Independent observer of the Global Fund

Global Fund Observer

NEWSLETTER

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CONTENTS OF THIS ISSUE:

Regional support partners of the RBM Partnership to End Malaria and the Global Fund organized a three-day workshop to prepare countries eligible for malaria funding, their partners, and consultants who will support these countries for the Global Fund application process for the 2020-2022 allocation period. During the meeting, the countries were guided on the application process, tools and timelines for the 2020-2022 funding cycle, to allow for forward planning.

4. NEWS: Global Fund and Germany's development agency train four countries on Resilient and Sustainable Systems for Health

BY IDA HAKIZINKA AND DJESIKA AMENDAH

The Global Fund and the German development agency GIZ's Back-Up Initiative, along with the Heidelberg Institute of Global Health, have delivered a training for four countries in writing funding requests to the Global Fund for Resilient and Sustainable Systems for Health, for the 2020-2022 grant allocation period. The training's main message was to encourage countries to adopt 'systems thinking' to address health-systems issues. Participants recommended that the training be scaled up.

5. ANALYSIS: Some key HIV interventions for adolescents and youth overlooked in funding request to the Global Fund for 2017-2019 funding cycle

BY SAMUEL MUNIU

The Global Fund aims to reduce HIV incidence by 58% in 13 high-burden countries in eastern and southern Africa by 2022, which will necessitate drastic reductions in HIV incidence among adolescents and youth. In their funding requests to the Global Fund during the 2017-2019 funding cycle, eastern and southern African countries prioritized social and sexual behavior change and social protection interventions within their HIV prevention activities for adolescents and youth, while pre-exposure prophylaxis was the least prioritized HIV intervention within this group. However, none of the selected countries included some interventions specifically targeting adolescents and youth, as UNAIDS' 'standard service package' recommends. Without these, countries are unlikely to reach their HIV reduction targets for adolescents and youth.

6. ANALYSIS: UNAIDS technical support identifies human rights, gender barriers and strengthens Global Fund grants

BY GEMMA OBERTH, KITTY GRANT AND ANDREA BOCCARDI

Since 2018, UNAIDS' Technical Support Mechanism has supported 32 human rights and gender assignments in 18 countries. Helping countries to roll out the new People Living with HIV Stigma Index 2.0 and the gender assessment tool have been core focus areas. Results have helped countries generate evidence, respond to findings from the Global Fund's Technical Review Panel and Office of the Inspector General, and strengthen Global Fund grant implementation.

7. ANALYSIS: Addressing low retention-in-care rates among people living with HIV in West and Central Africa – a literature review

BY DR PHILIPPE MSELLATI

In West and Central Africa, 47% of people living with HIV (nearly 18 million people) are not having their viral load monitored, and of these, 8 million are unaware of their HIV status. Around 24 million people have had access to antiretrovirals, but this number includes all those who have had initial contact with the antiretroviral distribution system, and does not reflect the actual number of people adhering to treatment or those being monitored at regular intervals. In large African cities, retention in care can be lower than 50% after 24 months. To remedy this, it is necessary to understand why people stop taking their treatment. This article reviews the literature around potential reasons for discontinuing care and how effective the solutions to remedy this have been, to date.

TOP

ARTICLES:

1. COMMENTARY: Is the Global Fund's principle of country ownership at risk?

Some implementers consider the Secretariat's strong influence in the development of funding requests to threaten countries' determination of their own solutions

Aidspan Staff **29 January 2020**

Since its creation, the Global Fund to Fight AIDS, Tuberculosis and Malaria has embraced four principles: partnership, country ownership, performance-based financing, and transparency.

Ownership, as stated by the Paris Declaration on Aid Effectiveness, indicates that "countries set their own strategies". The Global Fund's definition of country ownership "means that people determine their own solutions to fighting these three diseases, and take full responsibility for them. Each country tailors its response to the political, cultural and epidemiological context".

In 2013, Aidspan expressed the view that although country ownership appeared in the Global Fund's documents, in practice, the Secretariat, heavily and unduly, influenced the selection of Principal Recipients and the selection of activities funded by the Global Fund grants. This was the case under the previous, rounds-based funding.

Sadly, seven years later, many years into the 'new' funding model (post-rounds-based) in the 2020-2022 allocation cycle, the situation remains the same, judging by the allocation letters and their annexes that the Secretariat has sent to countries, as well as views expressed to Aidspan by some of these implementing countries.

Prescriptive allocation letters

In the many allocation letters seen so far by Aidspan, the Secretariat has provided details of implementation mechanisms, including where it wanted a country to change its Principal Recipient and the types of activities that the future grant should fund.

For example, the following extract from one allocation letter:

"In the HIV allocation […], there is $30 million designated by the Global Fund for key and vulnerable population (KP) needs, to be managed by civil society actors. These funds are to be invested in the consolidation and expansion of programs targeting KPs and Community-led efforts to maximize achievement of 90-90-90 for HIV and TB".

Currently, in many countries, the Global Fund country team participates in country dialogues, which are supposed to be national and inclusive forums for stakeholders collectively to think through issues and choose activities that could maximize the impact of Global Fund grants. In contrast, when the Global Fund was funding countries through its rounds-based system (up until 2013), the Secretariat was not allowed to engage with a country during the application process, as countries' proposals were competing with each other, but only did so as part of the 'administrative review' of applications, which checked that countries had submitted all the required documents, their applications were considered complete, and faciliatedTRP clarification processes prior to the grant's approval by the Board.

Some countries work within a tight deadline in preparing and submitting their grant proposals, which may negatively affect the quality of the funding requests. For this allocation period (2020-2022), countries received their allocation letters in the third week of December 2019. Many will submit their proposals in the first application window, for which the deadline is March 23, 2020. These countries have to organize their country dialogues and submit the first draft of their proposals to the Secretariat by the first week in February.

These proposals should rely also on National Strategic Plans for the different diseases and the health sector as well as reliable epidemiological, economic and social data. (For this allocation cycle the Secretariat has provided countries with a data set regarding the 3 diseases and the health system; we are not sure if countries were consulted during the process of creating their respective data sets.) The proposals are also sent to the Mock Technical Review Panel (TRP) organized by financial and technical partners like the RBM Partnership to end Malaria, or the Joint United Nations Programme on HIV/AIDS (UNAIDS) to help improve the quality of the submission.

The final proposals submitted to the Secretariat undergo several iterations between the country coordinating mechanism (CCM) and the Secretariat, until "everyone is happy with the quality of the proposal," as it was explained to Aidspan.

Countries also need to prepare and get organized in a timely manner

In fairness, it is worth mentioning that national officials in the CCM, Ministry of Health or other line ministries that are Principal or Sub-Recipients of the grants know that the Global Fund grants run on a three-year cycle and are also aware of the principle of country ownership. Thus, national strategic plans for the different diseases – and other data needed to select interventions and document them – should be ready by the time the Global Fund sends the allocation letters. In addition, most countries resort to the services of consultants to help them write their funding proposals. Those consultants' fees are often paid using partners' resources, making the consultants open to funders' "suggestions".

In some cases, the absence of national strategic plans and reliable data leaves room for a Global Fund Secretariat, bent on obtaining results, to fill the perceived vacuum (for example, including for the first time the country-specific data sets sent to countries along with their allocation letters).

Too much prescription may backfire

A member of a CCM expressed to Aidspan that those "iterations [after submission of funding requests to the Secretariat] are tiresome," and, he added, referring to Secretariat country team members, "at the end it is their money, they should do whatever they want with it."

Another government official, obviously unhappy with the extent of the instructions his country received from the Secretariat, told us that "they should come and write the proposals as they have already decided on the country priorities".

The Global Fund Secretariat is intent on serving countries' best interests by ensuring that Global Fund grants are used to achieve optimal impact, and at the same time must deliver results to the Board and to all within the Global Fund Partnership. It is therefore vital for the Global Fund Secretariat to help set directions in order to ensure that countries use the grants in the best possible ways to fight the epidemics. What is at issue is how to do this without being over-prescriptive.

No one in the Global Fund partnership wishes to compromise the principle of country ownership and put the effectiveness of the fight against the three epidemics at risk.

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2. INTERVIEW: "Ethics at the Global Fund means advancing our mission of ending the epidemics"

The Global Fund's first Ethics Officer explains ethics at work across the Global Fund partnership

Adèle Sulcas **28 January 2020**

Ethics is a cornerstone of the Global Fund. The Fund's creation was intrinsically an ethics-based decision writ large: the world's answer to the ethical question of how to enable equitable access to life-prolonging care and treatment, for those living with the world's three biggest killer infectious diseases, to those who previously did not have such access.

But ethics for the Global Fund did not stop with its creation or implementation of its first round of grants. The Fund faces a range of ethical dilemmas on a daily basis, from the highest strategic level to the most concrete, daily operational level: How should investments be split between prevention and treatment? Should they be allocated equally across all people affected by the diseases or invested where they will save the most lives? Will people

receiving funds be objective in deciding how those funds are spent? How does the Global Fund use patient data responsibly to inform programming? Should the Global Fund partner with organisations whose products might harm health if misused? Should a life-saving programme be suspended if the implementer is unable to dispose of medical waste safely? These are just a sampling of the daily ethical challenges the Fund faces.

The Global Fund Board adopted an Ethics Policy in 2002, shortly after its creation – what the Fund called its first "standard guidance to address the need of managing the diverse interests of its decision-makers". It introduced the Ethics and Integrity Initiative in 2014. One product of that initiative was the creation of the Ethics and Governance Committee in 2016, and then the establishment of the Ethics Officer role, with Nick Jackson starting as the Fund's first Ethics Officer in May that year. Prior to that, some ethics work had been carried out by the Legal department.

The GFO sat down with Nick Jackson to begin exploring the role of the Ethics Office across the Global Fund partnership. What follows is an edited transcript of that interview.

GFO: How would you define 'ethics'? What comes to mind when you are asked to identify examples of 'ethical' and 'unethical' behaviours?

Nick Jackson: Ethics are central to the decision-making process and oversight. The definition of 'ethics' is the process of working out the right thing to do in a given situation. It's about how we make decisions. We need to apply a range of moral principles – what are the rules, what do our internal virtues tell us, and what will be the consequences of the decision?

Ethics comes from the Greek work 'ethos', which roughly translated means what is acceptable in our society. This raises the challenge that ethics is dynamic, as society's expectations change – think about the #MeToo movement and Extinction Rebellion. Ethical norms can also vary widely based on geography, beliefs, etc. We operate globally, so we have to be agile in developing our standards, confident in applying them in contexts where there may be very different norms of behaviour and at the same time sensitive to that context.

> *"To reach and maintain high standards of ethical conduct, the Global Fund's core ethical values must be fully integrated into its culture and activities, including its grant programs, and complied with by all entrusted with Global Fund resources and/or responsibilities."*
>
> - From the Global Fund's Ethics and Integrity Framework

GFO: The ethical concept behind the Fund's creation is clear, but how does 'ethics' get put into practice at the Global Fund?

Nick Jackson: The ethics programme was established to embed the Ethics and Integrity Framework into the Fund's day-to-day operations and decision-making. The programme has been in place since 2016, is facilitated by the Ethics Office, and focusses on training and awareness-raising, impartial advice on Codes of Conduct and ethical dilemmas faced by stakeholders, integrity due diligence [see next paragraph], conflict-of-interest management, setting standards and policies, and responding to misconduct. It works across the Board and Committees, Secretariat and in support of our grant operations.

Firstly, we want to work with people and organisations who commit to ethics. To help this we have embedded a program of integrity due diligence where we look at the track record of individuals and organisations we are considering working with, so that decision-makers can be well informed about the integrity risks they are taking on.

Secondly, a key enabler of ethics is a 'fearless' but respectful culture where everyone can contribute fully, confidently put their views forward, call out breaches of our Codes of Conduct and respectfully debate the challenging topics that we have to deal with. Given our wide national, gender and professional diversity we need to make sure we hear all the voices in the room. Our attitude also needs to be outward-facing and forward-looking so that we are able to consider the broad range of factors which will need to be in place to get us to 2030.

Thirdly, we need appropriate risk-based programs for specific ethical risks. The first thing that comes to people's minds when asked about ethics is often headlines about 'unethical' behaviour by individuals or organisations. This can sadly be a long list: corruption, conflicts of interest, child labour, abuses of power, sexual exploitation, leaks of personal data, irresponsible promotion of products that can harm health, and environmental damage have all been reported as 'unethical'. We collaborate with the Risk department and others to make sure that the Global Fund broadly addresses these in a prioritised way. For example, to protect the independence of decision-making we have conflict-of-interest processes in place for the Board, the Technical Review Panel (TRP), the Technical Evaluation Reference Group (TERG), the Secretariat, and CCMs. To prevent conflicts of interest turning into corruption the Ethics Office adds to the already strong anti-corruption framework in the Global Fund by providing training and advice on good-practice anti-corruption controls. We are also continuing to strengthen the framework for preventing abuses of power and all forms of harassment.

Finally, and most importantly, we need a framework for including ethical considerations in decision-making because rules alone are not enough, especially where there is more than one 'right' answer. A framework for ethics in decision-making encourages us to consider all stakeholders, balance consequences with rules, consider long term vs. short term impacts, etc. All of this must be tested against the impact on the mission and broader achievement of the SDGs."

GFO: What effect has the 2019 Office of the Inspector General audit of the ethics and integrity framework had on the role or functions of the Ethics Office? And, looking

forward into the Global Fund's near future, what do you see as areas of development for the Ethics Office?

Nick Jackson: There is plenty more still to do. The 2019 OIG audit of the ethics and integrity framework identified areas to focus on going forward – completing the build-out of the frameworks for key topics such as abuses of power and anti-corruption, further clarifying responsibilities and accountabilities for the broader range of ethical risks, and updating Codes of Conduct. The audit was a positive learning experience for all involved. However, we need to be careful as there are widely varying expectations about how much the Global Fund can and should do. Ethical standards are like setting a speed limit – most good people will try to observe the speed limit. However, some of our stakeholders will expect us to put a few speed bumps in place, whereas others will expect us to put an officer on every corner with a speed camera. We need to have a mature conversation about risk prioritisation, accountabilities and the extent of our influence as we continue to roll out the programme. That said, I'm really looking forward to getting stuck into these further improvements over the next 12 months and beyond. Grant implementation is an area we need continued focus on given the nature of our relationship with implementers - it's early days in assessing and influencing their ethics and compliance programmes. Many already have strong programmes in place, but others less so. The ethics work relating to CCMs is a starting point.

To be successful in our mission of ending the epidemics by 2030 everyone in the Global Fund partnership needs to live our values and consider ethics in their decisions and actions – with the acid test being 'does my behaviour or this decision move us closer to ending the epidemics by 2030 and closer to SDG3?

GFO: You've outlined several main areas in which the Ethics Office has put concrete processes in place; at a more conceptual level, how would you describe the role of the Ethics Office?

Nick Jackson: The Ethics Office is at the service of the Global Fund's mission, and the work it undertakes aims to advance the Global Fund's strategic objectives. In practice, this means that the office is a resource to support individuals in considering and taking the most appropriate action or decision in their Global Fund roles, and in integrating an ethical mindset into their work. Ethics for me is about setting and raising the bar for our conduct and our decision-making. We want to make sure that no-one falls below the bar, but we also need to keep raising it.

Editor's note: For comments or ideas related to ethics or related topics you would like to see covered in the GFO, please contact ethics@theglobalfund.org or adele.sulcas@aidspan.org.

Further reading:

- *Global Fund Ethics and Conflict of Interest policy*
- *Global Fund Codes of Conduct (for recipients of Global Fund resources, suppliers, CCM members, and governance officials)*

- *'OIG Audit: Managing Ethics and Integrity at the Global Fund'(GF-OIG-19-016, 18 September 2019)*
- *Commitments made by Gavi, the Vaccine Alliance, and the Global Fund to address sexual exploitation and abuse and sexual harassment*

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3. NEWS: Workshop prepares countries and consultants to apply for Global Fund malaria funding for the 2020-2022 cycle

43 countries expected to submit malaria funding requests in the first two application windows

Ann Ithibu **28 January 2020**

A workshop to prepare countries that are eligible for Global Fund malaria funding in the 2020-2022 funding cycle, their partners and consultants for the grant application process, was held from 10 to 12 December 2019 in Nairobi, Kenya. This workshop came at a time when 43 countries were preparing to submit malaria funding requests to the Global Fund in the first two application windows, which have closing dates of 23 March and 25 May 2020 respectively.

The workshop was organized by the RBM Partnership to End Malaria Country Regional Support Partners Committee (CRSPC), working with key partners including the Global Fund, the World Health Organization (WHO) and others. It brought together more than 350 participants – including National Malaria Control/Elimination Programme Managers, Global Fund Focal Points, Monitoring and Evaluation Focal Points and Country Coordinating Mechanism (CCM) representatives - from 56 countries across the African, Asian and Latin American and Caribbean regions, as well as consultants who will support countries' development of malaria funding requests.

The workshop aimed to:

- Provide detailed information on the Global Fund Differentiated Application Process;
- Review RBM Partnership support tools to be used to support submission;
- Provide an overview of WHO technical recommendations for malaria;
- Support countries to develop their application development plans and timelines; and
- Compile and review technical support needs.

This article reports on key highlights from presentations and discussions held during the meeting. The main issues discussed during the workshop included:

Global progress against malaria has stalled

The world made significant progress against malaria in the last decade: the number of malaria cases fell steadily between 2010 and 2015 and the number of countries nearing elimination continued to grow. However, Pedro Alonso, Director of the WHO Global Malaria Programme, noted that progress against malaria has slowed in recent years. The numbers of malaria cases and deaths globally have leveled off at approximately 200 million cases and 400 000 malaria-related deaths per year. In fact, the World Malaria report notes that malaria is rising across some high-burden countries in Africa. To accelerate progress, Alonso called on the countries present in the meeting to increase investment in malaria programs and research; ensure equitable access to quality malaria care and treatment services; use quality real-time data to inform decision making; and further integrate malaria interventions in health systems.

Changes in the application process for the 2020-2022 cycle

The Global Fund noted that a survey of the 2017-2019 application process showed that the stakeholders desired further simplification of the application processes and materials with minimal changes to the process. As a result, the Global Fund has mostly maintained the same application process in the 2020-2022 cycle but with a few noteworthy changes, including:

- Streamlined application for Focused countries: The Global Fund has introduced a new application approach, Tailored for Focused countries, that has simplified applications for this group of countries
- Essential Data Tables: The Global Fund has also introduced an additional attachment to the application which contains tables of indicators for HIV, TB, malaria, and RSSH pre-filled by the Global Fund. The tables help standardize data used by countries in the funding request development process.
- Prioritized above-allocation request (PAAR): The countries will now submit PAARs, which is a list of costed and prioritized interventions that cannot be funded from the country allocation, at the same time as the funding request. The Global Fund recommends that the PAAR be equivalent to at least 30% of the allocation amount.

The Global Fund has described these changes in detail in the Applicant Handbook 2020-2022. (Aidspan also reported on these changes in December 2019.)

Lessons learned in the 2017-2019 allocation cycle

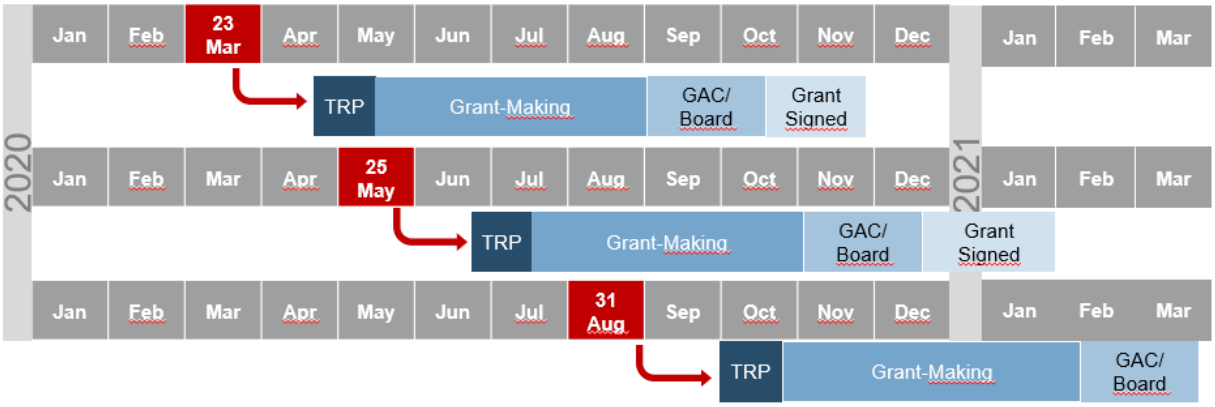
The fact that the application process remains mostly the same in the 2020-2022 application process provides an opportunity for the countries to build on the lessons learned in the 2017-2019 cycle. These lessons include:

Forward planning

The Global Fund encouraged applicants to plan in advance from the current grant end date to identify the most appropriate time to submit the funding request. On average, the application process takes nine months from funding-request submission to grant signing. Countries will need to keep this in mind to ensure they have enough time for grant-making and ultimately avoid disruptions in service delivery as they transition from current grants to the next one.

Generally, all applicants with grants ending in December 2020, as is the case for most of the active malaria grants, should plan to submit their funding requests in Window 1 (deadline 23 March 2020) or Window 2 (deadline 25 May 2020) (Figure 1).

Figure 1: Timing for applications and signing



Source: Global Fund Presentation – An overview of the application process

Note: *TRP - Technical Review Panel*
GAC: Grant Approval Committee

Use of malaria stratification as a prioritization tool

Countries can use stratification to explain how they have prioritized Global Fund resources and why. For instance, countries can demonstrate how their country dialogues have prioritized interventions based on a detailed analysis of the country's epidemiological stratification. Stratification is the classification of malaria according to the risk of disease - where risk ranges from very low, or moderate, to high - and is essential for effective targeting of interventions. Tanzania's representative, for instance, while sharing their experience in malaria stratification, noted that vector control interventions in areas classified as 'very low' risk are limited to the routine distribution of long-lasting insecticide nets , (LLINs) through antenatal care and clinics for children under five, whereas areas classified as 'high' have mass campaigns and continuous distribution of LLINs, targeted larval source management (LSM) and Indoor Residual Spraying (IRS). (The presentation from which this information is drawn is on file with the author.)

Malaria representation in the in-country program split discussions

The Global Fund does not allocate a specific amount to RSSH but instead encourages countries to draw funds from the three disease components to finance RSSH interventions. It is the responsibility of the country to determine what proportion of the allocation will fund RSSH interventions, although the Global Fund recommends an estimated 10-15% of the country allocation. [See separate article in this GFO on RSSH.]

For most countries, malaria contributed more towards RSSH as compared to HIV and TB during the 2017-2019 cycle. This time around, the Global Fund and the CRSPC advised the malaria representatives to take part actively in the in-country program split and RSSH

discussions; use a gap analysis to justify maintaining the program split for malaria; and push for the inclusion of malaria-related RSSH interventions – such as antenatal care (ANC), the Expanded Program on Immunization (EPI) and integrated community case management (iCCM) – in the RSSH allocation.

'Prioritized Above Allocation Request' works

The Global Fund supported countries to create efficiencies in their grants and channelled the savings through the portfolio optimization process, to fund interventions under the Prioritized Above Allocation Request (PAAR) in the 2017-2019 cycle. Through portfolio optimization, malaria secured $370 million – compared to TB ($216 million) and HIV ($184 million) – as countries had included impactful interventions targeting priority gaps in high/moderate-burden areas. The CRSPC advised countries to continue to prepare technically sound PAARs to increase their chances of being funded. The Global Fund also provides emergency funding, in emergency settings, where reprogramming is not possible; the CRSPC noted that the application process for emergency funding is now faster and more straightforward.

Pay attention to the TRP feedback from the 2017-2019 cycle

Applicants need to pay attention to TRP comments from the 2017-2019 period to avoid a repeat of the same in the 2020-2022 cycle. Countries may also highlight how they have addressed concerns raised by the TRP or any management conditions where relevant.

Key considerations while applying for grants in the 2020-2022 cycle

Throughout the meeting, the CRSPC, the Global Fund and WHO called on countries to draw their attention to some cross-cutting issues as they engage in their respective country dialogues, develop their funding requests and implement grants. We highlight the main points as follows:

Essential data tables

The Global Fund will populate the Essential Data Tables with data from the latest World Malaria Report and recent published surveys. However, it also encouraged countries to add more current data from alternate sources including routine data (from the Health Management Information System [HMIS]) and data from District Health Information Software 2 (DHIS2) and campaign reports, among others. The tables include key malaria indicators on epidemiology (such as prevalence, incidence, number of cases, etc.), case management (testing rate), vector control, Seasonal Malaria Chemoprevention (SMC), and elimination.

Resilient and sustainable systems for health

The Global Fund noted that the funding request process for RSSH funding will remain the same in the 2020-2022 cycle as before. It expects that countries will hold inclusive country dialogue where each country's internal stakeholders will agree on an amount for RSSH, modalities and timeline for request.

Unfortunately, in the current grants, countries tend to view RSSH as a stand-alone objective rather than as a service shared by the three diseases. In the 2020-2022 cycle, the Global Fund

is pushing countries to adopt a systems approach where they transition from input-focused support – such as the purchase of vehicles or one-off training – to strengthening the system, for instance, through the development and implementation of sound policies and strategies, and integrating them within the health sector to make the system sustainable.

Editor's note: A separate article in this issue of GFO focuses on a similar workshop related to RSSH. The article provides detail on the application process for RSSH funding.

Malaria, gender, and human rights

The CRSPC and the Global Fund called on meeting participants to mainstream gender and human rights in the application process. First, countries will need to ensure that their country dialogue includes diverse relevant communities. Then, countries need to include interventions which target populations that are most at risk and are often left behind. For instance, a country can propose to adapt information, education and communication (IEC) materials to reach different populations with different needs, education levels, language or culture. Applicants can include interventions that target populations in geographically isolated areas or remove barriers to accessing malaria services. Participants, such as those from Niger and Guinea-Bissau, cited positive experiences in the use of the Matchbox Tool which assesses how social, gender-related barriers impact a country's or region's malaria indicators.

Sustainability, transition, and co-financing

The Global Fund will require countries to embed the principles of the sustainability, transition and co-financing policy (STC) in the application process regardless of the type of funding request or of the country's status alo'. All applicant countries will be required to demonstrate how they will apply the principles of sustainability, transition and co-financing in their grants. The Global Fund noted that challenging operating environments will continue to benefit from flexibilities in the co-financing requirements.

Opportunities for integration of RMNCAH

The Global Fund aims to strengthen the delivery of HIV, TB, and malaria services along the reproductive, maternal, new-born, child, and adolescent (RMNCAH) continuum of care and to support integrated service delivery. The Global Fund has prioritized two areas for investment related to malaria: antenatal care and integrated community case management (iCCM), both of which go beyond malaria. The countries were encouraged to include these malaria-related RSSH interventions within the RSSH request.

Most countries to develop malaria funding requests under 'full review' approach

During the meeting, the Global Fund/CRSPC also announced the application approach assigned to 61 countries eligible for malaria funding and for two multi-country malaria grants. Nearly half of the countries (30) and one multi-country grant will submit funding requests under the 'full review' approach (see Table 1 below) in contrast with the 2017-2019 cycle when most countries used the 'program continuation' approach. However, this is in line

with the Global Fund's program continuation criteria, which stipulates that countries cannot use the program continuation approach in consecutive funding cycles unless the applicant has undertaken material revisions to the grants during the cycle.

More countries will use the 'tailored for National Strategic Plan' (NSP) approach during the 2020-2022 cycle (13, compared to five in the previous cycle). Others will use the other remaining approaches: 'tailored to focused portfolios' (13 countries and one multi-country grant), 'program continuation' (3), and 'tailored to transition' (2). The Global Fund had yet to confirm the type of funding request to be submitted by three countries: Democratic People's Republic of Korea (DPRK), Mali and Yemen.

The workshop provided an opportunity for the countries to review the application materials specific to the type of funding requests they are to submit.

Table 1: Country classification based on the application approach

Full review (n=31 countries)		Tailored for NSP (n=13)	Tailored for focused portfolios (n=14)	Program continuation (n=3)	Tailored for transition (n=2)	To be confirmed (n=3)
Afghanistan Angola Burundi Cameroon Central African Republic Chad Congo Congo (Democratic Republic) Côte d'Ivoire Guinea Guinea-Bissau Haiti India Liberia Madagascar Malawi	Mozambique Multicountry East Asia and Pacific RAI* Nepal Niger Papua New Guinea Philippines Senegal Sierra Leone Somalia South Sudan Sudan The Gambia Togo Zanzibar Zimbabwe	Bangladesh Benin Burkina Faso Eritrea Eswatini Ethiopia Indonesia Kenya Namibia Pakistan Rwanda Tanzania (United Republic) Uganda	Bhutan Bolivia Cabo Verde Comoros Djibouti Honduras Mauritania Multi-country Western Pacific* Nicaragua Sao Tome and Principe Solomon Islands Suriname Timor-Leste Venezuela	Ghana Nigeria Zambia	Guatemala Guyana	Democratic People's Republic of Korea (DPRK) Mali Yemen

Source: RBM Partnership grant orientation meeting (December 2019)

Multi-country grants

Next steps

Countries eligible to apply for funding received their allocation letters from the Global Fund in December 2019, and most have presumably embarked on their country dialogue process. The RBM CRSPC plans to organize "mock" TRP sessions in February to help refine

countries' funding requests before the submission of their applications in Window 1. The mock sessions allow country peer review of draft proposals, and expert review of near-final draft applications, before submission. The TRP will review applications submitted in the first window between 27 April and 2 May.

The December 2019 Nairobi RSSH worshop presentations are on file with the author.

Further reading:

- The Global Fund's Applicant Handbook 2020-2022
- From GFO Issue 370, 19 December 2019, "Global Fund announces $12.71 billion for 2020-2022 country allocations."RBM Partnership to End Malaria & the Global Fund. Malaria Matchbox Tool.

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4. NEWS: Global Fund and Germany's development agency train four countries on Resilient and Sustainable Systems for Health

Training aims to improve Kenya, Nigeria, Uganda and Zambia's upcoming RSSH funding requests

Ida Hakizinka and Djesika Amendah **29 January 2019**

The Global Fund to Fight AIDS, Tuberculosis and Malaria, in collaboration with the German development agency GIZ's Back-up Initiative, and the Heidelberg Institute of Global Health (HIGH), trained representatives of Kenya, Nigeria, Uganda, and Zambia in grant writing for Resilient and Sustainable Systems for Health (RSSH).

To "Build Resilient and Sustainable Systems for Health" is one of the Global Fund's four strategic objectives. This training comes as the Global Fund Secretariat implements the first action point of its RSSH Roadmap which is "to strengthen RSSH capacity and voice in the country dialogue process." Since introducing the New Funding Model in 2014, the Global Fund has focused 27% of its investments, about 5.8 billion, towards health systems. Those RSSH investments are direct investments in countries national health systems, e.g. building or renovating warehouses to store health commodities, and investments in disease programs with spillover effects on systems performance like purchasing laboratory equipment and training laboratory personnel for quality assurance that benefits the whole health system.

Participants in the training were representatives of CCMs, civil society, State and non-State Principal Recipients (PRs), Ministries of Health (including HIV, TB, Malaria and health system program managers), and partners. Aidspan participated in the meeting as an observer.

The training aimed to strengthen in-country dialogue

The trainers were Drs Olaf Horstick and Revati Phalkey from the Heidelberg Institute of Global Health. The training aimed to strengthen in-country dialogue by equipping key in-country stakeholders with the knowledge and instruments to be able to:

- Clearly understand the new Global Fund approach to RSSH and how this new approach could be expressed in a funding request
- Provide a coherent overview of what countries can do differently in this 2020-2022 RSSH grant, compared to previous ones
- Strengthen the ability of participants to identify the main challenges within the health system
- Strengthen the ability of participants to design high-impact RSSH interventions in the identified priority areas

The process for the Global Fund's current funding model involves the following steps. First, the Global Fund allocates funds to eligible countries for a three-year funding cycle. Countries receive an allocation letter with a total allocation and a suggested distribution of that total amount across the three diseases of HIV, TB and Malaria. RHSS does not have a separate budget allocation; it is supposed to be funded from the allocations for HIV, TB and malaria. The Global Fund encourages countries to either include RHSS activities within a disease grant or to present a stand-alone RHSS grant funding request.

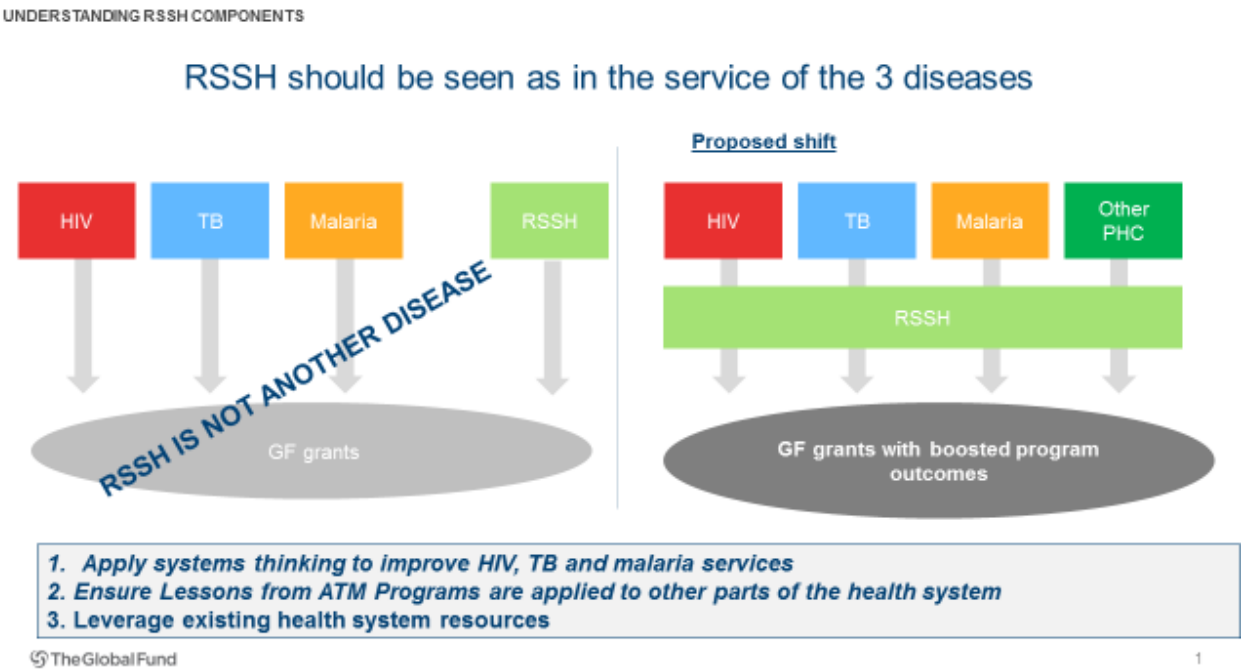
The Country Coordinating Mechanism (CCM) develops and submits a funding request, "which is the plan for how the country would use the allocated funds if approved," according to the Global Fund website. The funding requests are first reviewed by the Global Fund Secretariat, then sent to the TRP for evaluation. Upon successful evaluation by the TRP, the Board approves the proposal for funding. The proposal then goes to the grant-making stage, where the Global Fund Secretariat and the PR agree on details of the budget and activities. The last step is the signature of the grant contract.

The new approach for RSSH requests entails that countries identify the main challenges within their national health systems that impede the achievement of disease-specific goals; and conversely, the challenges in disease programs which strengthening the health system and multi-sectoral approach could resolve. This two-way identification first requires an effective and inclusive country dialogue where all voices are heard. Then a situation analysis, a selection of priority issues, the appropriate interventions, and the cost of those interventions need to be made explicit.

Investments in RSSH should improve the HIV, TB and malaria program outcomes

George Shakarishvili from the RSSH team in the Global Fund Secretariat explained the Global Fund's new approach to RSSH: RSSH should not be seen as another vertical program but rather as an element in the service of the AIDS, TB, malaria and other primary health care.

Figure 1: Resilient and Sustainable Systems for Health in the service of the three diseases



Source: Global Fund RSSH department

The RISE model and systems-thinking

Dr. Phalkey recommended that participants apply the RISE model in their approach to RSSH. The RISE model emphasizes four elements: Results, Innovation, Systems-thinking and Equity.

1. Measure and evaluate **R**esults, outcomes robustly
2. Use **I**nnovative approaches and evaluate them properly
3. Move from short-term support thinking to strategic **S**ystem-thinking including the private sector
4. **E**quity: Reach the poorest of the poor, the communities.

She added that the main message from the training is to encourage the participants to "adopt a systems-thinking approach to diagnosing issues in Health System Strengthening and mapping pathways to RSSH."

Some experience shared during the training

Participants discussed how they currently fund RSSH activities, conduct situation analyses, and choose priorities. Below we describe a few highlights of the discussions.

The Global Fund 2020-2022 allocation letters sent to countries in December 2019 indicate a suggested split of the allocation amongst the three diseases but is silent on how to fund RSSH activities. Countries are expected to fund RSSH activities from grants for the three diseases. All four countries in the training acknowledged that this situation creates their first challenge: though all stakeholders agree on the importance of the RSSH, disease programs are reluctant to see their available funds decreased for the benefit of RSSH, when those disease programs still have funding gaps. Dr. Joseph Kibachio, who represented the Permanent Secretary of

Kenya's Ministry of Health shared his country's experience: Kenya deducts 12.3% from all the disease grants to fund RSSH activities.

Christopher Chikatula, the executive secretary of Zambia's CCM, stated that the writers of their grants use a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis model for their country's situational analysis. Syson Namangada from Uganda's CCM explained that her country relies heavily on the National Strategic Plan for health, which is usually drawn-up every five-year with broad consultation of stakeholders for important information and statistics used for their situation analysis. Margaret Shelleng from Nigeria explained that in addition to the NSP, her country uses the results of the country dialogue, whose process has improved over time: "Instead of a meeting with more than 100 people in one room," Nigeria's CCM now conducts several smaller meetings where it can better collect stakeholders' views.

Participants also discussed issues of prioritization among competing RHSS priorities . Community responses and systems are weak in these countries despite their potential to improve grant performance and health outcomes. Strengthening them competes with another priority which is to strengthen Human Resources for Health like training or hiring more nurses for health facilities.

The trainers suggested that countries use a recognized model for the situational analysis and gave a few examples of models that they can use and reference for the publications. Participants received documents, including the TRP review guidance tool, they can use to conduct their analyses, determine their priorities and select their interventions.

Mr. Shakarishvili reminded the participants of the difference between system support and system strengthening. System support consists of short-term recurrent expenditures to make the system functional to effectively deliver HIV, TB, malaria, or other services. A top-up allowance for health workers is a health-system support. In contrast, system strengthening consists of expenditures with the potential to sustainably improve the system's performance in the medium and even long-term. Improving procurement and supply-chain for health commodities is an example of health system strengthening. The Global Fund prefers to lean towards system strengthening instead of system support.

The trainers took participants through a process of identifying high-impact interventions within their chosen national priority areas from the planning, the design of interventions to address the priority areas, and the identification of necessary resources and tools.

Some discussion points

During the training, participants raised RSSH topics that fundamentally impact the grants. Some of those topics are implementation arrangements, low integration of some RSSH activities in the disease programs in order to increase the impact of those interventions, considerable funding for international NGOs overhead and other management fees contrasting with limited funding for the same items for local NGOs, limited involvement of

African universities and research institutions in the grant writing, design, implementation, evaluation, and other related research.

Lessons learned

At the end of the two-day training, organizers asked for participants' feedback. This feedback would help improve future trainings as this training was the first organized on this topic.

All participants acknowledged the usefulness of the training and the fact that they will use their new knowledge to improve their upcoming funding requests. Prof Mokuolu Olugbenga from the Federal Ministry of Health of Nigeria said " the [TRP guidance tool] has provided a very useful guide focusing on RSSH. It will help with efficiency and time management as well."

Participants emphasized that they have few opportunities for frank discussion and collaborations between RSSH experts and disease programs' representatives. All participants overwhelmingly supported the idea advanced by one of them, to scale up such workshops and encourage senior-level policy-makers' participation. Participants suggested that organizers also invite core writers of proposal requests to the next similar training. To improve efficiency, those core writers should come with their existing drafts of funding requests so as to improve them as the training progresses. Others suggested that the trainings last at least three days to accommodate practical writing time and more sharing.

These types of contributions reinforced the view of Eva Schoening, from the GIZ Back-Up Initiative, who said, "this training allowed representatives […] to exchange relevant context-specific experiences and to benefit from a South-to-South learning approach."

Editor's note: The 'RSSH Roadmap' document is not publicly available on the Global Fund's website.

Further Reading

- 'Building Resilient and Sustainable Systems for Health (RSSH) Information Note' (23 August 2019)
- 'Everybody's Business: Strengthening health systems to improve health outcomes – WHO's framework for action' (2007).

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TOP

5. ANALYSIS: Some key HIV interventions for adolescents and youth overlooked in funding request to the Global Fund for 2017-2019 funding cycle

Social and sexual behavioral change is the most prioritized HIV prevention among AGYW in Cameroon, Eswatini, Kenya, Mozambique, Namibia, Tanzania and Zambia

Samuel Muniu **28 January 2020**

The Global Fund has committed to increasing investment in HIV prevention programming among adolescent girls and young women (AGYW), following its third strategic objective, "Promote and protect human rights and gender equality." Specifically, the Global Fund aims to reduce HIV incidence by 58% in 13 high-burden countries in eastern and southern Africa by 2022. An important element of this will be HIV prevention among AGYW, and the Global Fund has increased funding for interventions for this vulnerable group.

Besides funding HIV interventions within allocations during the 2017-2019 funding cycle, the Global Fund also set up matching funds to incentivize ambitious and innovative HIV interventions for adolescents and youth. Furthermore, in 2018, the Global Fund launched the 'HIV Epidemic Response (HER) initiative,' a private partnership in AGYW HIV programming, to increase the private sector's contribution in mobilizing resources to bolster HIV interventions targeting adolescent girls and boys, and young men and women.

In this article, we explore how eastern and southern Africa, a region with the highest prevalence of HIV among adolescent girls and young women, prioritized HIV interventions among this vulnerable group during the 2017-2019 funding cycle. Also, we analyze the extent to which these interventions follow the standard service package for HIV prevention among adolescents and youth recommended by the Joint United Nations Programme on HIV/AIDS (UNAIDS).

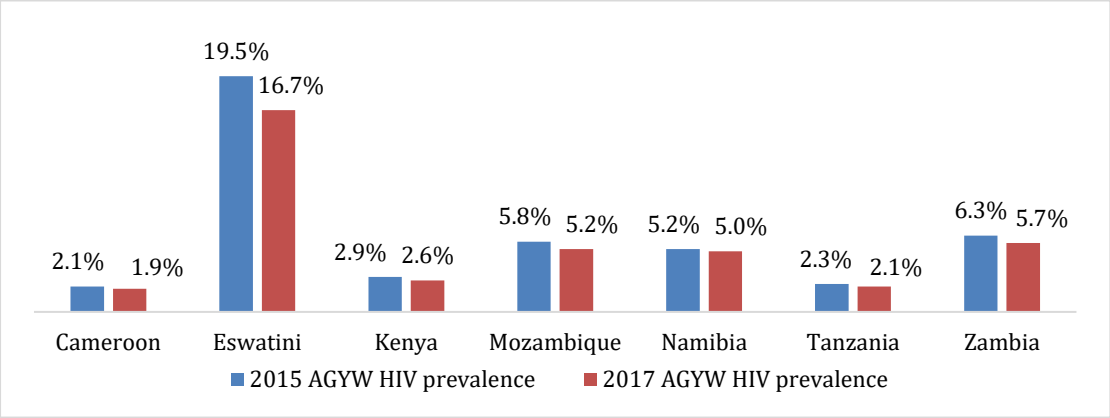
Data for this article comes from funding requests to the Global Fund for the 2017–2019 funding cycle. More specifically, from strategic priority areas under the module (a broad program area further subdivided into a comprehensive set of interventions) on prevention programs for adolescents and youth, in and out of school. We obtained data from seven countries for which data was publicly available out of the 13 in eastern and southern Africa, where the Global Fund has scaled up interventions among adolescent girls and young women during the 2017–2019 funding cycle. The seven countries are Cameroon, Eswatini, Kenya, Mozambique, Namibia, Tanzania and Zambia. We obtained HIV epidemiology data from UNAIDS.

AGYW HIV profiles of the seven countries

Of the seven countries analysed here, Eswatini had the highest prevalence of HIV among adolescent girls and young women at 16.7%, and the lowest was in Cameroon at 1.9%, according to the 2017 UNAIDS data. A comparison of the 2015 and 2017 data reveal a slight decline in HIV prevalence among adolescent girls and young women across all seven

countries. HIV prevalence among AGYW dropped by 2.8% in Eswatini, 0.6% in Mozambique and Zambia, 0.3% in Kenya, and 0.2% in Cameroon, Namibia and Tanzania.

Figure 1: HIV prevalence among AGYW

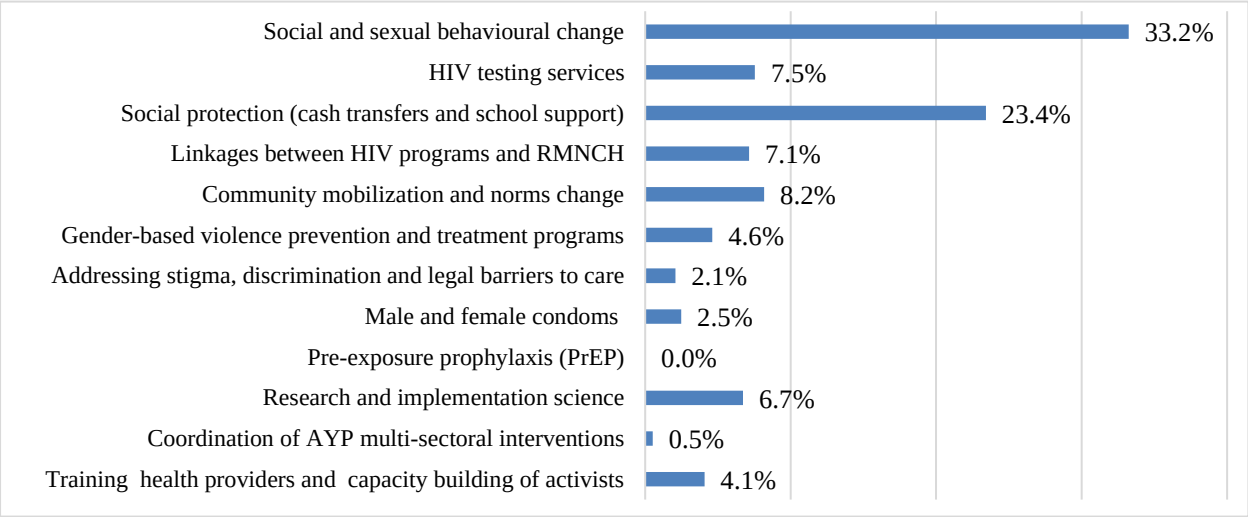


Source: UNAIDS Data 2017

Social and sexual behavioral change are the most prioritized HIV interventions among AGYW

The seven countries requested a total of $72,302,426 for HIV prevention interventions among adolescents and youth. The most prioritized set of interventions was social and sexual behavioral change for adolescents and youth; this intervention consumed 33.2 % ($24,024,742) of the funds. The second most-prioritized intervention was social protection, such as cash transfers, keeping girls in school, and livelihoods and economic empowerment at 23.4% ($16,930,927). The least-prioritized intervention was oral pre-exposure prophylaxis (PrEP) for this group, as none of the seven countries included it as a standalone program specifically targeting adolescents and youth.

Figure 2: Priority HIV interventions for AGYW in funding requests to the Global Fund for 2017-2019 funding cycle



Source: Aidspan, using data from funding requests to the Global Fund for 2017-2019 funding cycle

Distribution of adolescent and youth HIV interventions among the seven countries

All the seven countries included social and sexual behavior-change interventions and social support such as cash transfers and keeping girls in school, for HIV prevention among adolescent girls and young women in their funding request to the Global Fund during the 2017-2019 funding cycle. Eswatini excluded HIV testing services while Cameroon excluded community mobilization and norms change in their funding request for adolescents and youth programs. Of the seven countries, only Kenya included a program for coordinating multisectoral interventions for adolescents and young people with a view to improving programming, while Mozambique was the only country that included interventions to build the capacity of health providers and activists.

Table 1: Distribution of adolescent and youth HIV interventions among the seven countries

Adolescents and youth HIV Interventions	Cameroon	Eswatini	Kenya	Mozambique	Namibia	Tanzania	Zambia
Social and sexual behavioral change	X	X	X	X	X	X	X
HIV testing services	X		X	X	X	X	X

Social protection (cash transfers and school support)	X	X	X	X	X	X	X
Linkages between HIV programs and RMNCH		X			X	X	X
Community mobilization and norms change		X	X	X	X	X	X
Gender-based violence prevention and treatment programs			X	X	X	X	X
Addressing stigma, discrimination and legal barriers to care			X		X	X	
Male and female condoms				X		X	
Pre-exposure prophylaxis (PrEP)							
Research and implementation science		X	X		X	X	X
Coordination of AYP multi-sectoral interventions			X				
Training health providers and capacity building of activists				X			

Source: Funding requests to the Global Fund for 2017-2019 funding cycle

The 'standard service package' in AGYW programs

UNAIDS recommends a standard service package for adolescent girls and young women priority programs. UNAIDS developed the standard service package in 2016, considering evidence in systematic reviews of effective HIV prevention programs and high-quality experimental studies. The standard service package should include:

- Comprehensive sexuality education
- HIV testing and counseling
- Antiretroviral therapy
- Male and female condoms and lubricants
- Harm reduction for people who use drugs, and prevention for young sex workers and sexually exploited adolescent girls, and other key populations.

The seven countries included comprehensive sexuality education as part of the social and behavioral change interventions in the module on prevention programs for adolescents and youth, in and out of school. Similarly, in their funding request to the Global Fund during the 2017-2019 funding cycle, all the selected countries except Eswatini included HIV testing services, with antiretroviral therapy as a component, specifically for adolescents and youth.

Of the seven countries, only Mozambique and Tanzania included male and female condom interventions in the prevention programs for adolescents and youth module. When correctly and consistently used, condoms are highly effective in preventing sexually transmitted infections, including HIV, according to World Health Organization. Regarding voluntary medical male circumcision (VMMC), none of the selected countries included it as part of adolescent and youth interventions but rather under the prevention programs for the general population. This is despite VMMC interventions being documented to reduce the risk of HIV transmission posed by male sexual partners to adolescent girls and young women. Similarly, none of the selected countries offered harm-reduction services for adolescent drug users in the 'prevention programs for adolescents and youth' module but rather under the module on comprehensive prevention programs for people who inject drugs and their partners.

For very high HIV-incidence settings, UNAIDS recommends that in addition to the standard service package, programs should include PrEP access to all who are at risk of HIV infection, social protection interventions for adolescents and youth such cash transfers, incentives and parenting programs, school-based programs with demonstrated evidence, and intensive social and behavioral change programs and community outreach. The seven countries analysed here included all the additional recommended HIV prevention interventions for high HIV-incidence settings, except for PrEP access, in the prevention programs for adolescents and youth module, as standalone interventions.

Conclusion

In eastern and southern Africa, some key HIV interventions specific to adolescent girls and young women were excluded or least-prioritized in the funding request to the Global Fund in the 2017-2019 funding cycle. Without these interventions, countries are unlikely to reach their HIV reduction targets for adolescent girls and young women.

Further reading:

- UNAIDS 2016 'guidance' note: 'HIV Prevention among adolescent girls and young women'
- The Global Fund 2017 report: 'The Global Fund Strategy 2017-2022: Investing to End Epidemics'
- UNAIDS 2018 report: 'UNAIDS Data 2018'

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6. ANALYSIS: UNAIDS technical support identifies human rights, gender barriers and strengthens Global Fund grants

Stigma indices and gender assessments have generated critical evidence

Gemma Oberth, Kitty Grant and Andrea Boccardi **28 January 2020**

There is increased recognition that removing human rights- and gender-related barriers to accessing HIV- and other health services by populations living with and affected by HIV, is a prerequisite for ending AIDS, reaching Universal Health Coverage, reducing inequalities, and achieving many other Sustainable Development Goals by 2030. The 2016 Political Declaration on HIV and AIDS notes that "urgent consideration should be given to the promotion, protection and fulfilment of all human rights" and commits countries to "achieving gender equality and the empowerment of all women and girls." Similarly, the Global Fund's Strategy 2017-2022 has among its four strategic objectives to "promote and protect human rights and gender equality".

Despite this high-level acknowledgement and commitment, addressing human rights and gender barriers in Global Fund grants has been a challenge. In 2016-2017, nine baseline assessments conducted in the Fund's 20 human-rights focus countries found evidence of insufficient programs to reduce human rights-related barriers. On average, countries scored 2.08 out of a possible 5.00 (with 4.00 representing the threshold for comprehensive human rights programming). In May 2019, the Global Fund projected that if recent trends continue, it will achieve only three quarters of its target for reduced HIV incidence among adolescent girls and young women (42% compared to the 58% strategy target). (See separate article in this GFO on HIV prevention for this target group.)

Several initiatives aim to accelerate progress on human rights and gender equality. These include the Global Fund's Breaking Down Barriers Initiative, Community, Rights and Gender Strategic Initiative, and HER Initiative, as well as UNAIDS' Technical Support Mechanism (TSM). This article provides an overview of the latter.

UNAIDS has established a technical support mechanism to enable high-quality technical support provision to accelerate the AIDS response, towards achieving the Fast-Track targets and the commitments in the 2016 Political Declaration on HIV and AIDS. As a means to these ends, the TSM has a particular focus on effective and efficient Global Fund grant implementation.

Jointly managed by Oxford Policy Management and Genesis Analytics, the UNAIDS TSM provides short-term (3-6 months) technical support in over 100 countries, primarily in Africa, Asia, and the Pacific. Its main focus is to reach those who are underserved and at higher risk of HIV, thereby reducing inequities and strengthening the sustainability of effective programmes.

Since 2018, UNAIDS' has supported 32 human rights and gender assignments in 18 countries, making up approximately 15% of the TSM's overall portfolio. These assignments have mostly been geared towards achieving the Fast-Track targets on eliminating gender inequalities, eliminating stigma and discrimination, ensuring access to HIV-sensitive social protection, and ensuring access to HIV combination prevention services for key populations (Table 1).

Table 1. Overview of UNAIDS' human rights and gender technical support since July 2018

Assignment Type	Countries
People living with HIV Stigma Index studies	Burkina Faso, Eswatini, Lesotho, Namibia, Indonesia, the Philippines, Rwanda and Sierra Leone
HIV and social protection assessments	Lesotho, Malawi, Mali, Uganda and Zimbabwe
Gender assessments	Benin, Côte d'Ivoire, Malawi, Morocco, Sierra Leone, South Africa and Tanzania
Law and policy reviews	Asia Pacific (regional), Indonesia, Lao, Uganda, West and Central Africa (regional) and Vietnam
Development of five-year national human rights plans	Côte d'Ivoire and Ghana
Removing barriers to access faced by key populations	Estonia, Democratic Republic of Congo, Indonesia and Papua New Guinea

Helping countries to roll out the People Living with HIV Stigma Index has been a core focus of UNAIDS' recent technical support. Assignments in Burkina Faso, Eswatini, Lesotho, Namibia, Indonesia, the Philippines, Rwanda and Sierra Leone employed the new Stigma Index 2.0 methodology, which includes a broader range of health issues (beyond HIV), and

better captures intersectional stigmas faced by key populations. While the Index itself is led by national networks of people living with HIV, UNAIDS works in partnership with the Global Network of People Living with HIV (GNP+) to provide quality assurance, adapt tools, and do in-country capacity building.

The Stigma Index studies have helped countries build the necessary evidence to make effective use of Global Fund catalytic investments, especially matching funds. For instance, Eswatini's Stigma Index pointed to disclosure issues and limited treatment literacy among young people. This helped guide implementation of the country's $1.5-million matching funds grant for adolescent girls and young women, a portion of which is dedicated to increasing access to care and treatment for adolescents living with HIV. In South Africa's Stigma Index, the report showed that internalized stigma is still a major challenge, with more than 40% of people living with feelings of internalized stigma. Based on this finding, the country dedicated $1.9 million of its $5-million human-rights matching funds to support community-level anti-stigma champions, and invest in community-led research initiatives to measure and track improvements in self-stigma.

Gender assessments, too, contribute critical strategic information to guide national Global Fund decision-making. "When countries use data from qualitative gender assessments, such as UNAIDS' Gender Assessment Tool, there is better prioritization and design of interventions to address gender-related barriers, particularly for women and girls," said Heather Doyle, Senior Coordinator for Gender at the Global Fund. Doyle highlighted this point in a recent consultants' training in Senegal (see story in GFO 370). UNAIDS is currently supporting gender assessments in Benin, Côte d'Ivoire, Malawi, Morocco, Sierra Leone, South Africa and Tanzania. Results from the assessment in Malawi will help the country respond to the Global Fund's Office of the Inspector General December 2019 audit report of Global Fund grants to Malawi, which largely focused on weakness in the design and implementation of interventions targeting adolescent girls and young women. (See also the GFO article on the audit report.)

At the global level, UNAIDS technical support has also been invested in operationalizing the Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination, developing a reference document with the latest evidence on what works for ending discrimination in six settings (healthcare, education, household, justice, workplace, and emergencies and humanitarian; forthcoming). This document will further guide country-level programming on human rights, including in their Global Fund grants.

UNAIDS human rights and gender technical support is particularly critical in light of the Technical Review Panel's (TRP) Observations on the 2017-2019 Allocation Cycle. The TRP found that there were information gaps in some funding requests on the impediments to health services faced by key populations. In Indonesia, UNAIDS supported a mobility study which revealed that 34.3% of sex workers in Denpasar and 28.1% in Manado had moved in the past six months, and that mobile sex workers were more than twice as likely to experience discrimination when accessing health services. In Papua New Guinea, UNAIDS technical support responded to a lack of demand-creation strategies by delivering training and field

coaching for outreach workers on how to implement a "yes to test" calculator, with a focus on ensuring informed consent among key populations.

Human rights and gender are also mainstreamed in much of UNAIDS' other technical support provision, including national strategic planning and policy-making, as well as developing Global Fund funding requests. With technical support from UNAIDS, Congo's new National HIV Strategic Framework 2019-2022 includes legal education and information ("know your rights") for people living with HIV, key populations and survivors of gender-based violence, coupled with HIV-related legal services. In revising Sierra Leone's HIV Policy, UNAIDS technical support ensured that healthcare workers who provide information and services to key populations would not be considered in contravention of the law, which still criminalizes some of these groups.

In the Global Fund's upcoming 2020-2022 funding cycle, UNAIDS aims to supply human rights and gender experts to support national funding-request development processes. UNAIDS works in close collaboration with the Global Fund Secretariat to ensure this technical support is well-coordinated and strategically targeted. "We recently undertook a detailed mapping of available human rights-related technical assistance to countries, including that from UNAIDS, UNDP, Frontline AIDS and others," said Ralf Jürgens, Senior Coordinator for Human Rights at the Global Fund. "The partnership between the Global Fund and UNAIDS is critical for scaling up programs to remove human rights-related barriers to health services in the 20 priority countries and beyond," he said.

To request technical support through UNAIDS, prospective applicants are encouraged to approach their UNAIDS Country Director, or write to **tsm@unaids.org**.

Gemma Oberth and Kitty Grant are the focal points for human rights and gender assignments with the UNAIDS TSM. Andrea Boccardi is a Senior Community Support Adviser with the Human Rights and Gender Team and human rights and stigma & discrimination technical lead for the TSM at the UNAIDS Headquarters in Geneva.

Disclosure: *Both Gemma Oberth and Kitty Grant also consult directly with the Global Fund, supporting the Global Fund's Breaking Down Barriers Initiative and the Community, Rights and Gender Strategic Initiative. This was declared to Aidspan and was not considered a conflict of interest in light of the authors' unpaid contribution to the GFO in order to share information about the UNAIDS TSM.*

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7. ANALYSIS: Addressing low retention-in-care rates among people living with HIV in West and Central Africa – a literature review

Data indicate that current strategies for care and retention in antiretroviral treatment are not effective enough

Dr Philippe Msellati **29 January 2020**

The United Nations has set a three-fold target (’90-90-90’) for the HIV response by 2020: 90% of people living with HIV are tested and aware of their status, 90% of those have entered care, of which 90% (73% of people living with HIV) have an undetectable viral load. Many African countries are trying to achieve these goals. A recent publication by the *Global Burden of Disease group* indicates that out of a total of 195 countries, only 54 countries, including 10 in Africa, are expected to have 81% of PLHIV on antiretroviral treatment (ART) by 2020, and 12 countries will reach 90% on ART by 2030.

By the end of 2018, around 8 out of 10 people living with HIV (PLHIV) knew their HIV status, 78% (69–82%) of them were on antiretroviral treatment and 86% of these had a viral load under 1000 cp/ml. These figures, which are encouraging, also reveal that 47% of PLHIV (nearly 18 million people) are not having their viral load monitored, and 8 million of these are unaware of their HIV status. This is particularly an issue in French-speaking West and Central Africa. Although we have made very significant progress, we are far from reaching the 2020 targets.

Strategies to retain patients in care

Various articles highlight that access to treatment can be facilitated if various strategies are put in place to reduce the loss of patients between detection and treatment initiation, and during treatment, in low-income countries. These include immediate CD4 tests and treatment initiation, and supportive interventions, such as phone reminders, treatment literacy and support groups. These interventions can go a long way to meeting the second and third 90% targets. Decreasing the number of medical consultations and receiving relevant support from health-care staff and peers may help, but this has not yet been well documented. Providing a small transport allowance and nutritional support can help retain PLHIV in the care system, but support of this kind, modest as it may be, is not considered sustainable. It also creates equity issues with regard to patients with other health conditions.

Around 24 million people have had access to antiretrovirals, which is very encouraging given the situation in 2005. However, this figure represents those who have had at least initial contact with the antiretroviral distribution system and does little to demonstrate the actual number of people adhering to treatment or the number still being monitored at 6, 12 and 24 months, or for a longer period.

The third 90% target, which relates to viral load, requires good adherence and continued care. National and international programs focus a lot on this third area, which also includes a very attractive component for donors and programs: the provision of point of care (POC) diagnostic and prognostic services for CD4 counts and measuring viral load. It is often easier and more "attractive" to buy new equipment for facilities than committing resources to transport costs, for example, or to telephone costs to call patients and remind them about their appointments. It makes it possible to equip laboratories and account for budgets, but POC management, like all laboratory equipment, creates issues around training personnel, supplying commodities (including running water and electricity) and maintaining equipment.

To a certain extent, this approach constitutes placing trust in technological advances rather than it being a pragmatic response to real problems. However, enabling treatment literacy, for example, is fundamental to patient monitoring and should be included in the provision of care. This costs less but it plays an important role in terms of adherence and retention in care. It also makes it possible to better connect PLHIV with healthcare teams in charge of their care, provided that it is not limited to receiving orders or drug prescriptions.

Retention in care can be lower than 50% at 24 months among patients in large African cities. In order to remedy this, it is necessary to assess why people stop taking their treatment and the extent to which stopping treatment is the reason for leaving care compared to other factors (death, work or personal reasons for relocation). Studies show a very high proportion of patients lost to follow-up and a much lower proportion of deaths at 5 years: 42% and 6% respectively.

A study carried out in Côte d'Ivoire in 2000, before there was widespread access to antiretroviral treatment, revealed that specific procedures to investigate the status of registered patients (home visits, telephone contact with relatives, or reading funeral notices published in the newspaper) corrected the mortality rates of the cohort by 11%, 23%, and 30% at the end of the first, second and third years of follow-up. A study on mortality in 2008 at 11 African treatment sites that have introduced measures to correct declared mortality found similar, sometimes even higher figures, with mortality increasing by 1.2 to 8 times depending on the site.

Reasons for discontinuing care

Since the introduction of large-scale antiretroviral treatment programs in Africa, studies have been able to show that where mortality represents a substantial component of those "lost to follow-up", it did not correspond to all of those not followed-up. After the first year on antiretroviral therapy, the proportion of deaths among those lost to follow-up declines, replaced by undocumented transfers to other treatment centers and treatment dropouts. In this study, home visits were more effective than telephone calls to identify the circumstances of PLHIV lost to follow-up.

Discontinuing care can arise from multiple factors: poor treatment at health facilities, unplanned absences of health-care staff involved in other activities (this mainly relates to doctors and can be reduced through task shifting), and the chronic nature of the condition, which requires medical practices that differ from the prevailing model in Africa.

Stigma and self-stigma are major reasons for both not starting and leaving care. Even though health care staff and program managers may think that stigma has decreased, it is not the case for many PLHIV. They are still afraid of being identified as HIV positive and therefore hide their status, depriving themselves of support from family and friends, and preferring to give up on their treatment rather than being identified. In addition, traditional healers, and religious leaders in particular, sometimes ban the use of antiretrovirals. This has been seen in the

Democratic Republic of Congo where people living with HIV use prayer and do not return to seek care until a very advanced stage of illness.

Finally, despite the fact that antiretroviral treatment is free in most countries, the cost of transport, laboratory tests and drugs for opportunistic diseases are real obstacles to accessing care, particularly for the poorest and most vulnerable PLHIV. Furthermore, some people are not even aware that antiretroviral drugs are available free of charge, as free treatment is not the norm in African health systems. There is also a reluctance to devote scarce resources to patients who are wrongly considered to be terminally ill, especially when the disease is at a very advanced stage.

What solutions exist to stop people discontinuing care?

Decentralization of care appears to be a good strategy to reduce the number of patients lost to follow up. However, there are limitations to this approach. The most effective model appears to be initiation of treatment following testing in a health-care setting with monitoring and distribution at community level. This allows people living with HIV to have access to treatment near where they work or live. However, the best solution is probably to have multiple methods of distributing treatment and monitoring PLHIV - hospital consultations, community distribution points, patient clubs, etc. In this way, PLHIV could more easily decide to stay in care without fear of stigma and identification.
Ultimately, there is a need for greater understanding of retention in care and the factors that facilitate it or make it difficult, through qualitative research and operational studies.

Finally, for the last few years, prevention and testing have been targeted at 'key populations' that play an important role in the epidemic. However, over the last ten or fifteen years, the general population has lacked information on how the HIV and AIDS epidemic is evolving. If we want to meet targets around testing and retention in care for PLHIV, it is necessary, through massive information campaigns, to reach all of the adult population in Africa, as we did in the days when AIDS was a costly and deadly disease. Today the situation has changed, and we need to convince people to be able to reduce fear, stigma and exclusion from healthcare, enabling us to meet the United Nations targets.

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This is issue #372 of the GLOBAL FUND OBSERVER (GFO) Newsletter. Please send all suggestions for news items, commentaries or any other feedback to the GFO Acting Editor at adele.sulcas@aidspan.org. For issues relating to Francophone countries or the French edition of the GFO, the Observateur du Fonds Mondial (OFM), please contact OFM Editor Christelle Boulanger at christelle.boulanger@aidspan.org. To subscribe to GFO/OFM, go to www.aidspan.org.

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