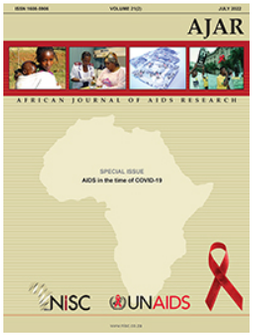

African Journal of AIDS Research

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/raar20

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To cite this article: Arlette Campbell White, Marc Péchevis & Adriana Jimenez Cuen (2022) Lessons learnt from UNAIDS virtual technical support to countries applying for funding from the Global Fund COVID-19 Response Mechanism, African Journal of AIDS Research, 21:2, 100-109, DOI: 10.2989/16085906.2022.2090394

To link to this article: https://doi.org/10.2989/16085906.2022.2090394

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Published online: 28 Jul 2022.

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African Journal of AIDS Research 2022, 21(2): 100–109

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AJAR
ISSN 1608-5906 EISSN 1727-9445
https://doi.org/10.2989/16085906.2022.2090394

Research Article

Lessons learnt from UNAIDS virtual technical support to countries applying for funding from the Global Fund COVID-19 Response Mechanism

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In 2020 the Global Fund for AIDS, Tuberculosis and Malaria initiated a new funding modality, the COVID-19 Response Mechanism, to mitigate the pandemic's effects on HIV, TB and malaria programmes and health systems in implementer countries. In 2021 UNAIDS introduced an innovative technical virtual support mechanism for COVID-19 Response Mechanism proposal development to help countries quickly implement COVID-19 interventions while at the same time adapting HIV and related services to the pandemic's circumstances and mitigate its impact while maintaining hard-won gains. It also intended to ensure more attention was paid to communities, human rights and gender considerations in proposal development, resulting in successful proposals to mitigate COVID-19's impact, bring human rights-based and people-centred HIV programmes back on track and even expand their reach through using new delivery platforms. In 2021, applications from 18 sub-Saharan African and Asian countries received in-depth remote peer reviews. We discuss the reviews' key findings and recommendations to improve proposal quality and identify future opportunities for virtual technical support. The model was successful and contributed to better quality funding applications, but also highlighted challenges in pandemic mitigation, adaptations and innovations of HIV programmes. Countries still fell short on comprehensive community, human rights and gender interventions, as well as innovations in HIV service delivery, especially in prevention and gender-based violence. Several other weaknesses meant that some countries would have to refine their programme design and implementation model in the final version of their funding application. There are implications for future assistance to countries trying to mitigate the impact of COVID-19 on their health programmes and innovative ways to deliver technical support using new technologies and local expertise.

Keywords: gender-based violence, HIV programme adaptations, COVID-19 impact mitigation, UNAIDS, remote peer review, technical assistance

This article is part of a special issue on *AIDS in the time of COVID-19*

Introduction

In 2020, the Global Fund for AIDS, Tuberculosis and Malaria (the Global Fund) established a special model, the COVID-19 Response Mechanism (C19RM), to respond to the urgent need for support to mitigate the impact of coronavirus on countries' disease programmes and health systems. As the pandemic took hold, new donor support to C19RM expanded the pool of emergency support available to countries. In 2021, the Joint United Nations Programme for HIV/AIDS (UNAIDS) set up an innovative virtual technical assistance (TA) mechanism to support countries preparing applications for C19RM's second phase. This virtual support desk mechanism comprised in-country TA (with the availability of a documents repository, clinics and one-to-one support) for proposal development and remote virtual peer reviews of draft grant applications by a team of experts working in English and French. The TA was designed based on experiences learnt in assisting countries to prepare their 2020–2022 Global Fund Funding Requests (FRs) and first applications to C19RM in the previous year, 2020. Some of the shortcomings identified in the first round of C19RM applications included the limited inclusion of community, rights and gender (CRG) interventions. Attention to CRG interventions was deemed important because of the rising number of human rights violations during COVID-19 lockdowns that affected people living with HIV (PLHIV) and key and vulnerable populations (KVPs), including gay men and other men that have sex with men and sex workers. There were also more reported cases of gender-based violence (GBV) in many countries. The potential of using community-based and community-led service provision was also often overlooked during those initial submissions.

Therefore, the main purpose of the virtual support for the second round of C19RM applications was to help countries to develop quickly proposals that would: (1) pay more

attention to CRG considerations; (2) mitigate the impact of COVID-19 on HIV programmes; and (3) design interventions to bring HIV programmes back on track and even expand their reach, tailored to the pandemic context in each country. However, support was also available for other aspects of proposal development, including TB and malaria programme mitigation as well as areas related to strengthening health systems, particularly community systems.

The virtual support was launched in May 2021 by the UNAIDS Technical Support Mechanism (TSM),[1] funded by a grant from the United States Agency for International Development through its Office of the Global AIDS Coordinator.

In this paper, we consider the lessons learnt in providing virtual support to assist countries in their efforts to mitigate the impact of coronavirus on their disease programmes and health systems. We explain the weaknesses found in the draft proposals reviewed through the TA support and make recommendations to help improve their quality in future. In addition, we also provide some considerations for applying new technologies and empowering local expertise in the provision of technical support.

The Global Fund's response to COVID-19

Since early 2020, many HIV, TB and malaria (HTM) programmes have faced significant disruptions due to COVID-19 related public health measures, supply chain challenges, impediments to health service attendance, and impact on health care systems (The Global Fund, 2021a). As countries went into lockdown, pandemic responses interrupted critical testing and prevention activities, particularly for KVPs who are most at risk of contracting HIV (The Global Fund, 2021b). In many countries, the national responses that inhibited movement negatively impacted HIV prevention programmes, especially for KVPs and adolescent girls and young women and their partners. Services such as antenatal care (ANC), HIV testing and early infant diagnosis, and treatment initiation/adherence, were all adversely affected. The pandemic also highlighted the central role of communities, community-led organisations, and community health workers in national responses.

Another key impact, which became apparent even in the very early stages of the pandemic in 2020, was the significant rise in GBV (UNDP, 2020) and human rights abuses (Mittal & Singh, 2020). Unemployment soared, and access to health care for the poorest and most vulnerable was compromised. COVID-19 made people less likely to seek health care because they could no longer afford to do so and/or they were afraid of being infected with the virus. Fear and uncertainty surrounding COVID-19 also increased stigma and discrimination.

In 2020, in response to the pandemic, the Global Fund introduced grant flexibilities and the C19RM to help countries fight COVID-19, mitigate its impacts on lifesaving HTM programmes, ensuring the availability of critical health commodities to deal with priority diseases, and prevent fragile health systems from being overwhelmed (The Global Fund, 2020). To date, the Global Fund has disbursed some USD 894 million in terms of 2020 grant flexibilities and C19RM grants (The Global Fund, 2021c).

Allocating extra funds to tackle programme disruptions

The Global Fund's allocation methodology sought to increase the impact of programmes to prevent, treat and care for people affected by HTM, and build resilient and sustainable systems for health. It allocated USD 12.71 billion for country allocations and USD 890 million for catalytic investments for the 2020–2022 allocation period but likely to be used between 2021 and 2023. All countries receiving funding from the Global Fund, including regional/multi-country recipients, were eligible to receive C19RM funding in addition to their 2020–2022 allocations. As per the core allocations, C19RM funds could be used until end 31 December 2023.

In 2021, the Global Fund received an emergency fund of USD 3.5 billion for the C19RM provided by the United States Government followed by additional contributions from Canada, Denmark, Germany, Luxembourg, the Netherlands, Norway, Sweden and Switzerland. Accordingly, the Global Fund was able to accelerate its response to the pandemic and continue support through C19RM 2.0 in 2021. As of 8 October 2021, the Global Fund had awarded a total of USD 4billion to more than 100 low- and middle-income countries to address COVID-19.

Under C19RM 2.0 in 2021, the Global Fund placed a stronger focus on strengthening partners' and communities' engagement. Eligible investments included: (1) actions to reinforce national responses to COVID-19; (2) pandemic-related adaptation of HTM programmes; and (3) strengthening health and community systems. The Global Fund also stressed that these three areas "should also incorporate cross-cutting activities that bolster community responses to COVID-19".

The details of how countries could access the C19RM funding can be found on the Global Fund website.[2]

In brief, all eligible countries were allocated a basic amount equivalent to 15% of the applicant's 2020–2022 country allocation which, in principle, they could expect to receive if they were to submit "ambitious, quality and prioritised" requests. Moreover, countries could access additional funds, initially the equivalent of 15% of their 2020–2022 country allocations, but this could be more or less for prioritised programmatic needs.

The size of the allocation awards took account of factors such as the country's COVID-19 burden, the extent of service disruption to Global Fund-supported programmes, the amount of C19RM 2020 funding previously awarded and grant absorption progress, and the availability of funding from other sources.

Countries could request funding through a full FR which includes programmatic activities. They also had the option to submit a Fast-track FR that would allow the urgent procurement of health commodities, including personal protective equipment (PPE), COVID-19 diagnostics and therapeutics and associated procurement and supply chain management costs. However, countries could only use up to half of their C19RM base allocation for a fast-track FR.

Approaches to be used and materials for developing a C19RM full FR were similar to those required for regular Global Fund FRs, e.g., meaningful stakeholder engagement (especially civil society and KVPs) and endorsement by the Country Coordinating Mechanism.

However, there were also some new aspects. It was expected that, based on the World Health Organization's guidelines for COVID-19 Strategic Preparedness and Response Plan (SPRP) development for 2021, countries would have prepared their own national plan (NSPRP) and thus their proposed C19RM activities should also be in line with the national plan's pillars as well as being coordinated with the national COVID-19 response coordinator (World Health Organization, 2021).

One other major factor affected the development and submission of C19RM FRs: the turnaround time from receipt of the Global Fund Allocation Letter, outlining the amount of funding for which the country was eligible to apply, to proposal submission was between four to eight weeks. When one considers that developing a full FR can take as long as six months or more, it is evident that such a short space of time, placing additional pressures on countries, was likely to result in insufficient attention paid to some important aspects of the FR.

UNAIDS C19RM technical support

The Global Fund had asked partners to support countries in the development of technically sound C19RM applications. In 2020 and early 2021, UNAIDS' TSM had provided extensive in-country and remote support to countries developing their 2020–2022 Global Fund FRs and helped raise USD 7.4 billion for 61 countries. It had also already assisted several countries with their first C19RM applications. The 2021 C19RM virtual support model was therefore built on experiences and lessons learnt from the Global Fund proposals and the first round of the C19RM.

During the same period, TSM also supported technical assignments for HIV mitigation, continuation of HIV services, adaptations and scale-up. Some of these were COVID-related (e.g., information on impact and responses, innovative models, support to national task teams and community-led systems responses), or had a partial COVID focus (e.g., service access plan, combination prevention innovations and social protection). UNAIDS also supported non-COVID assignments such as enhancing the resilience and recovery of national HIV responses in the time of COVID (e.g., differentiated HIV service delivery (DSD) including multi-month dispensing (MMD) of health commodities, and community-led responses and monitoring, and other innovations).

In 2021, TSM provided in-country assistance to four countries' C19RM applications (Botswana, El Salvador, Kenya, Zimbabwe) and virtual support to one country (Cabo Verde). However, the establishment of an online support mechanism for countries preparing their C19RM 2021 full FRs to the Global Fund was through an entirely new mechanism, never before piloted, and hence of particular interest. The support was entirely virtual, not only given COVID-19 travel restrictions but also because new ways of working through online mechanisms had resulted in savings, increased efficiency and enabled the peer review team to help a greater number of countries. Co-sponsors (UNICEF, WHO, and others) were kept informed during the peer review process and contributed by providing documents for the depository and participating in clinics; some even contributed to reviewing sections of the draft FRs.

The aim of the enhanced UNAIDS support was to enable countries to access additional funding from the Global Fund and submit quality C19RM full FRs, focusing on HIV impact mitigation and better attention to CRG considerations. This virtual support desk mechanism is depicted in Figure 1.

It comprised three components: (i) conducting remote peer reviews of funding applications and providing technical clarifications (virtual helpdesk); (ii) establishing a Community of Practice; and (iii) holding virtual clinics on topics relevant to C19RM proposal development. The Virtual Community of Practice is shown in Figure 2; each hexagon around the Community illustrates one of the components of the application for which TA was provided.

Countries could receive virtual support from specialists on HIV, COVID-19, CRG and community health systems, procurement and supply management, budgeting, and other thematic areas. TSM specialists — and others from UNAIDS and its co-sponsors — would conduct virtual desk reviews of

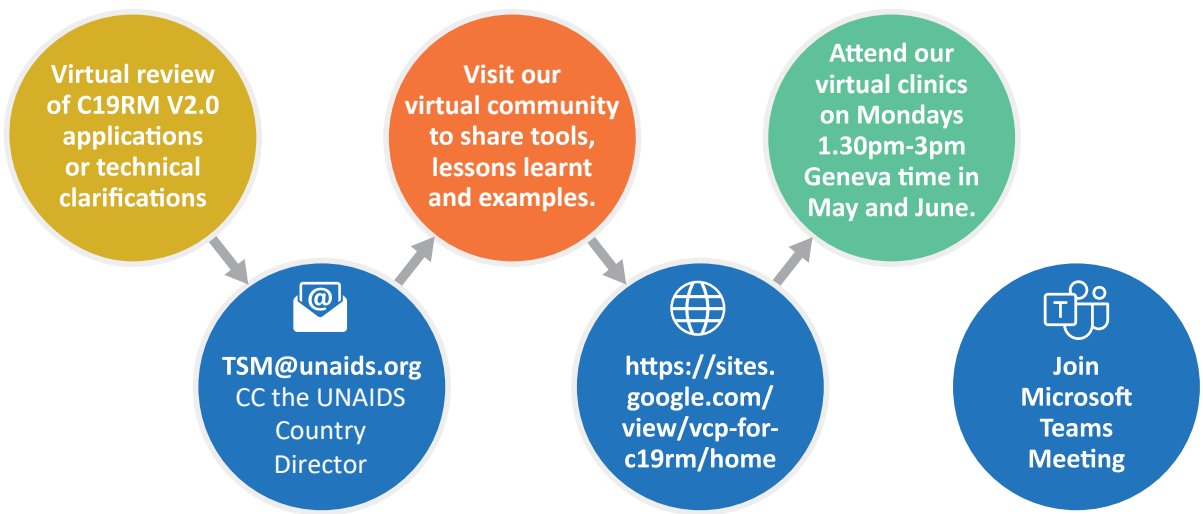

Figure 1: Virtual Help Desk for C19RM v2.0 Funding Requests with special focus on HIV impact mitigation and community systems

Figure 2: Virtual Community Of Practice

draft C19RM FRs or clarify technical questions. Consultants and those drafting FRs were able to access and share the latest guidelines and examples of COVID-19 adaptations and cross-cutting considerations for human rights and gender equality. Those interested could also participate in regular virtual clinics (webinars) on specific topics such as CRG, GBV, HIV mitigation, HIV prevention and service delivery through virtual innovations.

In a similar way as the reviews organised for Global Fund full FRs, remote desk peer reviews of draft C19RM FRs in English or French were conducted by a team of experts. In total, 18 draft FRs were submitted for peer review and, of these, four resubmitted their proposals for a second peer review. Applications came from Botswana, Central African Republic, Chad, Congo, Cote d'Ivoire, Gambia, Kenya, Liberia, Madagascar, Namibia, Nigeria, Pakistan, Senegal, Tanzania, Uganda, Zambia, Zanzibar and Zimbabwe. The corresponding immediate funding for 2021 approved by the Global Fund was close to USD 1.1 billion.

The peer review process generated several findings, some of which also apply to peer reviews of 'regular' Global Fund FRs. However, there were also new findings and lessons that are applicable to the development of any kind of FR, as discussed below.

Findings

Findings have been grouped under four different areas. First, weakness related to the completeness and presentation of the C19RM full FRs. Second, technical robustness of the applications. Third, opportunities and weaknesses for community engagement and initiation and expansion of community models. And lastly, findings related to gender equality, particularly addressing GBV and sexual and reproductive health and rights (SRHR).

The key findings of the peer reviews are that, in general, countries struggled in the limited time available to follow the application instructions and ensure completeness and technical robustness. They did not pay sufficient attention to adapting HIV prevention programmes to take account of the new context of maintaining service delivery in the time of the pandemic; and were especially weak in addressing the area of gender equality, human rights and community responses to HIV and COVID.

Finding 1: Countries experienced challenges to ensure completeness and follow the application's instructions

The peer reviews revealed persistent weaknesses in FRs. Although the time and resource constraints limited what

countries were able to prepare, the weaknesses discussed below nonetheless indicate a lack of attention to instructions.

(a) Draft FRs were not prepared early enough to review properly. The short time allowed to prepare quality FRs meant that countries needed to have assembled experienced personnel to prepare their FRs and work to a clear plan and timetable. The little time for turnaround implied insufficient planning. A minimum of 48 hours should have been allowed for peer reviews to enable the provision of detailed feedback.
(b) Instructions were not always followed. There was a surprisingly high incidence of inadequate/incorrect use of the detailed Global Fund templates and instructions. For example, key annexes were not always attached to draft FRs. Reviewers would have been better able to provide more comprehensive feedback had the necessary annexes, such as the budget, been attached. Detailed instructions needed to be followed to the letter or queries raised. However, if FR writers encountered difficulties, this suggests that a review of the Global Fund templates and instructions might be helpful.
(c) The FRs were seeking to obtain C19RM grants yet they did not provide sufficient information about the pandemic disruptions to the disease programmes and health systems. This resulted in what appeared to be an imbalance in the split of resources between 'pure COVID' activities and those mitigating the impact on responses to the three diseases and health system strengthening. On the whole countries seemed to find it easier to comment on health system challenges rather than HIV service disruptions in the detail needed to provide the evidence base for HIV programme adaptations. As a result, the HIV component was sometimes poorly thought through, and opportunities were missed or only partially addressed. Yet many countries were already implementing interventions such as DSD, MMD and HIV self-testing (HIVST) that could have been further expanded to respond to mitigating the impact of the pandemic on HIV services. Moreover, there may have been more openness to innovations due to the unusual circumstances; anecdotally, in many contexts it was reported that communities showed a readiness to organise themselves to provide DSD and MMD, for example, rather than being told how to do it or responding to central plans.
(d) Generally, proposals demonstrated a limited understanding of COVID-related good practices and options for interventions and resource allocation. Despite COVID-19 restrictions, some FRs included very high travel-related costs, e.g., meetings, workshops, training (one country had allocated 49% of its budget to this) instead of using virtual platforms, innovations or other new/not-so-new technologies. Applications should have contained much more information about: (i) programme disruptions due to the pandemic (and associated measures); (ii) the use of digital technology to provide information and services to targeted populations; and (iii) how the C19RM application and proposed adaptations to disease programmes to deal with the situation would get the programmes back on track.
(e) Sections on how interventions were prioritised were weak and inadequately explained how activities had been determined (as also seen in 2020 with 'regular' Global Fund FRs). The prioritisation process should be explained in full, including how interventions were assessed, ranked and selected for inclusion in the FR, and clearly state who was involved in the process.
(f) Global Fund grants are a performance-based funding mechanism so the anticipated outputs and results should be set out in the FR. Few applications did so; and, in those that did, the expected results were mostly unquantifiable and very poorly outlined across all countries. Outcomes should be SMART (specific, measurable, attainable, realistic, and time-bound).
(g) There was a failure to link the context (e.g., socio-economic) to corresponding proposed interventions and to the appropriate pillars of the NSPRP. In fact, in some proposals even failed to reference the NSPRP.
(h) Finally, there was insufficient consideration of DSD. A country attempting to mitigate the impact of the pandemic on HIV service delivery should provide DSD where possible or widen the use of existing DSD modalities such as HIVST and MMD.

At the peer review stage, most of the draft proposals reviewed were found to suffer from some or all of the above weaknesses. These must be avoided when preparing future submission for grant funding and should be highlighted in any training provided on proposal preparation.

Finding 2: Many funding requests displayed weak technical components

A strong technical focus is needed to convince a grantee of the validity of a proposal. The peer reviewers found most technical components to be weak. Typically, the weaknesses were:

(a) A lack of quantified data/information on COVID-19's impact on disease programmes and health systems which made it harder for countries to propose convincing evidence-based and measurable disease adaptations. A weak evidence base is equally true of many regular FR applications.
(b) Despite the significant impact on disease programmes, some countries only prioritised 'pure COVID' support with no or insufficient investment in health and community systems strengthening (such as capacity building).
(c) The strong impact of the pandemic on HIV programmes was inadequately described and supported with data and the proposed mitigation activities gave scant consideration to condom programming, pre- and post-exposure prophylaxis and mother-to-child-transmission (MTCT) through ANC. In future, the ANC and MTCT status needs to be better described to ensure the coherence of the context with the proposed modules. Overall, HIV adaptations were weak: applicants needed to address all affected services, including voluntary medical male circumcision, and consider initiating or scaling up tailored COVID-19 adaptations to HIV services such as MMD for HIV commodities, not only treatment-related but for prevention and harm reduction, HIVST where applicable, virtual interventions, and many others.
(d) Proposed actions lacked detail with many modules' interventions reading like shopping lists instead of

providing clear descriptions of prioritised effective activities. Often there was also no indication of whether countries had had any positive experiences rolling out innovative COVID-19 mitigation approaches and whether the proposed interventions would be based on those lessons learnt.

(e) There were missed opportunities to link services for adolescent girls and young women to ANC, GBV, SRHR and sexually transmitted infections, including HIV. The steep rise in GBV and human rights violations following the onset of the pandemic was anecdotally acknowledged yet there were no data on this. In countries with nomadic populations or refugee camps, there was a lack of consideration of the impact of GBV not only on women but on boys. Urban slums, with 'hotspots' of underserved communities such as migrants were also largely neglected.

(f) Even when FRs mentioned human rights violations and increased stigma and discrimination, they rarely included appropriate interventions to address these issues aimed at, for example, police, parliamentarians and legislative bodies.

(g) Community-led responses displayed missed opportunities and a lack of innovation. What made the C19RM different from the usual Global Fund FRs was the even higher importance placed on the role of the community. This was especially imperative given that service mitigation and adaptations also implied enhanced use of DSD, which would require greater use of community structures.

(h) It was evident that collaboration with opinion leaders and social influencers — such as politicians, mayors, artists, singers and footballers, for example — was insufficiently exploited to continue reaching people with HIV prevention and testing messages.

(i) TB programmes were badly hit by the pandemic, but TB activities were poorly developed in most applications, including joint HIV/TB activities.

(j) The Global Fund had encouraged applicants to consider "innovations" but those proposed made little use of new digital technologies, social media or eHealth, or alternative and new ways to provide essential services that were unable to function normally because of COVID. One of the reasons for this may be due to the problems inherent in bringing IT-based solutions to poor and/or rural communities.

(k) Finally, and somewhat surprisingly, applicants rarely considered how they could link C19RM activities to interventions under the existing Global Fund grants and those of the United States President's Fund for AIDS Relief (PEPFAR). This was a significant missed opportunity as synergies and better alignment would have allowed further integration of services and better technical efficiencies (avoiding duplication of activities).

Finding 3: Communities did not stand out sufficiently

The Global Fund consistently emphasises that applications must pay particular attention to community-based/led initiatives, especially those led by and/or offered to PLHIV and KVPs, and targeted at hard to reach/under-served groups such as internally displaced populations, prison inmates, miners and long-distance truckers. Yet not enough attention was paid to initiating or expanding the delivery of HIV services through community models even though these offered an alternative to those afraid to seek services from already overburdened health facilities. This gap was reflected in: (i) a lack of community-generated data (for example, countries could have undertaken a rapid assessment of KVP/PLHIV needs, the findings of which could inform gaps and needed interventions as was undertaken in certain regions and countries); and (ii) what appeared to be insufficient inclusion of representatives from KVPs in the FR development process. This was surprising given the Global Fund's emphasis on inclusive consultations for FR development reflected in detailed descriptions of the approach and participants involved. However, there were also legitimate difficulties in organising consultative processes, particularly with communities that are marginalised in terms of access to IT, data and confidence for remote consultative processes. More emphasis needs to be placed on building new processes and systems for community engagement in the COVID and post-COVID reality.

Also, there was an apparent lack of private sector involvement, when, in some countries, the private sector provides more than 50% of health care services, especially in urban areas. It is possible that many countries did not have a community systems specialist or expertise available. This must be addressed in future.

The Global Fund also wanted to see evidence not only of community engagement in developing FRs but also, once funding had been secured, how communities would continue to participate. However, it was often unclear to what extent the constituencies/communities would be involved in implementation. In fact, the related section was largely left empty in the drafts that came to the peer reviewers. The importance of civil society, including in FR development, implementation and monitoring, was frequently underestimated. For example, civil society was often not broken down by its constituents and there was an apparent lack of engagement of KVP- and PLHIV-led networks. It was unclear how funding prioritisation/re-prioritisation decisions were conveyed back to the constituencies or whether stakeholders were able to provide more inputs other than during the first consultations. No proposal noted whether the constituencies' costs were covered where appropriate (e.g., transport, etc.) or if consultations were held virtually and how this worked in communities without access to e-based platforms. This might show a disconnect between donors' expectations about what a robust proposal might look like on the one hand and, on the other, the issues that country stakeholders perceive are of most importance to them. For example, funders tend to want applicants to set out 'the ideal answer' rather than considering more country-specific proposals that have resulted from a sound process that addressed gaps in understanding and design through meaningful community engagement.

Finding 4: More attention was needed for interventions aimed at addressing women, GBV and SRHR

Under the C19RM, the Global Fund allowed greater emphasis on HIV impact mitigation through linking HIV and SRHR services. Integrating SRHR and HIV would allow

providers to be able to address an assorted range of issues including those related to gender concerns, such as GBV and human rights. It was noted that COVID-19 had also had a significant impact on family planning services, resulting in gaps in contraception and a rise in the number of unintended pregnancies (Ameyaw et al., 2021). Yet, despite the evident gaps in this area, interventions to respond to these were largely missing.

Some of the activities that might have been considered included, for example, ensuring continued supplies of contraceptives delivered through alternative mechanisms if clinics were closed due to COVID. For survivors of intimate partner violence, programmes needed to ensure that peer counsellors and communities (including KVPs) were readily able to access pre- and post-exposure HIV prophylaxis, and ensure the provision of rape kits, emergency contraception and psychosocial support.

Regarding GBV, ensuring continued access to women's centres and/or shelters became even more important, including temporary shelters, and especially for new clients given the rise in domestic abuse during the pandemic. Likewise, domestic violence helplines could have been strengthened and online virtual support networks leveraged by taking advantage of social media. For post-GBV cases, the provision of legal aid and expanded community paralegal programmes was an important consideration, as were prevention interventions aimed at law enforcement officers and judiciary. However, most proposals were weak in this area.

The role of the community in monitoring human rights had become even more important through increasing community awareness of potential rights violations in the context of COVID-19. However, we found that FRs rarely mentioned the extra barriers related to human rights violations and increased stigma and discrimination in the COVID context, resulting from the overuse of criminal laws and punitive approaches. This is an area that must be better addressed for HIV adaptations to mitigate the impact of pandemics on vulnerable populations. Interventions that applicants could have considered include:

- Supporting community and civil society efforts to prevent the introduction of new legislation or the application of existing legislation to criminalise exposure, non-disclosure or transmission of viruses and communicable diseases.
- Supporting efforts that refocus law enforcement measures to ensure public safety and refer marginalised groups to health and social services, and fund efforts to train law enforcement officers to ensure the protection of rights in implementing law enforcement actions.

Limitations of the peer reviews

The results described above were based on an observation of the peer reviews conducted for 18 countries. This was not a formal research project and there have been no other such studies to date. However, the C19RM FR peer reviewers had also previously conducted peer reviews for 'regular' Global Fund FRs and noted similar findings. The major limitation of the study, therefore, is that there is no formal baseline with which to compare findings.

Secondly, the peer reviews were conducted remotely so there was no first-hand observation of data and facts; we had to rely on the accuracy of the information in the FRs. For example, the lists of priorities which read as 'wish lists' could not be verified. Working remotely from the country teams developing the FRs meant that our own biases and opinions may have influenced our findings.

The limitations of the national pandemic response plans and proposed interventions (developed early in the pandemic and based on a limited understanding of its impact and response) could have been a constraint on the quality and scope of submissions — and perhaps the peer reviews themselves. It may have been problematic for the Global Fund to insist that the applications reflect the national plans rather than drawing on them mainly where useful.

Finally, the context of application development was unusual due to the urgency of the situation, COVID restrictions affecting consultations, and limited understanding of impact and good practices. The peer reviewers may have been aspiring to good practices that are difficult to expect in challenging circumstances and point to a need to build the capacity of consultants, adapt application and grant-making processes to deal with these types of issues, or build other mechanisms to deal more effectively with these constraints.

Countries are not referred to by name as this is privileged information.

Recommendations

We provide recommendations across five main areas: quality of the FRs, scaling up innovations, ensuring synergies with existing country grants and projects, establishing a stronger implementation M&E mechanism, and paying more attention to community system strengthening and community engagement.

1. Improve the quality of C19RM and core Global Fund funding requests.

Based on the above findings, there are several actions that can be taken to improve the quality of full FRs for C19RM and core Global Fund FRs:

(a) Attention must first be given to the resources available to develop an FR, including a constituency engagement strategy; and, if considered inadequate, the applicant should seek technical assistance from development partners (such as the virtual support provided by the UNAIDS TSM).

(b) Next, a team leader should be appointed to draw up a work plan and timetable for FR preparation. It was unclear if team leaders were designated early on in the context of this kind of emergency and what the local factors were constraining this task. In either case, it may point to a broader issue that, especially under rushed and unusual situations, it cannot be assumed that countries can apply basic good practices developed for other applications when more time is available.

(c) The timetable must make adequate allowance for: (i) following the directions for preparing the FR as set out by the Global Fund; (ii) identifying where the main thematic gaps are and determining how best to address them; (iii) addressing known difficult topics; (iv) researching

and gathering appropriate data; (v) exploring possible opportunities for innovation; and (vi) involving key stakeholders including representatives of communities, especially KVPs, civil society and the private sector.

(d) Ensure that the preparation timetable is adhered to.

(e) Explain in the draft FR: (i) what research/data collection was undertaken and what was not and why; and (ii) what assumptions were made and on what basis. This then helps foster a clear understanding of how interventions were ranked and prioritised for the FR.

(f) Ensure that, in developing priority activities: (i) they are clearly explained and the requirements for their implementation, including the estimated costs, are determined; (ii) the expected outputs and outcomes of possible activities are identified and evaluated; (iii) the opportunities for introducing innovations have been fully explored, making the best use of new technologies rather than rolling out business as usual, when the new and evolving context makes it even more important than before to deliver services differently; (iv) there is adequate consultation with the various stakeholders, that their contributions and views are noted in the proposal and that they understand how the priorities have been determined and ranked; and (v) implementation management and oversight are thought through so that the proposal adequately describes the leadership as well as the oversight and governance mechanisms that will ensure that proposed interventions deliver the expected results.

(g) Given the effects of COVID-19, attention must be paid to strengthening systems and cross-cutting approaches that will enhance longer-term service performance and limit the risk both that a future pandemic could undermine them but also that specific interventions may become outdated as the epidemic or treatments evolve. For example, very specific initial responses (e.g., a focus on buying ventilators) may become unnecessary as the pandemic loses momentum and fewer are infected. This highlights the importance of considering prioritising key health systems strengthening components, such as human resources for health and supply chain management, that have to be fit for purpose but also able to be flexible enough to change according to circumstances — especially when dealing with a pandemic.

There is also a need to continue strengthening service delivery models alongside the traditional health facility setup, either through community or digital health platforms, and that successful innovations are maintained and scaled up.

2. Maintain and scale up successful innovations

The Global Fund C19RM instructions clearly requested applicants to: (1) look for alternative and new ways to provide essential services that were currently unable to function normally because of COVID-19; and (2) identify mechanisms for optimising results and value for money. But, as we have noted, very few countries took advantage of technological innovations, especially for KVPs and CRG. In the next Global Fund funding window(s), but also at grant-making and implementation stages, countries will further need to explore and introduce new technologies for national programmes to move from purely physical interventions to virtual ones, across all thematic areas.

Such virtual interventions and responses as well as alternative HIV commodity delivery models (such as home delivery or delivery at tertiary locations) have already been deployed and documented in different regions as described in Box 1 (UNAIDS, 2022a; UNAIDS, 2022b) and knowledge of good practices and success factors is slowly growing. It is therefore important to disseminate that learning by enabling stronger collaboration between the Global Fund and its key technical partners (such as PEPFAR, UNAIDS, WHO and other TA providers) in different regions. Countries should not only consider innovations that have been introduced in other countries in their region but also in other regions where some countries may be way ahead of the curve.

3. Ensure synergies with existing grants and across component

We previously mentioned the frequent lack of information about programme disruption and even more so regarding how C19RM-requested funds complement domestic and other resources, despite the Global Fund's request to provide details on the "impact of COVID-19 on the overall health system, including the impact on continuity of services, particularly for key and vulnerable populations" and remembering that some countries already included aspects of HTM mitigation using funds from earlier grants (The Global Fund, 2020).

As C19RM grants should not be implemented in isolation from Global Fund and other partners' grants (such as those from PEPFAR and the COVID-19 Vaccines Global Access (COVAX)[3] immunisation effort through Gavi, the Vaccine Alliance), countries should judiciously review the relationship and linkages between the various grants and search for synergies during the grant-making and implementation phases (e.g., ensuring that monitoring and evaluation (M&E) supports, rather than complicates, multiple programmes), and address fundamental issues like supply chain management and capacity development.

In addition, countries could consider supporting COVID-19 vaccine demand generation and hesitancy particularly in the

Box 1: Virtual platforms for COVID-19 mitigation and HV adaptation

- Online support networks for KVP programmes:
  - Remote health counselling
  - COVID-19 information
  - Psychosocial support
- Virtual case management:
  - eHealth
  - Telemedicine and tele-results
  - Virtual consultations (by mobile phone)
- New communication approaches by using social media (WhatsApp, Instagram, Facebook, Twitter, TikTok, YouTube, hook-up apps, etc.)
- Leverage social influencers, bloggers, etc.
- Establishing hotlines, call centres
- Community-led mapping, influencer mapping, density mapping

African continent among PLHIV and KVPs, who may often be at a much higher risk of COVID-19 than the general population. Or identifying those interventions that could be integrated such as HIV prevention activities and COVID-19 education, testing and COVID-19 vaccine demand creation, which are often implemented by the same community implementers.

One of the limitations of the C19RM was the fact that FRs could not include HIV commodities as these were expected to be part of the core HIV grants. However, some countries struggled to scale up HIVST or MMD of HIV commodities, which were successful C19RM adaptations, due to the lack of or delayed supplies. These considerations may eventually lead to a programme revision of core Global Fund grants.

4. Establish a stronger implementation M&E mechanism

Beyond the lack of data on COVID-19's impact, and because the Global Fund does not require a M&E framework at the proposal stage, in future countries might consider working together with the Global Fund Country Teams to develop a framework with measurable indicators and targets to monitor C19RM grant implementation. This would also demonstrate how the new investments and adaptations are expected to succeed in supporting countries addressing COVID-19, mitigating its impact on the three diseases and the health system.

Going forward, countries will also need to:

- Consider the provision of information and data for refining strategies and programmes. Some countries will cope better with addressing COVID-19 than others who may struggle with the 'shifting sands' of new implementation models and changing COVID-19 epidemiology, depending on whether vaccine programmes are reaching the right beneficiaries.
- Be aware of global best practices.
- Conduct ongoing needs assessments to ensure that the priorities remain the same or are adjusted accordingly.

5. Pay more attention to community system strengthening and civil society involvement

The C19RM FRs noticeably lacked an emphasis on community health system strengthening. These are areas where UNAIDS, the Global Fund (through its CRG Strategic Initiative) and other partners such as Frontline AIDS can support countries to incorporate C19RM interventions that strengthen programme design, implementation, M&E, financing and service delivery. The importance of communities in C19RM grants, emphasised by the Global Fund, means that countries have to understand how to integrate public sector collaboration with civil society and community organisations in key areas of the responses to COVID and the three diseases. This integrated community systems strengthening approach should be discussed with key partners, like PEPFAR, to avoid any divergence or duplication of interventions and realise potential synergies and improved effectiveness across the whole health pyramid including the central, intermediary and peripheral levels.

Opportunities for new models of technical support

As previously discussed, most countries will still need further to develop, strengthen and refine their C19RM grants and national responses to tackle the pandemic and its impact on the diseases and health systems. This raises new challenges, but also opportunities, for technical support partners. There are also valuable lessons learnt that should be considered for future technical support.

There are five key opportunities:

1. Replicate the virtual support mechanism

The innovative virtual support achieved some noticeable successes despite limited time and resources. While not replacing in-country support, this model may be worth considering for the next stages (e.g., grant-making, implementation) and/or strengthening specific thematic areas which were noticeably weaker in proposals that did not get this support. Virtual support can also link experts between regions and countries and incentivise cross-fertilisation of new ideas and best practices. It can also work as a mentoring mechanism to support local consultants who want to develop new expertise in a particular area. However, connectivity limitations may make this difficult to support.

2. Rethink and revitalise capacity development/ orientation

During previous Global Fund grant periods there was a general perception that capacity development, technical support and webinars for FR development were not productive, and it was assumed that FR writing teams knew enough or could use and interpret standard guidance efficiently. However, C19RM challenges, travel restrictions, technological improvements, and the expanded involvement of stakeholders, have made webinars or 'clinics' indispensable for many. They confirmed that there is an imperative need to provide consultants assigned to assist in developing FRs with appropriate technical orientation to ensure high quality FRs. The pandemic also showed that the right mixes of in-country presence and remote support, like the remote peer review, assists the Global Fund application process and is a smart investment.

3. Continue to develop local expertise and engage local consultants

During the COVID-19 pandemic, it was clear that countries where investments had been made in building local knowledge and providing a pool of local consultants were more resilient and able to continue the provision of technical support despite travel restrictions.

4. Provide additional TA at grant-making and implementation phases

Many of the weaknesses identified in the reviewed C19RM FRs could still be corrected during grant-making and/or at start-up of grant implementation. In addition, TA providers should also further promote and support countries with routine 'non-material' and early 'material' programme revisions (formerly known as reprogramming) for both the C19RM and the core Global Fund grants. TSM has listed

potential areas where TA providers can still add value to the grant-making and implementation phases, as well as to further C19RM rounds, through best practices, prioritisation processes, innovation, indicative budgeting/costing, programme evaluations, tools and other materials.

5. Review existing technical support

Many pre-existing TA plans, such as UNAIDS' current regional and country-level virtual technical support plans, may under-represent assignments that explicitly build COVID resilience and impact mitigation for HIV programmes. They are likely to miss new opportunities created by COVID to accelerate HIV/TB service innovation and efficiency as part of C19RM or other grants. Countries and partners should revisit technical support plans, starting with country level assessments to identify the main gaps.

As we look at the way forward in resolving what might be some systemic challenges in mitigating COVID-19's impact on HIV responses, there are three critical gaps that need to be discussed with other partners: (1) the need to clarify Global Fund plans for refining weaker C19RM and HIV/TB grant responses, and addressing important gaps, e.g., underdeveloped community components, GBV-related interventions, etc.; (2) the division of TA roles and responsibilities between partners; and (3) plans for possible future C19RM FRs that could benefit from refined guidance and TA.

Conclusions

The experiences gained from applying the virtual support mechanism and the many peer review comments provide a wealth of information that should be built on and leveraged for support to future quality FRs for both C19RM and Global Fund grants. Moreover, countries can still build on some of these lessons at the grant-making and implementation phases.

Of the weaknesses in funding application noted in this article, one stands out in need of most emphasis: the importance of civil society, including communities' engagement and involvement in FR development, implementation, and monitoring. There is still insufficient engagement with — and underestimation of — civil society, especially KVPs and PLHIV-led networks; and this needs to be addressed by all partners.

Countries will soon start to develop the next cycle of Global Fund FRs for the funding cycle 2023–2025. — and maybe more C19RM FRs will be forthcoming — so it will be important for countries to take these findings and recommendations into account, and for partners to be ready to provide new models of technical support using virtual platforms and local knowledge.

Acknowledgements — This special issue of the *African Journal of AIDS Research* is sponsored by the Joint United Nations Programme on HIV/AIDS (UNAIDS).

The authors would like to acknowledge the support from the UNAIDS Technical Support Mechanism.

Notes

[1] See https://www.unaids.org/en/topic/TSM for a full description of the services provided by TSM.

[2] https://www.theglobalfund.org/en/covid-19/response-mechanism/

[3] COVAX is co-led by CEPI, GAVI and WHO, alongside key delivery partner UNICEF. See: https://www.who.int/initiatives/act-accelerator/covax.

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Manuscript received April 2022/ revised June 2022/accepted June 2022