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Prospective Country Evaluation

Democratic Republic of the Congo

2020-2021 ANNUAL COUNTRY REPORT

Commissioned by the Global Fund's Technical Evaluation Reference Group (TERG)

PATH

IHME

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AUTHORSHIP

PATH DRC

Dr. Salva Mulongo

Dr. Godefroid Mpanya

Eugène Manika

Constant Kingongo

Fedy Mukendi

IHME

Dr. Herbert Duber

Dr. Matthew Schneider

Audrey Batzel

Bethany Huntley

Thomas Glucksman

PATH

Allison Osterman

Dr. Katharine D. Shelley

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Acronyms and Abbreviations

ACT	Artemisinin-based combination therapy
ANICiiS	National Agency for Clinical Information and Health Informatics / Agence Nationale d'Ingénierie Clinique information et d'Informatique de Santé
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
C19RM	COVID-19 Response Mechanism
CAC	Cellule d'Animation
CAGF	Cellule d'appui et de gestion financière
CCM	Country Coordinating Mechanism
CODESA	Comité de développement sanitaire des aires de santé
COE	Challenging operating environment
CSS	Community Systems Strengthening
CT	Country Team
DHIS2	District Health Information Software 2
DPS	Provincial health authorities / Division provinciale de la santé
EDT	Essential data tables
FOSA	Health Facility / Formation Sanitaire
GAC	Grant Approvals Committee
HMIS	Health Management Information Systems
HRG-Equity	Human rights, gender, and equity
HZ	Health Zone
IBBS	Integrated bio-behavioral surveillance
iCCM	Integrated community case management
IHME	Institute for Health Metrics and Evaluation
IPTP	Intermittent preventive therapy in pregnancy
KII	Key informant interviews
KP	Key populations
LFA	Local Fund Agent
M&E	Monitoring and evaluation
MoH	Ministry of Health
MSM	Men who have sex with men
NFM2	New Funding Model 2 (Global Fund 2017-2019 allocation cycle)
NFM3	New Funding Model 3 (Global Fund 2020-2022 allocation cycle)
NSP	National Strategic Plan
OIG	Office of the Inspector General
PAAR	Priority above allocation request
PCE	Prospective Country Evaluation
PLHIV	People living with HIV
PNDS	National Health Development Plan

PNLS	National AIDS Control Program (Programme National de Lutte contre le Sida)
PR	Principal Recipient
PSSP	Progrès Santé Sans Prix
PU/DR	Progress update/disbursement request
PWID	People who inject drugs
RCA	Root cause analysis
RDQA	Routine data quality audit
RDT	Rapid diagnostic tests
RSSH	Resilient and Sustainable Systems for Health
SNIS	National Health Information System
SR	Sub-recipient
STI	Sexually Transmitted Disease
SW	Sex Worker
TERG	Technical Evaluation Reference Group
TRP	Technical Review Panel
WHO	World Health Organization

Executive Summary

The Prospective Country Evaluation (PCE) is an independent evaluation of the Global Fund commissioned by the Global Fund's Technical Evaluation Reference Group (TERG). The goal of the PCE is to evaluate the Global Fund business model in order to generate timely evidence that will inform global, regional and national stakeholders and accelerate progress towards meeting the Global Fund Strategic Objectives. During the 2020 evaluation phase, the evaluation approach was informed by the TERG's interest in understanding how the Global Fund grant cycle has facilitated or hindered the achievement of grant objectives during implementation within the 2018-2020 grant cycle, including around Resilient and Sustainable Systems for Health (RSSH), sustainability and equity, and whether lessons learned during the current grant have informed the next funding cycle.

The PCE utilized focus topics as a lens through which to evaluate the grant cycle and to better understand drivers of change and results. *HIV Differentiated Testing* and *Digital Health* focus topics, with their links to Global Fund Strategic Objectives and relevance to country- and global-level stakeholders, provided key results that paint a larger picture of how the Global Fund business model plays out in-country. A mixed methods approach was applied using data triangulation across interviews, budget variance analysis along the grant cycle, analysis of health system investments as strengthening vs. supportive, document review, and meeting observations. We examined how and why grants were modified along the grant cycle, successes and bottlenecks to implementation, and results achievement against grant performance targets.

NFM2 Funding request and grant making process (2017)

As noted in previous PCE reports, the differentiated approach employed starting in NFM2 improved the overall efficiency and timeliness of the funding request and grant making process in DRC. The intervention strategies and targets for both focus topics were found to be well-aligned with national strategic plans (NSPs). Looking at the changes made between the funding request budgets and the final budgets approved after grant making, with particular emphasis on the two focus topic areas, the PCE found significant shifts within budget modules and interventions. These changes resulted in a lower budget for differentiated HIV testing and a higher budget for digital health interventions, although the overall country allocation remained the same. It is of note that most budget changes made during grant making were negotiated between the principal recipients (PRs) and Country Team (CT) for reasons such as a redefining of priorities, making room for new initiatives (such as the supply chain transformation project), or a redistribution of the budget according to each PR's prerogatives and/or responsibilities. The increased investments in digital health reflected stronger prioritization for strengthening health information systems in NFM2.

NFM2 Grant implementation (2018-2020)

While all grants experienced poor performance and low absorption during the first year of grant implementation due to bottlenecks faced during grant start up related to the new NFM2 grant architecture, performance improved during the second year of implementation after procedures and coordination between PRs and SRs were resolved. Although COVID-19 did not have a major impact on overall grant implementation, there was a small decrease in some KP indicators during the final year of grant implementation.

While grant revisions have been used to program additional funds and reallocate unspent funds to high priority interventions, the PCE observed that budgets allocated to strategic objectives areas such as RSSH declined - including the budget for digital health interventions - while equity-related investments increased in malaria grants but decreased in HIV/TB grants.

Although revisions within the TB/HIV grants increased the budget and targets for HIV testing and treatment of TB patients, the HIV testing targets for key populations were not revised as planned due to the slowness of the HIV PRs to act on programmatic results and because of delays in the completion of the key population size estimate study. The HIV PRs chose to wait for the updated survey data, however by the time the validated results were made available in Q4 2020, it was considered too late to revise the NFM2 grants. While the business model provides PRs with the flexibility to make grant revisions mid-cycle, the PRs' agility and responsiveness are factors that limit grant revisions from being used to maximize results. Nonetheless, the results of the IBBS survey published in December 2020 fed into the process of estimating the NFM3 targets which remain ambitious.

Conclusions for NFM2:

1. The start-up of NFM2 grants was slow due to bottlenecks associated with operationalizing the new NFM2 grant implementation arrangements and establishing SR contracts. These delays affected grant performance and absorption during the first semester.
2. During grant implementation, grant targets for key populations were not revised in response to grants exceeding performance targets, nor in response to new study data (IBBS). This was a missed opportunity for maximizing grant impact.
3. RSSH investments in strengthening digital health were undermined during NFM2 by governance and leadership challenges within the Ministry of Health which if left unresolved will continue to impact progress in NFM3.
4. The availability and timeliness of data reported into DHIS2 improved during NFM2 due to the integration of national program data and PR databases in DHIS2 alongside the provincial level work of PRs and SRs to make data collection tools more available and develop the health zone data encoding framework. However, the process for integrating community-level data on health services provided to KPs is still ongoing and should remain a top priority along with reinforcing the use of this data to make decisions about resource allocations and service provision for KPs.

NFM3 Funding request and grant making (2020)

The PCE considered whether NFM3 investments demonstrated a 'change in trajectory' as opposed to 'business as usual' through the lens of the focus topics, including the extent to which data was used more effectively in setting targets. This was assessed based on changes in allocation levels and the scope of interventions, whether lessons learned during NFM2 were applied to the design of the NFM3 funding requests, and focus on equity, RSSH and sustainability compared to previous grants. Compared to 2017, the 2020 funding request process involved more visible and systematic use of data for prioritizing interventions and setting targets, due in part to updated epidemiological data. The Full Review approach, in comparison with the Program Continuation and Tailored Review applications used in 2017, provided the flexibility to reconfigure intervention strategies. As such, the request was considered more robust, especially around priority determination, intervention definitions, and target setting.

The funding request was also considered to be more inclusive, with meaningful engagement and participation from civil society and key population groups. The 2020 funding request shows potential for 'change in trajectory,' driven by a 28% increase in the HIV allocation. The increased allocation is planned to fund interventions that intensify prevention activities, support community systems, and reach a greater number of PLHIV who do not know their status through differentiated testing. There is strong evidence that equity will be more strongly prioritized in NFM3 considering the sizable scale-up of activities targeting KPs, combined with the expansion of interventions to reduce human rights and gender barriers to services.

With regard to health systems strengthening, the evidence for 'change in trajectory' is mixed. There was a reduction in overall RSSH investments and the funded activities continue to reflect an emphasis on supporting more than strengthening the health system[1]. The allocation reduction reflects some efficiencies, including consensus among donors around a minimum package of essential HMIS services at the province-level and a reduction in the number of provinces receiving Global Fund support for HMIS from 16 provinces in NFM2 to 8 provinces in NFM3, with a more comprehensive package of services. However, governance and coordination challenges could undermine progress if they go unresolved. The PCE observed factors that suggest there is potential for progress based on lessons learned during NFM2 that were applied to NFM3 grant design. These include more integrated service delivery models, improved RSSH performance monitoring and more rationalized financial support for digital health among financial partners and the establishment of certain priorities that will be closely monitored by the country team (for example, a matrix of responsibilities between the DSNIS and ANICIIS) to create greater coordination between key stakeholders to facilitate NFM3 implementation.

Conclusions for NFM3:

1. Even though the NFM3 grant design for RSSH features more integrated approaches and improved RSSH performance monitoring, country stakeholders considered support to disease components the primary objective of RSSH investments while support to the broader health system was considered secondary.

Recommendations

NFM2:

1. To avoid delays during the grant start-up, more intentional transition planning and coordination is required from the CCM, PRs and disease programs to avoid delays during grant start-up.
2. There is a need for PRs to be more proactive and responsive to new information and changes in programmatic and epidemiological context and to use grant revisions as a tool to act on programmatic results and update performance framework targets as needed to maximize grant results. The CCM and CT can play an important role in helping to identify opportunities for grant revisions and encouraging greater PR responsiveness.
3. The Ministry of Health must strengthen the coordination and collaboration between MOH entities involved in the implementation of GF grants to work in better synergy, for example by setting up a working committee between the DSNIS and ANiCiiS to coordinate activities in the digital health sector and in alignment with the PNDIS2. In addition, the CT, CCM, and PRs should collectively use their leverage to advocate with the Ministry of Health to address governance bottlenecks between the DSNIS and ANiCiiS for common digital health outcomes.

NFM3:

1. The Country Team and PRs should monitor and assess reporting on new RSSH indicators in NFM3 and share lessons learned with other countries.

[1] The "2S" analysis is based on the framework proposed by Grace Chee et al. (2013) and categorized systems support as activity inputs that contribute to improving services (e.g., requests for cars, computers, phones, travel costs for routine monitoring, training costs, etc.) whereas system strengthening was categorized as more comprehensive changes to performance drivers (e.g., requests for upscaling of volunteer networks, developing protocols for data quality monitoring, transferring to national procurement systems, digitizing HMIS data, etc.) More details on the 2S analysis are provided in the methods section.

Introduction

The Prospective Country Evaluation (PCE) is an independent evaluation of the Global Fund commissioned by the Global Fund's Technical Evaluation Reference Group (TERG) in eight countries, including the Democratic Republic of the Congo. The PCE aims to evaluate the Global Fund business model, investments and impact to generate timely evidence to inform global, regional and national stakeholders and to accelerate progress towards meeting the Global Fund Strategic Objectives[2]. PATH has partnered with the Institute for Health Metrics and Evaluation (IHME) to conduct the PCE with PATH DRC Country Office conducting the country-level data collection and analysis.

Previous PCE reports have detailed the establishment of the PCE platform, the progress and findings related to the Funding Request and Grant-Making process, and taken "deep dives" into the early implementation of Global Fund grants. With guidance from the TERG, this year's evaluation focused on how the Global Fund grant cycle has facilitated or hindered the achievement of grant objectives during implementation within the 2018-2020 grant cycle, and if lessons learned from the current grant have been applied to the next funding cycle.

Grant cycle approach for PCE 2020

The objective of the grant cycle analysis was to understand what, when, why and how grant investments change over time, including significant factors that influenced the implementation of and changes to the original grant. Specifically, the evaluation aimed to evaluate:

- how and why the 2018-2020 grants have been modified along the grant cycle (during grant making, implementation, and grant revision);
- how the Global Fund business model facilitates or hinders modifications along the grant cycle;
- whether and how grants are contributing to achieving progress towards (or away from) equity, sustainability and/or health systems strengthening objectives.

In addition, the 2020 funding request and grant making process for NFM3 was assessed on five themes: (1) Differentiation: tailored review and program continuation vs full review application; (2) Transparency, inclusion, and country ownership; (3) Moving beyond 'business as usual' to change in trajectory for achieving impact; (4) Data use and target setting; and (5) Value for money.

The Grant Cycle framework (Figure 1) provided by the Global Fund TERG was used as the primary evaluation framework for organizing PCE work in 2020. The Global Fund grant cycle begins with the funding request development leading to grant making and signing. This process takes approximately eight to nine months and is followed by a three-year implementation period during which funds are disbursed, activities are implemented, grants are modified through revision processes, and progress is monitored. During the third year of implementation, the next funding request development and grant making process begins for the upcoming grants and these should be informed by lessons learned from the current grants.

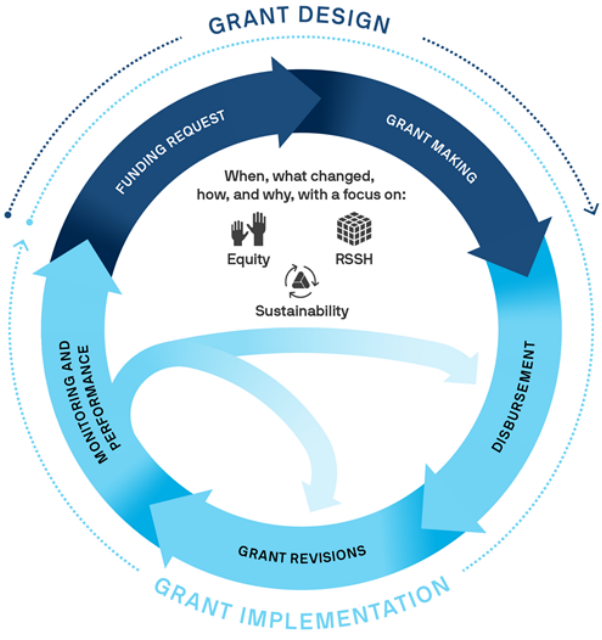
Focus topic rationale, intersection with SOs

To understand how the grant cycle framework plays out in-country and ensure a deeper understanding of the changes that are made, the PCE identified two topic areas that were applied as a lens through which to evaluate the cycle: *HIV Differentiated Testing* and *Digital Health*. Within the topic areas, the PCE assessed how equity, sustainability and RSSH are addressed throughout the grant

[2] https://www.theglobalfund.org/media/2531/core_globalfundstrategy2017-2022_strategy_en.pdf

cycle; the topic areas were chosen because of their linkages to these strategic themes, among other reasons.

Figure 1. Global Fund grant cycle framework



Topic 1: Differentiated Testing for HIV

The Global Fund incentivizes increased program quality and efficiency along the HIV testing and treatment cascade, through best-practices promotion and acceleration of country implementation of approaches through expert technical support. Differentiated testing is a client-centered service delivery model that simplifies and adapts HIV testing to better serve individual needs, thus improving the effectiveness of HIV testing (especially in key populations (KPs) where testing coverage is low). The model includes various testing modalities that are carried out in health facilities, non-health facilities, and community, including self-testing, and testing of relatives of a reference case with assisted partner notification, mobile outreach campaigns, etc. Differentiated testing is expected to respond appropriately to hard-to-reach groups experiencing barriers to accessing services (such as men who have sex with men, sex workers, people who inject drugs, transgender people, as well as other vulnerable populations such as adolescent girls and young women, partners of people living with HIV, and other KPs). DRC developed updated HIV testing guidelines in 2016 aligned to the latest WHO recommendations, including key strategic changes related to targeted and provider-initiated testing and counseling. The shift to differentiated HIV testing was first rolled out during the NFM2 grant cycle.

Linkages to **Equity**: Differentiated testing expects to increase testing among hard-to-reach, priority populations, with barriers to access. In NFM2, equity was considered by consolidating investments in nine high-priority provinces with high prevalence rates for the widest impact possible and in maintaining flagship activities to remove human rights and gender-related barriers to accessing services[3].

Linkages to **Sustainability**: Differentiated testing is more likely to be sustainable because it is cost-effective and adapted across the cascade of care, and thus a lower burden to the health system. By taking a client-centered approach, differentiated testing promotes more sustainable strategies like self-testing.

Topic 2: Digital health Strategy

The Global Fund is one of many partners supporting digital health in the DRC. The 2016-2020 national health development plan recommended strengthening the health systems by (a) improving the completeness, timeliness, and the quality of data; (b) improving the analysis and reporting of health information; and (c) improving the dissemination of health information.(2) This plan emphasizes the need to strengthen digital health and use appropriate software to allow for data storage and sharing

[3]A combined analysis of the strategic data for two diseases (HIV and TB) shows that 14 of the 26 provinces account for more than 70% of TB cases, 75% of PLHIV, 70% of TB patients co-infected with HIV, and over 80% of TB/PR cases.(1)

of all healthcare related activities such as patient management software for hospitals, financial management, and inventory management. The 2018-2020 Global Fund grants are supporting digital health through investments in the following areas:

- DHIS2
- Scale-up of TierNet (patient tracking system for People living with HIV (PLHIV) cohorts on ART)
- Scale-up of CERHIS (hospital information system that feeds into DHIS2)
- Data reporting' via SMS (SMS reporting in DHIS2 of diseases with epidemic potential)
- Digitization of health maps

Linkage to **RSSH**: Global Fund's support of digital health in DRC directly aligns with its strategic objective of building resilient and sustainable systems for health. Investments are expected to promote more integrated and interoperable health management and information systems.

Linkages to **Sustainability**: Investments in digital health are intended to improve sustainability by integrating parallel data collection systems, addressing data quality and analytic capacity to use data to inform strategic planning and improvements in service delivery.

Methods

The PCE employed a mixed methods approach to assess how Global Fund business model factors influence performance of grants throughout the different stages of the grant cycle. Relying upon analyses using both quantitative and qualitative data, the PCE assessed changes in planned resources and activities throughout the grant making process, revisions and performance during grant implementation, and changes to the next grant window. Triangulation of data across multiple sources and analytic approaches was used to ensure robustness of findings, and interpretation of findings was commonly based on more than one analysis.

Data

Primary data were collected through document review, meeting observations and key informant interviews (KIIs) to explore issues in-depth as well as and fact -checking interviews to fill information gaps (Table 1). KIIs elicited stakeholder perspectives on global- and country-specific evaluation questions and allowed the PCE to better understand grant cycle processes, including barriers and facilitators. Interviews also support data triangulation, interpretation and validation of results generated through quantitative analyses and document review. Interview transcripts and meeting notes were coded according to key themes using an online qualitative data analysis software (Dedoose).

Table 1. Process evaluation data sources for 2020*

Process	No.	Description of data sources
Document Review	116	- Core Global Fund guidance documentation related to the funding request process: Infonotes (HIV, TB, malaria, COVID-19, STC guidance, RSSH), GF technical brief, Funding model modular framework, COVID-19 Operational procedure...) - Allocation letter and associated memos (NFM2 and NFM3) - Funding request and related materials, including conceptual note - Global Fund audit and learning reports - Current grant documents including grant management letters, implementation letters, grant revision requests, PU/DRs, etc.

		- Newspaper articles - National strategic plans - Meeting minutes - Technical Review Panel (TRP) reviews - TRP observations 2017-2019 allocation cycle report - Operational Policy Manual - Global Fund Annual Report
Key Informant Interviews (33) Fact checking/validation interviews (10)	43	**National level KIIs**: CCM representatives; Cordaid national leadership; LFA; SANRU national leadership; CAGF; PNLS, PNLT, PNLP; PNCNS; ANICiis; DSNIS; PSSP; RENADEF; PASCO; UCOP+; PSSP; RACOJ **National-level fact checking interviews**: SANRU, PNLS, CCM **Subnational-level KIIs**: Cordaid leadership; Antenne SANRU **Global-level KIIs**: Global Fund Country Team
Meeting Observations	5**	CCM General Assembly, Global Fund biannual review, Global Fund CT missions

**Process evaluation data sources from 2017-2019 are available in previous PCE reports*
*** Due to challenges associated with COVID-19, the PCE has been able to observe a limited number of meetings during the 2020 period; meetings related to Global Fund Bi-annual review (June and Sept) were held virtually*

The PCE obtained detailed budgets for all active and planned grants from the Global Fund Secretariat for all funding requests, approved grants, awarded for grant making, and official revisions (with corresponding Implementation Letters). In addition to detailed budgets, LFA-verified progress update/disbursement requests (PU/DRs) were obtained for each grant up to the most recently available as of November 24, 2020. Country-level DHIS2 and programmatic data for HIV, TB and Malaria were used, as well as reports from health facilities on data completeness. Please see annex tables 4 and 5 for a full list of data assessed.

Analyses

Resource tracking

The PCE conducted detailed financial analyses of Global Fund budgets throughout the grant cycle for active NFM2 grants as well as available budgets from funding requests to grant making during NFM3. All budgets were analyzed through the grant cycle by recipient, disease, module, intervention, and focus topic. Observed changes in financial resources and prioritization between activities were triangulated using qualitative data collected during KIIs, document review, and additional interviews.

To identify modules, interventions, and activities that supported the digital health and differentiated testing focus topics, a keyword search was conducted. Using the keywords (Annex Table 3) related to each focus topic, a systematic process was developed to search descriptions of modules, interventions, and activities within detailed budgets to identify any funds that may have been related to the focus topics. Additional qualitative information collected by the PCE informed the final list of activities and interventions which were identified as focus topic related (Annex Tables 1 & 2).

Using the Global Fund's modular framework, the PCE tracked resources for RSSH and human rights, gender, and equity (HRG-Equity) related activities. HRG-Equity modules and interventions were identified using Global Funds' disease-specific technical briefs on gender, human rights, and key populations; gender technical briefs; and validated based on conversations with the Global Fund Secretariat and Community, Rights and Gender team.(3–5) A complete table of modules and interventions included in the PCE analysis of HRG-Equity is available on request.

An analysis of financial absorption (expenditure as a percentage of budget) within and across grants was conducted using PU/DRs. As each grant's PU/DR contains reported absorption at the module- and

intervention-level by semester, the PCE is able to observe trends in absorption by semester and intervention. Based upon the keyword search of activity descriptions, interventions that were identified as having a majority of funds (>50%) related to the focus topics were tracked to indicate absorption related to focus topics throughout the grant cycle. Similarly, absorption for RSSH and HRG-Equity related modules and interventions were tracked throughout the grant cycle.

Indicator performance tracking

Indicator achievement against targets are reported within the LFA-verified PU/DRs during grant implementation.(6) These data were also compiled and tracked over the grant cycle to understand changes in performance across the grant, focus topics, and RSSH and HRG-Equity. The observations from this data were used to guide KIIs and fact checking interviews to triangulate how the Global Fund business model facilitated or inhibited performance.

Root cause analyses

The PCE used root cause analyses (RCA) to further explore, analyze and understand the root causes underlying observed challenges or successes identified through a variety of triangulated data sources (KIIs, secondary data analysis, document review). Findings from the RCA support proposed actions/solutions.

RSSH Support vs. Strengthening "2S" analysis

The PCE analyzed RSSH activities in NFM2 and NFM3 according to whether they contributed to "systems support" or "system strengthening", drawing on definitions from Chee et al. (2013).(7) Per Chee et al.:

- "Supporting the health system can include any activity that improves services, from distributing mosquito nets to procuring medicines. These activities improve outcomes primarily by increasing inputs."
- "Strengthening the health system is accomplished by more comprehensive changes to performance drivers such as policies and regulations, organizational structures, and relationships across the health system to motivate changes in behavior and/or allow more effective use of resources to improve multiple health services."

The methodology used in the Technical Review Panel's (TRP) examination of RSSH in the 2017-2019 funding cycle notes that funding requests examples that were health systems support oriented included requests for cars, computers, phones, travel costs for routine monitoring, furniture and office equipment, payments for fuels and maintenance of vehicles, cost for regular training or overseas training, software, reimbursement for importation, among others.(8) Whereas funding requests characterized by more health systems strengthening interventions included requests for upscaling of volunteer networks; developing protocols for data quality monitoring; developing standard operating procedures for quality control in laboratories; transferring of the procurement system of Global Fund into the national procurement systems; digitizing HMIS data; developing strategies to engage with the private sector; providing technical assistance for DHIS2 roll-out, improving procurement and supply chain procedures including e-LMIS, and establishing medicine regulatory authority, among others.

We developed a coding methodology, aligned to Global Fund's RSSH modules in the modular framework, to designate each RSSH activity in the budget as either predominantly support or strengthening. Three parameters—scope, longevity, and approach—were examined for each RSSH intervention/activity pair, adapting upon the methodology previously used by the TRP, per these considerations:

Table 2. RSSH system support and strengthening coding parameters

Parameter	System Support	System Strengthening
Scope	May be focused on a single disease or intervention	Activities have impact across health services and outcomes; and systems may be integrated into the overall health sector
Longevity	Effects limited to period of funding	Effects will continue after funded activities end
Approach	Provide inputs to address identified system gaps	Revise policies and institutional relationships to change behaviors and resource use to address identified constraints in a more sustainable manner

Two coders independently applied a determination of support or strengthening after reviewing each intervention and activity description, and any relevant text in the funding request narrative, and cost category.

NFM2 Funding request to grant making

Our evaluation of the Global Fund grant cycle started with an examination of changes made during the 2017-2019 funding cycle. The differentiated approach to funding requests, which was first introduced for the 2017-2019 funding cycle, was utilized by DRC and improved the overall efficiency and timeliness of the process. As reported previously, the amount of time dedicated to the funding request and grant making process was reduced by approximately four months compared to the previous funding cycle.(9)

DRC submitted a Program Continuation request for malaria and a Tailored Review funding request for HIV/TB. This decision was based on the continued relevance of the current grants' strategic direction and acceptable performance and because of the delayed start-up of the 2015-2017 grants. The intervention strategies, targets and program design remained largely unchanged for the HIV component of the HIV/TB funding request because no new data was available on the epidemiological context. Although during the review process it was noted that HIV testing targets for KPs were not in line with normative guidance, preliminary KP mapping and size estimate results were only available for Kinshasa and so it was decided that the budget and testing targets would be revised during NFM2 implementation upon release of the 2017 Integrated bio-behavioral surveillance (IBBS) results.

We compared the intervention strategies and targets for both focus topics and found that they were well-aligned with national strategic plans (NSPs) (Annex Tables 1 & 2). In the 2017 HIV/TB funding request, HIV prevention interventions were closely aligned with those in the 2018-2021 HIV NSP for key population testing strategies, including HIV counseling and testing in health facilities and communities. The NSP objectives and performance measures were used to inform the NFM2 performance framework, indicating a contribution to the NSP strategic actions. NFM2 digital health interventions were informed by the 2016-2020 National Health Development Plan (PNDS) and the 2018-2020 National Health Information System (SNIS) strengthening plan which emphasizes the need to strengthen the DRC's digital health strategy and use appropriate software to allow for data storage and sharing for all activities related to primary health care, such as patient management software for hospitals, financial management, and inventory management.

To understand how program strategies and interventions are modified along the grant cycle, the PCE examined changes that were made between the funding request budgets, submitted by the CCM, and the final budgets approved after grant making, with particular emphasis on the two focus topic areas.

Key message: During grant making, the overall country allocation remained the same but there were numerous shifts within budget modules and interventions, which resulted in a lower budget for differentiated HIV testing and a higher budget for digital health interventions.

Various changes in the HIV budget occurred during grant making, including a 24% reduction in the overall HIV budget, 49% reduction in the differentiated HIV testing budget (from US$1.2 m to US$610,262), and a decrease in resources for Cordaid (-7.5%) and an increase in the MoH budget (+40.5%). The budget for differentiated testing includes interventions for testing key populations, including organizing evening mobile testing for men who have sex with men (MSM), sex workers (SWs), people who inject drugs (PWID), transgender people; training healthcare providers to assist PWIDs; organizing home visits, self-help groups, and community awareness-raising. While the SW testing was erroneously excluded from the budget during grant making, it was added back in the second semester of grant implementation through reprogramming of funds. This was after submission of the S1 2018 PU/DR in which poor performance for the indicator: "KP-3c(M): Percentage of sex workers who received a HIV test in the reporting period and received their results" was noticed.

Otherwise, most budget changes made during grant making were negotiated between the principal recipients (PRs) and CT for multiple reasons reflecting a redefining of priorities, or a redistribution of the budget according to each PR's prerogatives and/or responsibilities. Some small-scale changes resulted from differences in unit costs and/or reductions in activity scope so that resources could be reallocated to other budget modules (see Table 3). One major driver of budget changes was because DRC was selected for the Secretariat's supply chain transformation project. The CT and country stakeholders were notified of this during grant making and across all disease grants, various budget modules were cut to make a total of US$10 million available for the supply chain transformation project. The budget shifts illustrate some of the difficult trade-offs during grant making negotiations. On one hand, the Secretariat's supply chain management transformation project was responding to the Office of the Inspector General (OIG) audit on In-country Supply Chain Processes that found weaknesses within country supply chain systems that present significant risk to the achievement of Global Fund strategic objectives.(10) On the other hand, the reduced budget for KP testing has implications for achieving greater equity of health service provision because fewer KPs will be tested. Furthermore, the budget reductions for differentiated testing were contradictory to TRP guidance. KP targets did not meet normative guidance and DRC was advised to reconsider the targets in the performance framework. However, because updated epidemiological data on KP size estimates were not available to justify target setting, it was decided that the budget and testing targets would be revised during implementation based on the results of the 2017 IBBS study and KP mapping.

Table 3. Activities impacted by changes in the differentiated HIV testing budget

Activities with cost savings from revised unit costs	Activities with reductions in scope
● Mobile testing for MSM ● Harmonization costs for tents and mobile VCT for MSM ● Home-visit transportation costs for MSM	● Reduced number of mobile testing outings for MSM ● Reduced number of mobile outings and support groups for PWIDs from 12 to 9 in targeted Health Zones (HZs)

As reported by the PCE previously, while civil society groups were involved in the funding request development, they were less engaged during grant making. Since grant negotiations are typically

between Global Fund and Principal Recipients (PRs), stakeholders outside of the process lack visibility on how and why decisions are made.(9) This could explain why, during KIIs, some civil society groups reported that they felt their priorities were not well reflected in the NFM2 grants.

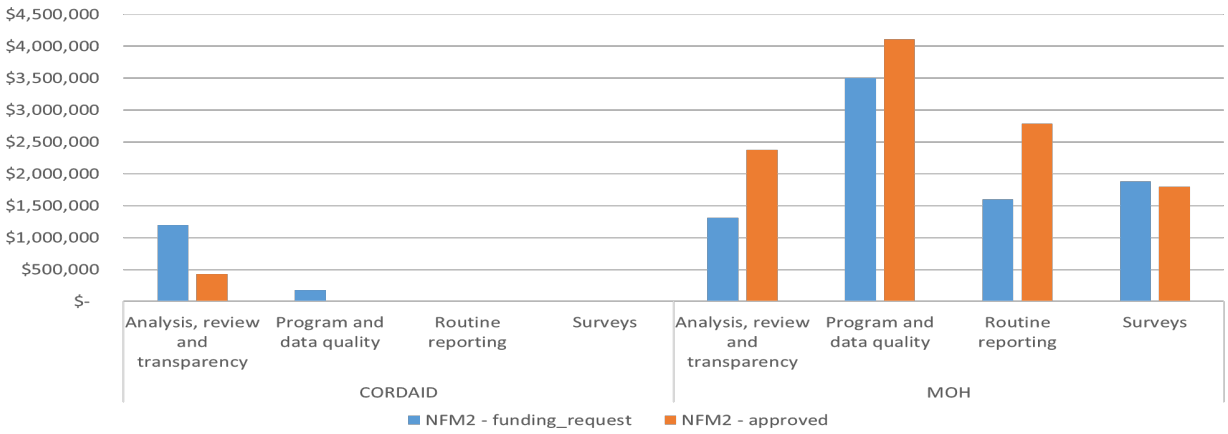
Key message: Investments in digital health, captured in the HIV/TB budgets, increased during grant making and reflect stronger prioritization for strengthening health information systems in NFM2.

Our analysis of digital health investments included three interventions captured under the Health management information system (HMIS) and M&E budget module that are intended to support digital health (1) analysis, review and transparency, (2) program and data quality, and (3) routine reporting. The survey intervention was not included within our definition of activities contributing to digital health. We were unable to compare the overall change in the budget for digital health between the funding request submission and grant making because the Program Continuation funding request for Malaria/RSSH did not include a detailed budget.

While the overall HMIS and M&E budget module increased from US$7.7 million to US$9.7 million in the HIV/TB grants (Figure 2), the portion of this budget allocated to the Cordaid grant decreased, shifting resources to the MoH grants. This can be explained by various budget shifts, including:

- Funds amounting to US$250,818 for the "Organizing monitoring missions for the project management unit" activity were transferred into the "Grant management" module which reduced the funds for the "Analysis, evaluation, review, and transparency" intervention.
- Funds totaling US$180,000 were cut from the "Program and data quality" intervention in the Cordaid grant since the routine data quality audit (RDQA) audit was already included in the MoH grant for US$45,000.
- Increase in the "Analysis, review, and transparency" intervention due to adjustments in participant transportation costs for attending biannual data validation meetings at the DPS level. Other budget efficiencies were gained from combining validation meetings for TB and HIV.
- Increase in the "Program and data quality" intervention due to selection of a higher-cost activity modality (data quality/M&E training instead of facility level supervision and coaching), as recommended by the CT and due to the scale-up of the TierNet activity.
- Increase in the "Routine reporting" intervention due to an adjustment in the number of data reporting registers required following the updated quantification results.

Figure 2. Change in budget for digital health interventions between NFM2 funding request and grant making



Source: Global Fund detailed budgets

There is little evidence that TRP comments influenced the shifts in digital health investments during grant making. In its response to TRP comments, the grant recipient referenced RSSH plans specified in the 2016-2020 PNDS, which consist of implementation frameworks at every level of the cascade of

care. It also specified that an annual PNDS implementation plan with priority actions is developed, acting as a framework for aligning interventions and resources.

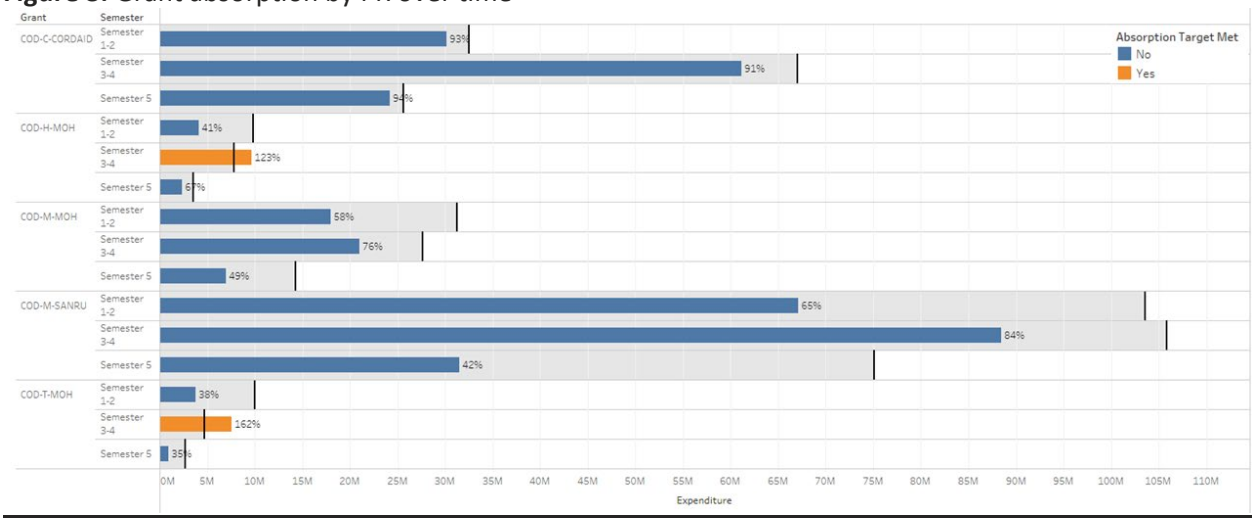
Grant Implementation

Key message: All grants performed poorly during the first year of grant implementation due to bottlenecks associated with grant start-up; various business model factors facilitated grant performance improvement during the second year of implementation, however this progress was compromised in the third year of implementation due to the impact of COVID-19.

As reported previously, the differentiated application approach facilitated timely approval of grants and on-time disbursements of funds from the Global Fund to PRs. However, grants were not 'implementation-ready' at the time of grant signature. As a result, the outgoing NFM1 SRs were extended by three months into 2018 to cover the transition period. NFM2 disbursements to sub-recipients (SRs) were delayed by 4-6 months, which is reflected in low grant absorption in the first semester of 2018 (Figure 3). Various factors contributed to the implementation delays in the first year and have been reported by the PCE previously, notably:

- The new NFM2 grant architecture that included a single transversal SR (rather than disease-specific SRs) for each province and led to delayed SR contracting;
- Consolidation of TB and HIV activities under a single PR to improve operationalization of the TB/HIV co-infection strategy;
- New arrangements for storing and transporting health commodities for greater national ownership.

Figure 3. Grant absorption by PR over time



Source: Global Fund PU/DRs Jan 2018 - June 2020

Implementation of differentiated testing for key populations

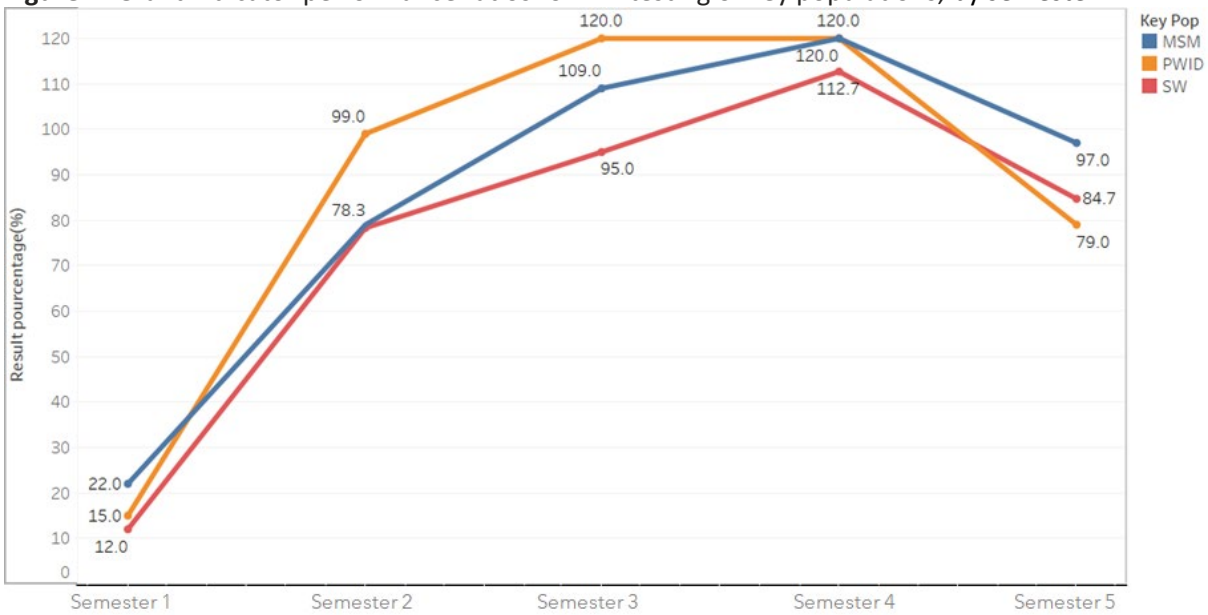
Differentiated HIV testing activities were primarily implemented by Cordaid and civil society SRs. Since SR contracts and disbursements were delayed following the transition to transversal SRs (rather than disease-specific SRs) as part of the new NFM2 institutional arrangements, which impacted the absorption rate and grant performance indicators in the first year (reported in the 2019 PCE report).(11) The implementation of community-level testing activities was delayed until April and June

of 2018. Also, as reported previously by the PCE, low adoption of the targeted testing strategy and new screening tool by health workers contributed to weak performance in 2018.(11)

Compared to S1 of 2019, by the second year of grant implementation (S3 and S4), grant indicators for MSM, PWID, and SWs were exceeding targets (Figure 4). This was due to the roll out of targeted testing activities but was also influenced by the low NFM2 targets which were based on outdated KP size estimates. During the first semester of 2020 (S5), there was a decline in achievements because mobile outings for KP screening and testing were halted during a four month period due to COVID-19.

Analyses conducted by the national HIV program (PNLS) revealed that HIV positivity rates remained low (around 4% for MSM and PWID; and 3% for SW). For example, the rate of HIV positivity for SWs reported by in Global Fund supported provinces is lower than the sex worker HIV prevalence rate found in the IBBS: Nord Kivu 2% vs. 11.8%; Sud Kivu 3% vs. 7.5%; Kinshasa 1% vs. 5.3%; Ituri 5.5% vs. 6.8%; Kasaï Oriental 4% vs. 11.8%; Kongo Central 4.4% vs. 3.9%; Tshopo 5% vs. 9.5%.(12) These results indicate continued weak access to HIV prevention services and a targeting issue in hotspots and among sex workers, especially since a large proportion of the sex worker population lives in hiding. This evidence, combined with the updated KP data, which showed KP size estimates were six times higher than estimated, suggests that the NFM2 testing strategies needed to be further reinforced and more ambitious testing targets are needed to achieve the goal of increasing the number of PLHIV that know their status. By the time the new data on HIV incidence were released in Q1 of 2020, development of the NFM3 funding request was already underway and both the CT and PR considered it too late in the NFM2 grant cycle to undergo a grant revision (discussed in greater detail below).

Figure 4. Grant indicator performance ratios for HIV testing of key populations, by semester



Source: Global Fund PU/DRs, January 2018-June 2020

Implementation of digital health interventions

Many digital health interventions have not been implemented due to various challenges, leading to the low absorption rates observed in 2018 (32%), 2019 (73%), and the first semester of 2020 (42%) (Figure 5). These absorption trends follow a similar pattern of low overall absorption of RSSH interventions (Figure 6). The primary driver of weak implementation of digital health interventions has been the country's political context, namely governance and leadership challenges within the digital health sector. The previous Minister of Health declared digitization of the DRC health system a top priority and created the National Agency for Clinical Information and Health Informatics (ANICiiS)

in December 2018, however this change took resources and personnel away from the National Health Information System Division (DSNIS) within the MoH, therefore reducing its capacity. It also caused numerous leadership and coordination challenges between ANICiiS and DSNIS since both agencies share responsibilities for implementing digital health interventions. The fact that ANICiiS has not been fully functional during NFM2 inhibited much of the progress that was achieved up until 2018 in terms of adopting and rolling out DHIS2 nationwide. Across the various NFM2 digital investments, issues such as choosing which digital platform the country should endorse has been a common bottleneck as a result of the government reorganization following the new President taking office in January 2019. These challenges are reflected in the DRC stakeholder quote below.

> *"There hasn't been a lot of progress because of the lack of a valid counterpart at the Ministry of Health. It's hard to push for systems when there is no clear responsible entity to drive and regulate; no clear decision making process regarding the choice of a system or piloting."*
>
> *Quote from a key informant*

Figure 5. Absorption of digital health interventions by Semester ($US)

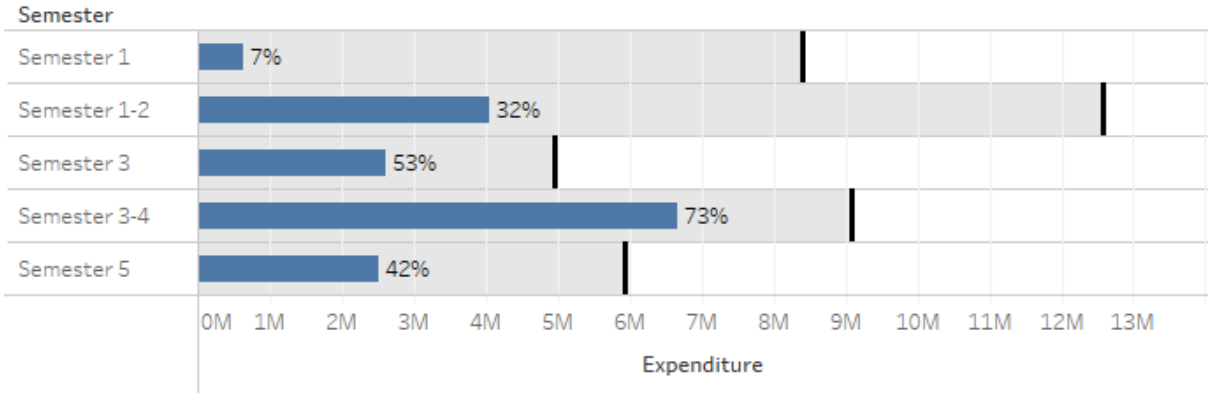
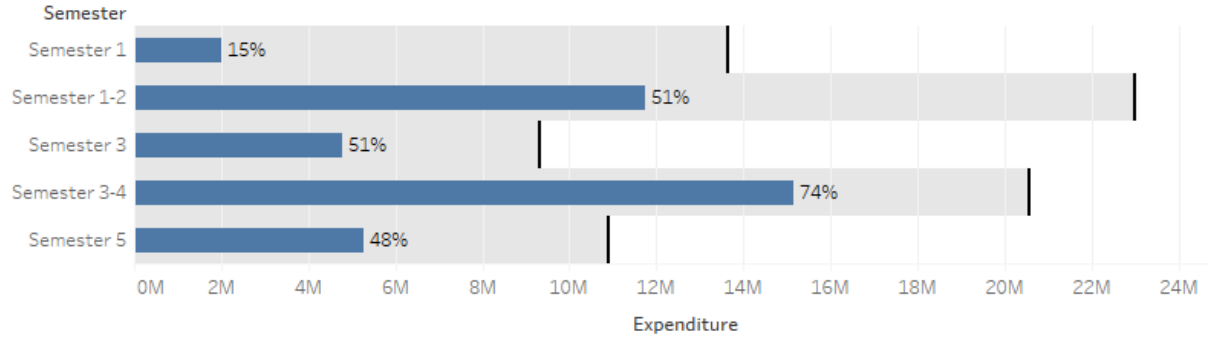


Figure 6. Absorption of RSSH budget by Semester ($US)



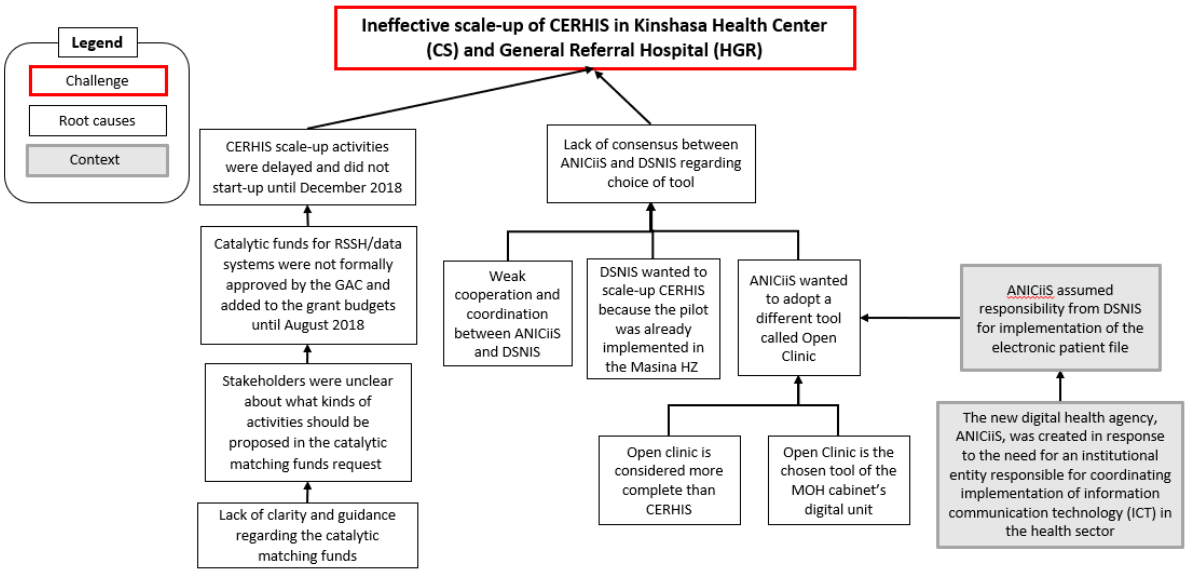
Source: Source: Global Fund PU/DRs, January 2018-June 2020

Other challenges have included cumbersome government procurement procedures, which made it difficult to establish V-SAT contracts, procure IT equipment and paper-based facility registers, creating major bottlenecks for data collection and scale-up of digital interventions such as CERHIS and TierNet. Logistical and equipment-related difficulties included lack of paper-based patient files, facilities without internet connections that are unable to transmit data, human resource retention, and equipment maintenance issues.

CERHIS is a hospital information system that feeds into DHIS2 that was piloted at the end of NFM1 in three health facilities (FOSA) in the Masina health zone of Kinshasa (Roi Baudouin, SC Bolingo and SC

Kitoka). The pilot proved its effectiveness in terms of improvement of data quality (availability, timeliness and accuracy), reduced health care worker workload so they could focus more on patient needs and improving quality of care, and finally to making data more available in DHIS2 to support program decision making. In NFM2, catalytic matching funds were meant to be used for scale-up, but this never occurred. However, the matching funds request was processed separate from the main grant and did not go through Grant Approvals Committee (GAC) approval until eight months into NFM2 implementation, which contributed to delays. Another procedural bottleneck was the requirement for Global Fund pre-approval (*Avis de non-objection*) for major expenditures and procurements, which was a requirement for catalytic funds and was intended to mitigate financial risk. Other root causes assessed by the PCE (Figure 7) included coordination challenges and lack of consensus between ANICiiS and DSNIS. While the CERHIS platform was chosen by the government, ANICIIS wanted to adopt the Open Clinic platform. Both platforms were assessed by an independent evaluation at the end of 2019 and the conclusion of that review was to extend the pilot phase of CERHIS while developing a clear health information digitization strategy and approach.

Figure 7. Root cause analysis of ineffective scale-up of CERHIS



TierNet is an electronic patient tracking system for clinical data to better monitor PLHIV cohorts on ART. The pilot project was implemented in five provinces (Haut Katanga, Kinshasa, Kongo Central, ex-Oriental, and ex-Kasai Oriental) in NFM1. The TierNet roll-out has been less affected by the governance and leadership issues governing digital health within the MoH because, unlike platforms such as CERHIS that cut across disease areas, TierNet is used for HIV case management only and is therefore overseen by PNLS. An evaluation of the TierNet pilot was one of the pre-conditions for scale-up, but the evaluation consultant was only recruited in March 2020 due to procurement delays related to contracting and was unable to travel because of COVID-19. As a result, the expansion to 357 additional health zones did not occur as planned. Nonetheless, some weaknesses in the pilot regions have been noted. For example, TierNet is not regularly updated, especially when operated by mobile data. Another challenge is that data for key populations are not captured in TierNet because the private health centers that provide health services to KPs do not currently report into the system. The interoperability that was planned between TierNet and DHIS2 will be initiated after the scale-up phase, starting with the pilot project in Kinshasa.

As part of the support to SNIS through the malaria grant, the notification of diseases with epidemic potential, as part of epidemiological surveillance, was another proposed activity. However, there have also been issues regarding the choice of which digital platform should be used. The text message

framework was supposed to be configured in DHIS2 but the WHO proposed another software, “EWars,” for epidemiological surveillance and discussions are currently ongoing regarding this choice between WHO's “EWars” and/or a DHIS2-integrated module. Lack of clarity regarding which entity within the MoH has authority to make a decision has stalled progress. This stage has already passed and the pilot phase in 5 provinces including Kinshasa started during NFM2 and continues during NFM3.

Investments in DHIS2 have been ongoing since NFM1 when the decision was made by the country to adopt DHIS2 as the primary platform for managing health information in DRC. As of 2017, DHIS2 had been rolled out to all 26 provinces and 516 health zones in the country, with support from the Global Fund and other technical and financial partners. Reporting completeness for each disease has improved between 2018 and 2019 (Figure 8) and the average facility reporting rate is currently over 95%. These improvements have been attributed to greater awareness within health zones on how to report data in DHIS2, increased feedback received by facilities to help troubleshoot data entry problems, the CT’s requirement that PRs use DHIS2 for PU/DR reporting and data analysis, and greater involvement by HZ level health care workers who travel to zones with weak internet coverage to obtain facility data for entry in DHIS2. The investments are also contributing to sustainability by integrating with the other systems for greater interoperability. For example, during NFM2 progress was made with integrating Cordaid and SANRU PR databases in DHIS2. Cordaid is currently using a parallel system to collect KP data, which also poses sustainability issues.

Despite this progress, gaps still remain in data quality and use, as well as the availability of data on key populations. Human resources challenges within DSNIS, such as shortages in information system specialists and turnover of trained personnel undermine its ability to respond to requests for technical support in a timely manner. Another challenge is that data from private centers that provide health services to key populations are not currently compiled in DHIS2. This data is currently collected by Cordaid and although the Cordaid database is now interoperable with DHIS2, data on KPs has not been synchronized because of the different reporting structure. As long as data on health services provided to key populations are not represented in the health information system, health providers and national health authorities will lack complete data needed to make decisions about resource allocations and service provision for key populations. This situation has implications for equity in terms of ensuring that the health system is capable of providing key and vulnerable populations with equitable access to health services. In response to this issue there are efforts underway to include community data in the DHIS2 platform. Other challenges include internet connection disparities between rural health zones and their better-connected urban counterparts. Network coverage is still weak in remote zones, specifically when electricity necessary to power relay antennas is lacking, and internet coverage remains unequal. This means that in health zones without internet, health care workers must travel long and risky distances to enter their data. These health zones are therefore more disadvantaged. For-profit private sector health facilities also have less access to DHIS2 support as compared to public and faith-based FOSA. To address internet connection issues, NFM2 grants included funding for VSAT, but establishing contracts with service providers was inhibited by cumbersome government procurement procedures.

Figure 8. Reporting completeness in DHIS2 by disease area

Source: Global Fund detailed budget

Key message: Grant revisions have been used to program additional funds and reallocate unspent funds to high priority interventions, however through this process, budgets allocated to strategic objectives areas such as RSSH declined while equity-related investments increased in malaria grants but decreased in HIV/TB grants.

As a High Impact portfolio, DRC has the flexibility to request grant revisions at any time during implementation. Across the five DRC grants, there have been a total of 22 grant revisions, including 11 additional funding revisions (for catalytic matching funds, portfolio optimization, and COVID-19 Response Mechanism [C19RM]), eight program revisions (formerly "reprogramming"), and three administrative revisions (Table 4). DRC did not undergo any revisions categorized as budget revisions. Rather, grant budgets were reviewed and revised each time there were program, additional funding, or administrative revisions. DRC's total budget grew by 14%, from US$542.9 million (including catalytic matching funds) to US$619 million over the course of NFM2 due to the injection of additional funding from portfolio optimization (US$47m) and C19RM (US$28.9m). On average, the approval duration for additional funding revisions was 153 days, 64 days for program revisions, and 58 days for administrative revisions.

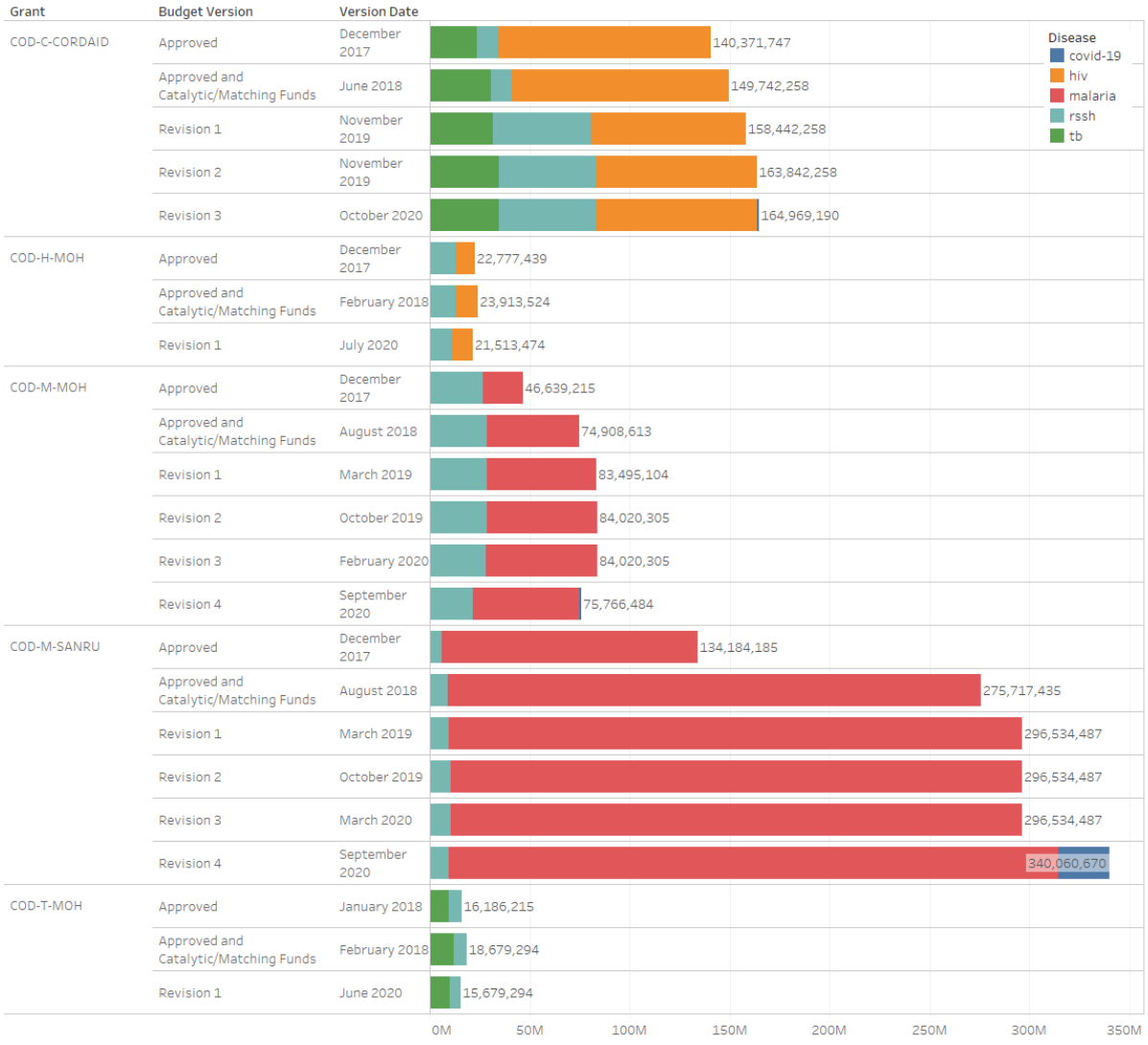
Table 4. Table of grant revisions during NFM2

	Number of revisions	Average of revision approval duration (days)	Average date of revision approval
DRC	**22**	**107**	**11/28/2019**
Additional Funding Revision	11	153	8/23/2019
Admin Revision	3	58	11/3/2019
Program Revision	8	64	4/20/2020

The priority above allocation request (PAAR) has been used to finance activities that were deemed high-priority by the Technical Review Panel (TRP) when additional funds were made available, namely for extending HIV testing and treatment coverage for TB patients and extending geographic coverage of the bed net distribution campaign for malaria prevention. Grant revisions have also been used to

reallocate resources within the grants, including shifting resources to high performing activities (and thus increasing grant programmatic and performance targets) but also shifting resources away from low absorbing interventions, such as RSSH. Although the grant revision triggers have varied, the intention of DRC stakeholders has been to use grant revisions as a tool for maximizing the utilization and absorption of grant resources, which is in line with Global Fund guidance that grant revisions are used to "ensure the continued effective and efficient use of Global Fund resources".(13) Figure 9 shows the revisions for each grant and the corresponding change in resources allocated to disease areas, RSSH, and COVID-19 response.

Figure 9. Changes in budget totals across revisions for all grants ($USD)



Source: Global Fund detailed budgets

Key message: HIV/TB grant revisions increased the budget and grant targets for HIV testing and treatment of TB patients but did not revise the HIV testing targets for key populations as planned due to the PR's lacking proactiveness and because results from the key population size estimate study were delayed, which was a missed opportunity for maximizing grant impact.

Grant revisions for the HIV/TB grants included the addition of approximately US$3 million in catalytic matching funds for removing human rights barriers. An additional US$8.7 million from Portfolio Optimization was used to extend HIV testing and ART treatment to TB patients. The revision process

was initiated by the Secretariat and began with the CT's review of the PAAR, from which they suggested increasing the HIV/TB co-infection investment which was rated "high priority" by the TRP. Since the grants had been exceeding TB patient testing targets, the CT suspected that the grant targets were not ambitious enough and could be revised upward with the allocation of additional resources. The suggestion was reviewed by country stakeholders, including the CCM, PRs and PNLS, who conducted their own analyses and decided to proceed with the grant revision, thereby increasing the budget and targets. The additional funding included US$4 million for health products (ARVs, HIV tests, and cotrimoxazole), US$2.2 million for transportation, freight and warehouse costs, and US$2.5 million for human resources, M&E and infrastructure costs. The revision extended coverage for TB patients to 59 new health zones where HIV prevalence is estimated to be 12% among TB patients. The ART coverage targets in the grant performance frameworks were also revised, increasing coverage from 34.9% to 43.2% (achieving an additional 29,773 patients on treatment by December 2020).

In conjunction with the additional funds revision, the differentiated testing budget for HIV increased from US$610,262 to nearly US$1 million (Figure 10). Considering the budget cuts that were made during grant making, the increase was intended to bring the budget closer in-line with the initial funding request budget, but KP testing targets remained the same. Since there was limited new data on KP estimates and HIV prevalence to inform the 2017 funding request, the HIV grants were approved by the GAC with the understanding that KP testing targets would be revised following the release of the 2017 IBBS study and KP size estimation study. During grant implementation, the PR did not revise the KP targets despite initial plans and programmatic data that showed KP testing largely exceeded the 2019 targets. Instead, the PR chose to wait for the updated survey data but the study results were delayed until Q1 of 2020 and, given the amount of time and administrative burden (in terms of staff time) associated with grant revision processes, the PR decided that it was too late in the grant cycle to revise the NFM2 grants. Since the NFM3 funding request development process was already underway, making substantive changes to grant scope and scale was not feasible because of the constraints on staff time.

Figure 10. HIV/TB grant revisions for HIV differentiated testing ($USD)

Grant	Gf Intervention	Budget Version: Approved	Approved and Catalytic/Matching Fun..	Revision 1	Revision 2	Revision 3
COD-C-CORDAID	HIV testing services for men who have sex with men	362,572	362,572	571,768	534,191	534,191
	HIV testing services for people who inject drugs	147,645	147,645	99,880	110,670	110,670
	HIV testing services for sex workers	12,630	12,630	322,255	304,097	304,097
	HIV testing services for transgender people	69,786	69,786	0	0	0
COD-H-MOH	HIV testing services for people who inject drugs	9,230	9,230	9,030		
	HIV testing services for transgender people	8,400	8,400	6,139		
Grand Total		610,262	610,262	1,009,071	948,958	948,958

% change: -100% 100%

Figure notes: COD-C-CORDAID contained four revisions throughout the grant cycle period observed during the PCE, while COD-H-MOH grant only contained two revisions. To access the final amount for HIV differentiated testing, Revision 2 from COD-H-MOH and Revision 4 from COD-C-CORAID can be summed which equate to US$964,127.

Source: Global Fund detailed budgets

Through grant revisions, resources have been progressively shifted away from RSSH, including the budget for digital health interventions.

DRC's NFM2 grant budgets included US$67.5 million for RSSH, including US$2.9 million in catalytic matching funds to boost investments in strengthening Health Management Information Systems (HMIS) and monitoring and evaluation (M&E). However, over the course of NMF2, the RSSH budget was reduced by approximately US$13 million (19.3%), including the budget for digital health interventions, which was reduced by approximately US$7.2 million (23.8%) (Figure 11).

Figure 11. Changes in RSSH budget, following grant revisions, across all grants combined

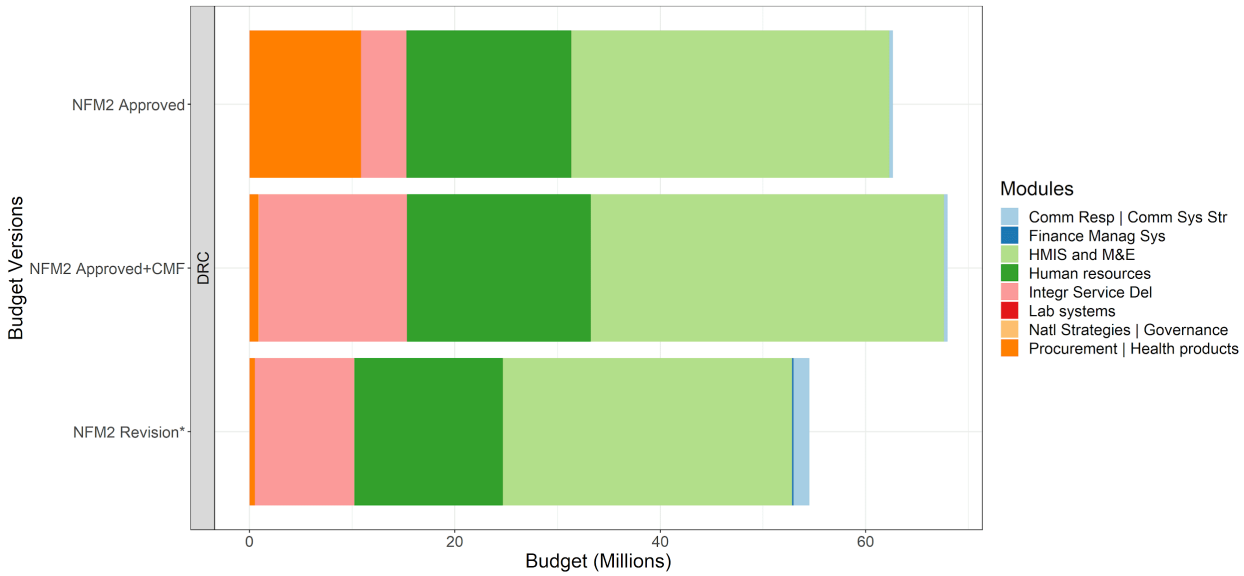


*Figure notes: CMF is Catalytic/Matching Funds. *Revision is the most recent official revision.*
Source: Global Fund detailed budgets

These reductions, executed through grant revisions, were primarily due to low absorption as a result of delayed implementation and non-implementation of RSSH investments. As such, the savings were reallocated either to different modules within the same grant or to other PRs to ensure proper implementation of activities and improve the absorption rate. For example, revision 2 for the MoH malaria PR and revision 3 for SANRU (*both program revisions*) transferred US$500,000 for conducting a data quality review from the MoH malaria PR to SANRU, the civil society PR (Figure 12). This survey should have been conducted by the MoH PR but was delayed in its implementation due to various factors, including administrative and procurement process delays, thus impacting the MoH PR absorption rate. Given that the results of the survey were expected to define the implementation of strategies for improving quality data, the CT initiated the revision to transfer this activity to SANRU. In this particular example, we note that the business model demonstrated flexibility and responsiveness to implementation realities since the revision enabled implementation of the data quality review, although by a different PR than originally planned.

There were two other examples of grant revisions that transferred unspent funds from the MoH PRs to the civil society PRs. In one example, since the CERHIS scale-up did not occur there was low absorption for the digital health interventions in Q3 of 2020. The approximately US$1 million in savings from this activity was then transferred from PNLP to SANRU for the purchase of malaria commodities (rapid diagnostic tests (RDTs) and Artemisinin-based combination therapy (ACTs)). In the second example, US$2.4 million from PNLS and US$3 million from PNLT were transferred to Cordaid to cover the increased commodity unit price and freight costs.

Figure 12. Grant revisions' impact on the budget for digital health (US$)

Grant	Gf Intervention	Budget Version: Approved	Approved and Catalytic/Matching Funds	Revision 1	Revision 2	Revision 3	Revision 4
COD-C-CORDAID	Analysis, review and transpare..	430,986	430,986	0	0	0	
	Program and data quality	0	0	0	0	0	
	Routine reporting	0	94,419	75,508	82,855	82,855	
COD-H-MOH	Analysis, review and transpare..	628,872	628,872	628,597			
	Program and data quality	3,719,247	3,719,247	2,137,622			
	Routine reporting	2,441,256	2,441,256	1,080,289			
COD-M-MOH	Analysis, review and transpare..	0	3,150,342	3,150,342	3,150,342	2,813,142	2,690,640
	National health strategies, alig..	0	39,032	39,032	39,032	39,032	0
	Program and data quality	4,605,311	4,428,202	4,428,202	4,428,202	5,651,156	5,221,085
	Routine reporting	10,177,304	4,935,884	4,935,884	4,935,884	4,050,130	1,886,832
COD-M-SANRU	Analysis, review and transpare..	1,241,813	2,859,669	2,859,669	1,891,278	1,891,278	1,863,466
	Routine reporting	3,436,941	4,843,318	5,205,560	5,442,498	5,442,498	5,219,189
COD-T-MOH	Analysis, review and transpare..	1,749,776	1,940,496	1,352,044			
	Program and data quality	389,553	389,553	384,740			
	Routine reporting	348,184	348,184	183,153			
Grand Total		29,169,242	30,249,459	26,460,642	19,970,091	19,970,091	16,881,212

% change: -100% 100%

Figure notes: COD-C-CORDAID contained four revisions throughout the grant cycle period observed during the PCE; COD-H-MOH grant contained two revisions; COD-M-MOH and COD-M-SANRU grants contained five revisions; COD-T-MOH grant contained two revisions. To access the final amount for HIV differentiated testing, the most recent revision can be summed across these grants, which equates to US$23,120,667.

Figure 13. Changes in HRG-Equity related interventions from grant revisions, all grants combined

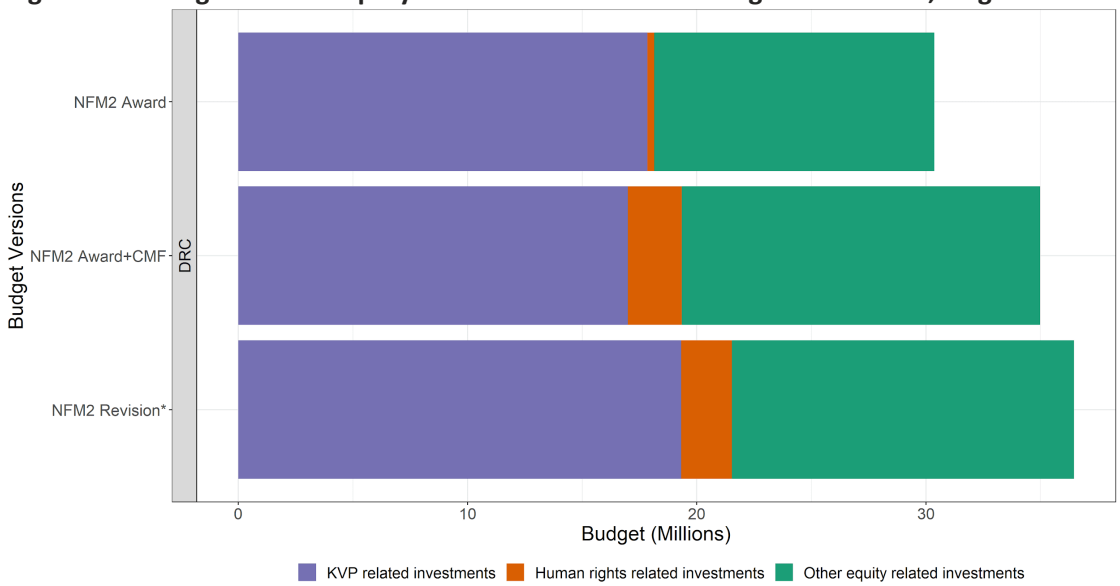


*Figure notes: CMF is Catalytic/Matching Funds. *Revision is the most recent official revision.*
Source (Figures 13 & 14): Global Fund detailed budgets

Through grant revisions, resources for HRG-equity related investments have increased in malaria grants but decreased in HIV/TB grants.

As shown in Figure 13, the addition of catalytic matching funds in NFM2 increased the amount of grant resources available for interventions dedicated to removing human rights and gender barriers to address equitable access to HIV, TB and malaria health services. Absorption of HRG-equity investments also improved between 2018 (37%) and 2019 (89%), but dropped in 2020 (54%) due to COVID-19's impact on grant implementation. Various grant revisions also impacted the NFM2 budget

for HRG-equity investments; in the HIV/TB grants approximately US$2.3 million was shifted away from HRG-equity interventions to other budget modules (15% decrease), whereas in the malaria grants approximately US$4.4 million in HRG-equity related interventions were added (38% increase). In the malaria grants, additional funds were made available through Portfolio Optimization in October 2020, which increased the budget for integrated community case management (iCCM) and intermittent preventive therapy in pregnancy (IPTP), both considered equity-related interventions in our budget variance analysis. Other budget revisions, including those that shifted resources away from HRG-equity interventions, were initiated by the PR without having to consult the CT as a result of GF budget flexibilities.

NFM2 grants were designed to address human rights and gender-related barriers to services by supporting community response and mobilization, networking, and capacity building, in combination with provision of quality health services. This also included several awareness-raising and capacity-building training for health care providers, law enforcement officers, and justice officials. These activities increased the number of health care professionals and community members trained in how to create more favorable conditions for ensuring access to health services by key populations and in the protection of human rights, the investments were still considered inadequate. Stigmatization and discrimination continue to present significant barriers to care at the family-, community-, and structural-levels. The 2019 Stigma Index survey reported that 4.5% of respondents were denied access to health services including dental care because of their HIV status.(14)

2020 Funding Request and Grant Making

In line with Global Fund's 2019 investment case for the Sixth Replenishment to fund NFM3, which made a case to 'do things differently' in order to meet its Strategic Objectives, the PCE's evaluation of the 2020 funding request and grant making processes examined what changed between the 2017 and 2020 funding request processes and considered how commitments to strengthening RSSH and HRG-equity have evolved.(15) As such, the PCE examined how well the funding request and grant making processes reflected Global Fund's commitments to differentiation, transparency, inclusion and country ownership. Through the lens of the two focus topics, the PCE considered the extent to which data was used more effectively in setting targets and whether NFM3 investments in the focus topic areas demonstrated a 'change in trajectory' as opposed to 'business as usual.' The PCE assessed evidence of 'change in trajectory' in terms of (1) changes in allocation levels and intervention scale/scope; (2) application of NFM2 lessons learned in the design of NFM3 strategies; and (3) changes in focus on equity, RSSH and sustainability compared to previous grants.

Key message: Compared to 2017, the 2020 funding request process was considered more robust with more meaningful and inclusive participation from civil society and a more noticeable use of data for determining priorities, defining intervention strategies and setting targets.

There was consensus among stakeholders that the 2020 funding request development process involved more visible and systematic use of data for prioritizing interventions and setting targets. This was made possible by the presence of updated epidemiological data which was not available when the 2017 was being developed. All funding requests were supported by triangulation of program review results, analysis of routine program data, disease modeling (such as Spectrum for HIV data projections), and various studies such as the key population mapping and size estimate study, a stigma index survey, and the 2018 baseline assessment on Scaling up Programs to Reduce Human Rights-Related Barriers to HIV and TB services. These studies provided better knowledge about KP hot spots

and barriers to accessing testing which helped inform the HIV testing targeting strategies proposed in the 2020 funding request.

> *"At 90% we relied on data to determine targets even in distributing the budget. We relied on MICS, EDS, data from our health system."*
>
> *"...I think that this process allowed the country to conduct a complete analysis with reviewed and updated data."*
>
> *Quotes from Key informants*

DRC stakeholders thought the essential data tables (EDTs) were a helpful new resource for preparing the 2020 funding requests, citing that they reduced the amount of work required to draft the funding requests by compiling all necessary data for analysis in one place. After launching the official NFM3 process, one of the key steps was the tool familiarization workshop, which saw high participation by all stakeholders active among all three diseases. The data provided in the tables complemented the contextual information provided by disease programs making it easier to identify and justify intervention priorities based on data. As demonstrated by the quote below, stakeholders repeatedly referenced the data in the EDTs and noted the utility of the tool, such as in developing the grant performance frameworks, although the programs needed to update the information included in the tables for certain data.

> *"The essential data tables helped us develop the performance frameworks. They were very important, they served as touchstones, guidance to better understand the indicators."*
>
> *Quote from key informant*

Another factor that facilitated greater data use, analysis, and application of lessons learned was that funding request development was preceded by program reviews and updated NSPs. All three national programs conducted program reviews in November 2019, a process that was supported by Global Fund both financially and technically. As part of the process, there were consultations at provincial- and national-levels with key and vulnerable populations, where their concerns with the current NSPs were voiced and suggestions were documented that helped inform the new HIV NSP 2020-2023. The new malaria NSP 2020-2023 was finalized in January 2020 in time to inform the funding request development.

A more transparent and significant participation from civil society, key populations, and PLHIV was observed at every step of the 2020 funding request, and was considered stronger than in the previous cycle. Compared to 2017, the 2020 funding request provincial dialogues were combined with provincial-level program reviews. The process allowed provinces to define their priorities, resulting in interventions tailored to their geographic and epidemiological context. Consultations with TB and HIV stakeholders occurred as part of the Global Fund's Breaking Down Barriers project and included a human rights and gender baseline assessment which was completed in June 2018. A second round of provincial consultations occurred in Q4 2019 and culminated in a TB-HIV multi-stakeholder meeting in January 2020 at which a list of priority activities to address HR barriers was produced to be included in the five-year costed Human Rights and Gender National Plan. The Breaking Down Barriers project was credited for contributing to a more nuanced analysis of human rights and gender barriers in the 2020 HIV/TB funding request and proposal of more robust strategies for addressing the barriers. In addition to facilitating the development of data-informed strategies, the national and provincial level program reviews and consultations assured the inclusiveness and transparency of the 2020 funding request development.(16) Triangulation of data collected through the KIIs and review of key documents (meeting minutes, attendance lists, etc.) confirms that there was strong and transparent participation of stakeholders at different levels of the funding request writing process. For example,

various stakeholder groups participated in the thematic working groups that developed the funding request. Other key interlocutors in the process included the CCM who supervised and coordinated strategic discussions and decision making throughout the grant writing process. The DRC CT supported the process by offering advice, guidance, and clarifications, which were recognized and appreciated by national stakeholders.

Country ownership of the 2020 funding request process was perceived as strong due to national leadership and alignment between the Funding Requests and NSPs. Country ownership was also demonstrated by the increase in country co-financing commitments, which grew from US$98.8 million to US$131.9 million between the 2017-2019 and 2020-2022 allocation periods. Further evidence of stronger country ownership was the perception of greater contribution of KPs and civil society informing the development of the differentiated HIV testing strategy. This was attributed to the strengthened capacity of civil society organizations such as PSSP, PASCO, UCOP+[4] that have benefited from the reliable support and funding from Global Fund.

Key message: DRC's submission of Full Review funding requests in 2020, compared to differentiated applications in 2017, provided the flexibility to reconfigure intervention strategies, which was justified by the 2020-2022 allocation increase and newly updated epidemiological data.

DRC application types changed between 2017 and 2020. For the 2017-2019 allocation period, differentiated funding requests were submitted, including a Program Continuation request for Malaria and a Tailored Review request for TB/HIV. This was because of delayed implementation of NFM1 grants that were only 18 months into implementation when the 2017-2019 funding request development cycle began and the strategies to be implemented were largely unchanged. For the 2020-2022 allocation period, DRC submitted a Full Review application for both Malaria and TB/HIV due to the availability of new epidemiological data and sizable increase in total country allocation (Table 5).

Table 5. Summary of DRC 2017-2019 and 2020-2022 allocation amounts and application type

Component	2017-2019 Allocation ($)	2020-2022 Allocation ($)	Agreed NFM3 program split	% Change	2017-2019 Application type	2020-2022 Application type
HIV	$122,687,456	$174,093,362	$156,551,166	27.6%	Tailored review, TB/HIV joint request	Full review, TB/HIV joint request
TB	$56,656,846	$76,950,962	$71,792,934	26.7%		
Malaria	$347,651,023	$393,891,463	$370,812,095	6.7%	Program continuation	Full review*
RSSH	NA	NA	$45,779,592	NA	NA	Full review*
Grand Total	$526,986,425	$644,935,787	$644,935,787	22.4%		

*The TRP recommended that the malaria 2020 FR go to iteration. As a result, the malaria and RSSH components were resubmitted as standalone funding requests.
Source: 2017-2019 and 2020-2022 allocation letters, 2020 Grant Making Final Review Forms

[4] Progrès Santé Sans Prix; Parlons Sida aux communautés; Union Congolaise des Organisations des Personnes vivant avec le VIH

Compared to the 2017 funding request process, stakeholders perceived the 2020 funding request process as more flexible, indicating that the Full Review application type gave them greater latitude to propose interventions and strategies based on data, evidence, country context and lessons learned during NFM2. For example, lessons learned from the evaluation of HIV testing strategies implemented by sub-recipient, *Progrès Santé sans Prix* (PSSP), revealed better results for reaching SW and MSM through online awareness-raising compared to traditional peer education, whereas peer outreach strategies were more effective for reaching transgender people. This information was used to improve the design of differentiated testing strategies for SW and MSM in NFM3 grants. Stakeholders who participated in both 2017 and 2020 funding request processes said the 2017 funding request development process was more restrictive because interventions were predetermined. It should be noted, however, that limiting major changes in intervention scope and strategies was how the differentiated application approach was able to streamline and improve the timeliness of NFM2 grant approval.

> *"If we had to compare the two funding request processes (2017 and 2020), we would say that the 2020 process did not restrict the country. For illustrative purposes, in 2017, they gave us funds while limiting interventions, we were in a state of need but we could not conduct all activities but in 2020, the country was allowed free expression based on priorities and lessons learned in 2017. We are free to propose interventions based on our priority needs, within budget limits."*
>
> *Quote from key informant*

The 2020 funding request and grant making process also placed greater emphasis on having "implementation-ready" grants. New checks were included in the grant making final review form in which the CT has to affirm that the PR has initiated activities to achieve implementation-readiness by the implementation period start date. Since the form is reviewed by the GAC and factors into their grant approval decision, there were stronger incentives in NFM3 to ensure that PRs were on-track to be implementation-ready. While the CCM is responsible for coordinating SR selection and approval, these processes are also supported by the CT, which can help nudge the process along. For NFM3, DRC's HIV/TB and malaria grants were closer to finalizing SR contracts, which had been a significant barrier to NFM2 grant start-up. Having learned from experience in NFM2, the CCM decided to renew all PRs for NFM3 based on the results of the NFM2 mid-term evaluation. Cordaid was renewed for the TB/HIV grant, SANRU for the malaria grants, and the Cellule de Gestion Financière (CAGF) for the implementation of Ministry of Health grants for all three diseases. Meanwhile, the process of evaluating SR performance was to be finalized by the end of October 2020. Preliminary results show that 22 out of 24 SRs will be renewed. The RSSH grant may be delayed since the TRP sent the malaria/RSSH grant to iteration and DRC stakeholders decided to split the malaria and RSSH components into separate stand-alone funding requests. At the time of writing, the RSSH grant GAC review is planned for December 2020.

Key message: The 2020 funding request shows potential for 'change in trajectory' by reaching PLHIV through differentiated testing, driven by the application of NFM2 lessons learned and greater prioritization of prevention and Community Systems Strengthening investments, made possible by the larger HIV allocation.

Between the 2017-2019 and 2020-2022 allocation periods, DRC's HIV allocation increased by 27.6% due to the successful 2019 Global Fund replenishment. Consultations were held between the Global Fund CT, country stakeholders, and technical partners and the decision was made to use the increased HIV allocation to intensify prevention activities. The decision was influenced in part by the new data, which showed a six-fold increase in the key population size estimate. It was also in response to historically low prioritization of prevention interventions despite DRC's epidemiological context,

which shows weak achievement of the first 90 in the HIV cascade: only 62% of PLHIV know their status.(17) As shown in Figure 14, DRC's budget for prevention increased from US$10.8 million to US$21.0 million between NFM2 and NFM3 (95% increase). The budget for differentiated HIV testing followed the same trend, increasing from US$610,262 to US$8,893,665. In NFM3, the budget module "differentiated HIV testing services" was added to Global Fund's modular framework, making it easier to track investments in this area.(18)

Figure 14. Budget variance in HIV investments between NFM2 and NFM3

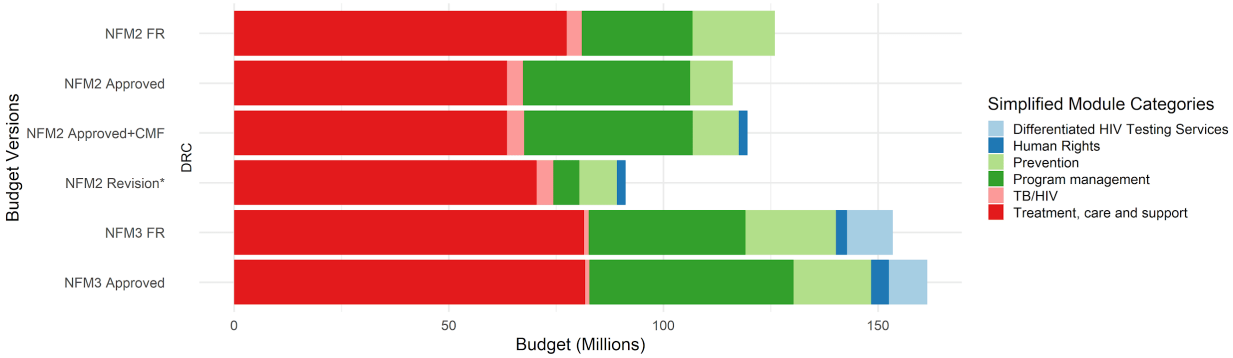


*Figure notes: CMF is Catalytic/Matching Funds. *Revision is the most recent official revision.*
Source: Global Fund detailed budgets

NFM2 revealed that finding and testing PLHIV remains the most critical intervention but is the most difficult to implement. As discussed in the previous chapter, HIV test kit stockouts and weak dissemination of the new targeted testing strategy undermined NFM2 results. Building on NFM2 lessons learned, the NFM3 testing strategy will be even more targeted in high priority provinces and focused on increasing testing among hard-to-reach priority populations and strengthening use of the risk-based screening tool by health workers. Among other lessons learned from NFM2 was the need to address dysfunctional community systems. The funding request set ambitious targets and proposed innovative programming to reach more key populations through community-based testing strategies and self-testing (Table 6). During grant negotiations these activities and targets were scaled back but remain significantly more ambitious, compared to NFM2. The stakeholders involved in grant negotiations said that the differentiated testing budget was cut in order to offset budget requirements for PSM and human resources, which are reflected in the increased program management budget (Figure 14). In addition to the overall budget reduction for differentiated HIV testing, a large portion of the budget was shifted from community-based testing to facility-based testing (Table 6). Stakeholders explained that the rationale was to prioritize essential activities that would contribute to achieving testing and treatment goals along the 90-90-90 cascade. However, this decision does not appear to be well-supported by the latest data and evidence which showed high HIV prevalence among KPs and a much larger KP population size than previously estimated.

Table 6: Differentiated Testing for HIV budget comparison between NFM3 funding request and approved at grant making budget

Focus Topic and Intervention	NFM3 Funding Request	NFM3 Approved
Differentiated Testing for HIV	**$ 10,633,562**	**$ 8,893,665**
Community-based testing	$ 7,540,100	$ 291,255
Facility-based testing	$ 2,934,815	$ 8,448,452
Self-testing	$ 158,647	$ 153,958

Although the scale will be smaller than originally planned in the FR, the community-based interventions are designed around more integrated approaches that strengthen community systems beyond disease-specific interventions. For example, instead of supporting individual community health agents operating vertically, NFM3 will support community-based organizations (e.g., CAC and CODESA) that are delivering comprehensive health prevention and promotion activities. There are also plans to gradually integrate KP-friendly sites (centres conviviaux) within the public facilities since health services for KPs have historically been provided by civil society organizations. Plans for NFM3 include training health facility staff in adapting services for KPs to make service offerings more welcoming and less stigmatizing.

There is strong evidence that equity will be more strongly prioritized in NFM3 considering the scaled-up activities targeting KPs, combined with the expansion of interventions to reduce human rights and gender barriers to services. As shown in Table 7, NFM3 testing targets for all key population categories are significantly higher than the NFM2 targets. The TRP noted that 2020 funding requests showed strengthened and expanded HRG interventions compared to previous rounds.(19) Key facilitators included: the use of data to define strategies for addressing HR barriers; the Global Fund-supported Breaking Down Barriers initiative which produced a baseline assessment and convened stakeholder consultations leading to the development of a five-year costed Human Rights and Gender National Plan with priority activities; and availability of catalytic matching funds.

Table 7. Differentiated HIV testing targets for NFM2 and NFM3

Key population category targeted	NFM2 target	NFM3 target (Funding request)	NFM3 target (Final approved at grant making)
Sex workers	42,437	175,492	346,332
Men who have sex with men	44,336	496,322	161,207
People who inject drugs	1,861	201,884	68,219
Transgender	N/A	24,566	19,345
People in prisons	N/A	39,862	24,259
TOTAL	**88,634**	**938,126**	**619,362**

Source: NFM2 grant performance frameworks and 2020 funding request and approved grant making performance frameworks

Key message: The 2020 FR shows mixed potential for 'change in trajectory' in terms of health systems strengthening; overall RSSH investments were reduced and continue to reflect an emphasis on supporting versus strengthening the health system. Governance and coordination challenges will also continue to undermine progress in digital health as long as they remain unresolved. Meanwhile, there is potential for progress through more integrated service delivery models, improved RSSH performance monitoring and better rationalized financial support for RSSH among financial partners.

As shown in Figure 15, investments in RSSH decreased by 21% between NFM2 and NMF3. In NMF2, the RSSH budget was US$67.6 million, including US$2.9 million in catalytic matching funds for HMIS and M&E but was reduced over the course of NMF2 implementation due to low absorption, as discussed in the previous chapter. RSSH investments in proportion to the total grant budget also decreased between NFM2 and NFM3, from 12% to 8%. In NFM3, investments in digital health, although smaller than in NFM2, received the largest portion of the RSSH budget (the HMIS and M&E module represents 56% of the total RSSH budget). The process for setting the NFM3 budget priorities for RSSH was complex and was supported by consultants and RSSH working groups. Interviews with

key stakeholders revealed that RSSH interventions supporting the three diseases were given priority over RSSH interventions strengthening the overall health system. This is further supported by our preliminary findings from the RSSH support versus strengthening "2S" analysis, which showed that the proportion of the RSSH budget dedicated to health system strengthening interventions decreased from 42% to 35% between the NFM2 approved budget and NFM3 funding request (Figure 16). The 2S analysis has not yet been applied to the NFM3 RSSH budgets from grant making but the PCE is in the process of updating the analysis and will incorporate in the final report. However, we noted an overall increase from US$48.2 to US$53 million in the RSSH budget between funding request and grant making which could affect the outcome of the analysis.

Figure 15. Budget variance in RSSH investments between NFM2 and NFM3

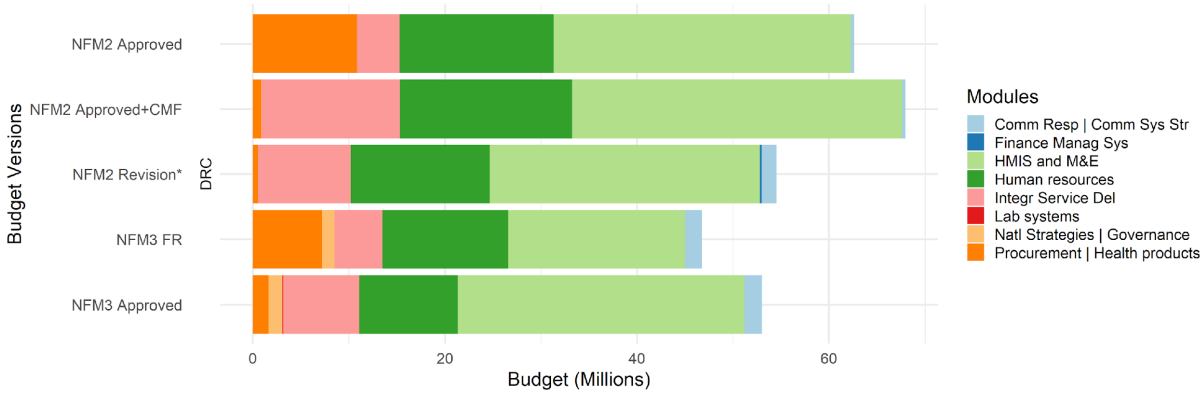
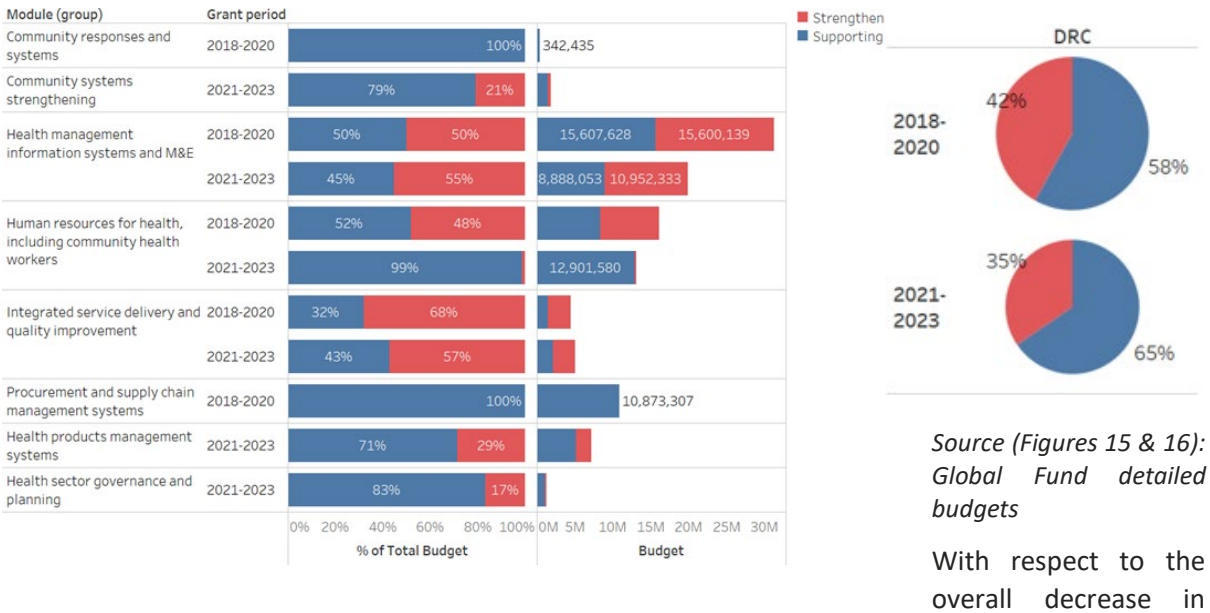


*Figure notes: CMF is Catalytic/Matching Funds. *Revision is the most recent official revision.*
Source: Global Fund detailed budgets

The increase in RSSH budget modules for HMIS and M&E (from $18.4 to $29.8 million) and integrated service delivery (from $5 to $7.9 million) were the most notable changes driving the overall increase in the RSSH budget between FR and GM (Figure 15). Interventions for civil registry and statistics, and administrative and financial data sources were added to the HMIS and M&E budget to facilitate monitoring country co-financing. Other factors driving changes included reclassification of activities within the appropriate budget interventions, changes in activity scale (e.g., increasing the frequency of provincial level data validation meetings), and readjusting unit costs based on updated costing data.

Figure 16. RSSH support versus strengthening "2S" analysis comparing NFM2 to NFM3 investments by RSSH module



Source (Figures 15 & 16): Global Fund detailed budgets

With respect to the overall decrease in

RSSH between NFM2 and NFM3, we found that various factors drove the decrease. In particular, priority was given to filling programmatic gaps in essential commodities and drugs needed for prevention and treatment services. In addition, a certain number of efficiencies were also achieved, making the RSSH budget more rationalized with greater support from other financial partners. In particular, headway was made in defining a minimum package of HMIS services that are essential for supporting HMIS at the province level and include internet connectivity, data collection tools, training, supervision, etc. Consensus around this minimum package of HMIS services should help reduce fragmentation and inequities in how provinces are supported by donors. The number of provinces receiving Global Fund support for HMIS was therefore reduced from 16 provinces in NFM2 to 8 provinces in NFM3, with the World Bank agreeing to cover the other 8 provinces. In addition, a certain number of HMIS and digital health interventions were put in the PAAR because they were pending the country's decision on which platform to use or had not adequately addressed CT concerns. For instance, one unresolved issue concerned the complementarity of various digital platform initiatives. It was for this reason that the CERHIS/Open Clinic intervention was included in the PAAR instead of the main grant, giving the country time to resolve the issue and align with other partners. By gaining pre-approval for priority interventions through the PAAR, the Global Fund business model is able to facilitate timelier approval when additional funds are made available during grant implementation. However, PCE observations in DRC and other PCE countries suggest that in practice, RSSH interventions in the PAAR are seldom selected when additional funds become available. This is likely because they are more complex interventions and require a longer time frame for successful implementation.

There is also evidence that the design of NFM3 RSSH and digital health interventions were built on lessons learned from NFM2. Key lessons from NFM2 and changes include:

- **Better integrated health services:** during the development of NFM3 funding requests, a more concerted effort was made to integrate the delivery of health services across disease verticals. Examples include greater support for community-based organizations involved in comprehensive health prevention and promotion, integrated supervision tools for the three diseases, and other Maternal and Child Health interventions, and capacity building for provincial health authorities (DPS). Also in NFM3, implementation of cross-cutting RSSH interventions will be consolidated in a stand-alone RSSH grant managed by the MoH/Cellule de Gestion Financière (CAGF) which is intended to deliver more integrated RSSH interventions and elevate health systems issues to the Secretary General and Minister of Health.
- **Greater emphasis on improving data quality and data use:** While NFM2 investments were successful in improving systems integration and reporting by all disease programs in DHIS2 (achieving greater than 90% data completeness), gaps remain in data quality, reporting timeliness, and use of data for program management that will be addressed during NFM3.
- **Enhancing coordination between public and private sectors:** The NFM3 grant will contribute to strengthening coordination with the private sector in relation to HMIS and governance. Integration of private sector data in DHIS2 is a key priority. Other investments include developing the official guidelines and standard operating procedures for how private health establishments will be integrated into national policy and information systems such as DHIS2 and LMIS, including at the provincial level.

We also noted a much stronger emphasis on monitoring RSSH performance in NFM3 with the inclusion of new RSSH coverage indicators for all six RSSH modules. The Global Fund updated the modular framework in 2019 through extensive revisions and development of new indicators for each of the RSSH modules, expanding from 13 to 24 RSSH coverage indicators. DRC's NFM3 performance frameworks include seven standardized RSSH coverage indicators and four custom indicators (Table

8). This was in comparison to NFM2, which included only three RSSH indicators (M&E-2a, PSM-3 and PSM-4). According to stakeholders, there was a concerted effort to develop indicators that could go beyond simply measuring outputs (such as facilities that receive supportive supervision), but also capture the quality of those supervision visits.

Table 8. RSSH indicators by RSSH module, comparing NFM2 to NMF3

RSSH Module	RSSH coverage indicators	NFM2	NFM3
HMIS and M&E	M&E-2a Completeness of facility reporting: Percentage of expected facility monthly reports (for reporting period) that are actually received	X	X
	M&E-2b: Timeliness of facility reporting: Percentage of submitted facility monthly reports (for reporting period) that are received on time per the national guidelines		X
	Custom: Completeness of facility reporting on logistics: Percentage of expected monthly reports (for reporting period) on logistical information that are actually received		X
	Custom: Timeliness of facility reporting on logistics: Percentage of submitted monthly logistics reports that are received 20 days following the reporting period		X
Human resources for health	Custom: Percentage of health agents that receive their salary top-up on time (within 30 days) against the number expected		X
Health products management system	PSM-3: Percentage of health facilities providing diagnostic services with tracer items available on the day of the visit or day of reporting	X	X
	PSM-4: Percentage of health facilities with tracer medicines for the three diseases available on the day of the visit or day of reporting	X	X
Integrated service delivery	SD-5: Percentage of facilities that receive supportive supervision – at least once per quarter		X
	Custom: Percentage of supervision pools that carried out quality supervision (according to standards and guidelines) during the year		X
Community systems strengthening	CSS-1: Percentage of community based monitoring reports presented to relevant oversight mechanisms		X
Health sector governance and planning	HSG-1: Percent of district health management teams or other administrative units that have developed a monitoring plan, including annual work objectives and performance measures		X

Conclusions and recommendations

Section	Conclusions	Recommendations and strategic considerations
New Funding Model 2 (NFM2)	1. The start-up of NFM2 grants was slow due to bottlenecks associated with operationalizing the new NFM2 grant implementation arrangements and establishing SR contracts. These delays affected grant performance and absorption during the first semester. 2. During grant implementation, grant targets for key populations were not revised in response to grants exceeding performance targets, nor in response to new study data (IBBS). This was a missed opportunity for maximizing grant impact. 3. RSSH investments in strengthening digital health were undermined during NFM2 by governance and leadership challenges within the Ministry of Health which if left unresolved will continue to impact progress in NFM3. 4. The availability and timeliness of data reported into DHIS2 improved during NFM2 due to the integration of national program data and PR databases in DHIS2 alongside the provincial level work of PRs and SRs to make data collection tools more available and develop the health zone data encoding framework. However, the process for integrating community-level data on health services provided to KPs is still ongoing and should remain a top priority along with reinforcing the use of this data to make decisions about resource allocations and service provision for KPs.	1. To avoid delays during the grant start-up, more intentional transition planning and coordination is required from the CCM, PRs and disease programs to avoid delays during grant start-up. 2. There is a need for PRs to be more proactive and responsive to new information and changes in programmatic and epidemiological context and to use grant revisions as a tool to act on programmatic results and update performance framework targets as needed to maximize grant results. The CCM and CT can play an important role in helping to identify opportunities for grant revisions and encouraging greater PR responsiveness. 3. The Ministry of Health must strengthen the coordination and collaboration between MOH entities involved in the implementation of GF grants to work in better synergy, for example by setting up a working committee between the DSNIS and ANiCiiS to coordinate activities in the digital health sector and in alignment with the PNDIS2. In addition, the CT, CCM, and PRs should collectively use their leverage to advocate with the Ministry of Health to address governance bottlenecks between the DSNIS and ANiCiiS for common digital health outcomes.
New Funding Model 3 (NFM3)	1. Even though the NFM3 grant design for RSSH features more integrated approaches and improved RSSH performance monitoring, country stakeholders considered support to disease components the primary objective of RSSH investments while support to the broader health system was considered secondary.	1. The Country Team and PRs should monitor and assess reporting on new RSSH indicators in NFM3 and share lessons learned with other countries.

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ANNEX

Table 1: Comparison of HIV Testing strategies and Targets from HIV NSP 2018-2021 used as the planning document for Global Fund Funding Request 2017.[5]

<table>
<tr><td colspan="2">HIV NSP 2018-2021</td><td colspan="2">2017 Global Fund HIV/TB funding request</td></tr>
<tr><td>Interventions</td><td>Indicator/Target</td><td>Interventions</td><td>Contributing Indicator/Target*</td></tr>
<tr><td>Strengthening of bidirectional integration of counseling and testing/DCIP, targeted community VCT and SRH at all levels of health system</td><td rowspan="5">Percentage of CSW that been tested and are aware of their status
Target by 2021: 80%

Percentage of MSW that been tested and are aware of their status
Target by 2021: 90%

Percentage of PWID that been tested and are aware of their status
Target by 2021: 92%</td><td rowspan="4">HIV testing services for MSM, CSW, transgender people and PWID</td><td rowspan="5">Percentage of KVP (CSW, MSM, Transgender, PWID) that has been tested and are aware of their status.
Global Fund Contribution to NSP
Target by 2020: 23%

Percentage of CSW that has been tested and are aware of their status
Global Fund Contribution to NSP
Target by 2020: 36%

Percentage of PWID that been tested and are aware of their status
Global Fund Contribution to NSP
Target by 2020: 18%

Note: Global Fund investments contributing to 2021 targets outlined in NSPs</td></tr>
<tr><td>Promotion of HIV counseling and testing as an advanced strategy with KPs</td></tr>
<tr><td>Implementation of HIV counseling and testing services, distribution of condoms and syndromic management of STIs adapted to vulnerable populations</td></tr>
<tr><td>Development of advanced and proximity strategies for HIV testing and counseling in communities</td></tr>
<tr><td>Promotion of mobile testing for HIV</td><td>Organizing evening mobile clinics for key populations (MSM, transgender people, and PWID)</td></tr>
<tr><td>Alignment</td><td colspan="3">Interventions listed in the NSP and Funding Request appear to be well aligned for testing strategies for key populations including facility- and community-based counseling and testing for HIV. In the funding request, the NSP performance measures and targets were used to inform the performance framework and Global Fund targets as contributing to the NSP strategic actions.</td></tr>
</table>

[5] CSW = Commercial Sex Worker

Table 2: Comparison of HMIS/Digital Health **SNIS 2018-2020 Strengthening Plan** used as the planning document for Global Fund funding request 2017-2019 HMIS/Digital Health.

HMIS/Digital Health SNIS 2018-2020 Strengthening Plan		funding request 2017-2019 HMIS/Digital Health	
Interventions	Indicator/Target	Interventions	Contributing Indicator/Target*
Gradual scaling up of patient file digitalization, with adapted tools that are proven and interoperable with DHIS2 in the FOSA.	Before the end of 2020: The completeness rate for basic SNIS reports is increased to 95% The promptness rate for basic SNIS reports is increased from 62% to 80% The data quality score is brought up to at least 80% by the end of 2020	Scaling up of CERHIS in Kinshasa HGRs and HCs	Proportion of reports received from facilities compared to those expected during the information communication period (completeness) 85% by the end of 2020.
Operationalization of DHIS2 data reporting via text message		Configuration of text message module in DHIS2 Pretest of reporting via text message in MAHAGI, BOMA, and BARUMBU health zones	
Equip FOSA with telephones to communicate monitoring data by text message		Equip FOSA with telephones to communicate monitoring data by text message	
Brief service providers and DPS and HZ cadres on the use of text messaging for SURVEPI reporting		Brief service providers and DPS and HZ cadres on the use of text messaging for SURVEPI reporting	
Supply HC, HGR and BCZ with telephone units to communicate SURVEPI data			
Make a health map of the health zones and areas		Make a health map of the health zones and areas	
Alignment	Conclusion: The funding request was based on and modeled after the budgeted and detailed SNIS plan.		

Table 3. Table of keywords used to initially identify activities for focus topics

Digital Health	dhis2	**Differentiated HIV Testing**	cdv mobile
	snis		diagnostic et traitement
	tiernet		diagnosis and treatment
	tier net		depistage vih
	information sanitaire		hiv testing
	information system		verification
	gestion sanitaire		data
	health management		donnees
	qualite des donnees		tdr
	data quality		rdt
	cerhis		procurement
			approvisionnement
			test