurance implementation was found to be lagging in many. Difficulties were seen in many FRs on integrating HTM into service/benefit packages. • Inconsistent level of quality and degree of information in funding landscape tables and RSSH Gaps and Priorities Annex making it difficult to assess for potential duplication of efforts and progress in domestic financing and co-financing. • Progress in some transition portfolios in how Applicants detailed key elements of sustainability (Financial: increased domestic financing. Programmatic: support to programs, transition and sustainability plans). However, operational plans were still missing on investments in areas such as human resources for health and for health products.	• Applicants should strengthen their PFM system to monitor health expenditures, including for HT • The Secretariat should support countries to gat and prepare a more complete financial landsca with visibility on how Global Fund spending sits alongside other external and domestic spendin a country. This should include RSSH investmer across all building blocks. • Partners and the Secretariat need to support applicants with integrating HIV, TB and malaria into PHC service and UHC benefit packages. • The Secretariat should provide the TRP with improved information on realization of co-financing commitments and domestic financing disease programs to enable the TRP to make a informed decision and help leverage and orient financing towards impactful interventions. • Partners and the Secretariat should support Focused and Transition portfolio countries with developing detailed analyses on key elements sustainability, with detailed operational plans or sustainability and transition that include the broader health systems and not just KPs and c society.

Lesson 3: Early-stages integration in PHC noted, but still a long way to go

Observations	Recommendationsto Partners and the Secretaria

• The TRP saw evidence of early-stage integration of PHC in some countries, but notes that mostFRs provided limited details on integratingdisease-specific service delivery into PHC. • An encouraging shift was seen towardsintegration of CHWs but missed opportunitieswere noted to address CSS as a holistic approach(e.g., civil society capacity building, CLM,community engagement and coordination, leadership building). • Many countries faced important challenges related to human resources for health (HRH) including shortages, quality, and donor dependency for in-service training and supervision. Limited examples were seen of the Global Fund or Partners supporting the strengthening of HRH in a comprehensive and sustainable way.	• Support a continued focus of applicants on integrating disease specific interventions into P • Address missed opportunities to strengthen all elements of CSS (especially CLM) and focus o linking programs with health systems as complements and not as replacements • Support applicants in developing comprehensiv plans for HRH including conducting labour mar analyses and developing human resource management systems to inform future HRH reforms towards programmatic impact and sustainability.

Lesson 4: Some progress on HMIS, LMIS and HPMS noted, but critical challenges remain

Observations	Recommendationsto Partners and the Secretaria

• Progress on use of data to plan interventions (especially with integrated health management information systems (HMIS) supported by C19RM), but data quality gaps continued. • Limited progress on the integration/interoperability of HMIS, Logistics Management and Information Systems (LMIS), and Human Resource Information Systems (HRIS)). • Focus and investment on supply chain management (such as HPMS supported by C19RM), but challenges persisted on procurement, regulatory capacity, stock management, warehousing capacity, information systems, and transportation (especially last-mile delivery [LMD]). Supply chain strategic plans of varying quality or absent. Evidence of increased investments in laboratory systems (such as sample transport, quality assurance, human resources, and logistics). These were largely complementary to investments supported by C19RM. However, limited evidence of having been informed by gaps analyses or detailed strategic plans.	• Technical Partners and the Secretariat should provide enhanced support to countries on using data to inform program decisions. • Technical Partners should support countries to accelerate the data integration process for their information management systems, including HMIS, LMIS, HRIS, and HPMS. • Technical Partners and the Secretariat should provide additional support to countries on supp chain strengthening. This support should includ focus on LMD and on using evidence-based prioritization to prevent stock-outs. • Technical partners should support countries wit performing laboratory system gaps analyses to inform strategic plans and build towards effecti laboratory systems which can better support th disease programs. • The Secretariat and Partners to provide further structured guidance on supply chain management, to help inform country-level supp chain management plans. This includes Global Fund policy guidance on infrastructure investments such as warehouses. • The Secretariat and Partners should work to identify ways that investments in health system strengthening can benefit from the use of count led and sustainable pooled procurement mechanisms.

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