

Guide to Using Round 10 of the Global Fund to Fight AIDS, Tuberculosis and Malaria to Support Health Systems Strengthening

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Updated from previous versions of this Guide developed for earlier rounds



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Feedback on this Guide is appreciated, and should be directed to the author.

I. Introduction

The Global Fund to Fight AIDS, Tuberculosis and Malaria holds much potential for advancing applicants' health systems strengthening (HSS) efforts, including by supporting cross-cutting HSS interventions that benefit more than one of the Global Fund's three target diseases. These cross-cutting HSS interventions will frequently also benefit health system needs and health priorities, such as maternal and child health, more broadly. As the need to strengthen health systems and revive the primary health care approach gains global support, and as countries work to make a comprehensive, integrated set of health services available to their whole populations, countries have increasingly turned to the Global Fund for HSS support. In Global Fund Round 5, HSS grants totaled \$43 million over their initial two years.¹ By Round 7, the comparable figure for clearly identified cross-cutting HSS interventions had risen to \$186 million.² This doubled to \$363 million in Round 9.³

Yet even as countries' use of the Global Fund for cross-cutting HSS interventions has increased, it remains relatively low compared to the immense health system needs facing many countries eligible for Global Fund grants. And it is low compared to the considerable degree to which these are obstacles to near- and long-term progress in improved outcomes for the Global Fund's priority diseases. Round 10 is a chance to build on the continued growth of Global Fund support for HSS, for more countries to develop ambitious, successful proposals to address their HSS needs - and in turn to improve the health of their people, especially that of disadvantaged populations.

This Guide provides information on how to use the Global Fund to support HSS, key opportunities that the Global fund presents for HSS, and more. Several points bear immediate emphasis. Applicants should be aware of several key points about the cross-cutting HSS that the Global Fund will support:

- The Global Fund is flexible in terms of the types of HSS interventions it will support; only very few types of interventions are categorically excluded from funding.
- Cross-cutting HSS interventions are those that will benefit the fight against more than one of the Fund's target diseases.
- The Guidelines for Proposals for Round 10 state that "[e]ach cross-cutting HSS intervention should ensure achievement of disease outcomes for HIV, tuberculosis, and/or malaria."⁴ That is, while there is much scope for interventions that have a broad, positive impact on the health system, with benefits beyond HIV, TB, and malaria, all interventions must also have a link to improving outcomes for the Fund's target diseases. Proposals should clearly explain this connection.
- HSS interventions should be linked to national health strategies and related plans. As the Guidelines state, "there must be a clear and logical justification given between the planned cross-cutting HSS interventions, the national health development plans or strategies, and improved outcomes for HIV, tuberculosis and/or malaria."⁵
- People with health systems expertise should be involved with Country Coordinating Mechanisms (CCMs) and proposal development, including stakeholders with expertise in planning and

¹ *Report of the Technical Review Panel and Secretariat on Round Five Proposals*. Presented at the 11th Board Meeting of the Global Fund, Sept. 28-30, 2005, at 11. Available at: http://www.theglobalfund.org/documents/board/16/GF-BM16-05_TRP_Report_R7_AnnexA.pdf.

² *Report of the Technical Review Panel and the Secretariat on Round 7 Proposals*. Presented at the 16th Board Meeting of the Global Fund, Nov. 12-13, 2007, at 25. Available at: http://www.theglobalfund.org/documents/board/16/GF-BM16-05_TRP_Report_R7_AnnexA.pdf.

³ *Report of the Technical Review Panel and the Secretariat on Round 9 Proposals*. Presented at the 20th Board Meeting of the Global Fund, Nov. 9-11, 2009, at 3. Available at: http://www.theglobalfund.org/documents/board/20/GF-BM20-09_Report_of_the_TRP_and_the_Secretariat_on_Round_9.pdf.

⁴ Global Fund Round 10 Guidelines for Proposals (May 2010), at 62. The page numbers for the Round 10 Guidelines for Proposals refer to the guidelines for single country applicants. Page numbers for multi-country applicants may differ from those cited here.

⁵ *Id.* at 61.

budgeting. Close collaboration between experts in health systems and particular health system areas (such as human resources) and disease programs will enhance the likelihood of success. National alliances on HSS or health system sub-sectors, such as on human resources (e.g., a multi-stakeholder Human Resources for Health Technical Working Group) should engage their country's CCM, and the CCMs should actively reach out to such groupings.

- HSS interventions should be linked to the applicant's assessment of the health system bottlenecks to improved outcomes in AIDS, tuberculosis, and/or malaria. Applicants may find existing analyses (e.g., for GAVI) that help with this assessment.

Round 10 presents an important opportunity to invest in highly strategic areas, such as strategy development and improving human resources management capacity, as well as to secure significant funds to invest in human resources and other health system areas, as long as the interventions are needed for improved HIV, tuberculosis, and/or malaria outcomes.

As indicated above, HSS interventions that are rooted in and linked to sound national health strategies are most likely to receive support from the Global Fund. If such strategies do not exist or require strengthening, countries should prioritize their development or improvement.⁶ These strategies can be used as the basis for support in future funding rounds.

Whether or not applicants submit a Round 10 proposal, they should plan early for Round 11. Applicants can use the time before Round 11 launches to engage in the planning (including, for example, strategic planning, needs assessments, and costing) and consultation that will lay the groundwork for an ambitious, strategic, and successful HSS-related proposal. Round 11 is also expected to see increased attention on HSS as the Global Fund moves forward on a joint funding platform for HSS with other development partners.

⁶ One of the core obligations of the right to the highest attainable standard of health is that countries “adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population . . . on the basis of a participatory and transparent process . . . [including] methods, such as right to health indicators and benchmarks, by which progress can be closely monitored . . . [and they] shall give particular attention to all vulnerable or marginalized groups.” Committee on Economic, Social and Cultural Rights, *General Comment 14, The right to the highest attainable standard of health*, U.N. Doc. E/C.12/2000/4 (2000), at para. 43(f). Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

II. Using This Guide

IMPORTANT NOTE: This Round 10 Guide contains revisions and updates from PHR's earlier guides on using the Global Fund to support health systems strengthening; though there are a number of additions, much of the content is unchanged. Many of the examples in this Guide are therefore drawn from earlier Global Fund rounds; many are also drawn from Round 9. This Guide has been updated to reflect Round 10 Guidelines for Proposals. Nonetheless, we urge applicants to carefully review the Round 10 Guidelines for Proposals. If there is any conflict with information contained in this Guide, the official Round 10 Guidelines for Proposals should be followed.

1. Who should use this Guide?

This Guide is intended to assist members of Country Coordinating Mechanisms (CCMs) and others involved in preparing proposals for Round 10 of the Global Fund to Fight AIDS, Tuberculosis and Malaria. This Guide provides assistance in thinking about and developing proposals that include health system strengthening activities. It might also help motivate countries to use the Global Fund to support such activities. Physicians for Human Rights (PHR) encourages civil society to engage their countries' CCMs about ways to include HSS in their proposals to the Fund, and hopes that the information provided in this Guide will support civil society in these efforts.

PHR also encourages government officials, civil society, institutions, and others who are engaged in HSS but may not have focused on the Global Fund in the past to use this Guide to learn how HSS priorities can be incorporated into Global Fund proposals, and to engage their CCMs accordingly. For example, PHR encourages national alliances on human resources for health (HRH), such HRH technical working groups or committees, to evaluate the considerable opportunities that the Global Fund presents for HRH, and to make use of the possibilities that Round 10 presents.

2. How definitive is this Guide?

The advice in this Guide is primarily drawn from comments by the Technical Review Panel (TRP)⁷ on a number of Global Fund rounds, including Round 9; analysis of successful Round 5 Health Systems Strengthening (HSS) proposals, Round 6 proposals with significant HSS elements, and Round 9 proposals with cross-cutting HSS sections; and Round 10 Guidelines for Proposals and other Round 10 material. PHR reviewed TRP comments on unsuccessful Round 5 HSS proposals and Round 6 proposals, though the full proposals were unavailable. PHR also reviewed comments from the TRP on several unsuccessful Round 9 proposals.

The advice provided in this Guide is meant to cover a variety of country circumstances, yet much will depend on the particular nature and goals of each proposal and the situation of each applicant. Applicants should consider how the advice and analysis in this Guide apply to their particular circumstances. This Guide is intended to supplement, not replace, other forms of support.

The advice and information contained in this guide is formed by careful analysis, but the final decision lies with the TRP. This Guide has not been reviewed or endorsed by the Global Fund.

3. Where can applicants turn for further support in developing Global Fund proposals related to health system strengthening?

⁷ The Technical Review Panel consists of independent experts who review Global Fund proposals and recommend which ones the Global Fund Board should approve.

PHR urges applicants to contact sources of technical expertise as needed. Applicants can contact their country's WHO Country Office. In addition, PHR and the Health Workforce Advocacy Initiative, a civil society-led international coalition, has developed a partial list of entities that are available to offer technical support in developing HSS-related Round 10 proposals. This list of technical support providers is available through: <http://physiciansforhumanrights.org/right-to-health/globalfund-round10.html>. Other organizations are very likely also available to provide technical support, and other entities are also available to assist in implementing HSS-related components of successful Global Fund grants.

PHR strongly encourages countries to draw on all available resources, especially local experts, to ensure that proposals are technically sound, and to seek external support where needed.

If applicants have questions related to the Global Fund proposal process, PHR suggests that they contact country Global Fund portfolio managers. Their names and email addresses can be found on the country page on the Global Fund website: <http://www.theglobalfund.org>. PHR encourages civil society organizations to contact their country's CCM to learn about their country's particular Global Fund process and to discuss ways in which health workforce and other HSS interventions can be included in the Round 10 proposal.

PHR also encourages applicants and others interested in the possibility of using the Global Fund in Round 10 to support HSS to review a toolkit on using the Global Fund and HSS in Round 10, which includes the present Guide and a number of other documents, including a short reference guide. The Health Workforce Advocacy Initiative and Health Systems 20/20 developed the toolkit, which is available at: <http://physiciansforhumanrights.org/right-to-health/globalfund-round10.html>.

III. Benefits of Using the Global Fund to Support Health System Strengthening

This section discusses a number of benefits of incorporated health systems strengthening in Global Fund proposals. It begins with overarching values of using the Fund to support HSS, and then provides a number of benefits of using the Fund to support system-wide approaches to health systems strengthening.

1. Overarching value of using the Global Fund to support health systems

a. Enabling HIV, tuberculosis, and malaria programs to succeed

In many countries, weak health systems are a central obstacle to successfully scaling-up and sustaining HIV, tuberculosis, and malaria programs. The Global Fund represents an opportunity to remove these obstacles and create enormous benefits for those infected with and affected by the Fund's three target diseases.

b. Helping fulfill obligations to highest attainable standard of health

Using the Global Fund to strengthen health systems to reduce the spread and impact of HIV, tuberculosis, and malaria will help many countries fulfill their human rights obligations, in particular the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health."⁸ Under international law, states are obliged to take steps "to the maximum of [their] available resources," including resources available through international assistance, to progressively realize the right to the highest attainable standard of health.⁹ By taking maximum advantage of the Global Fund's financial resources to strengthen the national health system in ways that will improve outcomes for at least one of the Fund's priority diseases and may also improve people's health in other ways, states demonstrate their commitment to a universal right to health.

Well-designed Global Fund proposals also provide an opportunity for states to take an important step towards realizing one of their core obligations under the right to the highest attainable standard of health: meeting the needs of poor, rural, and other marginalized populations.¹⁰ Health system strengthening activities included in Global Fund proposals should be designed with a particular emphasis on these populations. Members of these populations should also be encouraged and facilitated to have an active role in developing the proposals.

2. Further benefits from a system-wide, cross-cutting approach to health system strengthening

Health system strengthening activities may be tied to a particular disease (e.g., developing a supply chain for HIV/AIDS medications or incorporating HIV into existing health information systems) or system-wide, cross-cutting activities (e.g., strengthening the national supply chain or health information system) that benefit not only a particular disease program but also a wide range of health priorities - as long as the proposal clearly demonstrates a link between these interventions and disease specific outcomes for AIDS, tuberculosis, and/or malaria. Activities may also fall in the middle and benefit several health priorities including one of the Fund's target diseases; examples might include integrating reproductive health with HIV services, or maternal and child health care with programs

⁸ International Covenant on Economic, Social and Cultural Rights, G.A. res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, *entered into force* Jan. 3, 1976, at art. 12(1). Available at: <http://www1.umn.edu/humanrts/instree/b2esc.htm>.

⁹ *Id.* at art. 2(1).

¹⁰ Committee on Economic, Social and Cultural Rights, *General Comment 14, The right to the highest attainable standard of health*, U.N. Doc. E/C.12/2000/4 (2000), at para. 43(f). Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

which prevent mother to child HIV transmission. The focus of this Guide is cross-cutting HSS activities, and the following paragraphs will briefly examine the numerous benefits of a system-wide approach.

a. Benefiting other health priorities, including maternal and child health

In addition to supporting HIV, tuberculosis, and malaria programs, system-wide strengthening can benefit other health priorities. By strengthening the health workforce and other basic health system elements, applicants can address an array of health areas and create a workforce able to provide a range of health services, helping countries to reach the Millennium Development Goals and other health targets. For example, greater health worker density has enabled countries to increase coverage of measles vaccinations and skilled health workers attending births,¹¹ thereby reducing maternal mortality.

Indeed, the Global Fund now explicitly encourages applicants to look for ways in which their proposals can strengthen maternal and child health. Some countries have already begun to do so. Several successful Round 9 proposals gave particular focus to how their cross-cutting HSS interventions would benefit maternal and child health. For example, Cambodia included activities aimed at improving the quality and utilization of maternal health services, which will strengthen efforts to prevent mother-to-child transmission of HIV and increase detection of HIV, TB, and malaria. Activities included training and support for outreach workers, addressing financial barriers, upgrading health facilities, training on maternal and newborn health, and funding performance incentives that cover a continuum of care for mother and newborn services.¹² Senegal's proposal included a set of activities (including developing guidelines, rehabilitating health facilities, and improving quality control) to enable health centers to deliver an integrated set of services including HIV, TB, and malaria as well as maternal, newborn, and infant health.¹³ Paraguay's proposal included developing the content of family health (including HIV and TB) educational material.¹⁴

b. Avoiding harm to other health priorities

In nations without an adequate supporting infrastructure, scaling up programs to address individual diseases creates an additional burden on a limited workforce and risks harming efforts to address other health priorities, unless support is provided to the system to enable it to successfully handle these additional programs. Countries with severe health worker shortages may be unable to scale up disease-specific programs without drawing health workers away from other health services. Or new or expanded programs may further stress already overworked health workers, possibly compromising quality of care delivery and rendering them more likely to leave the country's health services.¹⁵

¹¹ World Health Organization, *World Health Report 2006: Working Together for Health* (2006), at 9-11. Available at: <http://www.who.int/whr/2006/>.

¹² Cambodia Country Coordinating Mechanism, Round 9 proposal (June 2009), at 60-67. Available at: http://www.theglobalfund.org/grantdocuments/9CAMH_1810_0_full.pdf.

¹³ Senegal Country Coordinating Mechanism (CCM)/Global Fund Senegal, *Senegal Proposal - Global Fund Round 9* (June 2009), at 64-66. Available at: http://www.theglobalfund.org/grantdocuments/9SNGH_1911_0_full.pdf.

¹⁴ Paraguay Coordination Mechanism of the Country, Supporting the Prevention and Control of HIV/AIDS, Tuberculosis and Malaria, Round 9 HIV/AIDS proposal (June 2009), at 47/77-48/77. Available at: http://www.theglobalfund.org/grantdocuments/9PRYH_1905_0_full.pdf.

¹⁵ Malawi's Round 5 proposal successfully argued this very point: "Staffing levels are clearly inadequate in Malawi to scale up the three disease specific programs as well as meet increasing demand for other health services. ART clinics, and other vertical disease programs, are likely to distract staff from other services already suffering from significant staff shortages. At the same time, integrated programs at primary care and hospital facilities...are placing increasing demand on the health workers that remain. . . . With increasing specialized ART/HIV/AIDS testing and counseling services, considerable extra burdens are placed on hospital staff undermining their ability to cope." Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 52. Available at: http://www.theglobalfund.org/grantdocuments/5MLWH_1142_0_full.pdf.

Singling out disease-specific programs for special benefits poses risks. If only health workers associated with these programs receive financial incentives to promote their retention, health workers not receiving these incentives may feel that they are being treated unfairly.¹⁶ This may lower their morale and lead to reduced quality of care and staff attrition. The Global Fund is not likely to support incentives that, while benefitting health services in one area, harm health services in other areas.¹⁷ A system-wide approach minimizes such harm to other health services and can benefit them instead.

c. Integration of health services

Pursuing a system-wide approach supports the integration of health services and avoids development of a parallel, disease-specific infrastructure that duplicates existing delivery systems and wastes scarce resources. For example, duplicate procurement and distribution systems require staff to manage multiple mechanisms for drug ordering, more complex information systems, and duplicate warehouses and distribution systems.¹⁸

Integration also has significant benefits with respect to improving health outcomes. For example, integrating HIV services with family planning services, maternal and child health services, and other primary health services, will significantly increase the reach of HIV interventions, expanding uptake of HIV services faster than a non-integrated approach. Integration will also enable programs to more comprehensively meet the needs of health service users, and help overcome the risk that stigma will deter some people from seeking services from facilities that are associated solely with HIV/AIDS. Countries may use the Global Fund specifically to expand the ability of the health systems to deliver a comprehensive package of integrated health services, including but not limited to services addressing the Global Fund's priority diseases.¹⁹

Although developing parallel infrastructure may be faster and possibly less expensive in the short term, over time a unified system will result in greater efficiency and sustainability, while the investments to strengthen this system may also benefit other health services. Ethiopia chose to develop its existing procurement and distribution system to handle anti-retroviral medications and drugs for opportunistic infections rather than construct a parallel system. Initially this led to slow procurement and a period of adjustment, but Ethiopia adapted and began “renting more warehouses, hiring more staff on short-term contracts, and contracting out specific elements of the procurement and distribution chain... [resulting in] very positive effects upon the efficiency of procurement.”²⁰ This is especially critical for HIV. Securing ARVs for all is both an emergency and a lifelong commitment by governments, and needs to be backed by functioning systems for the long-term, making this type of HSS integration imperative.

When applicants do seek support for disease-focused HSS interventions, they should be sure that these interventions do not come, in the words of the Global Fund's Technical Review Panel, “at the obvious expense of the broader healthcare system...[such as] by attracting staff away from [other elements of the healthcare system], or by developing an entirely vertical disease program in isolation from the remainder of the healthcare system. The TRP is critical of such approaches, and would not recommend them for funding.” The TRP's expectation is that proposed HSS activities, whether disease-focused or

¹⁶ For example, Zambia received Global Fund money in Round 4 to provide financial incentives to health workers providing anti-retroviral therapy. Ideally, such an approach would be complemented by efforts to secure funds to provide comparable incentives to other health staff.

¹⁷ “Distortion or staff diversion because of inconsistent Global Fund compensation is to be avoided.” Global Fund Round 10 Guidelines for Proposals (May 2010), at 75.

¹⁸ Kate Stillman & Sara Bennett (Partners for Health Reformplus Project, Abt Associates Inc.), *Systemwide Effects of the Global Fund: Interim Findings from Three Country Studies* (Sept. 2005), at 42. Available at: http://pdf.usaid.gov/pdf_docs/PNADF196.pdf.

¹⁹ See, e.g., Country Coordinating Mechanism (CCM)/Global Fund Senegal, *Senegal Proposal - Global Fund Round 9* (June 2009), at 64-66. Available at: http://www.theglobalfund.org/grantdocuments/9SNGH_1911_0_full.pdf.

²⁰ Kate Stillman & Sara Bennett (Partners for Health Reformplus Project, Abt Associates Inc.), *Systemwide Effects of the Global Fund: Interim Findings from Three Country Studies* (Sept. 2005), at 42. Available at: http://pdf.usaid.gov/pdf_docs/PNADF196.pdf.

cross-cutting, and however they are incorporated into the proposal, “strengthen, or at a minimum, not undermine the broader healthcare system.”²¹ The Round 10 Guidelines for Proposals direct applicants to explain possible unintended consequences of responding to health system weaknesses on a disease-specific program basis and how they intend to mitigate those risks.²²

At a May 2006 meeting in Cape Town, South Africa, a meeting of AIDS advocates, health systems experts, health officials and workers, and people living with HIV/AIDS agreed that countries should undertake “an explicit assessment and evaluation of which components...can be integrated into general health systems and which require vertical implementation in the short to medium term.”²³ If a vertical approach is chosen for the short-term (perhaps because of urgency combined with the serious weaknesses of existing systems), specific plans should be made - and the necessary measures taken - “for integrating all vertical components into the general health system in the medium and long term.” Finally, program planners should consider possible unforeseen consequences of their approach and “include contingency strategies to address potential problems.”²⁴

d. Meeting essential needs

In some cases, a system-wide approach is the only way to meet needs. Rwanda’s and Malawi’s Round 5 HSS proposals are both good examples. Realizing that its human resource shortage was too severe to resolve only on a disease-specific basis, Malawi secured a Global Fund grant that included system-wide measures to retain health workers and expand its capacity to train new health workers. Rwanda recognized that overall low utilization of health services was an obstacle to the success of its AIDS, tuberculosis, and malaria programs, so proposed measures to encourage utilization by improving overall access to health services. In Round 8, Mozambique and Zambia, both of which suffer severe shortages of health workers, received significant support from the Global Fund to train new health workers.

e. Building health systems accountable to communities

HSS interventions can include activities to make health systems more accountable to the people they serve. Cambodia’s Round 9 proposal included strengthening Health Center Management Committee (committees that each health center establishes that include community members, who can voice concerns and have these concerns communicated up the hierarchy) building community members’ understanding of their health-related rights (including their right to be heard); assisting poor and marginalized community members to present their health concerns to Commune Councils and follow-up as appropriate; training health workers on clients’ rights; developing material for health centers to inform clients of their rights, and; mass media education on clients’ rights, women’s empowerment, the cost and location of services, and health seeking behavior.²⁵ These are also examples Community Systems Strengthening (CSS) activities, which will be discussed more below.

²¹ *Report of the Technical Review Panel and the Secretariat on Round 6 Proposals*. Presented at the 14th Board Meeting of the Global Fund, Oct. 31-Nov. 3, 2006, at 27. Available at: http://www.theglobalfund.org/documents/board/14/GF-BM-14_10_TRPReportRound6.pdf.

²² Global Fund Round 10 Guidelines for Proposals (May 2010), at 46.

²³ Communiqué from Moving towards Universal Access: Identifying Public Policies for Scaling Up AIDS Treatment and Strengthening Health Systems in Developing Countries, a workshop sponsored by Gay Men’s Health Crisis with support from The Rockefeller Foundation, May 4-5, 2006, Cape Town, South Africa. Malawi’s Round 5 HSS proposal presents a good example of integrating a parallel system into the overall health system. Malawi outsourced the initial responsibility for recruiting Health Surveillance Assistants to a local agency, which will also quickly build the capacity of its National Health Services Commission. The Health Services Commission was to assume responsibility for recruiting Health Surveillance Assistants by 2008. Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 70. Available at: http://www.theglobalfund.org/grantdocuments/5MLWH_1142_0_full.pdf.

²⁴ Communiqué from Moving towards Universal Access: Identifying Public Policies for Scaling Up AIDS Treatment and Strengthening Health Systems in Developing Countries, a workshop sponsored by Gay Men’s Health Crisis with support from The Rockefeller Foundation, May 4-5, 2006, Cape Town, South Africa.

²⁵ Cambodia Country Coordinating Mechanism, Round 9 proposal (June 2009), at 58-60. Available at: http://www.theglobalfund.org/grantdocuments/9CAMH_1810_0_full.pdf.

f. Creating equitable health systems

The Global Fund's support for cross-cutting HSS interventions offers countries an opportunity to develop health systems that meet the needs of even those residents who live in the most remote areas, or who are very poor or otherwise marginalized. Such interventions will help countries meet their right to health obligations to making their health services equally available to all their people, and fulfill the Global Fund's own vision of equitable health systems. The Global Fund supports the development of health systems that are "equitable, efficient, sustainable, transparent and accountable." The assessment of health system weaknesses that the Global Fund requires is to "consider the broad range of health system weaknesses that affect access to services by key populations (including the different needs of women and men, girls and boys), sexual minorities, and people who are not presently visible to service delivery providers due to stigma, discrimination, and other barriers to equal access."²⁶

For example, countries such as Lesotho in Round 8 and Sierra Leone in Round 9 secured Global Fund grants to provide special allowances to encourage and enable health workers to serve in remote locations or other hardship areas, 391 health workers in the case of Lesotho, and in Sierra Leone, the 20% of the health workforce that was serving in rural and other areas of greatest need.²⁷ Tanzania's Round 9 proposal included funding for a fast-track recruitment process for 460 health workers to serve on two-year contracts in posts in rural districts and then transition to regular government health staff.²⁸ The HSS section of Benin's successful Round 9 HIV proposal included recruiting specialists for and organizing medical missions to ten of the countries most isolated areas.²⁹ Countries including Malawi, Ethiopia, and Benin have used the Global Fund to strengthen their community health workforce, which both increases access to health services, particularly in rural areas, and enables a continuity of care that reaches beyond the health facility and into the community.

Other proposals have included activities to improve access to health services. Rwanda's Round 5 grant included subsidies to fully support membership in a community-based health insurance plan for very poor populations and people living with HIV/AIDS and vulnerable groups, as well as 50% co-financing of membership fees for the other members of the health insurance plan in the six provinces that the proposal covered, whose populations are largely poor and rural.³⁰ Cambodia's Round 9 HIV proposal successfully sought funding to lower barriers to accessing health services, including among its activities working to develop affordable mechanisms for community in remote areas to travel to health centers and advocating for sustainable measures to reimburse emergency transportation costs for the poor.³¹

²⁶ Global Fund Round 10 Guidelines for Proposals (May 2010), at 60.

²⁷ Lesotho Country Coordinating Mechanism, Round 8 HIV/AIDS proposal (June 2009), at 72-73. Available at: http://www.theglobalfund.org/grantdocuments/8LSOH_1709_0_full.pdf; Sierra Leone Country Coordinating Mechanism, Round 9 HIV/AIDS proposal (June 2009), at 67-68. Available at: http://www.theglobalfund.org/grantdocuments/9SLEH_1915_0_full.pdf

²⁸ Tanzania National Coordinating Mechanism, Round 9 HIV/AIDS proposal (June 2009), at 57-58. Available at: http://www.theglobalfund.org/grantdocuments/9TNZH_1926_0_full.pdf.

²⁹ National Committee for the Co-ordination of the projects funded by the Global Fund against AIDS, TB and Malaria (CNC/Benin), Round 9 HIV/AIDS proposal (June 2009), at 86. Available at: http://www.theglobalfund.org/grantdocuments/9BENH_1797_0_full.pdf.

³⁰ Rwanda Country Coordinating Mechanism, Round 5 Health System Strengthening proposal (Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda) (June 2005), at 49-52. Available at: http://www.theglobalfund.org/grantdocuments/5RWNH_1199_0_full.pdf.

³¹ Cambodia Country Coordinating Mechanism, Round 9 proposal (June 2009), at 60. Available at: http://www.theglobalfund.org/grantdocuments/9CAMH_1810_0_full.pdf.

IV. Overview of Global Fund and Health System Strengthening Possibilities

This section of the Guide provides key points about the types of activities and ways in which the Global Fund will support HSS interventions in Round 10. For more details, please review carefully the Round 10 Guidelines for Proposals, especially pages 60-63 and Annex 3 (pages 86-89).

1. Overall scope and requirements for cross-cutting HSS interventions

- The Global Fund will support HSS activities that are specific to a single disease response or that are cross-cutting, that is, that address more than one of the Fund's priority diseases, and possibly also address health needs more broadly, including but not limited to the Fund's priority diseases.³²
- Global Fund "support for health systems strengthening is available where there is a demonstrated link to reducing the spread and impact of HIV, tuberculosis and/or malaria."³³ The TRP has also emphasized "Applicants must...demonstrate how their HSS request will improve the outcomes in relation to the three diseases."³⁴
- Global Fund Round 10 provides significant opportunities for ambitious proposals to support cross-cutting HSS interventions that have a clear link to improved AIDS, TB, or malaria outcomes. In its comments on HSS activities including in the Round 7 proposals, the TRP observed that while "proposals often identified weaknesses in the national health systems, many did not comment on what could be done to improve the situation and restricted their strategic actions to relatively minor interventions..."³⁵ Round 10 presents an opportunity to support not simply minor interventions, but rather to address fundamental health systems constraints to scaling up AIDS, TB, and malaria health services and improving outcomes for those diseases.
- HSS interventions should be based on an analysis of how health system weaknesses constrain efforts to improve outcomes for AIDS, tuberculosis, and/or malaria,³⁶ and "the ability of the current health and community system to achieve and sustain scaled up interventions to appropriately respond to the threat of the disease(s)."³⁷ Section 4.3 of the Guidelines for Proposals contains more information on the information to be included in this analysis. The analysis in s.4.3 should refer to existing analyses (such as from national health strategies), and existing analyses (such as a strengths, weaknesses, threats, and opportunities analysis) should

³² Cross-cutting HSS interventions are those that "may significantly benefit more than one disease." Global Fund, *The Global Fund's Approach to Health Systems Strengthening (HSS): Information Note* (May 2010), at 3. Available at: http://www.theglobalfund.org/documents/rounds/10/R10_InfoNote_HSS_en.pdf. See also Global Fund Round 10 Proposal Form, Section 4B (stating that one condition of including HSS activities in the cross-cutting HSS section 4B is that "the interventions required to respond to these gaps and constraints [in the health system] are cross-cutting and benefit more than one of the three diseases").

³³ Global Fund Round 10 Guidelines for Proposals (May 2010), at 89.

³⁴ *Report of the Technical Review Panel and the Secretariat on Round 9 Proposals*. Presented at the 20th Board Meeting of the Global Fund, Nov. 9-11, 2009, at 21. Available at: http://www.theglobalfund.org/documents/board/20/GF-BM20-09_Report_of_the_TRP_and_the_Secretariat_on_Round_9.pdf.

³⁵ *Report of the Technical Review Panel and the Secretariat on Round 7 Proposals*, Presented at the 16th Board Meeting of the Global Fund, Nov. 12-13, 2007, at 32. Available at: http://www.theglobalfund.org/documents/board/16/GF-BM16-05_TRP_Report_R7_AnnexA.pdf.

³⁶ As section 4B the Round 10 Proposal Form states, this form for cross-cutting HSS interventions may only be used if "the proposal identifies gaps and constraints in the health system that have an impact on HIV, tuberculosis and malaria outcomes." Global Fund Round 10 Proposal Form, Section 4B.

³⁷ Global Fund Round 10 Guidelines for Proposals (May 2010), at 33.

be included in the section or as an appendix to the proposal.³⁸ That is, along with addressing the particular constraints for the Global Fund’s target diseases, the analysis of health system weaknesses should extend to overall health system needs. In its Round 9 report, the TRP emphasized the importance of “applicants bas[ing] their HSS request on a gap analysis of their national health sector strategy which is supported by holistic needs assessment of the health system.”³⁹

- HSS interventions should be connected to national health strategies. In its comments on HSS interventions in Round 9 proposals, the TRP noted as a common weakness “that many applicants are often requesting a ‘shopping list’ of all theoretical HSS needs, without giving thought to longer-term HSS programmatic planning and expected impact.” Instead, the TRP stated, “HSS must be clearly presented as being auxiliary to, and flowing from, a national health strategy.”⁴⁰
- The analysis of health system weaknesses - and as relevant to the interventions included in the proposal, the proposal’s responses to them - should cover the need to enable equitable access to health services. The analysis is to address “the structural arrangements between government and civil society in order to ensure equitable access to health services,” “the country’s priorities in strengthening the health and community systems to ensure equitable access to services for men and women,” and “whether certain groups may face barriers to access, such as women and girls, key populations, adolescents, or barriers arising from geographic, urban/rural or other location issues.”⁴¹
- Applicants have considerable flexibility in their HSS interventions. Major categories of interventions are information, service delivery, medical products and technologies, financing, health workforce, and leadership and governance. These are based on WHO’s six health systems building blocks. Page 89 of the Round 10 Guidelines for Proposals (annex 3) provides more details. The only specifically excluded interventions are basic research and certain clinical research, and large scale capital investments such as building new hospitals or clinics.⁴² While Global Fund grants may not be used to build new health facilities, they may be used (and frequently have been) to rehabilitate health facilities (and health training institutions).
- Cross-cutting HSS interventions need not be limited to the health sector, and may cover, for example, education, the workplace, and social services.⁴³ Applicants should consider how underlying determinants of health may consider to improved HIV, TB, and malaria outcomes; few countries have taken advantage of this possibility.
- Applicants may include up to five cross-cutting HSS interventions in s.4B. Interventions can be broadly conceived and may include various activities and sub-activities. In Round 9, countries often included all activities for a single health system building block within a single intervention, though with exceptions. For example, Tanzania included its numerous activities to expand pre-service training capacity as one intervention, and activities to improve retention as another.⁴⁴ Ethiopia separated into two health workforce activities 1) strengthening

³⁸ *Id.*

³⁹ *Report of the Technical Review Panel and the Secretariat on Round 9 Proposals*. Presented at the 20th Board Meeting of the Global Fund, Nov. 9-11, 2009, at 21. Available at: http://www.theglobalfund.org/documents/board/20/GF-BM20-09_Report_of_the_TRP_and_the_Secretariat_on_Round_9.pdf.

⁴⁰ *Id.* at 20.

⁴¹ Global Fund Round 10 Guidelines for Proposals (May 2010), at 33.

⁴² *Id.* at 89 n. 32.

⁴³ *Id.* at 89.

⁴⁴ Tanzania National Coordinating Mechanism, Round 9 HIV/AIDS proposal (June 2009), at 48-62. Available at: http://www.theglobalfund.org/grantdocuments/9TNZH_1926_0_full.pdf.

leadership and management at district and hospital levels and 2) improving motivation and productivity of health extension workers.⁴⁵

There should be internal coherence and a shared purpose within each intervention. For example, a number of successful Round 9 proposals had a variety of activities addressing health services within one interventions, but all with a common objective, such as an intervention in the successful HSS section of Senegal's Round 9 to expand coverage of integrated services (HIV, TB, and malaria and maternal, neonatal, and infant health), addressing such diverse issues as developing guidelines, rehabilitating health facilities, improving supervision and quality control, and developing an equipment maintenance system.⁴⁶ The objective of improving the quality of maternal health services in Cambodia's Round 9 proposal tied together such activities as mobilizing outreach workers, decreasing financial barriers to these services, rehabilitating health facilities, and introducing performance incentives related to maternal and newborn services.⁴⁷ By contrast, the TRP said that several HSS intervention in Burkina Faso's unsuccessful Round 9 proposal "lack specific focus and confuse a number of unrelated activities."

- The Global Fund now explicitly encourages countries to integrate maternal and child health into their proposals, including in their HSS interventions. The Global Fund Board "strongly encourages CCMs to look at opportunities to scale up an integrated health response that includes" maternal and child health in their proposals.⁴⁸ This does not remove the need to connect HIV interventions to improved HIV/AIDS, tuberculosis, and/or malaria outcomes.

2. Structure for including cross-cutting HSS interventions in proposal form

- Cross-cutting HSS activities may be included within a disease-specific component of the proposal or in the separate cross-cutting HSS section, s.4B. This is described in more detail in the Global Fund's HSS information note (http://www.theglobalfund.org/documents/rounds/10/R10_InfoNote_HSS_en.pdf). Countries may 1) include all cross-cutting HSS interventions as part of the description of and along with disease-specific interventions (s.4.4.1) of a single disease component; 2) divide cross-cutting HSS interventions among the disease-specific interventions of several disease components (e.g., AIDS and malaria), or; 3) include cross-cutting HSS interventions in the separate section on cross-cutting HSS interventions (s.4B). There should be no duplication of HSS interventions included in the diseases-specific component and the separate section s.4B. Therefore, if applicants include any cross-cutting HSS interventions in the disease component (s.4.4.1), these same interventions must *not* be included in s.4B. Unless there is particular reason to do so based on the proposal and its interventions, it may be best to avoid spreading cross-cutting HSS interventions across both the disease component (s.4.4.1) and the separate section 4B. Placing all HSS interventions in one place (if this fits with the logic of the proposal) may facilitate TRP review.
- Applicants may only submit one s.4B form, as part of one of the disease proposals. An applicant could not, therefore, submit one s.4B form as part of a malaria proposal and another as part of an HIV proposal.

⁴⁵ Ethiopia Country Coordinating Mechanism, Round 9 Tuberculosis proposal (June 2009), at 39-44. Available at: http://www.theglobalfund.org/grantdocuments/9ETHT_1837_0_full.pdf.

⁴⁶ Senegal Country Coordinating Mechanism (CCM)/Global Fund Senegal, *Senegal Proposal - Global Fund Round 9* (June 2009), at 64-66. Available at: http://www.theglobalfund.org/grantdocuments/9SNGH_1911_0_full.pdf.

⁴⁷ Cambodia Country Coordinating Mechanism, Round 9 proposal (June 2009), at 62-67. Available at: http://www.theglobalfund.org/grantdocuments/9CAMH_1810_0_full.pdf.

⁴⁸ Global Fund Board, *Decision Points*, 21st Board Meeting of the Global Fund, April 28-30, 2010, at 27 (Decision Point GF/B21/DP20). Available at: http://www.theglobalfund.org/documents/board/21/GF-BM21-DecisionPoints_en.pdf.

- When an applicant’s proposal includes the s.4B section on cross-cutting HSS interventions, the TRP may recommend for approval: a) both that section and the full disease proposal of which s.4B is a part; b) only the disease proposal (i.e., the disease component excluding the cross-cutting HSS interventions in s.4B), or; c) only the cross-cutting HSS interventions in s.4B, but not the rest of the disease component.

When cross-cutting HSS interventions are included in s.4.4.1, along with disease-focused activities, the TRP will assess those interventions “as an integral part of its review of the relevant disease proposal(s).”⁴⁹ In this case, the cross-cutting HSS interventions and disease-focused activities will rise or fall together. The TRP will recommend the full component for Global Fund approval, including the cross-cutting HSS interventions, or it will recommend that the Fund does not approve that disease proposal, in which case the cross-cutting HSS interventions would not be approved either.

The potential de-linking of the diseases-specific activities and the cross-cutting HSS interventions in the approval process has significant implications. Applicants who might otherwise be reluctant to use the Global Fund for ambitious HSS activities for fear that this could harm the chances of other pieces of the proposal being approved can incorporate those ambitious cross-cutting HSS interventions in s.4B without putting the disease-specific activities at risk. And likewise, if there is concern about the quality of the disease component, putting the cross-cutting HSS interventions in s.4B would enable those interventions to be approved - subject to their technical merit and based on criteria of TRP review (included in Annex 2 of the Round 10 Guidelines for Proposals) - even if the disease component is not.

The potential of having the TRP recommend for approval only the HSS section, and not the disease component with which it is associated, is real. In Round 8, the TRP recommended for approval only the HSS section - and not the disease-specific part of the proposal - for eight proposals.⁵⁰ At the same time, in Round 8, the TRP recommended for approval the disease-specific piece of the proposal, but not the HSS section, for seven proposals.⁵¹ In Round 9, the TRP recommended for approval only the HSS section and not the associated disease component in six cases.⁵² This points to a significant value in using the separate section on cross-cutting HSS interventions so that technical deficiencies in either the HSS section or the disease component does not preclude funding for the other piece of the proposal.

- Disease-focused HSS interventions should be included in s.4.4.1, not in s.4B.⁵³
- If applicants include the cross-cutting HSS interventions in s.4B, they must also include disease-program activities in s.4.4.1. A proposal may not consist only of interventions in s.4B.⁵⁴

⁴⁹ Global Fund, *The Global Fund’s Approach to Health Systems Strengthening (HSS): Information Note* (May 2010), at 3. Available at: http://www.theglobalfund.org/documents/rounds/10/R10_InfoNote_HSS_en.pdf.

⁵⁰ *Report of the Technical Review Panel and the Secretariat on Round 8 Proposals*. Presented at the 18th Board Meeting of the Global Fund, Nov. 7-8, 2008, at 5. Available at: http://www.theglobalfund.org/documents/board/18/GF-B18-10_TRP_ReportToBoard_and_Annexes2-5-6.pdf.

⁵¹ *Id.*

⁵² *Report of the Technical Review Panel and the Secretariat on Round 9 Proposals*. Presented at the 20th Board Meeting of the Global Fund, Nov. 9-11, 2009, at 3. Available at: http://www.theglobalfund.org/documents/board/20/GF-BM20-09_Report_of_the_TRP_and_the_Secretariat_on_Round_9.pdf.

⁵³ “All disease program activities that may also benefit the health system must be included in section 4.4.1 and not section 4B.” Global Fund Round 10 Guidelines for Proposals (May 2010), at 60.

⁵⁴ “A disease proposal cannot include section 4B without including other disease program activities in section 4.4.1.” *Id.* See also Global Fund, *The Global Fund’s Approach to Health Systems Strengthening (HSS): Information Note* (May 2010), at 2 (“applications cannot request funding solely for HSS cross-cutting interventions”). Available at: http://www.theglobalfund.org/documents/rounds/10/R10_InfoNote_HSS_en.pdf.

- While proposals must include some disease-specific activities in s.4.4.1, the cross-cutting HSS interventions do *not* have to be linked to the particular disease-specific activities including in s.4.5.1. As stated above, the cross-cutting HSS interventions *do* need to be linked to improving AIDS, TB, and/or malaria outcomes.
- Whether to include cross-cutting HSS interventions in s.4.4.1 along with disease-focused activities or in the separate s.4B cross-cutting HSS interventions section can be a difficult decision without a clear right or wrong answer (as long as the activities truly cross-cutting, and will benefit more than one of the Fund’s target diseases; otherwise they must be included in s.4.4.1). The following are several factors applicants may consider in deciding whether to include these cross-cutting HSS interventions in s.4.4.1 or s.4B:
 - Consider how related the planned cross-cutting HSS interventions are to the disease-focused activities in the disease proposal. If they are closely related, and the success of the disease-focused activities is linked to the HSS activities, it may make sense to include the cross-cutting interventions in the disease section.
 - Consider whether the HSS interventions will predominantly benefit one disease or more than one of the Fund’s priority diseases. If an intervention is a response to a health system weakness that only affects one of the diseases, or if it will occur through a disease program, it must be included in the component for that disease. If the intervention will benefit more than one of the Fund’s target diseases, but will address a health system weakness that is primarily a constraint to one of the diseases, it may make the most sense to incorporate the intervention in section s.4.4.1 for that disease component.
 - If the applicant is unsure whether the HSS interventions will benefit more than one disease, the applicant should include the interventions in the disease-focused part of the proposal in case the interventions are not truly cross-cutting.
 - If the health system weaknesses that the HSS interventions will address present significant obstacles to better outcomes for more than one of the Fund’s target diseases - and therefore the HSS interventions will help achieve improved outcomes for more than one of the target diseases - the applicant may want to address them in the separate section s.4B. That way, in case the TRP does not approve the disease-focused section of the proposal, there is still a real chance that it will approve the cross-cutting HSS interventions, as happened for more than a dozen proposals across Rounds 8 and 9.
 - If the cross-cutting HSS interventions clearly address health system weaknesses that affect more than one of the Fund’s target diseases, and the applicant is therefore having difficulty logically dividing up the interventions among different disease components, the applicant may want to include these cross-cutting HSS interventions in the separate section s.4B.

3. Process of developing HSS interventions

- The Global Fund expects that key health system stakeholders will be involved in developing proposals that include cross-cutting HSS interventions - which is, in any case, critical to the development of successful HSS-related proposals. In particular, applicants must provide “information on the level of involvement of government and non-government [including private sector] stakeholders in the development of section 4B.” Applicants should “[m]ake reference to the participation of representatives of key populations and sexual minorities, and how they may have helped to identify appropriate health systems service delivery areas to serve key populations.”⁵⁵ In its 2007 decision on the Global Fund’s strategic approach to HSS, the Fund’s Board “[r]ecommend[ed] that applications provide evidence of the involvement of relevant HSS stakeholders in the Country Coordinating Mechanism - including at least one nongovernment in-

⁵⁵ Global Fund Round 10 Guidelines for Proposals (May 2010), at 62.

country representative with a focus on HSS and one government representative with responsibility for HSS planning.”⁵⁶

PHR strongly recommends that the CCM actively reach out to national structures that are involved in health systems strengthening (such as committees and working groups associated with Sector Wide Approaches, health sector strategic plans, and human resources for health) to ensure that they are aware of the potential use of the Global Fund for HSS, and that they participate in developing the proposal. An extensive list of categories of stakeholders that can and generally should be engaged in country-level health workforce partnerships is included in Annex 1 of the Global Health Workforce Alliance’s publication *Human Resources for Health: Good Practices in Country Coordination and Facilitation* (available through: <http://www.who.int/entity/workforcealliance/countries/ccf/ccf/en/index.html>).⁵⁷ The CCM should reach out to civil society organizations and institutions that are addressing HSS.

4. Community systems strengthening

- The Global Fund explains Community Systems Strengthening (CSS) as “an approach that promotes the development of informed, capable and coordinated communities and community-based organizations.” Its goal “is to achieve improved health outcomes by developing the role of key populations and communities and of community-based organizations in the design, delivery, monitoring and evaluation of services and activities related to prevention, treatment, care and support of people affected by HIV, tuberculosis, malaria and other major health challenges.”⁵⁸ “CSS is a way to improve access to and utilization of formal health services...[and to increase] community engagement...in health and social care, advocacy, health promotion and health literacy, health monitoring, home-based and community based care and wider responses to ensure an enabling and supportive environment for such interventions.”⁵⁹ CSS will help ensure the responsiveness of health systems to people’s needs, provide a continuity of care between health facilities and communities, enable health systems to better reach marginalized populations, and strengthen the accountability of health systems.
- The Global Fund, through a civil society consultation process, has identified six “core components” of CSS: 1) advocacy and enabling environment; 2) community networks, linkages, partnerships, and networks; 3) resources and capacity building; 4) community activities and service delivery; 5) organizational and leadership strengthening, and; 6) monitoring and evaluation and planning.⁶⁰ For more information on CSS, please see the Global Fund’s CSS information note (http://www.theglobalfund.org/documents/rounds/10/R10_InfoNote_CSS_en.pdf) and the Global Fund’s Community Systems Strengthening Framework (http://www.theglobalfund.org/documents/civilsociety/CSS_Framework.pdf).

⁵⁶ Global Fund Board, 16th Board meeting, decision point 10, *Strategic Approach to Health System Strengthening* (Nov. 2007). Available at: http://www.who.int/healthsystems/gf_board_decision07_hss.pdf. Section 2.1.3 of the Round 10 Proposal Form, part of the section addressing eligibility, directs applicants to “[d]escribe the capacity and experience of the CCM (or Sub-CCM) on health systems strengthening issues.” Global Fund Round 10 Proposal Form, Section 2.1.3.

⁵⁷ Global Health Workforce Alliance, *Human Resources for Health: Good Practices in Country Coordination and Facilitation* (2010). Available through: <http://www.who.int/entity/workforcealliance/countries/ccf/ccf/en/index.html>. At the time of publication of the present Guide, a December 2009 draft is available through this website; a final version should be available shortly.

⁵⁸ Global Fund Round 10 Guidelines for Proposals (May 2010), at 7-8.

⁵⁹ Global Fund, *Community Systems Strengthening Information Note* (May 2010), at 1. Available at: http://www.theglobalfund.org/documents/rounds/10/R10_InfoNote_CSS_en.pdf.

⁶⁰ *Id.* at 2; Global Fund Round 10 Guidelines for Proposals (May 2010), at 87-88; Global Fund, *Community Systems Strengthening Framework* (May 2010), 14-31. Available at: http://www.theglobalfund.org/documents/civilsociety/CSS_Framework.pdf.

CSS activities are critical to ensuring an effective community-level response to the three diseases and to fully incorporating remote, impoverished, and other marginalized populations into national responses to the three diseases - and to ensuring that their voices and perspectives inform these responses. The Global Fund encourages applicants to include and highlight CSS interventions in their proposals, and has noted the increased importance of CSS in Global Fund proposals.⁶¹

- Applicants may apply for CSS activities as part of a diseases specific approach (s.4.4.1) or, if the CSS activities will benefit the response to and achieve improved outcomes for more than one of the Fund's priority diseases, they may be incorporated in section s.4B.⁶²
- CSS activities, which may include advocacy, can help build accountable health systems (such as included in Cambodia's Round 9 proposal, as described above).⁶³ CSS activities that can help build accountable health systems could include such interventions as:
 - monitoring, analyzing, and engaging policymakers on the budget for health;
 - monitoring and advocacy around the availability of health services locally;
 - advocating for increased health funding and improved policies to develop equitable health systems that meet the needs of everyone, including marginalized populations;
 - advocating for incorporating human rights, including the right to health, into policies and budgeting, and;
 - educating community members on their rights and helping them to secure their rights.

⁶¹ Global Fund Round 10 Guidelines for Proposals (May 2010), at 47; Global Fund, *Community Systems Strengthening Information Note* (May 2010), at 1, 3. Available at: http://www.theglobalfund.org/documents/rounds/10/R10_InfoNote_CSS_en.pdf.

⁶² Global Fund Round 10 Guidelines for Proposals (May 2010), at 61.

⁶³ Please see page 12 of this Guide.

V. Finding Opportunities to Support Health System Strengthening

In considering the use of the Global Fund for health system strengthening, applicants can look at opportunities to apply for health strengthening from at least three perspectives.

- The first is the perspective of constraints: what are health system constraints that they must overcome to reduce the spread and impact of the target disease(s)?
- A second is that of existing health sector strategies: are there funding gaps in an existing health sector strategy that the Global Fund can support?
- A third is the need to develop or strengthen a health sector strategy or related strategy (e.g., a human resources for health plan): despite being a critically important basis for action, do national, provincial, or district level strategies not yet exist or require strengthening?

These all represent excellent opportunities for using the Fund to support health systems strengthening.

1. Overcoming health system constraints to reducing the spread and impact of AIDS, TB, and/or malaria

When developing their proposals, applicants should consider the range of HIV/AIDS, tuberculosis, and malaria services needed and the health system constraints on delivering those services to all people in need of them. Applicants should bear in mind national strategies for achieving these goals, as well as commitments such as universal access to HIV services by 2010. What are the current and anticipated HSS constraints to initiating, scaling up, and sustaining interventions to reduce the spread and impact of the target diseases, and what are constraints to successful grant performance, both for previous Global Fund grants and for other activities included in the Round 10 proposal?

The HSS activities that may be included in the proposal are not limited to those required for successful implementation of disease-specific interventions in the Round 10 proposal. At the same time, it is important that applicants analyze Round 10 proposal goals and consider how health systems must be strengthened to achieve those goals. It is critical that such health systems strengthening be included in the proposal to enable it to be successful. The TRP will very likely be skeptical of the feasibility of a proposal that identifies system constraints to disease-specific activities, but then fails to explain how the constraints will be addressed.

Questions that can help shape the proposal include: What are the health system constraints that must be overcome? What HSS activities will be necessary to initiate new activities in the target disease areas or ensure that current programs can succeed? What will be needed to scale up these programs as rapidly as possible to reach all in need, ensure their quality, and sustain progress? What new barriers might emerge as the programs continue to expand?

A constraint may exist if AIDS, TB, or malaria activities cannot be successfully scaled up within the limitations of the current health systems. Or a constraint exists if implementing disease-related activities may be possible, but would come at the expense of the broader health system. For example, as a result of a human resource shortage, the only way for a country to achieve ART targets may be to draw health workers away from other health care services, thereby harming these other health services.⁶⁴ Applicants may seek support from the Fund to overcome such constraints.

Building a health workforce for the future

⁶⁴ Malawi's Round 5 HSS proposal explains this well: "Staffing levels are clearly inadequate in Malawi to scale up the three disease specific programs as well as meet increasing demand for other health services. ART clinics, and other vertical disease programs, are likely to distract staff from other services already suffering from significant staff shortages. At the same time, integrated programs at primary care and hospital facilities, such as [Essential Health Package] TB and malaria interventions, are placing increasing demand on the health workers that remain." Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 52. Available at: http://www.theglobalfund.org/grantdocuments/5MLWH_1142_0_full.pdf.

Even as applicants should address and respond to immediate health worker needs, a lack of long-term capacity can put the sustainability of HIV, tuberculosis, and malaria programs at grave risk. In addition to activities that meet immediate needs, the Global Fund also allows support for applicants in building capacity for the future, as long as applicants can demonstrate that such actions are required for the longer term success of efforts to reduce the spread and impact of the target diseases. In Round 5, Malawi proposed expansion of health professional pre-service training capacity “to have adequate numbers of qualified staff for the future.”⁶⁵ The TRP agreed that this was appropriate, noting that one of its strengths was that it “address[ed] both the immediate need to deliver services [and] the longer term need to build capacity to train the next generations of workers.”⁶⁶

In Round 6, Mozambique received funds to expand its pre-service training for basic and middle level health professionals, including support for training 510 basic level and 11 middle level health professionals.⁶⁷

In Rounds 8 and 9, several countries have used the Global Fund for very significant support for pre-service training for health workers. Mozambique’s successful Round 8 proposal included training approximately 30% of the additional pharmacist and laboratory technicians, general and maternal and child health nurses, and clinical officers (the professions identified as having the closest connection to achieving AIDS, tuberculosis, and malaria outcomes) that Mozambique sought to train through 2013 based on its health workforce plan, as well as salary support for 1 year for these health workers (bridging the time between graduation and when they would be put on the civil service payroll). This totaled training for 4,380 new health workers, along with 180 instructors. The proposal also included training and salary support for 1,600 community health workers.⁶⁸ Also in Round 8, the Global Fund Board approved Zambia’s HIV proposal, including its cross-cutting HSS section, which contained support for expanding and rehabilitating ten health worker training institutions, recruiting tutors as a short-term strategy as more tutors are being produced, maximizing training capacity through public-private partnerships, reducing student attrition, and improving adherence to training standards.⁶⁹

In Round 9, the cross-cutting HSS section in Eritrea’s successful malaria proposal included training for 1,500 new associate nurses and 150 new laboratory technicians, and upgrading 400 associate nurses to nurse-midwives.⁷⁰ Tanzania successfully sought Global Fund support in Round 9 to execute expansion plans for 36 health training institutions (including to expand classroom space, laboratories, student housing, and libraries, to recruit additional instructors, and to provide needs-based grants) and to complete and execute expansion plans for additional training institutions. The proposal also included renovating 21 hospitals to train certain cadres, introducing clinical staff to teaching methods, and incentivizing them for their teaching and mentoring roles. These activities will combine to approximately double the country’s health professional student intake from 3,501 to 6,885.⁷¹

2. Supporting an existing strategy

⁶⁵ *Id.* at 10.

⁶⁶ This and ensuing references to the Technical Review Panel’s statements and views on Round 5 proposals and Round 6 are based on the TRP review forms for Round 5 and Round 6.

⁶⁷ Mozambique, Round 6 HIV/AIDS proposal (Mozambican National Initiative to Expand Coverage for Prevention, Care, Support and Treatment for Persons Affected by HIV/AIDS) (Aug. 2006), at 54. Available at: http://www.theglobalfund.org/grantdocuments/6MOZH_1381_595_full.pdf.

⁶⁸ Mozambique, Global Fund Round 8 HIV/AIDS proposal (July 2008), at 85-86. Available at: http://www.theglobalfund.org/grantdocuments/8MOZH_1719_0_full.pdf.

⁶⁹ Zambia Country Coordinating Mechanism, Round 8 HIV/AIDS proposal (2008), at 5-6, 67-68. Available at: http://www.theglobalfund.org/grantdocuments/8ZAMH_1781_0_full.pdf.

⁷⁰ Eritrea Country Coordinating Mechanism, Round 9 malaria proposal (Eritrea Towards Universal Coverage of Malaria Prevention and Treatment Interventions) (May 26, 2009), at 77-79. Available at: http://www.theglobalfund.org/grantdocuments/9ERTM_1835_0_full.pdf.

⁷¹ Tanzania National Coordinating Mechanism, Global Fund Round 9 HIV/AIDS proposal (2009), at 48-53. Available at: http://www.theglobalfund.org/grantdocuments/9TNZH_1926_0_full.pdf.

Limited funding may prevent the implementation of existing health sector strategies. The Global Fund can help fill those funding gaps, where such funding is necessary to overcome constraints in advancing efforts to fight AIDS, tuberculosis, and/or malaria. PHR encourages applicants to develop HSS interventions that are based on existing strategies. This will ensure that these actions are harmonized with other health sector activities and part of a coherent and comprehensive approach (assuming existing strategies are of good quality), and thus most likely to be effective and to contribute to broader health system strengthening. Also, this will ensure that they are consistent with the national health sector development plan and its timeframe.

The Global Fund itself forcefully suggests that cross-cutting HSS interventions “should not be developed in isolation from existing national strategies.”⁷² Drawing on comments of the TRP, the Global Fund’s Round 10 information note on HSS references the value of drawing on the gap analysis in the national health strategy. The information note continues, “[t]his ensures that the proposed HSS interventions are based on analytical diagnoses of the underlying causes of health systems challenges and that the resulting funding request is clearly presented as being auxiliary to, and flowing from, a national health strategy.”⁷³

If it is not possible to address constraints through an existing strategy, applicants may develop targeted interventions to address the constraints. They might also scale up programs, or replicate interventions that have been successful in other countries, if circumstances are sufficiently similar and local conditions are considered in tailoring the intervention to fit the country context. If cross-cutting HSS actions are not part of an existing, comprehensive plan, applicants should describe how these actions are part of a functioning system or comprehensive approach.

Applicants should also describe, to the extent possible, how such interventions relate to the country’s health plans and policies broadly, even if existing strategies do not specifically address these interventions. For example, an intervention might include incentives for instructors at health professional training institutions, so as to attract and retain teachers needed to train additional health workers. If the national health sector strategy discusses the need to train more health workers (or even simply the need for more health workers), the applicant should describe this connection with the strategy, even if the health sector strategy does not specifically address the fact that the difficulty attracting and retaining teachers is one obstacle to training more health workers.

3. Creating or strengthening national health plans, sub-national health plans, and sub-sector plans

The Global Fund represents an opportunity to support the development or revision of national health sector plans, comprehensive plans at the district or provincial level, or plans that cover a particular element of the health system, such as human resources for health. Ensuring robust national health strategies and associated plans is particularly important with the growing focus of development partners - including the Global Fund itself - on realizing the commitments of the Paris Declaration on Aid Effectiveness. Through such mechanisms as the Joint Assessment of National Strategies (JANS), now in its pilot stage,⁷⁴ development partners are expressing increased commitment to align their support with national health strategies and priorities. This requires that countries have strong strategies in place.

⁷² Global Fund Round 10 Guidelines for Proposals (May 2010), at 61. And as noted above, the TRP stated: “HSS must be clearly presented as being auxiliary to, and flowing from, a national health strategy.” *Report of the Technical Review Panel and the Secretariat on Round 9 Proposals*. Presented at the 20th Board Meeting of the Global Fund, Nov. 9-11, 2009, at 20. Available at: http://www.theglobalfund.org/documents/board/20/GF-BM20-09_Report_of_the_TRP_and_the_Secretariat_on_Round_9.pdf.

⁷³ Global Fund, *The Global Fund’s Approach to Health Systems Strengthening (HSS): Information Note* (May 2010), at 4. Available at: http://www.theglobalfund.org/documents/rounds/10/R10_InfoNote_HSS_en.pdf.

⁷⁴ For more on the JANS process, see International Health Partnership, *Joint Assessment of National Strategies*, http://www.internationalhealthpartnership.net/en/about/j_1253621551, accessed April 17, 2010.

Such plans have many benefits. They can:

- serve as the basis for a coordinated response by all international and domestic partners;
- create a comprehensive, coherent approach to developing the health sector, which will translate into improved health outcomes and increased opportunities for partners (such as the Global Fund) to invest in the health sector;
- incorporate values, such as equality and a pro-poor response, throughout the health sector;
- provide an opportunity for broad input and participation in developing the national response to the population's health needs;
- catalyze policy reforms and the development of monitoring and evaluation systems that facilitate sustainable strategies;
- clarify funding needs, which can then be used to advocate within government and with international partners for the necessary funding;
- reduce transaction costs with development partners and help ensure that development partner support is aligned with country priorities; and
- define investment needs that can then be incorporated into the national budgeting process, including through Poverty Reduction Strategy papers and Medium Term Expenditure Frameworks. This can serve as a basis to help ensure that macroeconomic policies are designed to adequately fund these needs.

Technical and other financial support may be needed to develop a national plan. The Global Fund, which can support strategic planning and strategy development, can help finance this support,⁷⁵ as long as applicants can demonstrate the necessary link between developing these plans and improving outcomes for the Fund's target diseases. Applicants might argue that the development of a plan is necessary for ensuring a comprehensive, coherent, and effective response to the health system constraints and weaknesses that limit achieving improved outcomes for the target diseases, and to ensure that the response to the Fund's target diseases will contribute to broader health system strengthening, rather than risking unintended negative consequences.⁷⁶

Applicants can also argue that a comprehensive health sector plan can help ensure that health sector investments promote equity and address needs of marginalized populations - and applicants should ensure that their plans do so. Previous TRP comments have indicated the TRP's support for equity, and Round 10 Guidelines themselves expressed the Fund's support for "equitable, efficient, sustainable, transparent and accountable health systems."⁷⁷

When developing health sector plans, countries should involve members of civil society (including members of marginalized populations), health workers, and other stakeholders in the planning process. Such participation will help ensure the successful implementation of the plan, can build trust among health system users and health workers, and can help ensure that the plan meets the population's health needs, including the needs of poor and other marginalized populations. In their proposals, applicants should explain mechanisms to provide for genuine participation in the planning process.

⁷⁵ World Health Organization officials agree: "If human resource development plans are not presently available, the framework of the Global Fund permits support to technical assistance to lay those foundations." Sigrid Dräger, Gulin Gedik & Mario Dal Poz, "Health workforce issues and the Global Fund to fight AIDS, Tuberculosis and Malaria: an analytical review." *Human Resources for Health* (2006) 4:23. Available at: <http://www.human-resources-health.com/content/4/1/23>.

⁷⁶ Kenya explained in its proposal that improved district health planning and management capacity is needed so that plans reflect the disease burden and local solutions. Further, improved understanding of the purpose of collecting data, along with developing a culture of operational research to define best practices, will enable district health teams "to define locally relevant approaches for improving health service delivery." This capacity will also enable planners and managers to address the "complex issues of health prioritization, resource need assessment and allocation based on the availability of . . . robust strategic information." Kenya Country Coordinating Mechanism, Round 6 Tuberculosis proposal (August 2006), at 78, 72, 64. Available at: http://www.theglobalfund.org/grantdocuments/6KENT_1351_0_full.pdf.

⁷⁷ Global Fund Guidelines for Proposals Round 10 (May 2010), at 60.

The Global Fund has previously supported planning. Cambodia's successful Round 5 HSS proposal focused largely on planning, including better linking Global Fund planning to the Ministry of Health's core strategic planning processes, strengthening linkages between health system planning and financing, and strengthening technical planning capacities for health. In Round 6, Kenya received funds to train "district health management teams in the development of integrated, comprehensive and implementable district health plans with a robust monitoring and evaluation system."⁷⁸ This training was expected to enable all districts in Kenya to have good quality and comprehensive health plans by the end of the five-year grant. In Round 9, Fiji's proposal, with its cross-cutting HSS section focused on improving the country's health information system, including among its activities developing a national plan on health information management.⁷⁹ And also in Round 9, Paraguay successfully sought funding for a range of HSS interventions that included technical support to prepare a Plan for the Optimisation and Redistribution of Human Resources and for a Strategic Plan for Human Resource Management and Development.⁸⁰ One sample HSS indicator in the March 2008 Addendum to the Fund's Monitoring & Evaluation Toolkit highlights the potential of using the Global Fund to support this planning process: "Health sector development strategic plan developed, agreed, implemented and reviewed annually."⁸¹

Developing a comprehensive human resources for health plan

Developing human resources plans, along with specific strategies and budgets to implement the plans, is an important step in beginning to overcome the health workforce crisis that constrain many countries burdened by AIDS, tuberculosis, and malaria. Indeed, African Union health ministers committed to "[p]repare and implement costed human resources for health development plans" in the October 2005 Gaborone Declaration on a Roadmap Towards Universal Access to Treatment and Care.⁸² And the Africa Health Strategy 2007-2015 calls on governments to "[d]evelop costed national human resources development and deployment plans, including revised packages and incentives, especially for working in disadvantaged areas."⁸³ The Kampala Declaration and Agenda for Global Action agreed to at the First Global Forum on HRH in March 2008 recognizes the centrality of national health workforce plans to an effective, coordinated national response.⁸⁴ Most countries have developed health workforce plans of some sort, though they often have significant shortcomings, such as not being costed, lacking an implementable plan of action, not being sufficiently based in human rights, and not actually being implemented. Round 10 could provide the funds to support countries in meeting the above commitments on planning and developing plans that are "costed and evidence-informed, consistent with

⁷⁸ Kenya Country Coordinating Mechanism, Round 6 Tuberculosis proposal (August 2006), at 74. Available at: http://www.theglobalfund.org/grantdocuments/6KENT_1351_0_full.pdf.

⁷⁹ Global Fund, *Fiji Grant Performance Report External Version* (last updated April 16, 2010), at 4. Available at: http://www.theglobalfund.org/grantdocuments/9FJIT_1956_914_gpr.pdf.

⁸⁰ Paraguay Coordination Mechanism of the Country, Supporting the Prevention and Control of HIV/AIDS, Tuberculosis and Malaria, Round 9 HIV/AIDS proposal (June 2009), at 48/77. Available at: http://www.theglobalfund.org/grantdocuments/9PRYH_1905_0_full.pdf.

⁸¹ Global Fund, *Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria* (2nd ed.) Addendum March 2008 (March 2008), at 22. The Global Fund now has an updated monitoring and evaluation toolkit. Global Fund, *Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening*, 3rd Edition (Feb. 2009). Available at: http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HSS_en.pdf.

⁸² Gaborone Declaration on a Roadmap Towards Universal Access to Treatment and Care, 2nd Ordinary Session of the Conference of African Ministers of Health (CAMH2), Gaborone, Botswana, Oct. 10-14, 2005, at 2(v). Available at: <http://physiciansforhumanrights.org/library/documents/reports/gaborone-declaration.pdf>. Earlier, the Fourth Ordinary Session of the Assembly of the African Union, meeting in January 2005, urged Member States to "Prepare inter-ministerial costed development and deployment plans to address the Human Resources for Health Crisis." Assembly of the African Union, Fourth Ordinary Session, Jan. 30-31, Abuja, Nigeria, *Decision on the Interim Report on HIV/AIDS, Tuberculosis, Malaria and Polio*.

⁸³ Africa Health Strategy 2007-2015, at para. 56. Adopted at the Third Session of the African Union Conference of Ministers of Health, Johannesburg, South Africa, April 9-13, 2007. Available at: http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY.pdf.

⁸⁴ Global Health Workforce Alliance, *Kampala Declaration and Agenda for Global Action* (March 2008). Available at: <http://www.who.int/workforcealliance/Kampala%20Declaration%20and%20Agenda%20web%20file.%20FINAL.pdf>.

human rights principles, including gender sensitivity, and based on projected needs,” as called for by the Global Health Workforce Alliance.⁸⁵

Such plans are most likely to be successful if a core leadership team meets regularly to help develop the plan and ensure that it is implemented, if there is a consensus-building process among stakeholders, if they are developed through a multi-sectoral, multi-stakeholder process, if all stakeholders have meaningful input into the planning process, and if a clear monitoring and evaluation strategy is developed to ensure that adjustments are made as necessary. For more on national processes that can support the development and implementation of national health workforce plans, please see the guide from the Global Health Workforce Alliance on *Human Resources for Health: Good Practices in Country Coordination and Facilitation*.⁸⁶

Enabling a wide range of stakeholders to participate throughout this process is pivotal to the plan’s success and necessary as a matter of human rights, specifically the right of people to participate in decisions related to their health.⁸⁷ PHR has developed a guide on using a human rights framework in developing a health workforce plan (available at: <http://physiciansforhumanrights.org/library/documents/reports/the-right-to-health-and-health-workforce-planning.pdf>).⁸⁸ The Health Workforce Advocacy Initiative has developed a practical reference guide to incorporating human rights considerations into the national health workforce plan and its planning and monitoring and evaluation processes (available at: <http://physiciansforhumanrights.org/library/documents/reports/incorporating-right-to-health.pdf>),⁸⁹ as well as *Guiding Principles for National Health Workforce Strategies* (available at: http://www.healthworkforce.info/advocacy/HWAI_Principles.pdf).⁹⁰

WHO and several partners have also developed an HRH Action Framework to assist with health workforce planning. It is available at: <http://www.capacityproject.org/framework/>.⁹¹

Applicants may also wish to lay the groundwork for a successful health workforce plan by seeking funds to support activities that can help ensure an evidence-based plan. In Round 6, Kenya did this by planning studies on factors that influence health worker motivation and by carrying out TB/HIV

⁸⁵ Global Health Workforce Alliance, *Moving Forward from Kampala: Strategies, Priorities, and Directions of the Global Health Workforce Alliance: 2009 to 2011* (2009), at 9. Available at: http://whqlibdoc.who.int/publications/2009/9789241598033_eng.pdf.

⁸⁶ Global Health Workforce Alliance, *Human Resources for Health: Good Practices in Country Coordination and Facilitation* (2010). Available through: <http://www.who.int/entity/workforcealliance/countries/ccf/ccf/en/index.html>. At the time of publication of the present Guide, a December 2009 draft is available through this website; a final version should be available shortly.

⁸⁷ “A further important aspect [of the right to health] is the participation of the population in all health-related decision-making at the community, national and international levels.” Committee on Economic, Social and Cultural Rights, *General Comment 14, The right to the highest attainable standard of health*, U.N. Doc. E/C.12/2000/4 (2000), at para. 11. Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

⁸⁸ Physicians for Human Rights, *The Right to Health and Health Workforce Planning: A Guide for Government Officials, NGOs, Health Workers and Development Partners* (2008). Available at: <http://physiciansforhumanrights.org/library/documents/reports/the-right-to-health-and-health-workforce-planning.pdf>.

⁸⁹ Health Workforce Advocacy Initiative, *Incorporating the Right to Health into National Health Workforce Plans: Key Considerations* (Nov. 2009). Available at: <http://physiciansforhumanrights.org/library/documents/reports/incorporating-right-to-health.pdf>.

⁹⁰ Health Workforce Advocacy Initiative, *Guiding Principles for National Health Workforce Strategies* (2008). Available at: http://www.healthworkforce.info/advocacy/HWAI_Principles.pdf.

⁹¹ One tool that human resource planners might find useful, particularly in the context of HIV/AIDS, are the joint Management Sciences for Health/World Health Organization publication *Tools for Planning and Development Human Resources for HIV/AIDS and Other Health Services*, available at http://www.who.int/hrh/tools/tools_planning_hr_hiv-aids.pdf.

workload assessments.⁹² Applicants may consider studies in related areas, such as those influencing health worker migration and rural retention, or they may wish to conduct overall workload assessments, that cover the Fund's target diseases but are not limited to them. In Round 9, Tanzania's proposal included a review of several innovative health workforce strategies, including the country's Emergency Hiring Program that posted staff in remote rural areas, to guide further planning.⁹³

4. Building human resource management capacity

Many countries that have health workforces that cannot meet their population's health needs suffer from poor human resource management, including a lack of human resource capacity within health ministries and a lack of human resource professionals working in the health sector. This limits the capacity of health ministries to engage in strategic policy development and to effectively implement human resource strategies and policies at the national, district, and facility levels.

Applicants can seek support in a variety of areas to strengthen human resource management, such as building the capacity of human resource units in health ministries, developing or strengthening training and mentoring programs for human resources for health managers, undertaking human resource management related activities (such as standardizing job descriptions, developing health worker performance assessments, and providing supportive supervision), and deploying human resource managers to hospitals and larger clinics.⁹⁴

Applicants can argue that without building human resource management capacity, they will be unable to effectively develop and implement the human resource policies that are needed to overcome the crisis in human resources for health, which in many countries is a major constraint to improved HIV/AIDS, tuberculosis, and malaria outcomes. In Round 9, several countries successfully applied for activities to strengthen human resource management, including Benin (to undertake a health worker census, purchase software and on human resource management and provide training on the software, and strengthen the skills of human resource management officials),⁹⁵ Paraguay (including to conduct a health worker census, develop a Strategic Plan for Human Resource Management and Development, design a human resource management information system, improve health worker supervision, implement a performance assessment system, develop a prize and incentive system for health workers, and hire professionals to strengthen human resource monitoring),⁹⁶ Tanzania (to create a human resource information system and strengthen the capacity of managers to implement the human resource performance management system),⁹⁷ and Ethiopia (to train supervisors of urban Health Extension Workers and cover transportation and other costs for supervision of Health Extension Workers in remote areas).⁹⁸

For more information on how to include interventions to build health sector human resource management capacity in Global Fund proposals, please contact James McCaffery

⁹² Kenya Country Coordinating Mechanism, Round 6 Tuberculosis proposal (August 2006), at 74, 78. Available at: http://www.theglobalfund.org/grantdocuments/6KENT_1351_0_full.pdf.

⁹³ Tanzania National Coordinating Mechanism, Global Fund Round 9 HIV/AIDS proposal (2009), at 59. Available at: http://www.theglobalfund.org/grantdocuments/9TNZH_1926_0_full.pdf.

⁹⁴ James McCaffery & Ummuro Adano, *Global Fund Round 9 Opportunity to Build Human Resource Management Capacity: the central pillar in health systems strengthening initiatives* (Oct. 2008). Available through: <http://physiciansforhumanrights.org/right-to-health/globalfund-round10.html>.

⁹⁵ National Committee for the Co-ordination of the projects funded by the Global Fund against AIDS, TB and Malaria (CNC/Benin), Round 9 HIV/AIDS proposal (June 2009), at 86. Available at: http://www.theglobalfund.org/grantdocuments/9BENH_1797_0_full.pdf.

⁹⁶ Paraguay Coordination Mechanism of the Country, Supporting the Prevention and Control of HIV/AIDS, Tuberculosis and Malaria, Round 9 HIV/AIDS proposal (June 2009), at 47/77-48/77. Available at: http://www.theglobalfund.org/grantdocuments/9PRYH_1905_0_full.pdf.

⁹⁷ Tanzania National Coordinating Mechanism, Round 9 HIV/AIDS proposal (June 2009), at 56-57, 79. Available at: http://www.theglobalfund.org/grantdocuments/9TNZH_1926_0_full.pdf.

⁹⁸ Ethiopia Country Coordinating Mechanism, Round 9 Tuberculosis proposal (June 2009), at 44. Available at: http://www.theglobalfund.org/grantdocuments/9ETHT_1837_0_full.pdf.

(jmccaffery@capacityproject.org) and/or Paul Marsden (pmarsden@intrahealth.org) of Capacity*Plus* or Ummuro Adano (uadano@msh.org) of Management Sciences for Health.

VI. Selected Issues in Constructing a Successful Proposal

This section examines several aspects of constructing successful proposals: 1) linking cross-cutting HSS interventions to reducing target diseases; 2) sustainability; 3) several issues related to salary support and incentives; 4) the importance of a comprehensive approach; 5) the value of applying for technical support, and; 6) monitoring and evaluation systems.

1. Linking cross-cutting HSS interventions to the Fund's target diseases

In both Rounds 5 and 6, some applicants found it difficult to demonstrate the required link between health system strengthening activities and reducing the spread and impact of AIDS, tuberculosis, and/or malaria.⁹⁹ In Round 9, the TRP highlighted the importance of applicants demonstrating how their HSS request would improve outcomes for the Fund's target diseases.¹⁰⁰ Malawi's and Rwanda's successful Round 5 HSS proposals, along with Kenya's Round 6 tuberculosis proposal, which focused on HSS activities, all provide good examples of how to demonstrate this link. Each proposal qualitatively described and presented evidence on the severity of the problem; described the relationship of the problem to the target diseases and used data to demonstrate this relationship, and; included impact indicators for the target diseases.

Strategically linking health system activities to HIV, tuberculosis, or malaria activities can strengthen and help affirm the link between the health system activities and the target diseases. For example, all of the health workers supported through Malawi's proposal were to be trained in HIV interventions, and the overseas training for tutors would provide them qualifications for curricula on HIV, tuberculosis, and malaria. Applicants should be sure that when applying for cross-cutting HSS actions, these interventions are designed to ensure that they will contribute to the fight against at least two of the Fund's target diseases, such as by ensuring that new health workers are trained in these diseases. If needed, applicants should apply for funds to support such activities (such as incorporating HIV competencies into the pre-service curricula).

The following paragraphs examine in depth how Rwanda, Malawi, and Kenya demonstrated the link between their proposals' HSS activities and the target diseases. Summaries of a number of other successful health systems strengthening-related proposals is available through the Toolkit on Using Round 10 of the Global Fund for Health Systems Strengthening developed by the Health Workforce Advocacy Initiative and Health Systems 20/20 (available at: <http://physiciansforhumanrights.org/right-to-health/globalfund-round10.html>).

a. Rwanda's Round 5 HSS proposal

i. Summary of proposal

Rwanda's Round 5 HSS proposal identifies the lack of interaction between the population and the health services as a central obstacle in its efforts to combat AIDS, tuberculosis, and malaria. The proposal seeks to increase this interaction by improving financial access for the poor and other groups and by improving the performance and quality of the health delivery system.

⁹⁹ In Round 5, proposals had to demonstrate that all health system strengthening activities "are necessary prerequisites to improving coverage in the fight against any or all of the three diseases," according to the Round 5 Guidelines for Proposals. In Round 6, Guidelines required that health system strengthening activities be "linked to reducing the impact and spread of any or all of the three diseases" and that they be "necessary." In Round 10, cross-cutting HSS interventions should have "a clear and demonstrated link to improved HIV, tuberculosis and/or malaria outcomes." Global Fund Guidelines for Proposals Round 10 (May 2010), at 89.

¹⁰⁰ *Report of the Technical Review Panel and the Secretariat on Round 9 Proposals*. Presented at the 20th Board Meeting of the Global Fund, Nov. 9-11, 2009, at 21. Available at: http://www.theglobalfund.org/documents/board/20/GF-BM20-09_Report_of_the_TRP_and_the_Secretariat_on_Round_9.pdf.

The proposal achieves the first objective through a community-based health insurance scheme. The Global Fund will support the full cost of membership in the insurance scheme for the very poor, people living with HIV/AIDS, and members of vulnerable groups, and 50% of the membership costs for the entire poor rural populations of the six provinces covered by the proposal. The proposal achieves its second objective primarily in two ways: 1) supporting pre-service and in-service training of health professionals and administrative and supervisory staff in health financing, health insurance, financial management of human resources, quality assurance, and monitoring and evaluation,¹⁰¹ and; 2) providing electricity to 74 health centers for facilitate laboratory services, safekeeping of vaccines, and addressing nighttime emergencies.

Through its proposed aims, the project seeks to improve financial accessibility of health services (leading to 30% growth in service utilization), improve access to quality prevention, care, and treatment in the health system's periphery, improve management of district health services, and increase community involvement in the health care system.

Rwanda's Round 5 HSS proposal is available at:

http://www.theglobalfund.org/grantdocuments/5RWNH_1199_0_full.pdf

ii. Linking HSS to the diseases

Severity of problem and data to make the case

Rwanda's proposal emphasizes that a major obstacle in controlling HIV/AIDS, tuberculosis, and malaria is the lack of interaction between the health services and affected populations. The proposal states the urgency of improving health access to the fight against the Global Fund's three priority diseases: "This lack of action between the health services and the diseased population jeopardises seriously any progress in the control of HIV/Aids, TB, malaria, and associated diseases."¹⁰² And elsewhere: "it seems indispensable to assure the financial access to health services and to gradually improve their quality in order to address the disease burdened caused by the three target epidemics."¹⁰³

The proposal includes powerful statistics to highlight the severity of the problem of lack of access, such as the fact that in rural areas, people contact the health system in only 60% of disease episodes and that "average treatment costs in the case of a single episode of disease are next to equal to the median monthly income of a rural household."¹⁰⁴

Relationship of problem to target diseases (including statistic link)

The proposal observes that even if particular health services, including TB, are free due to external funding, "the very entry into the health system remains a persisting and principal obstacle."¹⁰⁵ It specifically notes that the first consultation for TB is subject to user fees, and that "the availability of prompt and appropriate treatment of malaria remains one of the fundamental challenges within the Rwandan health system, and the need to increase the financial accessibility is of paramount importance in this context."¹⁰⁶

¹⁰¹ Notably, the Rwanda proposal includes training for management and administrative cadres, who often receive less attention than clinical staff but are also very important to the functioning of the health system. By contrast, the TRP stated that one weakness of the Round 5 HSS proposal of the Democratic Republic of Congo was that it did not provide for the training needs of management and administrative cadres, suggesting that countries should pay attention to these cadres.

¹⁰² Rwanda Country Coordinating Mechanism, Round 5 Health System Strengthening proposal (Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda) (June 2005), at 39. Available at: http://www.theglobalfund.org/grantdocuments/5RWNH_1199_0_full.pdf.

¹⁰³ *Id.* at 43.

¹⁰⁴ *Id.* at 39.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.* at 40.

In many countries (and possibly Rwanda itself), much the same could be said with respect to HIV/AIDS: Even if HIV services are free, user fees that deter initial contact with the health services will prevent opportunities for HIV counseling and testing that such contact would promote. Even if the HIV testing and counseling itself is free, if other essential health services require point-of-service payments, people may not interact with the health system in the first place, and so will not have the opportunity to be tested.

The proposal provides data to connect health service utilization to the fight against AIDS, tuberculosis, and malaria. These three diseases account for at least half of the country's entire disease burden,¹⁰⁷ and that of the 3 million annual health consultations in Rwanda, 1 million are related to malaria, 400,000 to cough as the first sign of tuberculosis, and 300-600,000 to HIV-related diseases.¹⁰⁸ Therefore, a significant portion of the increased health service utilization can be expected to be related to HIV, tuberculosis, and malaria.

Impact indicators linked to target diseases

Rwanda's proposal links its activities to a direct impact on HIV and tuberculosis. Its impact indicators include maintaining a stable HIV prevalence rate in pregnant women (5.1%), increasing tuberculosis detection rates from 45% to 70%, and improving tuberculosis treatment completion rates from 58% to 85%.¹⁰⁹

b. Malawi's Round 5 HSS proposal

i. Summary of proposal

Malawi's Round 5 HSS proposal is dedicated to human resource strengthening, as Malawi has one of the most significant health worker shortages in the world. The proposal seeks to achieve its goals of reducing HIV transmission and mortality and increasing output of highly skilled health workers through four objectives:

- Increase community-based services by recruiting and training 4,200 health surveillance assistants (HSAs), including 1,000 people living with HIV/AIDS. Compensation levels for these and other HSAs will enable these community-based health workers to benefit from the 52% salary increase already provided to other health cadres.
- Recruit and retain the 54 doctors, 100 nurses, 100 clinical officers, and 100 counselors needed to staff planned ART clinics, support expenses of 25 expatriate pediatricians and 20 internal medicine specialists, and recruit and support the additional 1,028 community nurses needed to provide the Essential Health Package, which includes tuberculosis and malaria services.
- Expand number and skills of nurse and other health professional tutors (teachers) by supporting 100 tutors in overseas training programs and developing advanced degree programs at health professional training institutes.
- Build capacity of training institutions through support for scaling up facilities and supporting curriculum development.

Achieving these objectives will fill substantial gaps in Malawi's Emergency Human Resource Programme and expand the capacity of health facilities to deliver the Essential Health Package and HIV/AIDS services.

Malawi's Round 5 HSS proposal is available at:

http://www.theglobalfund.org/grantdocuments/5MLWH_1142_0_full.pdf

¹⁰⁷ *Id.* at 38.

¹⁰⁸ *Id.* at 43.

¹⁰⁹ *Id.* at 45.

ii. Linking HSS to the diseases

Severity of problem and data to make the case

Malawi's proposal states that "[a]nalysis of the previous national AIDS strategy and the phase 1 of the Global Fund Round 1 HIV/AIDS grant showed that human resource capacity is a major constraint to scaling up."¹¹⁰ The country's "health system's civil service suffers from one of the worse staffing shortages in Africa creating a near breakdown in capacity to deliver a basic level of health care, especially in rural areas."¹¹¹ The proposal emphasizes the Malawian government's desire to scale up HIV, tuberculosis, and malaria services as well as other health services, and to scale up services for the target diseases in a way that did not harm other health services. It states that this is not possible at current staffing levels: "The shortage of health workers in Malawi is the most major constraint to meeting the EHP [Essential Health Package] service requirements for the Millennium Development Goals including scaling up ART and other HIV/AIDS/TB/malaria services."¹¹²

The proposal then provides data to back up these statements. Among other things, it compares detailed information on Malawi's health worker shortage to shortages in other sub-Saharan African countries, provides vacancy rates of health worker cadres, observes that four districts have no physicians at all, and presents the nurse-to-patient ratios, which are very poor. The proposal includes specific information on human resource needs for ART scale-up, based both on international norms and a workload analysis from Malawi's own ART clinics.

Like Rwanda's proposal, Malawi's proposal highlights the high level of overall health services delivery in the country that is related to the three diseases, including that 60% of hospital occupancy is due to HIV-related diseases, and the fact that more than the majority of work of health surveillance assistants - many of whom are trained through the proposal - is related to the three diseases.¹¹³

Relationship of problem to target diseases (including statistic link)

The proposal links the shortage in human resources to the country's ability to address HIV, tuberculosis, and malaria. "Only a small fraction of PLWHA have access to ART and less than 10 percent of all health centers in Malawi are capable of delivering the" Essential Health Package (EHP), which includes tuberculosis and malaria services. The proposal further explains, "Community based services especially in rural areas are almost devoid of EHP services."¹¹⁴

The proposal also explains that the health workers whose numbers are to be increased through the proposal are critical to ART delivery, counseling, and home-based care, as well as to an improved response to tuberculosis and malaria, and that they will improve the effective utilization of existing HIV/AIDS finances. They will also fill human resource "gaps left by staff moving to ART clinics."¹¹⁵ All health workers supported by the proposal will be trained in HIV interventions and, since the majority of patients in Malawi are HIV-positive, all health workers funded by the proposal will also provide HIV services.

Impact indicators linked to target diseases

¹¹⁰ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 8. Available at:

http://www.theglobalfund.org/grantdocuments/5MLWH_1142_0_full.pdf.

¹¹¹ *Id.* at 50.

¹¹² *Id.*

¹¹³ *Id.* at 10.

¹¹⁴ *Id.* at 49.

¹¹⁵ *Id.* at 68.

Malawi's proposal directly relates human resource improvements to specific HIV-related improvements that human resource development will result in, including increasing the percent of community members who receive HIV counseling and testing from 3% to 10%, enabling above ART adherence to increase from 95% to 98%, and increasing the percent of home-based care patients who are followed-up and provided treatment from 25% to 75%.¹¹⁶

c. Kenya's Round 6 TB proposal

i. Summary of proposal

Kenya recognized that its previous tuberculosis proposals to the Global Fund, which had been approved, would increase demand on the health system, and that health system capacity had to be increased to meet this demand. The proposal addresses three areas to build capacity to scale up the country's integrated TB/HIV program.

- Most of Kenya's dispensaries, primary level health facilities, lack the ability to offer even basic TB/HIV services. The proposal seeks funds to rehabilitate many of these facilities so that in five years, at least 80% would be able to provide basic TB/HIV services, up from 16% at present. Activities included procuring microscopes, other laboratory equipment, furniture, and power supply equipment; renovating examination rooms, and; maintaining equipment and physical infrastructure.
- The proposal seeks build health workforce capacity, including by recruiting 155 additional staff (40 nurses, 15 clinical officers, and 100 laboratory technologists) and improving in-service and pre-service training, primarily for TB/HIV. The proposal will fund studies on health worker motivation, and will support the production and distribution of a variety of job aids. To improve health workforce planning and deployment decisions, the proposal will fund TB/HIV workload assessments. These will be used to develop a human resource development plan for TB, which will be merged with overall human resources for health plan that Kenya will develop.
- The proposal will support health planning and management capacity by training district health management teams in the development of comprehensive, implementable district health plans. These are to include robust monitoring and evaluation systems and built-in operational research to define best practices in the delivery of integrated TB/HIV services.

Kenya's Round 6 TB proposal is available at:

http://www.theglobalfund.org/grantdocuments/6KENT_1351_0_full.pdf

ii. Linking HSS to the diseases

Severity of problem and data to make the case

The proposal focuses on how a lack of health facilities, especially at the primary level, that offer integrated TB/HIV services immediate access to these services, and includes several powerful statistics to demonstrate this fact. The proposal explains that these primary level facilities, especially dispensaries, are critically important because "the bulk of the population accesses its health care from them."¹¹⁷ Higher level facilities that are more likely to offer TB/HIV services are at large health facilities that may be inaccessible to most communities. Further, the proposal states that user fees are still charged at hospitals, but not primary level facilities.¹¹⁸

The proposal states that "Kenya is facing a human resource for health crisis," that due to "an attempt to control the Government wage bill there has been no significant recruitment of health staff in the public sector for over a decade and therefore, large human resource gaps have emerged that threaten

¹¹⁶ *Id.* at 55.

¹¹⁷ Kenya Country Coordinating Mechanism, Round 6 Tuberculosis proposal (August 2006), at 71. Available at: http://www.theglobalfund.org/grantdocuments/6KENT_1351_0_full.pdf.

¹¹⁸ *Id.* at 56, 64.

the ability of the country to deliver on its health objectives.” Further, the proposal explains the need to expand the number of health facilities as the population rises - and that in fact funding is being used to develop new facilities - yet “[w]ithout bringing in more [human resources], this [increase in the number of health facilities] will worsen the human resource gaps.”¹¹⁹ Kenya’s proposal observes that “several health care facilities . . . closed as a result of lack of health care staff.”¹²⁰

In less detail, the proposal also refers to both low productivity - “[t]he human resource for health equation does not end with numbers alone,” the proposal correctly observes - and weak health management capacity.¹²¹ “There has been a lot of effort to “expand the financial envelope available for health,” the proposal asserts, “but there has been no equal zeal to pursue better health planning and health resource management.”¹²² Yet “[i]t is critical that health planners and managers at district level are well versed with the complex issues of health prioritization, resource need assessment and allocation based on the availability of a robust strategic information.”¹²³

The proposal refers to the fact that “only 16% of dispensaries, a small proportion of truly primary level facilities, are able to provide the basic package of TB/HIV services.” Even “of the 1605 health units that offered TB services in 2005 only 700 (43.6%) were offering smear microscopy services.”¹²⁴ With respect to health personnel, the proposal includes the statistic that based on current staff numbers of staffing ratios, the country is experiencing a shortage of 17,041 health personnel,¹²⁵ yet “[i]f the needs are to be based on workload, it is very likely that larger gaps will emerge.”¹²⁶

Relationship of problem to target diseases (including statistic link)

Kenya’s linkage between the problems its Round 6 proposal addresses and tuberculosis is founded on two principles. First, reminiscent of both Malawi’s and Rwanda’s proposals, is to increase access to health services, in this case integrated TB/HIV services. The central goal of the proposal “is to expand the capacity of the health care system to deliver integrated TB/HIV services, especially at primary levels of the health care system, in order to improve access to these services and thus, increase TB case detection and treatment success rates.”¹²⁷

Second, the proposal is premised on an increase of demand for TB services that the full implementation of earlier Global Fund proposals will create without a commensurate increase in the capacity of the health system to deliver these services: “The full implementation of activities in round of 2 and 5 and in particular the Communication and Social Mobilization activities of round 5, may lead, as intended, to a massive increase in the demand for services yet both grants were not designed to strengthen the system to cope with this demand. This proposal is intended to form the bridge between demand for health services that the previous grants may create and the supply of those services.”¹²⁸

That only 16% of primary care facilities dispensaries provide integrated TB/HIV services provides a clear link between the lack of capacity at these facilities and the availability of TB/HIV services. To further bolster this link, the proposal includes a table with “data to suggest that TB case notification is directly related to health facility density in Kenya,” while conceding that “the evidence is imperfect.”¹²⁹

¹¹⁹ *Id.* at 63.

¹²⁰ *Id.* at 57.

¹²¹ *Id.* at 63.

¹²² *Id.* at 63-64.

¹²³ *Id.* at 64.

¹²⁴ *Id.* at 56.

¹²⁵ *Id.* at 62.

¹²⁶ *Id.* at 63.

¹²⁷ *Id.* at 71.

¹²⁸ *Id.* at 76.

¹²⁹ *Id.* at 55 (the table is on page 56).

The proposal also presents data on decreasing improvements in TB case notification, which had been increasing “at 12-16% annually, [though] in 2005 there was an increase of only 3% compared with 2004.” Kenya’s proposal offers that “[o]ne hypothesis for the decline in annual case notification between 2003-05 is the possibility that the health care system has reached a ‘saturation’ point and can no longer cope find additional cases. This would imply that TB case notification will only rise again if the health care system is ‘boosted’ to increase its capacity to cope with the demand for TB services.”¹³⁰

Impact indicators linked to target diseases

The proposal includes indicators both on key TB measures as well as health system capacity to deliver TB services and the population to access them. These include increasing case notification by 50% by year 5, increasing successful outcomes from 82% to at least 85%, increasing the proportion of dispensaries offering the full basic DOTS package and select HIV services from 16% to 40%, and increasing the total number of sputum smear examinations for new patients by 50% by year 5, and maintaining updating of HIV testing for TB patients at over 80%.¹³¹

2. Sustainability¹³²

The Global Fund’s Guidelines for Proposals require countries to address how they will sustain activities included in their proposal, including financial sustainability. As the Round 10 Guidelines for Proposals state clearly, this does **not** mean that applicants need “to demonstrate financial self-sufficiency for the targeted interventions by the end of the proposal term.” Rather, applicants “should include how the proposal is addressing issues such as capacity to absorb increased resources and recurrent expenditures, and how national planning frameworks are seeking to increase available financial and non-financial resources to ensure effective prevention and control of the disease(s).”¹³³

Examined below are the ways in which several countries have addressed the sustainability of health systems strengthening costs, especially salaries, in Global Fund proposals. These are not mutually exclusive possibilities; an applicant might demonstrate sustainability through several different approaches, such as through an increasing domestic health budget along with support from international partners. The Global Fund does not have different standards or special requirements for demonstrating sustainability of salaries as compared to other interventions, though as addressed below, the Global Fund does ask that applicants explain how salaries in Global Fund proposals are harmonized with existing salary scales and practices.

In short, countries are not required to be able absorb the full salaries included in their proposals into their budgets at the end of the grant period. Nor are they required to have an identified development partner that has agreed to provide future funding. However, the more certain applicant plans are with respect to sustaining salaries beyond the grant period, whether through domestic resources, development partner support, or both, the more favorable the likely response from the TRP. The TRP is also likely to look more favorably on proposals where at least a portion of the post-grant period salary requirements is provided from domestic resources¹³⁴ - though this transition is not a formal requirement.

¹³⁰ *Id.* at 55.

¹³¹ *Id.* at 87.

¹³² Parts of this section not referring to Round 5 are quoted from the *Guidance to the Global Fund to Fight AIDS, Tuberculosis and Malaria and Support for Human Resources for Health* (pages 14-15), which Physicians for Human Rights produced in April 2005 and is available at: <http://physiciansforhumanrights.org/library/documents/reports/guidance-to-the-global-fund.pdf>.

¹³³ Global Fund Round 10 Guidelines for Proposals (May 2010), at 46.

¹³⁴ One criterion that the TRP is to assess as part of its review is whether the proposal “[d]emonstrate[s] the potential for the sustainability of the approach outlined, including addressing the capacity to absorb increased resources and the ability to absorb recurrent expenditures.” *Id.* at 85. As stated above, this does *not* mean that countries must absorb the full salaries into their budgets - just as they are not required to take over other

As these possibilities will demonstrate, there are a number of ways in which countries can address sustainability, including for health worker salaries. Countries that require development partner assistance to meet the costs of salaries and incentives to fund the health workforce they require to meet their population's health needs, particularly for AIDS, tuberculosis, and/or malaria, should view the Global Fund as a potential source of support. Physicians for Human Rights encourages countries to consider how to take advantage of this possibility, including to compensate community health workers.

At the same time, applicants should consider the many ways in which investments that can be completed within the life of the grant can be used to strengthen health systems, including by improving health worker retention, in the country overall and in rural or other hard-to-reach areas in particular. For example, accommodations are an important incentive to attract and retain health staff in rural areas; the Global Fund can be used to construct such housing, as Tanzania did in its Round 9 HIV grant.¹³⁵ Strengthening basic rural health infrastructure, including by rehabilitating facilities and ensuring that they have access to electricity and clean water, can promote rural retention. Installing Internet and other information and communications technology can help reduce professional and personal isolation in rural areas, while facilitating mentoring and professional development opportunities, all of which can help with retention. Other shorter term strategies that may have a long term impact on retention, both in rural areas and nationally, including training and other measures to improve human resource management and improving working conditions, such as by ensuring safe working conditions for health workers and ensuring adequate levels of medicines, functioning equipment, and supplies. Loans may also be offered as an incentive, such as a car loan incentive scheme in Ghana¹³⁶ and a revolving fund that Tanzania included in its successful Round 9 proposal. Tanzania will use seed money from the Global Fund to advance newly employed health workers their salaries during the 3-6 month interim period (or longer) before they begin to receive their regular salaries; health workers will return the money once they begin to receive their regular salaries (including the back pay).¹³⁷

a. *Absorbing costs into national budgets*

Particularly where only a small number of health workers are being hired, countries might simply state that they will be absorbed into the national budget. Where more substantial numbers of health workers will be hired, and are expected to be covered by the government after the Global Fund grant ends, applicants should explain, if possible, what will enable the government to absorb these additional expenditures. For example, a country might have a policy to increase its health budget, which could accommodate the additional salaries. Rwanda used a planned national health budget increase to help demonstrate sustainability in a successful Round 3 HIV proposal.¹³⁸ Lesotho, which included in its Round 8 HIV proposal incentives for health workers, pointed to a scaled-up health workforce response and the level of the incentives. It explained that the government would be able to gradually assume the incentive cost "over the five-year transition period while the [Government of

recurrent costs, such as for anti-retroviral drugs and other medication. It does mean that at least beginning this transition to domestic resources can only enhance the proposal's prospects for approval.

¹³⁵ Tanzania National Coordinating Mechanism, Round 9 HIV/AIDS proposal (June 2009), at 57. Available at: http://www.theglobalfund.org/grantdocuments/9TNZH_1926_0_full.pdf.

¹³⁶ Sabine Garbarino, Tomas Lievens, Peter Quartey & Pieter Serneels, *Ghana Qualitative Health Worker Study: Draft report of preliminary descriptive findings* (Nov. 2007), at 20. Available at: <http://www.moh-ghana.org/UploadFiles/Publications/HealthWorkerStudy090825084556.pdf>.

¹³⁷ Tanzania National Coordinating Mechanism, Round 9 HIV/AIDS proposal (June 2009), at 57. Available at: http://www.theglobalfund.org/grantdocuments/9TNZH_1926_0_full.pdf. The advanced wages will be repaid as soon as the regular wages come through. *Id.*

¹³⁸ Rwanda Ministry of Health, Round 3 HIV proposal (Decentralisation of the overall management of people living with HIV/AIDS), (2003), at 48. Available at: http://www.theglobalfund.org/grantdocuments/3RWNH_711_0_full.pdf.

Lesotho] scales up its response to the [human resources for health] crisis....the incentives have been determined at a level which would be affordable to government in the long term.”¹³⁹

If a country proposes to sustain activities by increases in domestic health spending, the applicant should, if possible, should explain how these increases will be possible. Otherwise, the TRP might be concerned about sustainability, as for example in Round 5, when the TRP expressed concerned about the sustainability of Kenya’s HSS proposal, in part because “[a]lthough the government has a policy to increase health sector budget it is not linked to any ability to mobilize additional resources.”

There are several ways a government might be able to demonstrate that increased domestic resources will be available for health. A government might plan to reallocate its budget priorities towards health, in line, for example, with the commitment of African countries to allocate at least 15% of the government budget to the health sector.¹⁴⁰ Several countries have discussed in their proposals policy reforms that will increase funding for the health sector. Zambia stated in its Round 4 HIV proposal that it is implementing a public sector reform plan, freeing additional resources “which will be channeled to the social service sectors, especially health.”¹⁴¹ Malawi’s Round 5 HSS proposal cited a medium-term pay reform policy that it is implementing, which included “eliminat[ing] donor dependency and lessen[ing] the threat of employee earning loss should donor funding decrease.”¹⁴²

A government might have a strategy to increase overall revenue, such as through economic policy changes or economic growth. Rwanda’s Round 5 HSS proposal explained several mechanisms through which the economy would grow, making more money available for health. That proposal described how poverty reduction, economic development, and the government’s commitment to health will increase domestic funds available for health. As the country implements its Poverty Reduction Strategy, people’s economic situation will improve so an increasing proportion of people will be able pay towards the health insurance. The proposal noted that improved health - in part due to the impact of the proposal - will lead to “increased population wealth through improved health,” this “[i]n concordance with the insight of the WHO Commission on Macroeconomics and Health.” Furthermore, the Rwanda’s government will be able to contribute more funds to health due to economic growth, funds from debt cancellation, and its commitment to increase the health sector’s share of the government budget.¹⁴³

Depending on policies that countries are in fact implementing or planning to implement, applicants may be able to cite other ways in which overall government revenue - and hence funding available for health - would grow, such as through tax reform, reducing tax evasion, and capturing (such as through taxes and royalty payments) increased revenue from natural resources and directing the funds to social expenditures. Social health insurance is another option for raising revenue for health in some country contexts, particularly where it can be implemented in a genuinely equitable fashion that contributes to universal coverage, including for poor and marginalized populations, and is developed through a participatory process that involves and satisfactorily addresses issues raised by disadvantaged populations. Countries might also consider a dedicated tax for health.

¹³⁹ Lesotho Country Coordinating Mechanism, Round 8 HIV/AIDS proposal (Stepping up Universal Access: A Multi-Sectoral Partnership Response to HIV at Community Level) (2008), at 80. Available at: http://www.theglobalfund.org/grantdocuments/8LSOH_1709_0_full.pdf.

¹⁴⁰ *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, Organization of African Unity summit, adopted April 27, 2001, Abuja, Nigeria, at para. 26. Available at: http://www.un.org/ga/aids/pdf/abuja_declaration.pdf.

¹⁴¹ Zambia Country Coordinating Mechanism, Round 4 HIV proposal (Scaling-Up Antiretroviral Treatment for HIV/AIDS in Zambia) (2004), at 54. Available at: http://www.theglobalfund.org/grantdocuments/4ZAMH_831_0_full.pdf.

¹⁴² Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 73. Available at: http://www.theglobalfund.org/grantdocuments/5MLWH_1142_0_full.pdf.

¹⁴³ Rwanda Country Coordinating Mechanism, Round 5 Health System Strengthening proposal (Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda) (June 2005), at 54. Available at: http://www.theglobalfund.org/grantdocuments/5RWNH_1199_0_full.pdf.

If countries include support for both salary payments and strengthening human resource management information systems in their proposals, the proposal could at least partially pay for itself: the elimination of ghost workers (workers who are on the payrolls but are not actually working, or might not even exist) and unearned allowances that is made possible through improved human resource management can free enough resources to hire significant numbers of health workers.

Countries should avoid seeking to sustain health worker salaries or other costs through regressive measures such as user fees. In its Round 9 section on HSS, Sierra Leone planned to sustain salary incentives beyond the Global Fund grant period primarily by having health facilities introduce user fees (as well as with basket funding).¹⁴⁴ The TRP responded that this is both “unlikely to generate sufficient funding to match the external support requested in this proposal” and that “there is extreme concern on how the effect of user fees will impact on improvements in access and utilization. The gains realized through the implementation of this Round 9 program could be reversed.” While recommending the proposal for approval, the TRP requested that in order to obtain final Global Fund approval, Sierra Leone should first “explain how alternative solutions will be considered after the end of the Round 9 grant.”

b. Progressive involvement

The TRP has expressed support for approaches that progressively shift salaries from the Fund to the government. The TRP cited as one weakness of Botswana’s unsuccessful Round 6 tuberculosis proposal was that “[l]ab technical and support personnel salaries are to be fully supported via the requested funding from the Global Fund and without the progressive involvement of the” Ministry of Health. By contrast, the TRP praised how Swaziland’s Round 6 malaria proposal addressed sustainability (though the proposal failed), noting the “increasing contribution of the government up to >50% of the overall budget.”

A similar TRP interest in the gradual transfer of responsibility away from the Global Fund and its structures relates to the development of local capacity. The TRP saw as a weakness in the unsuccessful Round 6 Central African Republic malaria proposal that “[n]o description of the local capacity to administer malaria grants included how UNDP intends to phase out its role as the recipient of Global Fund grants in [the Central African Republic] (after four previous grants).”

c. Support from development partners

Countries may also be able to maintain support for salaries through donor-supported country plans or other possibilities of receiving additional external resources. For example, Swaziland referenced its Poverty Reduction Strategy in its Round 4 HIV proposal.¹⁴⁵ Cambodia, in its Round 4 HIV proposal, referred to the support it receives from the United Kingdom’s Department for International Development (DFID), the World Bank, and the Asian Development Bank, which provided funding to the country’s Health Sector Support Project.¹⁴⁶ Malawi’s Round 5 HSS proposal stated that Malawi had received a commitment from DFID for a minimum of 6-10 years beginning in 2004.¹⁴⁷

External commitment need not be this explicit. Rwanda’s Round 5 HSS proposal expressed confidence that “[i]t is extremely probable that eventually additional needed funds for the project’s continuation”

¹⁴⁴ Sierra Leone Country Coordinating Mechanism, Round 9 HIV/AIDS proposal (June 2009), at 68. Available at: http://www.theglobalfund.org/grantdocuments/9SLEH_1915_0_full.pdf.

¹⁴⁵ Swaziland’s Round 4 HIV/AIDS proposal is available at: http://www.theglobalfund.org/grantdocuments/4SWZH_820_0_full.pdf, at 69.

¹⁴⁶ Cambodia’s Round 4 HIV/AIDS proposal is available at: http://www.theglobalfund.org/grantdocuments/4CAMH_775_0_full.pdf, at 73.

¹⁴⁷ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 73. Available at: http://www.theglobalfund.org/grantdocuments/5MLWH_1142_0_full.pdf.

will be available because the project [community-based health insurance] is within a framework “endorsed by practically all development partners in Rwanda, among them [the] World Bank, UN Agencies, bilateral partners, and the Churches.”¹⁴⁸ In Round 9, Sierra Leone noted that a system of basket funding that it was establishing would help pay for salary increases (in addition to the user fees that the TRP expressed considerable concern about) as the Global Fund grant came to an end.¹⁴⁹

Where external resources will be needed for sustaining salaries or other health systems spending, but have not yet been secured, applicants should provide any evidence that they are likely to secure such funding. Rwanda’s description of how the community-based health insurance is within a framework endorsed by development partners is a good example. Countries may want to state (where it is true) and provide any evidence that: (1) health (and sustaining salaries and supporting the health workforce, if that is the issue at hand) is a national priority; (2) the government is committed to aggressively seeking the necessary external resources; and (3) to the extent possible, increased domestic resources will be used to sustain the salaries. It would also be useful to refer to any budgetary and development plans or frameworks (such as Medium Term Expenditure Frameworks) of which the salaries or other the health system strengthening activities at issue are a part.

d. *Innovative financing sources*

Malawi’s Round 5 HSS proposal included an innovative financing strategy. Its Medical College has a strategic plan that will enable the College to generate income through “enrolment of students from [Southern African Development Community] countries, income generation from private practice by various departments, and the opening of a medical clinic to the public.”¹⁵⁰

In determining their strategies, Physicians for Human Rights urges countries to adhere to the right to health, including its requirement to protect marginalized populations, including the poor.¹⁵¹ For example, one possible financing strategy, user fees, has been found to significantly reduce access to health services by the poor,¹⁵² and so PHR recommends against using this mechanism to pay for salaries.

e. *Special circumstances*

Malawi’s Round 5 HSS proposal argued that the severity of the country’s health worker shortage required sustainability to be viewed differently than might otherwise be the case. The proposal explained that DFID’s Permanent Secretary for Health has “indicated that the human resources shortages in Malawi had reached such a critical point that ‘measures that might not otherwise be considered as sustainable’ needed to be urgently implemented.”¹⁵³

¹⁴⁸ Rwanda Country Coordinating Mechanism, Round 5 Health System Strengthening proposal (Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda) (June 2005), at 54. Available at: http://www.theglobalfund.org/grantdocuments/5RWNH_1199_0_full.pdf.

¹⁴⁹ Sierra Leone Country Coordinating Mechanism, Round 9 HIV/AIDS proposal (June 2009), at 68. Available at: http://www.theglobalfund.org/grantdocuments/9SLEH_1915_0_full.pdf

¹⁵⁰ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 65. Available at: http://www.theglobalfund.org/grantdocuments/5MLWH_1142_0_full.pdf.

¹⁵¹ Committee on Economic, Social and Cultural Rights, *General Comment 14, The right to the highest attainable standard of health*, U.N. Doc. E/C.12/2000/4 (2000). Available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>.

¹⁵² See discussion and citations in Physicians for Human Rights, *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa* (June 2004), at 82. Available at: <http://physiciansforhumanrights.org/library/documents/reports/report-2004-july.pdf>.

¹⁵³ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 73. Available at: http://www.theglobalfund.org/grantdocuments/5MLWH_1142_0_full.pdf.

3. Salaries and incentives: Several important considerations

Applicants may include support for salaries in their Global Fund applicants. The Fund frequently supports salaries of health workers in its grants. In some cases, such as Malawi's Round 5 HSS proposal and Kenya's Round 6 TB proposal, the Fund supports salaries of significant numbers of health workers. The Malawi proposal covered salaries for more than 1,000 community nurses and several hundred of other health professionals, along with the full salaries of more than 4,000 Health Surveillance Assistants and salary increases for several thousand more. As detailed later in this section, salary incentives in Sierra Leone's and the Democratic Republic of Congo's Round 9 proposals are to cover thousands of health workers, including more than 11,000 in the case of the DRC. As with other HSS activities, if a proposal includes cross-cutting HSS interventions to recruit health workers and pay their salaries, the applicant will have to demonstrate the connection between these activities and improved HIV, TB, and/or malaria outcomes.

Several considerations related to using the Global Fund to support salaries and incentives are discussed below.

a. Salary support

In its comments to the Global Fund Board on Round 6 proposals, the TRP suggested "that the following points be taken into account in guiding future proposals for the funding of" human resource strategies, which the proposals should locate within the broader national context:

i. Proposals for salary support and/or premiums within the public sector and/or NGOs and private sector institutions should be located within and justified in terms of:

- *the overall human resources policy of the relevant institution(s);*
- *the existing salary scales;*
- *the expected specific contribution of such additional resources to the disease specific targets;*
- *the expected impact (positive and negative) of the strategy on other aspects of the healthcare system;*
- *how any negative expected impacts will be mitigated; and*
- *plans to shift the salary costs to the national budget and the timetable for this; and*

ii. For NGO and/or private sector institutional proposals, particular attention should be given to describing the nature of the relationships and interactions between these institutions and the relevant public sector institutions, and how the proposal might improve these for mutual benefit (to the extent that this is feasible);¹⁵⁴

The TRP would seem most likely to recommend for approval proposals that include significant salary support if the levels and nature of salary support is based on national health strategies or other planning frameworks. Indeed, the Round 10 Guidelines state that while "[t]he Global Fund does not want to limit human resource funding," it "seeks to ensure that any proposed financing of salaries, compensation, volunteer stipends and top-ups paid is consistent with current [human resource] compensation in the health sector, both in the public and nonpublic domain including civil society. Distortion or staff diversion because of inconsistent Global Fund compensation is to be avoided."¹⁵⁵ In section 5.4.2 of the proposal form, applicants will need to explain how the compensation included in their proposals is consistent with existing practices, and should provide evidence in this regard, such as health workforce strategies, national health strategies, and frameworks or agreements (including inter-agency policies or agreements with development partners) that address salary and compensation levels. The Global Fund also specifically requests that "if public sector financing is an important share

¹⁵⁴ *Report of the Technical Review Panel and the Secretariat on Round 6 Proposals*. Presented at the 14th Board Meeting of the Global Fund, Oct. 31-Nov. 3, 2006, at 27. Available at:

http://www.theglobalfund.org/documents/board/14/GF-BM-14_10_TRPReportRound6.pdf.

¹⁵⁵ Global Fund Round 10 Guidelines for Proposals (May 2010), at 75.

of the budget, the applicant should explain how the proposed financing of salaries will be reflected in the medium-term expenditure framework.”¹⁵⁶

It is possible to receive Global Fund salary (or other compensation) support outside existing compensation policies. This, however, must be justified. If the country has no framework on salaries, it can still receive Global Fund support for salaries. In this case, “the applicant should...submit an explanation how proposed compensation relates to existing salary levels in the country.”¹⁵⁷

b. Incentives

If applicants seek funding for retention and incentive schemes, whether to retain health professionals in the country or to induce them to serve in rural and other deprived areas, they should provide the details of these incentives and retention strategies, if the package has been developed. In Round 5, countries frequently failed to include detail on incentives for health workers, a weakness that the TRP cited on several occasions. Proposals should also be clear on who will be eligible for incentives - for example, only health workers at government health facilities, or also those at church-run health facilities - as well as the districts or other areas that such health workers will be located, and why these areas were selected. Applicants should also present any evidence that incentives will work, such as success of a pilot program or health worker input in designing the incentive package.

There is a growing trend to develop performance-based incentives. Where applicants include these in their proposals, to the extent possible they should explain how performance will be measured and how the incentives will be managed. The TRP was concerned that the cross-cutting HSS section of Benin’s Round 9 HIV proposal provided “insufficient information . . . on management of and accountability for the performance bonuses” (even as the TRP was positive about the fact that “the application of performance bonuses is well-aligned with the Ministry of Health (MoH) [human resources for health] strategy”).

c. Mitigation or avoiding harm to other health services, and the potential for broad-based incentives or salary support

i. What potential do incentives have for harming non-targeted health services or regions?

One common strategy to help retain health workers is to provide salary top-ups or other incentives and benefits, such as housing allowances, car loans, and special training opportunities. If such incentives are provided to only some health workers, the incentives are likely to attract workers to the opportunities that provide these incentives. For example, if the incentives are provided only to health workers in HIV/AIDS clinics, the incentives could draw health workers away from primary health services. If incentives are only provided to health workers in only certain regions of the country, health workers may migrate to those regions.

This migration can be the point of incentives, as when incentives are provided to health workers to serve in rural or other hardship areas. When not part of an intentional strategy to redeploy health workers, the migration can harm regions that lose health workers.

As indicated above, the TRP has expressed severe reservations about HSS activities that harm other parts of the health system. It was this concern that the TRP cited as a weakness in Zimbabwe’s unsuccessful Round 6 HIV proposal. That proposal would have provided increased salaries through a Salary Augmentation Program to nurses, pharmacists, and physicians in the 39 districts in Zimbabwe that had ART programs. Health workers in other districts would not receive the augmented salaries. The TRP stated, “It may be difficult to avoid serious inequities/inequalities with the SAP [Salary Augmentation Program] between supported districts and those that are not.” The TRP was evidently

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

concerned that these inequities in health worker pay would lead to harmful distortions and internal movement of health workers.

It should be noted that this was not the only concern that the TRP had about Zimbabwe's Salary Augmentation Program. The TRP further explained that no evidence had been "presented that this salary augmentation would lead to significant improvement in health worker retention. Without some evidence that this intervention would have the desired impact this cannot be recommended at this time." As explained more below, applicants seeking funds to support investments should always provide evidence that the incentives are likely to succeed. Zimbabwe's hyperinflation at the time may have presented an extra difficulty in providing evidence of a positive impact.

In Round 4, Zambia successfully sought Global Fund support in its HIV proposal for more than 5,000 nurses, doctors, and other health workers who were to be providing ART services (as well as other health services).¹⁵⁸ One factor that may have helped Zambia's proposal succeed where Zimbabwe's failed was that Zambia's ART program was not limited to particular parts of the country. Instead, "ART centres are targeted for both urban and rural populations in all the 72 districts of the Country to ensure the service is as near as possible to the persons in need."¹⁵⁹

ii. How can applicants avoid or mitigate harmful distortion from incentives? Can applicants seek funding for broad-based incentives or salary support?

Applicants can engage in several strategies to help ensure that incentives serve their intended purpose of helping to retain health workers without risking harm to other parts of the health sector or country. Preferably, the incentives for which applicants seek funds from the Global Fund should be part of a comprehensive approach to incentives (and if possible, an overall, comprehensive approach to strengthening the health workforce) that covers all health workers, unless the incentives are aimed at strategically encouraging health workers to serve in rural or other underserved areas. PHR strongly encourages applicants to consider the use of incentives and other strategies to deploy health workers to rural and other underserved areas.

The Global Fund could then be used to fund a piece of that strategy, for example, connected to health workers provided in activities related to the Fund's target diseases (which could potentially cover a significant portion of the health workforce) - but designing the incentives in ways that will not harm other health services. If this is the approach applicants take, they should if possible have a strategy for funding the rest of the incentives strategy, whether from the government or international partners. If funding is not available for the rest of the strategy, applicants should make clear that the incentives for which they seek support are part of a comprehensive plan, and that the applicants are actively seeking sources of funding for the rest of the strategy - as they in fact should be.

In at least several cases, applicants have successfully used the Global Fund to provide incentives and regular salary increases on a nationwide basis. In its Round 5 HSS proposal, Malawi received funding to increase the compensation of all Health Surveillance Assistants, a community-based cadre of health workers who have an important role in providing Malawi's Essential Health Package, including HIV/AIDS, tuberculosis, and malaria health services. That is, their retention was clearly linked to providing services in the Fund's priority areas. If applicants seek funding for salary increases or incentives to help retain all health workers of one or more category, they should if at all possible explain these workers' involvement in AIDS, tuberculosis, and malaria activities to demonstrate that their retention is necessary to sustaining and scaling up services in these areas.

The nationwide salary enhancements in Malawi that the Fund supported were for a single cadre, extending to Health Surveillance Assistants the salary increases that other cadres were receiving

¹⁵⁸ Zambia Country Coordinating Mechanism, Round 4 HIV/AIDS proposal (Scaling-Up Antiretroviral Treatment for HIV/AIDS in Zambia) (2004), at 54. Available at:

http://www.theglobalfund.org/grantdocuments/4ZAMH_831_0_full.pdf.

¹⁵⁹ *Id.* at 29.

through other funding sources. A proposal seeking salary support or incentives for a wider range of health workers, on a national basis, would be more ambitious still. But more recent Global Fund rounds have demonstrated that it is possible for the Global Fund to support such a proposal - as long as the applicant makes the necessary connection to improving outcomes for at least one of the Fund's priority diseases.

Lesotho's Round 8 HIV proposal indicates that in the face of serious health workforce challenges, the TRP may well look favorably on proposals that seek salary support or incentives for large numbers of health workers from multiple cadres whose responsibilities contribute to addressing the Fund's priority diseases - and hence to improved outcomes for these diseases - but who also provide a wide range of other health services. Lesotho's Round 8 HIV proposal, which the TRP recommended for approval, included salary complements for more than 1,200 health workers at all levels (not only a single cadre) - nearly one-third of the entire formal sector health workforce¹⁶⁰ - as well as monthly hardship allowances for 391 health professionals working at rural primary health care clinics. These health workers provide a full range of health services, including HIV and TB services, but also many other health services. The salary complements and hardship allowances were based on Lesotho's national human resource strategy.¹⁶¹

And in Round 9, Sierra Leone successfully included in its proposal a salary incentive for most clinical health staff ("Grade 2 up, including Maternal and Child Health Aides (MCH aides) and Nursing Aides"), who make up something less than 50% of the total health workforce. The incentive, combined with a regular salary increase from the government in 2009, would mean doubling health worker salaries compared to 2008. The proposal also included an additional allowance for the 20% of health staff serving in remote areas.¹⁶²

The successful Round 9 proposal for the Democratic Republic of Congo included performance incentives for health workers in 256 of the 515 health zones in the country; health workers in the other 259 health zones already receive salary top-ups from other development partners. The incentives will cover 20 health workers in each general referral hospital and 5 health workers in each health center, amounting to 11,120 health workers in all. In addition, during for the final three years of the proposal, the performance incentives will be extended to seven health workers in each of the other 259 health zones who had been receiving premium payments from an earlier Global Fund proposal that will draw to a close. Sixty central level managers will also receive the premiums.¹⁶³

In all cases, applicants must explain the link between the incentives or salary support for which they are seeking Global Fund money and achieving improved outcomes for AIDS, tuberculosis, and/or malaria. The Democratic Republic of Congo proposal explains that the performance incentives will cover a basic set of activities that cover but extend beyond the three diseases so that incentives for working on one or several diseases does not dissuade health personnel from providing health services

¹⁶⁰ Lesotho's 2004 human resource for health strategic plan reports that in Lesotho, "approximately 3,790 [health workers] are employed in the formal health sector operated by the Government of Lesotho (GOL), the Christian Health Association of Lesotho (CHAL), other Non Governmental Organizations (NGOs), and the private for-profit sector." The large major of these health workers are employed by the Government or CHAL. Lesotho Ministry of Health and Social Welfare, Human Resources Development and Strategic Plan 2005-2025 (2004), at 3-1. Available at: http://www.equinet africa.org/bibl/docs/LEShres_200307.pdf.

¹⁶¹ Lesotho Country Coordinating Mechanism, Round 8 HIV/AIDS proposal (Stepping up Universal Access: A Multi-Sectoral Partnership Response to HIV at Community Level) (2008), at 73-74. Available at: http://www.theglobalfund.org/grantdocuments/8LSOH_1709_0_full.pdf.

¹⁶² Sierra Leone Country Coordinating Mechanism, Round 9 HIV/AIDS proposal (June 2009), at 66-70. Available at: http://www.theglobalfund.org/grantdocuments/9SLEH_1915_0_full.pdf. The incentive for staff Grade 2 and up may cover about 41% of the total health workforce. The proposal references 6,030 total health workers in Sierra Leone, of whom 2,483 are health professionals. *Id.* at 66.

¹⁶³ Democratic Republic of Congo Country Coordinating Mechanism, Round 9 TB proposal (June 2009), at 36-37, 79-80. Available at: http://www.theglobalfund.org/grantdocuments/9ZART_1822_0_full.pdf.

addressing other diseases and health conditions.¹⁶⁴ Applicants should also explain how the salaries and incentives are linked to national health workforce strategies and other planning frameworks.

As noted above, applicants should also consider innovative incentive possibilities, beyond salary support, including various allowances (such as for housing), loans, enhanced professional development possibilities, flexible hours, and more. For more on incentives, see *Guidelines: Incentives for Health Professionals*, developed by several international health professional bodies, available at: http://www.who.int/workforcealliance/documents/Incentives_Guidelines%20EN.pdf¹⁶⁵

4. Pursuing a comprehensive approach

It may be useful to explain how interventions included in cross-cutting HSS actions are part of a comprehensive approach. For example, if interventions include providing incentives for health workers to serve in rural areas, the applicant might explain how these incentives are part of a comprehensive approach to strengthen the health workforce overall, part of a comprehensive approach to strengthening the health workforce particularly in rural areas, or part of an otherwise well-functioning health system in rural areas.

This discussion might include several aspects. In the above example, the incentive structure could itself be comprehensive, such as the package received by physicians (and now other health workers as well) serving on contract in rural parts of Zambia, including a hardship allowance, housing allowance, allowance for their children's education, and graduate training opportunities.¹⁶⁶ The Global Fund proposal might add one or several incentives - for example, hardship and housing allowances - to an existing incentive, such as preference in receiving certain training opportunities. The proposal might explain what other actions are being taken to retain health workers and improve their motivation overall, in addition to the incentives to serve in rural areas, such as activities to improve recruitment procedures, improve human resource management, and improving working conditions. Another dimension to comprehensiveness might be explaining other efforts to improve rural health infrastructure so that health workers posted in rural areas can do their jobs, such as electrifying and rehabilitating rural health facilities and improving the drug distribution system. Applicants may also find it appropriate to describe planned but not yet implemented activities that would contribute to a comprehensive approach. If these activities do not yet have a source of funding, applicants should consider whether the Global Fund is an appropriate financing source for these activities.

It may also be that the intervention is filling a gap in an otherwise functioning system. For example, the physical infrastructure might exist in the rural areas, systems might exist to get medicines and other key items to clinics in a timely fashion, but the clinics have too few health workers. Incentives to encourage health workers to serve in rural areas would then help fill this gap and create a functioning system where health services can be delivered.

As emphasized above, applicants should explain how the HSS interventions included in their proposals relate to their national health strategy and other relevant planning and policy documents and frameworks, including sub-sector strategies such as, in the above example, a human resources for health plan.

¹⁶⁴ *Id.* at 79, 85.

¹⁶⁵ International Council of Nurses, International Hospital Federation, International Pharmaceutical Federation, World Confederation for Physical Therapy, World Dental Federation & World Medical Association, *Guidelines: Incentives for Health Professionals* (2008). Available at: http://www.who.int/workforcealliance/documents/Incentives_Guidelines%20EN.pdf.

¹⁶⁶ Jaap Koot et al., *Supplementation Programme Dutch Medical Doctors 1978-2003 Lessons learned; Retention Scheme Zambian Medical Doctors 2003-2006 Suggestions: Final Report* (Dec. 2003), at 27.

5. Technical support for implementing proposals

One challenge some successful Global Fund applicants face is that they receive short-term technical support to help develop their proposal, but then lack needed support in implementing that proposal once approved. Therefore, applicants should do their best to determine what technical support they will need to implement their proposal, include in the proposal a request for funds for that technical support, and if possible, identify where that technical support will come from. The Global Fund has also produced an information note (*Strengthening Implementation Capacity: Information Note*) on including technical assistance plans in Global Fund proposals to strengthen implementation capacity and program quality (http://www.theglobalfund.org/documents/rounds/10/R10_InfoNote_TA_en.pdf).

6. Health systems monitoring and evaluation system

A strong monitoring and evaluation system can help ensure the success of Global Fund programs, and contribute to successful health systems strengthening efforts overall. It can enable problems to be quickly identified and understood, and thus help lead to their rapid correction. Developing these systems is particularly important for health systems strengthening activities given the complexities of health systems, their many interacting parts, and the resulting difficulties of quickly identifying and correcting problems absent a systematic approach to health systems monitoring and evaluation, including collecting timely and comprehensive information. Such a systematic approach will also provide important information about the effectiveness of new strategies that the Global Fund may support, such as those related to health worker retention, and enable those strategies to be adjusted if they are not yielding the expected results.

WHO, with support from the Health Metrics Network, has developed a Service Availability Mapping tool which can form the basis of a health systems monitoring and evaluation system. This tool combines a simple questionnaire on health facility capacity (as it relates to human resources, basic infrastructure, equipment, and supplies) with software and personal digital assistants (PDAs) to create a detailed picture of health system capacity to deliver certain health services. For example, the tool can measure whether the various health system elements required for a facility to deliver comprehensive HIV/AIDS services are in place. Along with measuring health systems, the tool can be adjusted to measure other areas of interest, such as coverage of school-based HIV education programs.

The tool has been employed in about a dozen countries to paint a picture of health systems at the district level. In at least one instance, in 23 districts across several regions in Tanzania, the Service Availability Mapping has taken place at the level of the individual health facility, covering more than 1,040 facilities.¹⁶⁷ More information is available at <http://www.who.int/healthinfo/systems/serviceavailabilitymapping/en/index.html>. To learn more, applicants should contact the Health Metrics Network at:

Telephone: +41 (0)22 791 5494

Fax: +41 (0)22 791 1584

Email: healthmetrics@who.int

Web-form: <http://www.who.int/healthmetrics/contact/en/index.html>

The Global Fund explicitly encourages countries to use Round 10 to strengthen the ability of monitoring and evaluation frameworks to “disaggregate data by age and sex, and by key populations to enable countries to undertake gender sensitive programming” if the frameworks do not currently do so. It similarly encourages countries to plan activities to collect information on key populations where there are identified gaps in epidemiological data.¹⁶⁸

¹⁶⁷ Ministry of Health and Social Welfare, Tanzania Mainland & Ministry of Health and Social Welfare, Zanzibar, collaboration with the World Health Organization, *Tanzania Service Availability Mapping: 2005-2006* (2007), at xi, 9. Available at: http://www.who.int/healthinfo/systems/SAM_CountryReport_Tanzania.pdf.

¹⁶⁸ Global Fund Round 10 Guidelines for Proposals (May 2010), at 51.

VII. Features of Successful Global Fund Proposals on Health System Strengthening

The two largest HSS proposals approved in Round 5, those of Malawi and Rwanda, included a number of common features. Proposals that include health systems strengthening activities may be more likely to be approved for funding if they include many of the following features.

1. Strong links to reducing spread and impact of target diseases: As detailed in section VI.1, both proposals included strong links to the Global Fund's target diseases. They both explained the linkages convincingly and provided data to support these linkages.

2. Strong health system analyses: Both proposals had strong and detailed analyses of the current health system situation and relevant national strategies and plans. The proposals had particularly detailed analyses of the health system element that was the focus of each proposal - the major gap in current efforts against the target diseases - human resources in the case of Malawi and health system utilization and financing in the case of Rwanda.

3. National commitment and interventions based on health strategies: Both proposals were based on national strategies to which the countries were clearly committed. Rwanda's community health insurance program was already being funded by multiple development partners in various provinces, and was the subject of a draft national law, which would create a national policy of covering all families with health insurance, with a special emphasis on vulnerable groups. Malawi's proposal sought to fill in funding gaps in that country's Emergency Human Resource Programme. The government of Malawi had shown a clear commitment to addressing its human resource shortage. Five years earlier, in 2000, Malawi had "developed an HR Finance Plan that was submitted and rejected by the GF." Malawi had since designed and begun to implement the emergency program, which was integrated into the country's Sector Wide Approach and included "6-year staffing targets and [set] out cost-effective, sustainable strategies for meeting the targets."¹⁶⁹

4. Strong chance of success: Both proposals made a convincing case that they would have an impact. Malawi sought to fill in gaps in its Emergency Human Resource Programme, which addresses both immediate and longer-term needs with a focus both on training and retaining health workers. Rwanda's proposal was able to cite country-specific evidence that members of health insurance schemes utilized the health services three to five times more than non-members,¹⁷⁰ demonstrating that the proposal would increase use of health services, including for the Fund's target diseases.

5. Pro-poor and pro-marginalized populations: Both proposals were pro-poor. Rwanda's proposal was fundamentally about improving access to health services by the poor. The first objective of the proposal was to remove financial barriers to health service utilization. The grant from the Global Fund was to enable Rwanda to co-finance health insurance membership fees for the poor and to fully cover the cost of the health insurance membership fees for the very poor, orphans, and people living with HIV/AIDS. An estimated 83% of the people who will benefit from Rwanda's proposal live in rural areas.

Malawi's proposal, too, will have considerable benefits for the poor and rural dwellers, who are hit hardest by the health worker shortage. The country's Essential Health Package, which the increased health staff levels will support, "is based on the premise of reducing inequities in access to service

¹⁶⁹ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 52. Available at: http://www.theglobalfund.org/grantdocuments/5MLWH_1142_0_full.pdf.

¹⁷⁰ Rwanda Country Coordinating Mechanism, Round 5 Health System Strengthening proposal (Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda) (June 2005), at 10. Available at: http://www.theglobalfund.org/grantdocuments/5RWNH_1199_0_full.pdf.

delivery for all Malawians.”¹⁷¹ The proposal explains, “Of primary importance is the positive affect additional [human resources] will have on health services at rural community levels that have been critically compromised by staff migration.”¹⁷² The proposal includes interventions to recruit, train, retain, and support health surveillance assistants, whose community outreach functions will primarily benefit rural communities. The purpose of including health surveillance assistants in the proposal is to “rapidly scale-up ARV and other HIV/AIDS services in underserved areas, to improve equity in HR supply and compensation, and to build rural community access to the EHP including TB/malaria services.”¹⁷³

6. Support from other development partners: Both Rwanda’s community-based health insurance scheme and Malawi’s human resource program receive support from other development partners. Rwanda sought Global Fund money to introduce the insurance scheme in six of twelve districts because Rwanda’s government and development partners, including U.S. Agency for International Development (USAID), the World Bank, and the German Agency for Technical Co-operation (GTZ), were already funding similar programs, or would soon be funding programs. Malawi’s Emergency Human Resource Programme was also receiving support from the United Kingdom’s Department for International Development (and from reprogrammed funds from Malawi’s Round 1 Global Fund grant).

7. Address major obstacles: The proposals both focused on particularly significant obstacles to scaling up HIV, tuberculosis, and malaria interventions. Malawi faces “overwhelming [human resource] obstacles,” and the proposal calls the human resource shortage “the major constraint to delivering effective health care.”¹⁷⁴ Rwanda’s proposal states that the lack of the population’s interaction with health services “jeopardises seriously any progress in the control of HIV/Aids, TB, malaria, and associated diseases.” The very name of the proposal indicates the importance of access to quality health services, calling it “the missing link” in Rwanda’s efforts to combat AIDS, tuberculosis, and malaria.¹⁷⁵

¹⁷¹ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 76. Available at: http://www.theglobalfund.org/grantdocuments/5MLWH_1142_0_full.pdf.

¹⁷² *Id.* at 52.

¹⁷³ *Id.* at 61.

¹⁷⁴ *Id.* at 49, 9.

¹⁷⁵ Rwanda Country Coordinating Mechanism, Round 5 Health System Strengthening proposal (Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda) (June 2005), at 39. Available at: http://www.theglobalfund.org/grantdocuments/5RWNH_1199_0_full.pdf.

VIII. What Applicants Can Learn from the Technical Review Panel's Comments on Earlier Proposals

The TRP's comments on previous proposals provide important guidance to applicants in developing their Round 10 proposals. Comments in this section are drawn primarily from the 30 Health System Strengthening proposals from Round 5. Several comments are also included from Round 6 and Round 9 proposals. Where not otherwise noted, proposals described are Round 5 HSS proposals.

This section will review some of the weaknesses and strengths that the TRP cited in these proposals. The comments discussed below are divided into two overarching categories, those that relate to the Global Fund proposal development in general, and those that are specific to the health system strengthening content of the proposals.

This section relies entirely on the TRP comments. Proposals that the TRP did not recommend for approval were not available to Physicians for Human Rights. Characterizations of proposals used below are those used by the TRP, unless otherwise indicated.

Each proposal is unique. Brief TRP observations on particular proposals cannot serve as an absolute guide to other proposals. Some of the TRP's comments are indeed likely to apply in all or nearly all cases, such as the need to include unit costs in the budget. Other observations, however, depend more upon the particular proposal and country circumstances. Final judgment rests with the TRP.

A. General Advice Arising from HSS-Related Proposals

In addition to the analysis below, PHR strongly recommends that people involved in preparing proposals review Chapter 4 of *The Aidspan Guide to Round 8 Applications to the Global Fund - Volume 1: Getting a Head Start*, available through <http://www.aidspan.org/guides/>, which provides lessons from Round 3-7.

1. Detailed, realistic budgets: Countries should be very careful in developing budgets. Countries should be sure to:

- Ensure that budget summaries and budget details are consistent with each other.
- Include quantities and unit cost for each budget item.
- Ensure that overall budgets are realistic, neither unreasonably high nor low for the interventions proposed, and that unit costs are realistic.
- Ensure that expenditure projections are not unrealistically front-loaded (such as determining that the work for a 3-year, \$10 million contract to computerize medical records would be completed by the second quarter of year one) and that they are spread over the period of time that the activities are most likely to take.
- Describe funding projections from partners for activities similar to those included in the proposal.
- Include a budget for 5 years if activities proposed will cover 5 years.
- Ensure that budget allocations to various entities (such as a Christian Health Association or Central Board of Health) are consistent with the level of activities those entities will provide, and that the budget is not allocated to entities not described in the work plan.

The TRP frequently cited weaknesses even for successful HSS sections of Round 9 proposals that were related to the budget, such as insufficient detail on unit costs or on the rationale for quantities to be purchased, lack of information about what the budgeted activities (such as student recruitment) actually entail, high unit costs, the need to disaggregate budget information (such as for the various inputs in renovating health training institutions, strengthening laboratories, and conducting a health worker census), inconsistencies in the budget, failure to budget certain expenses, and large expenditures for which the costs were not justified.

The TRP comments to the Global Fund Board on Round 6 and HSS also provided advice on budgeting and certain HSS activities:

Several of the proposals also contained budget items for improvement of infrastructure and/or procurement of equipment aimed at HSS. The TRP would like to make the following suggestions in relation to guiding proposals that cover these items:

- i. Proposed expenditures should be justified in terms of the national infrastructure development plan;*
- ii. The contribution of the proposed expenditures towards achievement of the disease specific targets in the proposal should be made explicit;*
- iii. Unit costs should be justified in terms of unit cost patterns within the national budget; and*
- iv. Provisions for long term maintenance, as well as provision of necessary supportive environment (power supply, trained technicians etc) should be clearly spelled out to avoid the situation where, as was seen in Round 6 in a number of proposals, applicants are applying for funding for new infrastructure, rather than proposing an effective arrangement to more effectively utilize resources that they already have;¹⁷⁶*

2. Modest administrative costs: The TRP may question a proposal that devotes a significant portion of its budget to administrative costs. One weakness of Liberia's Round 6 malaria proposal was that it allocated 25% of its budget to cover administrative costs, which the TRP said "seem[s] excessive." A weakness that the TRP cited of Nigeria's Round 6 malaria proposal was that 21% of its budget was for planning and administrative costs. Excessive administrative costs were also a common weakness in Round 5.

3. Sufficient details: Applicants should provide sufficient details on their planned activities, including work plans and the timing of their activities. Given that the TRP criticized approximately 13 HSS proposals in Round 5 for lacking details or specificity - nearly half of the HSS proposals - countries are advised to err on the side of including more detail when unsure how specific to be. Along with general concerns about lack of details and clarity on timing and work plans, the TRP noted that one country (among those applying for HSS in Round 5) listed multiple implementing entities, but did not explain which entity would do what.

4. Relationship to previous grants and other sources of funding: A number of HSS proposals in Round 5 were either poorly integrated into previous grants that countries had received from the Global Fund or poorly integrated with other sources of funding. For example, the TRP observed that North Sudan's proposal was insufficiently clear and detailed on how the proposed HSS activities would link to, complement, and build on USAID and other funding for similar issues. By contrast, the TRP noted that a strength of Ethiopia's proposal was that it "addresses one of the key weaknesses in the implementation of previous Global Fund grants," procurement and supply management, while a strength of Madagascar's Round 5 HSS proposal was that the geographic regions covered by that proposal matched those covered by HIV/AIDS, malaria, and tuberculosis proposals from Round 1-4. A strength of the HSS section Eritrea's Round 9 was its "[c]ontribution and complementarity of other partners in HSS especially the Global Alliance for Vaccines and Immunization (GAVI)."

Countries should also make any appropriate links between HSS activities and related disease-specific interventions for which they are seeking funding in Round 10. In Round 5, for example, the TRP faulted Burundi's HSS proposal for not linking the training included in the HSS component with training included in the HIV and malaria components.

5. Realistic indicators: A number of countries had trouble with their indicators in Round 5. The problems varied. Some proposals included activities without any indicators for those activities;

¹⁷⁶ *Report of the Technical Review Panel and the Secretariat on Round 6 Proposals.* Presented at the 14th Board Meeting of the Global Fund, Oct. 31-Nov. 3, 2006, at 27. Available at: http://www.theglobalfund.org/documents/board/14/GF-BM-14_10_TRPReportRound6.pdf.

applicants should be careful to include indicators for all activities. The TRP called several countries' indicators weak or unrealistic. Several specific critiques were that indicators focused too much on committees, that indicators seemed designed to meet the needs of donors rather than of local decision makers, and that the indicators could not be measured.

The Global Fund's *Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening* (3rd edition) has an extensive section on possible indicators for health systems strengthening (http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HSS_en.pdf). Applicants lacking relevant expertise would also be well-advised to work with technical partners with health systems expertise in developing appropriate indicators.¹⁷⁷

Countries that are facing difficulties with health system strengthening-related indicators may also consider contacting the Health Metrics Network (<http://www.who.int/healthmetrics/>), which is hosted by the World Health Organization. The Health Metrics Network should be able to help or direct applicants to the relevant individuals or organizations who will be able to assist. The contact information for the Health Metrics Network is:

Telephone: +41 (0)22 791 5494

Fax: +41 (0)22 791 1584

Email: healthmetrics@who.int

Web-form: <http://www.who.int/healthmetrics/contact/en/index.html>

6. Realistic pace of activities: The TRP deemed several proposals to have overly ambitious schedules for reconstructing and rehabilitating facilities in Round 5. For example, Liberia's Round 5 proposal called for rehabilitating and reconstructing several hospitals and training institutions, along with 100 primary care clinics, in six months. Countries should therefore ensure that the pace for their activities, including facility construction and rehabilitation, is realistic.

7. Principal recipient capacity: Countries should be sure that the Principal Recipient has the capacity to carry out its responsibilities. One country's Round 5 HSS proposal was rejected in part because the Principal Recipient lacked management and information systems, had not been subject to an external audit, and had extremely limited staff.

8. Proposal coherence: If various entities or regions contribute to the proposal, the CCM should ensure that the pieces come together to form a coherent whole. The TRP reported that South Africa's Round 5 HSS proposal was a collection of proposals from provinces, NGOs, and the private sector, rather than a coherent national proposal. The HSS section Burkina Faso's Round 9 HIV proposal had human resources, including training, as a cross-cutting theme across the various HSS interventions, but, according to the TRP, "no effort was made to demonstrate any internal coherence between those cross-cutting interventions," just as there was "no conceptual or operational coherence between the four major proposed strategies dealing with prisoners, handicapped people, contracting between public sector and civil societies, blood donors and reference laboratories."

9. Added value for regional proposals: Regional proposals must demonstrate how they add value to strictly national strategies and approaches. Three of the weaknesses that the TRP listed for the one regional HSS proposal in Round 5, which aimed to create a network of public health training institutions in four African countries, were related to a failure to demonstrate the added value of a regional approach and a failure to adequately integrate the proposal with national plans. In particular, the TRP reported that the proposal did not make the case for a regional network, did not adequately link the proposal to the training needs and demands of each country, and did not make a convincing case for a regional approach as opposed to having each training institution work within its country's national strategy.

¹⁷⁷ The Global Fund's monitoring and evaluation toolkit and other guidelines and tools for monitoring and evaluation are available through: http://www.theglobalfund.org/en/me/guidelines_tools/.

10. Capacity to manage significant scale-up: If institutions will receive significantly increased funds and responsibilities, applicants should explain how those organizations will be able to manage the increased funds and responsibility. In the Round 5 regional training institution HSS proposal, the TRP stated, “Other than adding of project staff at [the Makerere University Institute of Public Health], the proposal does not address how these training institutions will be able to manage teaching programs and funds that are much larger than their current operations.”

B. Health System-Specific Strengthens and Weaknesses

1. Careful health systems analysis, including gaps: The TRP values careful analysis of the health system, particularly as relevant to the proposal. The TRP noted that a number of Round 5 HSS proposals were weak in this area. Several countries provided inadequate details on their current health staff situation. For example, Liberia’s proposal did not include proposed staff levels of rural clinics, health centers, and district hospitals and Mali’s proposal did not address the baseline number of staff. Benin’s proposal did not include what the TRP called “basic simple information” on public and private sector coverage. Burundi’s proposal, according to the TRP, had only a superficial analysis of health system weaknesses, ignoring such underlying problems as governance, while Nigeria failed to explain how its proposal fit into other health system reforms.

Applicants should explain in detail gaps in health system needs, especially those for which funds are sought. For example, a weakness of the Round 5 HSS regional (Ghana, Uganda, Zimbabwe) proposal, which was focused on training, was that it included only a “superficial” analysis of the gaps in training needs. A country that seeks Global Fund support for health workforce strengthening, therefore, should include a careful analysis of the current health workforce and its gaps, including as related to the country’s capacity to initiate, implement, and sustain HIV, tuberculosis, and/or malaria activities. The TRP reported that a major strength of the HSS section of Tanzania’s successful Round 9 HIV proposal was that it “concretely quantifies” the health system limitations in the health system areas that the proposal addressed.

2. Health system element details: Health system strengthening activities should include a certain level of detail. The TRP noted a number of health system strengthening areas in which proposals were inadequately detailed in Round 5. Applicants provided insufficient details on a scheme to reduce financial barriers for the poor; on improving conditions of service for health workers; on rehabilitating training schools and health facilities in poor condition, including detailed unit costs; on what contracting services at the community level would entail; on a doctor retention scheme; on how more than 1,000 health personnel proposed to be recruited would be recruited, selected, and retained, and; on the costs and on the number of health workers in different categories, including community health workers, to be trained.

The TRP noted the following proposed activities as insufficiently detailed in Senegal’s Round 5 HSS proposal: “Agree to contracts for people (150 workers), resources and skills available to help fight against the 3 diseases,” “Implement incentive measures,” “Implement risk-sharing mechanisms,” “Implementing case management mechanisms for the indigents,” “Promote the practice of self-evaluation in care facilities,” “Implement a drug monitoring system,” and “Awareness-raising of personnel on ethical matters.”

Explaining why beneficiary regions are selected

Proposals that will benefit particular regions should state which those regions are and how they are selected. For example, according to the TRP, Zambia’s Round 5 HSS should have included information on which districts would benefit from the increased human resources and how those districts would be selected. Thus, if an incentive scheme will increase the number of health workers in rural or deprived areas, the applicant should explain which these regions are and how they have been selected. The TRP

also considered the failure to explain how target districts would be selected a weakness of Senegal's Round 5 HSS proposal.

3. Strategies likely to succeed - demonstrating feasibility: The TRP will not approve a proposal that it believes cannot achieve its goals. Applicants therefore will have to propose strategies that they can succeed, and demonstrate to the TRP that these strategies can succeed. This concern about the proposal's chance of success appears to underlie the TRP observations on Round 5 HSS proposals that a weakness of several proposals was that they did not address certain issues. Presumably, the TRP believed that these issues had to be addressed, whether or not through the Global Fund, in order for the proposal to succeed.

For example, the HSS section of Ghana's Round 9 HIV proposal, focused on the health information system, but according to the TRP, included "neither an activity nor a link with other interventions that clearly documents the ambition to improve the use of information in decision-making." As another example, Burundi's Round 5 HSS proposal, which addressed human resources largely through incentives, gave "[i]nsufficient attention . . . to understanding motivation, placement, retention, or professional development," according to the TRP. The TRP may have viewed the proposal's response as a simplified or superficial response to a complicated problem, and thus one unlikely to succeed. Incentives will not always be seen as a simplified response. If the goal is overall human capacity development, a strategy that relies only on incentives is indeed overly simplistic. But if the goal is to increase health services in rural areas, incentives - particularly if they are detailed and the areas to be served as well as how they are selected are described - may be a perfectly reasonable approach, one that is the focus of an increasing number of country efforts (even as this is not the only strategy to increase access to health providers in rural areas).¹⁷⁸

a. Comprehensive response to health workforce crisis

Zambia's Round 5 HSS proposal, which addressed recruitment, pre-service training, and staff retention, had, according to the TRP, "little if any discussion of how other HR issues will be addressed; for example, supervision, in-service training, and overall personnel management." This suggests that proposals that address human resources should be as comprehensive as possible in discussing plans and activities to address the human resource situation in its totality. A comprehensive approach to a human resource crisis, one that includes both the elements that Zambia's proposal included and those that the TRP cited that it did not, is indeed important to a successful response. A strength that the TRP cited of the HSS section of Benin's Round 9 HIV proposal was that "[t]he interventions address in a sound way the qualitative, quantitative and motivational factors that determine the efficacy of the deployment of adequate health cadres with due notion for geographical disparities."

The proposal itself need not seek funding for activities in all of these areas. For example, Malawi's successful proposal did not include funds for the critical area of human resource management. However, the proposal discussed Malawi's longer term human resource development strategy, which included multiple strategies on improving human resource management, such as staff development and career management, building Ministry of Health human resource policy and planning capacity, and developing performance-based management approach, as well as such critical issues as staff working and living conditions.¹⁷⁹ In other ways, Malawi's proposal was itself comprehensive. For example, Malawi sought funds not only to train and cover the current salaries of Health Surveillance Assistants, but also to increase their salaries in line with other health cadres in order to help retain them, to provide them in-service training, and to supply them with bicycles.

¹⁷⁸ Several strategies to strengthen the health workforce in rural areas are described in an excerpt from PHR's Round 6 version of this Guide, available at: <http://physiciansforhumanrights.org/hiv-aids/docs/excerpt-guide-globalfund-round6.pdf>.

¹⁷⁹ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 61. Available at: http://www.theglobalfund.org/grantdocuments/5MLWH_1142_0_full.pdf.

Therefore, to the extent that an applicant's response to the health workforce crisis is comprehensive, the applicant should clearly make the full breadth of its response to the TRP, as discussed above at section VI.4. And the applicant should strongly consider using the Round 10 application to help fill in gaps, to complement existing measures on human resources so as to implement a more comprehensive approach.

4. Meaningful community participation: Countries should involve communities in health and health system planning. Not only do people have the right to participate in decisions that affect their health, but the TRP may well look more favorably upon proposals that demonstrate meaningful community participation in health systems, including members of poor and other marginalized populations. The TRP criticized Burundi's Round 5 HSS proposal for taking a superficial approach to community participation in health systems. By contrast, the TRP expressed clear interest in Madagascar's proposed "process of involving community in the administration of equity funds," as the community would "decide who among the poor should be eligible for subsidies and get equity funds." The TRP commended the HSS section of Paraguay's Round 9 HIV proposal for its "commitment to involve communities in health care and building their capacity to play their role effectively."

5. Integrated approach for addressing target diseases: The TRP has explicitly recognized the value of an integrated approach for health information systems, where countries avoid creating separate, parallel structures for different diseases, instead developing structures that integrate the needs of various programs. The TRP cited as a weakness in Burundi's Round 5 proposal the fact that in the proposal, "Health information systems are organized around needs of programs (HIV, TB, malaria) rather than the decisions that need to be made by different levels of health workers and organizational units." This, the TRP stated, could result in "continually adding data requests without coherent integration and simplification of" health information systems. More recently, in Round 9, the TRP was concerned that an information system that Ghana proposed, with its scope limited to AIDS, TB, and malaria, "appears a missed opportunity to strengthen the system in absence of clear justification of this restriction of scope."

6. Support for health system strengthening strategies: To the extent possible, proposals should explain the national strategy for addressing identified health system needs, especially constraints that a country identifies as interfering with efforts to reduce the spread and impact of the Fund's target diseases, and how the proposal is consistent with the national strategy. The Global Fund is increasingly concerned with the connection between proposed HSS interventions and national strategies, and as explained elsewhere in this Guide, this is reflected in the Round 10 Guidelines for Proposals.¹⁸⁰

The TRP observed that in its Round 5 HSS proposal, the Democratic Republic of Congo failed to elaborate a strategy for health system strengthening. The TRP cited several times as a major weakness of the HSS section of Uganda's Round 9 proposal its failure to reference a national human resources strategy, and a weakness of Burkina Faso's Round 9 proposal was that "[t]he proposed interventions [in the cross-cutting HSS section] are not properly contextualized within the framework of the National Health (Development) Plan; they are not related to weaknesses and gaps in the health system . . . ; and they are therefore lacking any evidence base to assess their priority character in strengthening the health system."

By contrast, the TRP commended the Round 5 HSS Eritrean proposal for being consistent with the draft National Health Strategic Plan and the HSS section of its Round 9 proposal for being consistent with the Ministry of Health Primary Health Care strategy, the Health Sector Strategy Plan, and the National

¹⁸⁰ The Guidelines for Proposals suggest that applicants should not develop responses to health system weaknesses and gaps "should not be developed in isolation from existing national strategies." Global Fund Round 10 Guidelines for Proposals (May 2010), at 61. The March 2008 addendum to the Global Fund's Monitoring and Evaluation Toolkit, used in Rounds 8 and 9, noted the importance of having HSS being "[c]onsistent with (where they exist) national policy directions, for example, a health sector development plan, a national financing strategy or a health workforce plan." Global Fund, *Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria* (2nd ed.) Addendum March 2008 (March 2008), at 19.

Health Policy, the Ethiopian proposal for being “well embedded in the national health sector development strategy,” Ghana’s proposal for being “well integrated in the national health sector development strategy and plan,” and Rwanda’s proposal for being “fully integrated in the national health sector development and health care financing strategy.” Zambia’s Round 5 HSS proposal “is consistent with a broad range of national policy instrument.” Rwanda detailed its health financing strategy in Round 5, and Malawi’s Round 5 proposal, based on that country’s Emergency Human Resources Programme, provided considerable detail on the country’s strategy for addressing its human resource crisis. South Sudan’s Round 9 proposal’s HSS section, noted the TRP, is “fully consistent with” the primary health care approach of Southern Sudan’s new constitution. And the TRP cited as a strength of the HSS section of Benin’s Round 9 HIV proposal that it “cohere[s] with the National Health Development Plan (2009 - 2018), which also has annexes like: the Human Resources Strategic Development Plan for the Health Sector (2009-2018); the National Policy regarding the Health information system, etc.”

7. Inclusion of non-government sector: Countries should define how the proposal will impact non-governmental sectors and how it will divide activities and responsibilities between the government and non-government sectors. The Round 10 Guidelines for Proposals state that “[t]he Global Fund recognizes that non-government organizations, the private sector and communities affected by the disease(s) are each an integral component of the health system, as is the government sector.” And accordingly, the Guidelines encourage applicants to “consider the broad range of non-government sector needs in any assessment of overall weaknesses and gaps in strategies to ensure increase demand for, and access to required services and/or care.”¹⁸¹

The TRP cited as a weakness of several Round 5 proposals their failure to address how the Ministry of Health would work with the private sector, how activities would be divided between the public and church-based sectors, and how health facilities not run by the government would be involved in and impacted by the proposal.

While the roles of the governmental and non-governmental health sectors vary by country, in general proposals will benefit by addressing both sectors. Ethiopia’s Round 5 HSS proposal covered needs of both the public and private sectors, which the TRP cited as a strength of that proposal. Similarly, the TRP commends Ghana’s Round 5 proposal for “acknowledg[ing] the key role of NGOs, religious organizations, the private sector, and non-health personnel,” and Mali’s “use of civil society [to complement] the public sector program.” Applicants may benefit from including information on the proportion of health services provided by each sector, which is in both Rwanda’s and Malawi’s successful Round 5 proposals. In Round 9, a strength of the HSS section of Cambodia’s HIV proposal was that it “seeks to use community-based organizations (CBOs) for increasing the demand and utilization of care.” The TRP cited favorably the fact that the HSS section of Paraguay’s Round 9 HIV proposal recognized “the role of the private sector in health care provision.” If a proposal focuses exclusively on the public sector, the proposal can only benefit from explaining this decision.

8. Evidence of success: Where applicants can provide evidence that the strategies included in their proposals are likely to succeed, they should do so. For example, Ghana’s Round 5 HSS proposal included a focus on community-based health care staff which, the TRP observed, had been tested in Ghana and resulted in “evidence that it can generate major health benefits.”¹⁸² Rwanda’s successful Round 5 HSS proposal “is evidence-based on several years of experience and evaluation of the community health insurance system in Rwanda.”

By contrast, although in Round 5 Ethiopia proposed higher training incentives to retain staff in rural areas, the TRP questioned whether these incentives would in fact help retain staff in rural areas. Any evidence that incentives will work - perhaps they are designed based on input from health workers who

¹⁸¹ Global Fund Round 10 Guidelines for Proposals (May 2010), at 61.

¹⁸² More information on community-based health care in Ghana is available in *Providing Doorstep Services to Underserved Rural Populations: Community Health Workers in Ghana* (Oct. 2006), is available at: http://www.capacityproject.org/images/stories/files/community_health_workers_ghana.pdf.

are the target of the incentives, or a pilot program suggests that such incentives would have an impact - should be presented.

9. Support for rural/deprived areas and equity: The TRP looks favorably on proposals that effectively address health worker and systems needs in rural and other deprived areas and that promote equity. A weakness of Kenya's Round 5 HSS proposal was that it failed to demonstrate whether its scheme to recruit more than 1,000 health workers would "ensure the availability and retention of qualified personnel at the lower, more remote area where the gaps are the greatest." This weakness also arose from a failure to link the proposed activities with the proposal's objectives; a more equitably distributed workforce to promote equal access to essential health services was one of the Kenyan proposal's objectives.

The TRP cited as a weakness that Uganda's Round 5 proposal made "no mention of the approach needed to deliver services in the areas of the country suffering from ongoing conflict." The TRP again demonstrated concern about the ability of poor people to access health services when it included in a comment about weaknesses of Senegal's Round 5 HSS proposal the observation that the government "maintains user-fees in its health facilities."

By contrast, the TRP considered one strength of Zambia's Round 5 HSS proposal that it "focuses on strengthening health services for underserved and poor rural populations." Another strength of that proposal was that its focus on "human resources capacity is consistent with the plan to roll out ART to rural hospitals and health centers." The TRP describes Rwanda's successful Round 5 HSS proposal as "an innovative and creative effort to address an issue that is largely neglected in current international development programs, i.e. to establish a system of social protection for the very poor, for orphans, and for people living with AIDS." In addition, the TRP commended Ghana for its focus on community-based primary health care services. Such a community-based approach is particularly important to providing care in rural areas. A major strength of the HSS section of Cambodia's Round 9 HIV proposal was that it "addresses the issue of improving financial access to health care services by contributing to the equity funds." And a strength that the TRP cited in an otherwise unsuccessful proposal, Burkina's Round 9 HIV proposal, was that its HSS section aimed to improve the ability of prisoners and people with disability to health services in urban areas.

10. Limited focus on workshops, meetings, and research: The TRP is skeptical of proposals that focus too heavily on activities that do not directly benefit patients or strengthen the health system, such as workshops, meetings, consultants, and research. These activities are permitted, but a high proportion of the budget generally should not go to these activities. Of South Africa's Round 5 HSS proposal, the TRP observed: "A large proportion of the budgets from the provinces is allocated to salaries, workshops, meetings and consultancies with very high fees. There is no evidence of direct benefit to people living with HIV and AIDS strengthening of health infrastructure." The TRP stated that 20% of Pakistan's budget in its Round 5 HSS proposal going to research amounted to "an overemphasis on research . . . given the Global Fund's mandate."

11. Salaries consistent with national standards: The TRP found a number of salary costs in Liberia's Round 6 TB proposal to be excessive. It considered the proposed annual salaries for medical officers and salaries to be "excessive when compared with [Ministry of Health] salaries." A salary of \$65,000 for a TB expert seemed excessive to the TRP, as did incentives for the program manager and deputy program manager.¹⁸³ By contrast, the TRP cited as a strength of the HSS section of Sierra Leone's Round 9 proposal that "planned staff incentives of doubling remuneration (20 percent is from government) are reasonable and acceptable (and in line with the national Human Resources plan), as well as the rural incentives."

¹⁸³ Please see section VI.3 above for more information about including salaries in Round 10 proposals.

12. On-site training where possible: Botswana’s Round 6 TB proposal included external venue costs for training that required equipped laboratory benches. The TRP criticized this, stating that the training should take place in a reference laboratory.

13. Length of training should reflect position responsibilities: In Cote d’Ivoire’s Round 6 HIV proposal, the TRP believed that the proposed short training courses would be inadequate to prepare trainees for the responsibilities they would assume.

14. Avoid creation of highly vertical programs: As explained earlier in this guide, the TRP is critical of vertical disease programs that risk harming the overall health system. Swaziland’s Round 6 HIV proposal would have created a “highly vertical HIV treatment system,” with health workers assigned to exclusively HIV programs, and with salaries that appeared to be significantly higher than those of other health workers in Swaziland. The TRP expressed its concern that this might “have a potentially serious negative impact on overall health sector performance in Swaziland.” This highly vertical approach appears to be the major reason that the TRP did not recommend this proposal for approval. By contrast, a strength of the HSS section of South Sudan’s Round 9 HIV proposal was that it avoided parallel systems by phasing into the Ministry of Health line departments a large number of services that NGOs were currently offering. A key strength that the TRP cited for the HSS section of the Democratic Republic of Congo’s Round 9 TB proposal was that “[t]here is an integrated system approach to continue to develop and implement HSS activities across DRC for the whole health sector and not for a specific disease component.”

15. Innovations welcomed: The TRP is interested in seeing innovative approaches to HSS. It favorably cited as “very innovative” the introduction of a “Lab-in-a-Suitcase (LIS), a portable and solar power compact laboratory set which provides 85 percent of basic/routine laboratory tests required for the diagnosis of most common diseases” in the HSS section of Eritrea’s Round 9 HIV proposal. The TRP cited approvingly the that HSS section of Tanzania’s Round 9 HIV proposal “took advantage of best practices from NGO initiatives to improve health management systems and expand human resources for health.” At the same time, it is important to justify why the innovation is needed. One weakness that the TRP found in the HSS section of Uganda’s Round 9 HIV proposal is that it created a new position (counselor) without explaining why this is needed, or exactly what the position entailed (for example, whether and how it would benefit malaria and TB). The TRP also questioned whether the new approach to counseling that the position entailed required piloting before being rolled out to 960 health facilities.

16. Avoid introducing user fees to replace Global Fund financing: While the HSS component of Sierra Leone’s Round 9 proposal was successful, the TRP cited two major weaknesses, both related to user fees. The proposal stated that to sustain salary incentives beyond the Global Fund grant period (along with basket funding), health facilities would be asked to introduce user fees.¹⁸⁴ The TRP responded that this is “unlikely to generate sufficient funding to match the external support requested in this proposal” and that “there is extreme concern on how the effect of user fees will impact on improvements in access and utilization. The gains realized through the implementation of this Round 9 program could be reversed.”

17. Broad stakeholder involvement in proposal development: The TRP commended the process of developing the HSS section of Eritrea’s Round 9 HIV proposal for “its consultative process with key stakeholders, especially child and reproductive health programs, districts, women unions and partners.” A strength of the HSS section of Tanzania’s Round 9 HIV proposal was that “[t]he proposal development process engaged major stakeholders in health systems.”

18. Avoid duplication between HSS section and disease-specific sections and other funding sources: Applicants should avoid duplication between disease-specific sections and the cross-cutting HSS

¹⁸⁴ Sierra Leone Country Coordinating Mechanism, Round 9 HIV/AIDS proposal (June 2009), at 68. Available at: http://www.theglobalfund.org/grantdocuments/9SLEH_1915_0_full.pdf.

section, and between the cross-cutting HSS section and earlier grants or activities being funded by other partners. For example, the TRP cited as a weakness of Cambodia's Round 9 HIV proposal that "five of the NGOs nominated to implement the HSS activities are the same as those involved in the implementation of the disease-specific program. There is therefore insufficient clarity on the division of labor and allocation of funding to allay concern about overlap and duplication." The TRP cited a risk of the HSS section of the Democratic Republic of Congo's Round 9 proposal that there could be double payment of staff because of possible duplication with an earlier Global Fund grant. The TRP considered a weakness of Burkina Faso's Round 9 HIV proposal that it indicated that other donors were contributing to HSS, including information systems (an area addressed by the proposal), but "there is no commentary on how the other HSS inputs have been taken into account so that the Round 9 HSS request is only for unmet needs." Applicants should explain how proposed activities will not duplicate those supported by other funders where activities are similar. For example, a weakness of the HSS section of Guinea-Bissau's Round 9 malaria proposal was that "[v]arious other supporting stakeholders are already involved in HSS activities....The proposal does not provide enough information about the complementarity or possible overlaps....There is no information on the geographical distribution (which zones, areas or centers) and no justification for it."

19. Links to women's and children's health: The TRP can be expected to look favorably on interventions that will improve women's and children's health. The TRP favorably cites the fact that Eritrea's Round 9 HSS interventions "addresses health systems needs of all the three Global Fund targeted diseases (Malaria, HIV/AIDS and Tuberculosis) and addresses links to reproductive health." Similarly, the TRP commended the HSS section of Cambodia's Round 9 HIV proposal for its "focus on improving maternal and child care [which] provides a good synergy with the HIV/AIDS service program, especially PMTCT."

IX. Resources

1. Publications related to the Global Fund and technical support

The Health Workforce Advocacy Initiative and Health Systems 20/20 have developed a toolkit to support countries in using Global Fund Round 10 for health systems strengthening. It includes numerous resources, including the present Guide and a reference guide (<http://physiciansforhumanrights.org/library/documents/reports/global-fund-hss-reference-guide.pdf>). The full toolkit is available at: <http://physiciansforhumanrights.org/right-to-health/globalfund-round10.html>

For a broader overview of applying to the Global Fund, PHR recommends applicants review *The Aidspan Guide to Round 10 Applications to the Global Fund*, available through <http://www.aidspan.org/guides/index.htm>. Volume 1 of the Round 8 version of this guide includes a valuable section on lessons from previous rounds. *The Aidspan Guide to Developing Global Fund Proposals to Benefit Children Affected by HIV/AIDS* is also available through this website.

The World Health Organization has various documents that should be useful in supporting inclusion of HSS interventions in Global Fund proposals, including a short paper on making the case for health system strengthening, available at: http://www.who.int/healthsystems/gf_round10/en/index.html

Population Action International has produced a guide on integrating reproductive health into Global Fund proposals, *A Practical Guide to Integrating Reproductive Care Health and HIV/AIDS into Grant Proposals to the Global Fund*. It is available at: http://www.populationaction.org/PDFs/IA/Integration_Guide.pdf

A publication on technical support interventions for HIV/AIDS, tuberculosis, malaria, and other major diseases, including health systems strengthening activities, and available technical support related to the Global Fund and other sources of global health financing, is accessible through: <http://www.backup-link.de/>

2. Selected resources on human resources for health

Physicians for Human Rights, *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa* (2004). Available at: <http://physiciansforhumanrights.org/library/documents/reports/report-2004-july.pdf>

Physicians for Human Rights, *Bold Solutions to Africa's Health Worker Shortage* (August 2006). Available at: <http://physiciansforhumanrights.org/library/documents/reports/report-boldsolutions-2006.pdf>. Several other innovative responses to health worker shortages, excerpted from PHR's Round 6 version of the present Guide, can be found at: <http://physiciansforhumanrights.org/hiv-aids/docs/excerpt-guide-globalfund-round6.pdf>

Physicians for Human Rights, *The Right to Health and Health Workforce Planning: A Guide for Government Officials, NGOs, Health Workers and Development Partners* (2008). Available at: <http://physiciansforhumanrights.org/library/documents/reports/the-right-to-health-and-health-workforce-planning.pdf>. This guide explains how to ground health workforce plans and the planning process in human rights. A related, easy-to-use tool on the right to health and health workforce planning is: Health Workforce Advocacy Initiative, *Incorporating the Right to Health into Health Workforce Planning: Key Considerations* (November 2009). Available at: <http://physiciansforhumanrights.org/library/documents/reports/incorporating-right-to-health.pdf>. For an authoritative explanation of the right to the highest attainable standard of health, please see Committee on Economic, Social and Cultural Rights, *General Comment 14, The right to the highest attainable standard of health* (2000), available at: <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>

The Capacity Project has published a series of case studies as part of their *Health Workforce “Innovative Approaches and Promising Practices” Study*. These cover promising practices in Ghana, Malawi, Namibia, and Uganda, are available through: http://www.capacityproject.org/index.php?option=com_content&task=view&id=164&Itemid=158

World Health Organization, *World Health Report 2006: Working Together for Health* (2006). Available at: <http://www.who.int/whr/2006/>

The World Health Organization and several partners have developed an HRH Action Framework to assist with health workforce planning, available at: <http://www.capacityproject.org/framework/>. The Framework links to a number of human resources for health tools. Some human resources for health tools can also be accessed at <http://www.who.int/hrh/tools/>.

The HRH Global Resource Center “is a global library of human resources for health (HRH) resources focused on developing countries,” and is available at: <http://www.hrhresourcecenter.org/>

EQUINET has an extensive set of publications on the health workforce and other issues pertaining to health and equity in Africa through their website: <http://www.equinet africa.org/>

The Global Health Workforce Alliance website contains various resources, including on costing health worker needs (<http://www.who.int/entity/workforcealliance/knowledge/publications/taskforces/ftfproducts/en/index.html>), scaling up health worker education (http://www.who.int/entity/workforcealliance/about/taskforces/education_training/en/index.html), and an overall roadmap on addressing the health workforce (the Kampala Declaration and Agenda for Global Action) (<http://www.who.int/entity/workforcealliance/Kampala%20Declaration%20and%20Agenda%20web%20file.%20FINAL.pdf>): <http://www.ghwa.org/>

An open access (free) journal on Human Resources for Health is available at: <http://www.human-resources-health.com>

The Manager’s Electronic Resource Center, which contains a wide range of tools for health managers in such areas as human resources for health, leadership, finances, information, managing drug supplies, community health services, health systems reforms, and organizational management, is available at: <http://erc.msh.org/>

The Eldis Health Systems Resource Guide, which contains an extensive set of resources on human resources for health and other health system issues, is available at: <http://www.eldis.org/go/topics/resource-guides/health-systems> (health systems) and <http://www.eldis.org/go/topics/dossiers/human-resources-for-health> (human resources for health)



Physicians for Human Rights (PHR) mobilizes health professionals to advance health, dignity, and justice and promotes the right to health for all.

Since 1986, PHR members have worked to stop torture, disappearances, and political killings by governments and opposition groups and to investigate and expose violations, including: deaths, injuries, and trauma inflicted on civilians during conflicts; suffering and deprivation, including denial of access to health care, caused by ethnic and racial discrimination; mental and physical anguish inflicted on women by abuse; loss of life or limb from landmines and other indiscriminate weapons; harsh methods of incarceration in prisons and detention centers; and poor health stemming from vast inequalities in societies.

PHR's Global Health Action Campaign works with health professionals, students, and concerned citizens to advocate for effective, well-funded, integrated health systems that are equitable and accessible to all. The Campaign aims to establish the right to health as the framework governments use to develop, implement, and fund health programs. The right to health is also a means to hold governments accountable for the health of their populations and for meeting their international obligations.

As one of the original steering committee members of the International Campaign to Ban Landmines, PHR shared the 1997 Nobel Peace Prize.

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