

Guide to Using the Global Fund to Fight AIDS, Tuberculosis and Malaria to Support Health Systems Strengthening in Round 6

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Using this Guide

Who should use this Guide?

This Guide is meant to assist members of Country Coordinating Mechanisms and other individuals and organizations involved in preparing proposals, or providing input into these proposals, for Round 6 of the Global Fund to Fight AIDS, Tuberculosis, and Malaria. The next-to-last section, which provides some models of successful human resources for health initiatives, may also be useful to individuals and organizations involved in work on human resource and health system strengthening. While the primary purpose of this Guide is to serve as a technical guide in thinking about and developing proposals that include health system strengthening activities, we also hope that it can help motivate countries to use the Global Fund to support such activities.

How definitive is this Guide?

Much of the advice in this Guide is drawn from analysis of the Round 5 Health System Strengthening proposals by the Technical Review Panel (TRP), the independent experts who review Global Fund proposals and recommend which ones the Global Fund Board should approve, as well as from several proposals approved by the Global Fund. Unsuccessful Round 5 Health System Strengthening (HSS) applications were generally unavailable to us. While the TRP's comments provide some lessons that appear to have general application, ultimately the judgments of the TRP will be based on the unique nature of each proposal.

While we hope this advice can be of use, only limited advice can be provided through this Guide. Much will depend on the particular nature and goals of each proposal. Therefore, much support in proposal development will have to be provided on a case-to-case basis.

We hope that users of this Guide will take the advice and information it contains in the spirit it is given, as a well-considered opinion formed of careful analysis, but not as the final word. The final word lies with the TRP.

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

We urge applicants to contact the World Health Organization (WHO) or other sources of technical expertise as needed. For technical questions on health systems or to seek technical support in developing health systems strengthening aspects of proposals, please contact WHO. In particular, along with your country representative, you can contact Barbara Stilwell (stillwellb@who.int), coordinator for performance improvement, including management, in the human resources department; Mario Dal Poz (dalpoz@who.int), coordinator for evidence and tools for policymaking, planning, and decision making in the human resources department, or; Jean Yan (yanj@who.int), coordinator for work on health professionals' roles and education in the human resources department.

If you have questions related to the Global Fund proposal process, we suggest that you contact your country's Global Fund portfolio manager. You can find out the name and email address of your country's portfolio manager through your country's page on the Global Fund website (<http://www.theglobalfund.org>).

Why you should use the Global Fund to support health system strengthening

What is the value of using the Global Fund to support health systems?

In many countries, weak health systems are a central obstacle to successfully scaling-up and sustaining HIV, tuberculosis, and malaria programs. The Global Fund, and specifically this Sixth Round, presents an opportunity to make significant strides in funding the activities required to remove these obstacles, creating enormous benefits for the people infected and affected by the Fund's three target diseases. Last round, for example, the Global Fund enabled Malawi to strengthen its health workforce in both the near and longer term, Rwanda to significantly improve access of poor people to health services, and Cambodia to strengthen its drug procurement and distribution system and its health sector planning capacity.

Along with benefiting HIV, tuberculosis, and malaria programs, health system strengthening activities will often benefit other health priorities; this is the case for the Round 5 HSS proposals of Rwanda, Malawi, and Cambodia, for example. Indeed, absent health system strengthening activities, additional programming for individual diseases, such as HIV/AIDS, in countries with particularly fragile health systems risks harming efforts to address other health priorities, as more is demanded of an already stressed system and overburdened health workers without providing the support to the system to enable it to successfully handle these additional programs. Round 6 can strengthen health workforces and other basic health system elements, and in so doing help ensure that the Global Fund strengthens rather than weakens health systems and the effort to address an array of priority health areas.

Will including health system strengthening activities strengthen or weaken the overall proposal?

As long as the health system strengthening section is technically sound, applicants that include these activities have the potential to strengthen the HIV, tuberculosis, or malaria proposal in which these activities are included. This is particularly true of activities that address constraints in implementing other aspects of the Round 6 proposal. Indeed, the TRP is likely to be very hesitant about approving proposals that recognize health system constraints to successfully implementing the disease-specific activities yet fail to describe a strategy for overcoming these constraints, including seeking funding as needed. After all, these constraints would make successful implementation of these proposals unlikely.

It is important that these health system strengthening sections are technically strong, otherwise a weak section on health system strengthening will likely negatively impact the TRP's evaluation of the entire proposal. Therefore, we strongly encourage countries to draw on all available resources to ensure that their proposal is technically sound, including civil society and other local experts, along with international expertise, such as the WHO.

Scope of potential Global Fund support for health system strengthening

When may a country apply for Global Fund money to support health system strengthening activities?

Fundamental requirement for health system strengthening support

Health system strengthening activities can be included in Global Fund proposals as long as the activities are necessary and "linked to reducing the impact and spread of" HIV, tuberculosis, and/or malaria. According to the Guidelines for Proposals, "Proposals may include health system strengthening activities provided that these activities are linked to reducing the impact and spread of any or all of the three diseases. In addition to describing this linkage, applicants should explain why the proposed activities are

necessary. In order to demonstrate the link, the proposed health systems interventions should be related to disease specific goals and impact indicators.”¹

A gap analysis is a good way to consider this requirement. As a general rule, if weakness in a certain area of health systems will prevent an applicant from successfully initiating, scaling-up, and sustaining programs to address the target diseases, that area represents a gap that the Global Fund can help fill. For example, if the lack of health workers constrains a country’s ability to scale-up and sustain AIDS treatment programs, the Global Fund can support health workforce strengthening activities, just as the Fund can be used to procure AIDS medication if the lack of drugs is a constraint.

The fundamental requirements of linkage and necessity can be met under several circumstances.

Particular circumstances for health system strengthening support

A. Health system strengthening activities needed for the successful implementation of the Round 6 proposal

In some cases, countries may face health system constraints to successfully implementing HIV, tuberculosis, or malaria activities in the same proposal (and possibly also another Round 6 proposal if the country is applying for grants in more than one disease category). In this case, such constraints should be described in section 4.4.4, and the health system strengthening activities will respond to those constraints, at least those that are not otherwise being addressed through other mechanisms (e.g., other development partners).

We strongly encourage applicants to include in their proposals health system activities required to make the HIV, tuberculosis, and malaria activities of Round 6 succeed. The Proposal Form itself notes that applicants “are encouraged to” apply for health system strengthening funding for activities required to overcome identified health system constraints that applicants otherwise lack the means to adequately address.² Proposals should fully describe their strategy for overcoming these constraints, and where additional funding is required, use this opportunity to seek funding for health system strengthening activities that would enable countries to overcome these constraints.

Addressing these constraints might require system-wide activities, such as national efforts to retain health workers, or a more disease-specific approach, such as hiring physicians and nurses who are expert in HIV/AIDS treatment, care, and prevention and can meet immediate needs of health facilities providing AIDS treatment and other HIV services. Part of Malawi’s Round 5 HSS proposal, for example, was to recruit and retain medical specialists and doctors needed to staff clinics providing anti-retroviral therapy (ART), and to retain nurses, counselors, and clinical officers for these clinics.³

B. Health system strengthening activities needed to enable scale-up and sustainability of HIV, tuberculosis, or malaria activities funded by an earlier Global Fund grant, other development partners, or the government and local partners

Applicants may also apply for funding to support HSS activities that are “necessary” and “linked to reducing the impact and spread of any or all of the three diseases,” yet unrelated to Round 6 HIV, tuberculosis, or malaria activities. As the Proposal Form explains, “Certain activities to strengthen health systems may be necessary in order for the proposal to be successful and to initiate additional HIV/AIDS, tuberculosis, and/or malaria interventions. Similarly, such activities may be necessary to achieve and

¹ Guidelines for Proposals: Sixth Call for Proposals (May 2006), at 23-24. Available through: <http://www.theglobalfund.org/en/apply/call6/documents/>.

² Proposal Form: Sixth Call for Proposals (May 2006), at sec. 4.6.6. Available through: <http://www.theglobalfund.org/en/apply/call6/documents/>.

³ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 58, 62-63. Available at: http://www.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf.

sustain scale-up.”⁴ The Guidelines state that applicants are “encouraged to include funding in respect of such activities.”⁵

That is, the health system strengthening activities may be necessary to achieve – or to sustain – HIV, tuberculosis, or malaria activities that are already underway, perhaps being funded by an earlier round of the Global Fund or by another donor. For example, a country might need funding to strengthen its health workforce so that bilateral assistance for AIDS treatment can be effective.

C. Health system strengthening activities required to initiate new HIV, tuberculosis, or malaria activities

An applicant may be planning to implement new HIV, tuberculosis, or malaria programs, but cannot do so without health system strengthening. Countries may apply for Global Fund resources in these circumstances.

D. Health system strengthening activities required to prevent HIV, tuberculosis, or malaria activities from harming other health services

Countries may also apply for Global Fund support for health system strengthening activities if health system weaknesses will prevent them from implementing HIV, tuberculosis, or malaria programs without harming other health interventions. For example, as a result of a country’s human resource shortage, it may be that the only way for the country to achieve ART targets would be by drawing health workers away from providing other health care services.⁶ Attempting to scale up target disease interventions at the cost of providing other essential health interventions is not sustainable – or quite possibly even achievable – in the context of national efforts to simultaneously scale up other essential health services to meet the Millennium Development Goals and other health goals.⁷ The Global Fund recognizes that a country should not have to remove health workers from other health programs in order to support HIV, tuberculosis, and malaria programming. Countries may therefore apply seek support for health system strengthening activities in these circumstances.

Do health system strengthening activities need to be linked to the particular HIV, tuberculosis, or malaria activities included in the Round 6 proposal?

No. A country might require health system strengthening activities to scale-up or sustain HIV, tuberculosis, or malaria activities already being funded or being planned outside the context of the Round 6 proposal. Requests to support such activities are perfectly acceptable. In these cases, the health

⁴ Proposal Form: Sixth Call for Proposals (May 2006), at 30. Available through: <http://www.theglobalfund.org/en/apply/call6/documents/>.

⁵ Guidelines for Proposals: Sixth Call for Proposals (May 2006), at 23. Available through: <http://www.theglobalfund.org/en/apply/call6/documents/>.

⁶ Malawi’s Round 5 HSS proposal explains this well: “With extreme health sector staff shortages, scaling up of ART and HIV/AIDS/TB/malaria services, either vertical or integrated, will require a close inter-relationship with the overall public health civil service to minimize the staffing impact on other EHP services. . . . it should not be assumed that hospitals and community based facilities currently have sufficient staff to redeploy 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. . . . The MOH is aware of these synergetic relationships within the health sector, and has worked toward smoothing the disruption to staffing deployment patterns. It is committed to an integrated approach to scaling up ART and services for the three diseases while strengthening the overall health system.” 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/search/docs/5MLWH_1142_0_full.pdf.

⁷ In addition to meeting the Millennium Development Goals, African health ministers have committed “to the achievement of Universal Access to Treatment and Care by 2015 through the development of an integrated health care delivery system based on essential health package delivery close-to-client.” 2nd Ordinary Session of the Conference of African Health Ministers, *Gaborone Declaration on a Roadmap Towards Universal Access to Treatment and Care*, (Oct. 2005). Available at: http://www.phrusa.org/campaigns/aids/pdf/gabarone_declaration.pdf.

system strengthening activities will be unrelated to the disease-specific activities included in the proposal. For example, a country might apply for HIV prevention activities along with health system strengthening activities required for ART scale-up being supported by an earlier Global Fund grant. Or a country might apply for health system strengthening activities required for malaria treatment when the only malaria-specific activities in the proposal related to bednets.⁸

May a proposal include *only* health system strengthening activities?

Yes. A proposal may include only health system strengthening activities because these activities do not have to be linked to other activities in the Round 6 proposal, and there is no requirement that a proposal include non-health system strengthening activities. For example, a country might be limited in its ability to reduce the spread and impact of HIV, tuberculosis, and malaria because of low utilization of health services or because it has too few health workers. If a country's CCM determines that it does not need additional support in HIV, tuberculosis, or malaria programs – though this is unlikely to be the case for most Global Fund applicants – that country could apply only for activities aimed at increasing the population's utilization of health services or strengthening its health workforce.

In other words, the Global Fund does not discriminate against health system strengthening activities. Just as a proposal could focus solely on drug procurement and distribution if the lack of anti-retroviral medication was preventing a country from scaling up its AIDS treatment programs, a country could develop an HIV proposal focused solely on health workforce strengthening if analysis reveals that the health worker shortage is the major barrier to the success of AIDS treatment programs.

May a proposal include more than one type of health system strengthening activity?

Yes. No rule limits the number of health system areas for which a country make seek funds in Round 6. For example, a country might apply for health workforce strengthening, improving health system financing, and improving the medicine distribution system. Countries should not apply for more activities than they can anticipate successfully implementing. As described below, if the Technical Review Panel believes that a proposal is overly ambitious and therefore infeasible, the Panel is likely to reject the proposal. The fundamental requirements described above must be met for each area.

May an applicant seek support for both system-wide health system strengthening activities and more vertical health system strengthening activities?

Yes, proposals may include both system-wide and more target-disease-focused health system strengthening activities. For example, as detailed more below, Malawi's proposal supports system-wide human resource activities such as expanding the capacity of pre-service training institutions while also supporting the retention of health workers needed at ART clinics.

If an applicant is seeking support for health system strengthening activities, may the applicant also seek funding for HIV, tuberculosis, and/or malaria activities?

Yes. A country may submit up to three proposal components in Round 6, one for HIV, one for tuberculosis, and one for malaria. Health system strengthening activities may be included in any of these components. Including health system strengthening activities does not prevent a country from applying for other activities needed to combat HIV, tuberculosis, or malaria. Health system strengthening activities can represent a small or large portion of funds sought.

⁸ Many health system strengthening activities, particularly those that are system-wide, will have benefits to a wide range of programs. For example, health workforce strengthening might be particularly urgent to meet AIDS treatment goals, but will also benefit HIV prevention.

What health system strengthening activities may a country apply for?

A. A wide range of activities....

Applicants may use the Global Fund to support a wide range of health systems strengthening activities. Notably, in Round 5, the Technical Review Panel did not reject any health system strengthening activities as being automatically ineligible, though in some cases applicants failed to demonstrate that the health system strengthening activities applied for were necessary to succeed in the fight against the target diseases.

The Guidelines to the Proposal Form includes a non-exhaustive (partial) list of activities that that the Fund will support:

- *Health workforce mobilization, training and management capacity development;*
- *Local management and planning capacity in general, including financial management;*
- *Health infrastructure renovation and enhancement, equipment, and strengthening maintenance capacity;*
- *Laboratory capacity;*
- *Health information systems, inclusive of monitoring and evaluation;*
- *Supply chain management, especially drug procurement, distribution, and quality assurance;*
- *Innovative health financing strategies to respond to financial access barriers*
- *High level management and planning capacity;*
- *Engagement of community and non state providers;*
- *Quality of care management; and*
- *Operations research.*⁹

Since this is a partial list, while most activities will be covered by the above list, applicants may apply for activities not included here. The one exception is that the Guidelines explicitly prohibit using Global Fund money to build new hospitals and clinics or other large-scale infrastructure investments..

Global Fund grants in Rwanda and Haiti demonstrate the breadth of activities that can be covered. Rwanda's Round 5 HSS proposal explicitly sought health system funding to improve health service utilization by improving health service quality. This means that in certain circumstances, Global Fund grants may be used to help strengthen basic health infrastructure. In Rwanda's case, this meant providing electricity to the 40% of health centers in six provinces. The need to improve health service utilization is the same rationale that Partners in Health used to convince the Global Fund to permit it to re-allocate a portion of Round 1 grant money to purchase essential drugs for a rural clinic. The drugs were part of a successful strategy to significantly increase patient utilization of a health facility where very poor quality had discouraged patients and health workers alike from showing up.¹⁰

In all cases, the fundamental requirement described above must be met: all health system strengthening activities must be "necessary" and "linked to reducing the impact and spread of any or all of the three diseases." These activities must be needed to fill in gaps in current or planned HIV, tuberculosis, or malaria programs.

B. May be directly linked to HIV, tuberculosis, or malaria....

Health system strengthening activities may be directly related to one or more of the diseases. They may be discrete, disease-specific health system strengthening activities that overcome particular constraints to implementing that proposal or other AIDS, tuberculosis, and malaria programs in the countries. For

⁹ Guidelines for Proposals: Sixth Call for Proposals (May 2006), at 24. Available through: <http://www.theglobalfund.org/en/apply/call6/documents/>.

¹⁰ Joia S. Mukherjee, "HIV-1 care in resource-poor settings: a view from Haiti," *Lancet* (Sept. 20, 2003) 362: 994-995; private communication with Joia Mukherjee, April 15, 2005.

example, applicants could seek funding to improve financial and human resource management at health facilities providing AIDS treatment.

C. Or may result in system-wide health system strengthening required for success of HIV, tuberculosis, or malaria programs.

Health system strengthening activities may also be system-wide. That is, they do not have to be directly tied to HIV, tuberculosis, or malaria programs. Rather, they may be part of the overall national strategy to strengthen the health system or a specific health system element (such as human resources) that will help reduce the spread and impact of HIV, tuberculosis, or malaria. This is the successful approach that Rwanda and Malawi took in Round 5, as they respectively received grants to improve overall access to health services and strengthening national health human resources. Such an approach remains possible in Round 6.

These system-wide activities might be relatively discrete – training health professionals, managers, and administrators in financial management, for example – or more broad, such as supporting a significant portion of a national human resource strategy.

May a country apply for health system strengthening activities that will not have an immediate impact?

Yes. Building health system capacity for the future is central to sustaining HIV, tuberculosis, and malaria programs. When Malawi included expansion of health professional pre-service training capacity in its Round 5 HSS proposal “in order to have adequate numbers of qualified staff for the future,”¹¹ the TRP agreed that this was appropriate. Indeed, it noted that one of the strengths of Malawi’s proposal was that it “addresses both the immediate need to deliver services but also the longer term need to build capacity to train the next generations of workers.”¹² Therefore, Round 5 demonstrated that the Global Fund will support activities needed not only to meet immediate needs, but also longer-term needs.

As described more below, the TRP is interested in seeing that countries seeking support for health workforce strengthening are taking a comprehensive approach to their human resource needs. Therefore, while the TRP was quite receptive of Malawi’s request to help meet its longer term health workforce needs, the TRP might be more skeptical of a proposal that sought to meet a country’s longer term needs when no strategy was in place to address more immediate needs.

What health system strengthening proposals were successful in Round 5?

Rwanda

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.

The proposal achieves the first objective through a community-based 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

¹¹ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 10. Available at: http://www.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf.

¹² This and ensuing references to the Technical Review Panel’s statements and views on Round 5 proposals are based on the TRP review forms for Round 5.

resources, quality assurance, and monitoring and evaluation,¹³ 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.

Malawi

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 delivery the Essential Health Package and HIV/AIDS services.

Cambodia

Cambodia's Round 5 HSS proposal focuses on two areas currently marked by fragmentation, health sector planning and drug procurement and distribution. In the area of planning, Cambodia will increase harmonization across Global Fund-supported programs and health programs by aligning them with the country's Health Sector Strategic Plan 2003-2007 and the National Strategic Development Plan 2006-2010, including by harmonizing strategic planning, linking Country Coordinating Mechanisms with the national planning process, and strengthening provincial coordinating mechanisms in provinces with significant Global Fund-supported activities. The proposal will strengthen the Ministry of Health's capacity to implement existing planning and monitoring and evaluation processes by strengthening links between budgeting and planning processes within the Ministry, providing timely feedback on bottlenecks to implementing the sector's Annual Operational Plan, and through other measures. Further, the proposal will support technical assistance to strengthen technical planning capacity for managers at national, provincial, and district levels, including in developing analysis and program budgeting skills.

Cambodia's drug procurement and distribution system is currently characterized by multiple bodies, varying standards, and inefficiencies and delays in procurement. To correct these programs, Cambodia

¹³ It is notable that the Rwandan proposal included 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 proposal of the Democratic Republic of Congo was that it did not provide for the training needs of management and administrative cadres, suggesting that these are cadres that countries should pay attention to.

will strengthen the forecasting, procurement, storage, and distribution processes for medicines, vaccines, and medical supplies. Activities will include reviewing inventory control procedures at the Central Medical Stores and developing an emergency response system to deal with stock-outs.

System-wide health system strengthening activities

What are benefits of system-wide approach?

Country circumstances will determine the nature of health system strengthening activities for which countries apply. Some applicants may have relatively strong health systems with narrow needs directly related to their AIDS, tuberculosis, or malaria programs. The Global Fund presents an important opportunity for countries to meet these needs to help ensure the success of these programs. Many applicants, however, particularly those with fragile health systems that are strained by a heavy burden of disease, could benefit greatly by taking a system-wide approach to health system elements in their proposals, rather than trying to address these elements only on a vertical, disease-specific basis.

Necessary to meet needs

In some cases, such an approach is the only way to adequately meet needs. Rwanda's and Malawi's Round 5 HSS proposals are both good examples. Malawi's human resource shortage is too severe to resolve only on a disease-specific basis, such as by focusing only on retaining health workers involved in certain disease-specific activities. Thus, Malawi received a Global Fund grant that includes system-wide measures to retain health workers and to greatly expand capacity to train new health workers. Rwanda recognized that low utilization of health services was an obstacle to the success of AIDS, tuberculosis, and malaria programs, and only by increasing overall access to health services can these programs succeed.

Avoiding harm

A system-wide approach will also often be necessary to avoid harm to other health services. Countries suffering severe health worker shortages likely will be unable to significantly scale up disease-specific programs without drawing health workers away from other health services. Or new or expanded programs would increase the burden on already overworked health workers, thus increasing the risk that they will "burn-out" and leave the country's health services (and the country) or that the quality of care that they provide will be compromised.¹⁴

The harm could occur in other ways as well. For example, if only health workers involved in certain AIDS-related activities receive special financial incentives to promote their retention, health workers not receiving these incentives could feel that they are being treated unfairly. This risks lowering their morale, leading to reduced quality care and increased attrition.

Widespread benefits

¹⁴ Malawi's Round 5 proposal states: "With extreme health sector staff shortages, scaling up of ART and HIV/AIDS/TB/malaria services, either vertical or integrated, will require a close inter-relationship with the overall public health civil service to minimize the staffing impact on other EHP services. . . . it should not be assumed that hospitals and community based facilities currently have sufficient staff to redeploy, and that in-service training and supplies alone are required to roll out ART/HIV/AIDS/TB/malaria programs. 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 EHP TB and malaria interventions, are placing increasing demand on the health workers that remain. Providing HIV/AIDS/TB/malaria integrated services has placed overwhelming stress on facility and community nursing staff already running at a 65% shortfall. . . . 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/search/docs/5MLWH_1142_0_full.pdf.

By contrast, a system-wide approach will benefit other health services. The same health workers who are needed to provide HIV, tuberculosis, and malaria services will also provide other health services. Similarly, newly trained health workers will provide a range of health services.¹⁵ Reducing the health worker shortage will benefit a wide array of health services and help countries achieve the Millennium Development Goals and other health targets. For example, a higher density of health workers enables countries to achieve higher level of coverage of measles vaccinations and of skilled health workers attending births,¹⁶ which is needed to reduce maternal mortality.

Integration of health services

A system-wide approach will also support the integration of health services, rather than the development of parallel, disease-specific infrastructure. A parallel infrastructure stands to create inefficiencies and duplications with the national health system that are a poor use of scarce resources. For example, duplication of procurement and distribution systems may mean that “health staff at the facility level need to manage multiple mechanisms for ordering drugs, more sophisticated information systems need to be put into place to handle the various sources of products, and there may be straightforward duplication of warehouses and distribution systems.”¹⁷

Parallel infrastructure also may mean lost opportunities to benefit overall health services. Ethiopia is experiencing these benefits, after choosing to use the existing procurement and distribution system to handle anti-retroviral medications and drugs for opportunistic infections. Initially, using the existing system led to slow procurement, but over time, the system “made a number of changes to its mode of operation – including renting more warehouses, hiring more staff on short-term contracts, and contracting out specific elements of the procurement and distribution chain – which appeared to be having very positive effects upon the efficiency of procurement.”¹⁸

When should countries take a system-wide approach to system strengthening, and when should they develop separate, vertical health system components for HIV, tuberculosis, or malaria programs?

This decision will have to be made on a case-by-case basis. The potential for system-wide impact that could benefit the three diseases plus many other health needs, as well as the demands of sustainability, favor a system-wide approach, such as by utilizing and strengthening the existing distribution system to also distribute HIV medications, the approach Ethiopia has taken. On the other hand, the demands of acting quickly to save lives may mean that medicines can be distributed more efficiently, or other activities carried out more quickly and effectively, by establishing and using a separate, parallel system.

Physicians for Human Rights encourages applicants to follow recommendations that came out of a May 2006 meeting in Cape Town, South Africa, of AIDS advocates, experts in health systems, officials from

¹⁵ “The MOH is . . . committed to an integrated approach to scaling up ART and services for the three diseases while strengthening the overall health system. . . . As much as possible, the services for HIV/AIDS/TB/malaria will be integrated with EHP services both at facility and community levels. This will have the added value of disease-specific funding providing critical HR input to the overall health infra-structure and supplementing for the HR gaps left by staff moving to ART clinics. Of primary importance is the positive affect additional HR will have on health services at rural community levels that have been critically compromised by staff migration. GF support to increased staffing to improve coverage of interventions for HIV/AIDS/TB/malaria will thus provide significant added value to the overall Malawi public health service and its workforce.” 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/search/docs/5MLWH_1142_0_full.pdf.

¹⁶ World Health Organization, *World Health Report 2006: Working Together for Health* (2006), at 9-11. Available at: <http://www.who.int/whr/2006/en/index.html>.

¹⁷ 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://www.phrplus.org/Pubs/Tech080_fin.pdf.

¹⁸ *Id.*

AIDS programs and Ministries of Health, people living with HIV/AIDS (PLWHAs), and health workers from both developing and developed countries. Meeting participants agreed that countries should undertake “an explicit assessment and evaluation of which components of AIDS treatment programs can be integrated into general health systems and which require vertical implementation in the short to medium term. This new way of planning should include specific plans for integrating all vertical components into the general health system in the medium and long term. Additionally, program planners must be aware that initial decisions about which components of AIDS treatment programs should be integrated into the general health system and which should be vertical, may have unforeseen, deleterious consequences. Thus, planning must include contingency strategies to address potential problems that might arise out of such difficult decisions.”¹⁹

A good example of integrating a parallel system into the overall health system comes from Malawi’s Round 5 HSS proposal. The responsibility for recruiting Health Surveillance Assistants will initially be outsourced to a local agency, which will also build the capacity of Malawi’s National Health Service Commission. The Health Service Commission will assume responsibility for recruiting the Health Surveillance Assistants by 2008.²⁰

What are some possible strategies for including system-wide health system strengthening activities in a Global Fund proposal?

Proposals that seek to significantly impact a major part of the health system, like human resources, have great potential to contribute to the fight against AIDS, tuberculosis, and malaria. The very ambition of such proposals also presents special challenges. The proposals will have to convince the TRP that however ambitious they may be, the proposals are feasible, that is, that the countries have the capacity to successfully implement the proposed activities.

One strategy that an applicant country might employ to help demonstrate to the TRP that the activities it proposes are feasible is to seek funding for health system strengthening activities that are part of an existing program of action. This might include seeking funding for:

- a portion (or portions) of a health sector investment program (e.g., Sector-Wide Approaches) that will build national health systems as necessary to achieve results in the area of AIDS, tuberculosis, and/or malaria (applicants seeking funds to support a common funding mechanism such as Sector-Wide Approaches should complete section 4.6.7 of the Proposal Form);
- a portion (or portions) of a comprehensive national health system strategy; or
- a portion (or portions) of existing plans for a particular health system component, such as a plan for human resources for health.

Another strategy is to scale-up interventions that have already demonstrated success. This might include:

- scaling up existing, successful health system strengthening interventions, such a pilot project limited to one portion of the country; or
- introducing health system strengthening interventions that have demonstrated their value in sufficiently similar circumstances in another country.

If the above scenarios do not match a country’s current circumstances or needs, an applicant might seek funding for discrete, adequately planned interventions that relate to critical health system obstacles. These might include providing health workers well-defined incentives to serve in rural and other

¹⁹ A 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.

²⁰ 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/search/docs/5MLWH_1142_0_full.pdf.

underserved areas or training health professionals, managers, and administrators in fiscal management, human resource management, and strategic planning.

Applicants should ensure that system-wide health system strengthening activities needed to fill gaps in initiating, scaling up, and sustaining HIV, tuberculosis, or malaria activities are properly designed to fill these gaps. For example, support for pre-service health professional training may be needed to sustain anti-retroviral therapy, but will have limited impact on AIDS treatment unless ART is incorporated into the curricula. Such incorporation is important programmatically, and something that applicants should note in their proposals (and incorporate funding for, if the curriculum is not already being revised).

If a country lacks a health system plan of action, may it use the Global Fund to seek funding to develop such a plan, along with the leadership and other capacity required to successfully implement the plan?

Yes, if the applicant can demonstrate that the health system weaknesses for which a plan must be developed – or the particular health system element for which planning is desired (such as human resources) – present obstacles to reducing the impact and spread of HIV, tuberculosis, or malaria, and that a plan and a strategy to ensure its implementation are needed to help overcome these weaknesses. Comprehensive, costed plans can promote a strategic approach to addressing some of the most complicated health challenges that policymakers face.²¹ Countries without such plans and the capacity to implement them should consider using the Global Fund to support relevant activities.

To our knowledge, no country has made such use of the Global Fund to date to develop a costed, operational human resource plan, or such a plan for another health system element. Except for large-scale infrastructure investments, any health system strengthening activity is allowed, however, as long as the basic requirements of necessity and disease linkage are established. The Global Fund has been used to support planning. For example, 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 managers.

The illustrative list of health system strengthening activities included in the Guidelines for Proposal includes several relevant items, in particular "High level management and planning capacity" and health workforce mobilization and capacity development.²² Section 5.6 of the Proposal Form, which seeks budgeting information on three functional areas, including technical and management assistance, describes that technical and management assistance as including "technical assistance costs related to planning [and] technical aspects of implementation, management, monitoring and evaluation." This wording is instructive as a matter of good practice. The mere development of plans is insufficient to guarantee action. An initial planning process should be accompanied by developing the capacity to quickly act on the plan, to monitor its implementation and impact, and to update the plan as necessary. Furthermore, the planning process should include wide stakeholder involvement and consensus building, which will significantly increase the chances that the plan will indeed be implemented, while helping avoid tensions among different health cadres.

Note that a Global Fund proposal risks being rejected if it is too small,²³ so either funding requirements of the planning process must be significant enough to justify a separate grant or, as would more likely be the case, the proposal should include other activities.

²¹ African health ministers have recognized the necessity of costed and comprehensive human resource plans. In the October 2005 Gaborone Declaration on a Roadmap Towards Universal Access to Treatment and Care, African Union health ministers committed to "[p]repare and implemented costed human resources for health development plans." 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://www.phrusa.org/campaigns/aids/pdf/gabarone_declaration.pdf.

²² Guidelines for Proposals: Sixth Call for Proposals (May 2006), at 24. Available through: <http://www.theglobalfund.org/en/apply/call6/documents/>.

²³ See the sub-section below on appropriate proposal size, at 20.

Developing a human resource plan of action

At least in the area of human resources for health, such plans should include a core leadership team that meets regularly to help develop the plan and ensure that it is implemented, a consensus-building process among stakeholders, and a clear monitoring and evaluation strategy to ensure that the plan remains on track and adjustments are made as necessary. We recommend that applicants review the joint Management Sciences for Health/World Health Organization publication “Tools for Planning and Development Human Resources for HIV/AIDS and Other Health Services” for more information on developing a national human resources for health plan. The publication is available at: http://www.who.int/hrh/tools/tools_planning_hr_hiv-aids.pdf.²⁴ This publication includes information on the areas that these plans should cover and on the critically important process of developing such plans.²⁵

For more information about human resource planning, you can contact Norbert Dreesch at WHO (dreeschn@who.int) or Mary O’Neil at Management Sciences for Health (moneil@msh.org).

Do disease-specific funds provide opportunities to strengthen other health services?

Yes. For example, a country might receive funds to monitor certain disease-specific practices, such as anti-retroviral therapy or the implementation of universal precautions to protect health workers from HIV and other bloodborne infections. Those funds may lead to more supervisory visits to health facilities, supervisory visits that can be used not only to monitor these practices, but to provide health workers feedback on other health services, to receive feedback from health workers on their needs, and to carry out other supervisory functions. Similarly, health workers visiting health facilities as part of monitoring and evaluation activities for malaria in mothers and children could collect other information related to maternal and child health.

Features of successful Global Fund proposals on health system strengthening

What are the features of a strong Global Fund proposal that contains significant health system strengthening activities?

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

Strong links to reducing spread and impact of target diseases: As detailed more below, 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.

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.

²⁴ The publication also can be ordered, free of charge for individuals and organizations in developing countries, at: <http://www.msh.org/resources/publications/ebookstore/product.cfm?p=225>.

²⁵ Another useful tool for human resource management planning in the context of HIV/AIDS is Management Sciences for Health, *Human Resource Management Rapid Assessment Tool for HIV/AIDS Environments: A Guide for Strengthening HRM Systems* (2003). Available at: http://www.msh.org/what_MSH_does/hcd/pdf/hrm_rapid_assessment_tool.pdf.

National commitment and 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 sets out cost-effective, sustainable strategies for meeting the targets."²⁶

Strong chance of success: Both proposals made a convincing case that they would have an impact. Malawi sought to fill in gaps in their Emergency Human Resource Programme, which addresses both immediate and longer-term needs and focused both on training and retaining health workers, so that new health workers would not simply leave the country. 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.²⁷

Pro-poor: 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 will 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 delivery for all Malawians."²⁸ 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."²⁹ 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."³⁰

Support from other development partners: Both Rwanda's community-based health insurance scheme and Malawi's human resource program are receiving 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

²⁶ 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/search/docs/5MLWH_1142_0_full.pdf.

²⁷ 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/search/docs/5RWNH_1199_0_full.pdf.

²⁸ 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/search/docs/5MLWH_1142_0_full.pdf.

²⁹ *Id.* at 52.

³⁰ *Id.* at 61.

also receiving support from the United Kingdom's Department for International Development (and from reprogrammed funds from Malawi's Round 1 Global Fund grant).

Discrete focus: Both Malawi's and Rwanda's proposals had a relatively narrow focus within the area of health system strengthening. Malawi's proposal was entirely focused on human resources for health. Rwanda's proposal addressed two key obstacles to increasing on health service utilization, financial barriers and perceived low quality.

The Global Fund certainly has no rules against proposals that cover multiple areas of health system strengthening, and the experiences of Rwanda and Malawi do not mean countries should restrict themselves to a single area of health system strengthening. Cambodia's successful Round 5 HSS proposal, for example, covered two areas, health system planning and drug forecasting, procurement, and distribution. These experiences do, however, suggest that a proposal that is focused on a limited number of areas within the realm of health system strengthening might have a greater chance of success than a proposal that addresses a very wide range of issues. This might be because the TRP would view more focused proposals as being more realistic and achievable than a proposal that covers many different issues. A proposal that is more ambitious in the scope of activities covered should take extra care to demonstrate its feasibility.

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."³¹ 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.³²

One benefit of focusing on the most important obstacles is that, if successful in achieving their objectives, such proposals are more likely to have an impact on the target diseases than if proposals focus on more minor constraints that, even if overcome, might have only minimal impact because of other large obstacles that remain.

What are some elements that health system strengthening-related proposals can include to help ensure that, if approved, they will be successful?

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 in implementing 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 acknowledged the importance of this technical support. Section 5.6 of the Proposal Form seeks budgeting information on three functional areas, one of which is technical and management assistance (another is monitoring and evaluation).

Health systems monitoring and evaluation system

A strong monitoring and evaluation system can also help ensure the success of Global Fund programs. This will enable problems to be quickly identified and understood, and thus help lead to their rapid correction. Developing these systems is particularly important for health system strengthening activities

³¹ Id. at 49, 9.

³² 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/search/docs/5RWNH_1199_0_full.pdf.

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. 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.

The Health Metrics Network, hosted by WHO, has developed a Service Availability Mapping tool which forms 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 one case, in the Mwanza Region of Tanzania, the Service Availability Mapping has taken place at the level of the individual health facility. More information is available at <http://www.who.int/healthinfo/systems/samintro/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 5855

E-mail: healthmetrics@who.int

What can we learn from the Technical Review Panel's comments on Round 5's Health System Strengthening proposals?

The TRP's comments on the 30 Health System Strengthening proposals from Round 5 are an important source of guidance to countries applying for health system strengthening activities in Round 6 as part of their HIV, tuberculosis, or malaria proposal components. This section will review many of the weaknesses and, where instructive, strengthens that the TRP cited in its comments on the Round 5 Health System Strengthening proposals. The comments discussed below are divided into two overarching categories, those that relate to the Global Fund proposal writing 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 always 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, particularly those related to the content of proposals, depend more upon the particular proposal and country circumstances. Final judgment rests with the TRP.

General advice arising from HSS proposals

In addition to the analysis below, we strongly recommend that people involved in preparing proposals review Chapter 3 of *The Aidspan Guide to Round 6 Applications to the Global Fund*, available through <http://www.aidspan.org/guides/index.htm>, which also provides lessons from previous rounds.

Detailed, realistic budgets: Countries should be very careful in developing budgets. Many of the unsuccessful Round 5 HSS proposals had various weaknesses in their budgets, including discrepancies between the budget summary and budget details, the failure to include unit costs (a very common

problem) and other details, unrealistic budgets, the failure to fully detail the first two years of budget,³³ unrealistic allocation of expenses across time (front-loading of expenses, 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), excessive administrative costs, the failure to describe how partner funding of similar activities would overlap with the budget request, the failure to include a 5-year budget, and allocation of most of the budget to a government entity when the proposal and work plan described only the health service needs of a Christian Health Association.

Therefore, 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 and that they are spread over the period of time that the activities are most likely to take.
- Ensure that administrative costs are realistic.
- 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.

Appropriate proposal size:

Not too small...

Countries must be sure that their proposals are not too small to justify a separate grant. In Round 5, Georgia's proposal was deemed too small to merit a separate Global Fund grant. Georgia's proposal was worth \$436,320 over two years and \$814,320 over five years. Such concerns are less likely to arise in Round 6, where health system strengthening activities will be included in disease components and therefore, will typically be supplemented by disease-specific interventions.

...but not beyond applicant's capacity to implement

In several cases, the TRP expressed concern that proposals were too ambitious or broad. This concern appears to be closely linked to doubts about the proposals' feasibility. The TRP indicated that South Sudan's Round 5 HSS proposal was overly ambitious for a country emerging from a 50-year conflict. Similarly, referring to Burkina Faso's proposal as "too unfocused and broad," the TRP stated that "[i]t does not appear to be feasible to implement effectively in the timeframe." The TRP did not approve Eritrea's grant request in part because the TRP viewed it as too ambitious, covering a very wide range of needs. The TRP was concerned about the proposal's feasibility; the TRP observed that "[t]he workplan lacks unit costs and sufficient details to determine that full implementation can feasibly be accomplished." Therefore, all applicants need to demonstrate that they will be able to carry out the proposed activities. Applicants with ambitious proposals should make extra efforts to demonstrate their proposal's feasibility, including through detailed budgets and workplans.

Further, recall the need to link each item to the target disease. An applicant that seeks funding in a wide range of health system areas should include solid analysis explaining why activities in each of these areas are needed to help fill gaps in achieving and sustaining HIV, tuberculosis, or malaria programs, or to initiate new activities in these disease areas.

³³ The Proposal Form for Round 6 requires a detailed budget for years one and two, with the first year broken down by quarters, and summarized budget information and assumptions for the remainder of the proposal period. Proposal Form: Sixth Call for Proposals (May 2006), at sec. 5.2. Available through: <http://www.theglobalfund.org/en/apply/call6/documents/>.

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 for lacking details or specificity – nearly half of the HSS proposals – countries are advised to err on the side of including more detail when in doubt of 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 listed multiple implementing entities, but did not explain which entity would do what.

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 Secretary of Health 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 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.

Changes to the proposal form in Round 6 should help applicants avoid these difficulties. Unlike the Round 5 form, the Round 6 proposal form specifically asks about linkages to both current Global Fund grants and to other donor-funded programs.

Countries should also make any appropriate links between HSS activities and related disease-specific interventions for which they are seeking funding in Round 6. Last round, 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.

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

Countries that are facing difficulties with health system strengthening-related indicators should 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 5855

Email: healthmetrics@who.int

Realistic pace of activities: The TRP deemed several proposals to have overly ambitious schedules for constructing and rehabilitating facilities. In the first year of its grant, Ethiopia sought to complete work upgrading 100 health facilities, from identifying which facilities needed upgrading through completing the work and commissioning the facilities. Liberia's timeline was even more ambitious, as its proposal called for rehabilitating and reconstructing several hospitals and training institutions, along with 100 primary care clinics, in six months.³⁴ Countries should therefore ensure that the pace for their activities, including facility construction and rehabilitation, is realistic.

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

³⁴ In Round 6, applicants may not seek funds to construct new clinics or hospitals.

Principal Recipient lacked management and information systems, had not been subject to an external audit, and had extremely limited staff.

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.

Sustainability:³⁵ South Sudan's Round 5 HSS proposal failed in part because of the TRP's concern over the sustainability of recurrent costs. The TRP recommended that a "[g]radual approach might be more feasible giving [Secretariat of Health] capacity to develop sustainable sources of revenue." The TRP was also concerned about the sustainability of Kenya's 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." If, therefore, a country proposes to sustain activities by (or part by) increases in domestic health spending, it would be useful if possible to explain how these increases will be possible (such as budget reallocation or increased government revenue).

Earlier rounds

Based on earlier rounds, there are several ways that countries can demonstrate that salaries and other recurrent costs can be sustained after the Global Fund grant expires. Particularly where only a small number of health workers are being hired, countries can simply state that they will be absorbed into the national budget, as Sierra Leone did for its Round 4 proposal. Countries may also refer to plans to increase their health budgets, as for example, Rwanda did in its Round 3 proposal. Zambia stated in its Round 4 proposal that it is implementing a public sector reform plan, freeing additional resources "which will be channeled to the social service sectors, especially health."³⁶ If countries include support for both salary payments and human resource management in their proposals, the proposal could pay for itself: the elimination of ghost workers (workers who are on the payrolls but are not actually working, or may 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.

If countries are unable to sustain these salaries through domestic resources, they may refer to the 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.³⁷ 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 provide funding to the country's Health Sector Support Project.³⁸

Countries might also refer to budget support they receive from donors and plans to use those funds to help support salaries, or to other external resources that they plan to seek from external sources. Particularly where the source for sustaining these funds is not secured and where domestic resources cannot fully support the increased wage bill, countries may want to state (where it is true): (1) sustaining these salaries and supporting the health workforce 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.

³⁵ 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://www.phrusa.org/campaigns/aids/pdf/guidance_global-fund.pdf.

³⁶ Rwanda's Round 3 HIV/AIDS proposal is available at: http://www.theglobalfund.org/search/docs/4ZAMH_831_0_full.pdf, at 54.

³⁷ Swaziland's Round 4 HIV/AIDS proposal is available at: http://www.theglobalfund.org/search/docs/4SWZH_820_0_full.pdf, at 69.

³⁸ Cambodia's Round 4 HIV/AIDS proposal is available at: http://www.theglobalfund.org/search/docs/4CAMH_775_0_full.pdf, at 73.

In determining their strategies, Physicians for Human Rights urges countries to recognize that one possible strategy, user fees, has been found to significantly reduce access to health services by the poor,³⁹ and so recommends against using this mechanism to pay for salaries.

Round 5: Malawi and Rwanda

In their Round 5 HSS proposals, Malawi and Rwanda cited a mixture of policies and domestic and external sources of funds that will enable them to reduce the need for donor funds while continuing to receive the needed support from development partners.

Domestic revenue

Malawi cited a medium-term pay reform policy that it is implementing, which includes “eliminat[ing] donor dependency and lessen[ing] the threat of employee earning loss should donor funding decrease.”⁴⁰ Also, Malawi’s 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.”⁴¹

Rwanda’s proposal explained 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.⁴²

External support

Malawi has received a commitment from the United Kingdom’s Department for International Development (DFID) for a minimum of 6-10 years beginning in 2004.⁴³ Rwanda’s proposal expressed confidence that “[i]t is extremely probable that eventually additional needed funds the project’s continuation” will be available because the project is within a framework “endorsed by practically all development partners in Rwanda, among them [the] World Bank, UN Agencies, bilateral partners, and the Churches.”⁴⁴

³⁹ 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://www.phrusa.org/campaigns/aids/pdf/braindrain.pdf>.

⁴⁰ 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/search/docs/5MLWH_1142_0_full.pdf.

⁴¹ *Id.* at 65.

⁴² 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/search/docs/5RWNH_1199_0_full.pdf.

⁴³ 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/search/docs/5MLWH_1142_0_full.pdf.

⁴⁴ 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/search/docs/5RWNH_1199_0_full.pdf.

Malawi's proposal also 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."⁴⁵

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.

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 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."

Health System-specific strengths and weaknesses, and implications

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 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.

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

⁴⁵ 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/search/docs/5MLWH_1142_0_full.pdf.

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 on 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 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. Senegal’s proposal was also criticized for not explaining how target districts would be selected.

Details on incentives

In Round 5, countries frequently failed to include detail on incentives for health workers, a weakness that the TRP cited on several occasions. If countries 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 must provide the details of these incentives and retention strategies. They should not seek funding for unspecified incentives. 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. Applicants should also present any evidence that incentives will work, such as success of a pilot program or information on health worker input in designing the incentive package.

Strategies likely to succeed: 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 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, Burundi’s 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 likely 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 – so long as 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).⁴⁶

The TRP will have to believe that the incentives can work. Mozambique proposed only staff housing to assist in retention in rural areas, which the TRP believed would be insufficient, as it noted as a weakness of the proposal that no other mechanisms were suggested.

Comprehensive response to health workforce crisis

Zambia’s 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

⁴⁶ More information on strategies to strengthen the health workforce in rural areas is provided below in the section on innovative approaches to addressing the health worker shortage, at 30.

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.

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 includes 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.⁴⁷ 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.

Many countries are not presently implementing a comprehensive response to the health workforce crisis. To the extent that an applicant's response to the health workforce crisis is comprehensive, however, the applicant should clear make the full breadth of its response to the TRP. And the applicant should strongly consider using the Round 6 application to help fill in gaps, to complement existing measures on human resources so as to implement a more comprehensive approach.

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. The TRP criticized Burundi's 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."

Integrated approach for addressing target diseases: The TRP has explicitly recognizes the value of an integrated approach (which is discussed more above) 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 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.

Integration into 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 target disease(s). The TRP observed that the Democratic Republic of Congo failed to elaborate a strategy for health system strengthening. By contrast, the TRP commended the Eritrean proposal for being consistent with the draft National Health Strategic Plan, 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 proposal "is consistent with a broad range of national policy instrument." Rwanda detailed its health financing strategy, and Malawi's proposal, based on that country's Emergency Human Resources Programme, provides considerable detail on the country's strategy for addressing its human resource crisis.

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

⁴⁷ 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/search/docs/5MLWH_1142_0_full.pdf.

non-government sectors. 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 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 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 proposals. If a proposal focuses exclusively on the public sector, the proposal can only benefit from explaining this limitation.

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 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."⁴⁸ Rwanda's successful proposal "is evidence-based on several years of experience and evaluation of the community health insurance system in Rwanda."

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

Support for rural/deprived areas: The TRP looks favorably on proposals that effectively address health worker and systems needs in rural and other deprived areas. A weakness of Kenya's 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 Kenya proposal's objectives.

The TRP observed with dismay that Uganda's 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 proposal the observation that the government "maintains user-fees in its health facilities."

By contrast, the TRP considered on strength of Zambia's 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 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.

Limited focus on workshops, meetings, and research: The TRP is skeptical of proposals that focus too heavily on activities that does not directly benefit patients, such as workshops, meetings, consultants, and research. This is not to say these activities are not permitted; they are. But a high proportion of the budget generally should not go to these activities. Of South Africa's proposal, the TRP observed: "A large

⁴⁸ More information on community-based health care in Ghana is provided below in the section on innovative approaches to addressing the health worker shortage, at 30.

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 going to research amounted to “an overemphasis on research . . . given the Global Fund’s mandate.”

How should the link be made between health system strengthening activities and reducing the spread and impact of AIDS, tuberculosis, and/or malaria?

Some applicants found it difficult to demonstrate the link between health system strengthening activities and reducing the spread and impact of AIDS, tuberculosis, and/or malaria, as health system strengthening activities are required to do.⁴⁹ Malawi’s and Rwanda’s successful Round 5 HSS proposals both made strong links between fighting the diseases and system-wide health system strengthening. Both proposals emphasized and presented evidence on the severity of the problem; provide a qualitative description of the problem to the target diseases, and use data to demonstrate this link; and have impact indicators for the target diseases.

Strategic linkage of health system activities to HIV, tuberculosis, or malaria activities can also strengthen this link. For example, all of the health workers supported through Malawi’s proposal will be trained in HIV interventions, and the overseas training for tutors will include providing them qualifications for curricula on HIV, tuberculosis, and malaria.

Rwanda

Rwanda’s proposal makes the link between its activities, aimed at increasing access to health services by the poor, and the three diseases with a strong case that a major obstacle in controlling HIV/AIDS, tuberculosis, and malaria is the lack of interaction between the health services and affected populations.

Severity of problem

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 plainly 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.”⁵⁰ 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.”⁵¹

Data to make the case

The proposal includes powerful statistics to highlight the severity of the problem of lack of access, such as the fact that in rural areas, the health system is contacted 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.”⁵²

⁴⁹ 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 Guidelines for Proposals. In Round 6, Guidelines require 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.”

⁵⁰ 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/search/docs/5RWNH_1199_0_full.pdf.

⁵¹ *Id.* at 43.

⁵² *Id.* at 39.

Relationship of problem to target diseases

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.”⁵³ 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.”⁵⁴

In many countries (and possibly Rwanda itself), much the same could be said with respect to HIV/AIDS: Even if certain HIV/AIDS services are free, user fees that deter initial contact with the health services will prevent opportunities for voluntary counseling and testing (VCT) that such contact would promote. VCT may be free, but if other health services have costs, people may never interact with the health system and so will not have the opportunity to be tested.

Statistical link between problem and HIV, tuberculosis, and malaria

The proposal also provides data to demonstrate the connection between lack of interaction with the health services to AIDS, tuberculosis, and malaria, including that these three disease account for at least half of the country’s entire disease burden,⁵⁵ 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.⁵⁶ In other words, 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%.⁵⁷

Malawi

Severity of problem

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.” 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.” 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.”

Data to make the case

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,

⁵³ *Id.*

⁵⁴ *Id.* at 40.

⁵⁵ *Id.* at 38.

⁵⁶ *Id.* at 43.

⁵⁷ *Id.* at 45.

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.⁵⁸

Relationship of problem to target diseases (including statistical 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."⁵⁹

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."⁶⁰ All health workers supported by the proposal will be trained in HIV interventions and, since the majority of patients in Malawi are HIV+, all health workers funded by the proposal will also provide HIV services.

Impact indicators linked to target diseases

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%.⁶¹

Innovative approaches to addressing the health worker shortage

We highlight here several innovative approaches to addressing the health worker shortage: a model for providing HIV services to health workers in Swaziland, compensation for community and home care-givers also in Swaziland, several strategies for strengthening the health workforce in rural areas, and a strategy employed in Uganda to scale up AIDS treatment in the face of the health worker shortage. We also highlight a basic but often overlooked approach to addressing the health worker shortage, improving health workplace safety.

HIV treatment and other services for health workers

In many AIDS-burdened countries, a major cause of health worker attrition is that health workers are dying of AIDS. Treatment and other HIV services for health workers are therefore not only part of a response to AIDS, but also to the health worker shortages that most of these countries face.

⁵⁸ Government of Malawi, Round 5 Health System Strengthening proposal (Health Systems Strengthening and Orphan Care and Support) (June 2005), at 10. Available at:

http://www.theglobalfund.org/search/docs/5MLWH_1142_0_full.pdf.

⁵⁹ *Id.* at 49.

⁶⁰ *Id.* at 68.

⁶¹ *Id.* at 55.

Health workers typically have about the same prevalence of HIV infections as the general population. They face special obstacles to HIV testing and other HIV services, including treatment, because of confidentiality concerns that are unique to health workers. They may be unable to keep their HIV status confidential from their co-workers, who also serve as their own health providers, and they may fear that patients will shun them or their health facility if patients know that their health providers are HIV-positive. These concerns are in addition to the overall level of stigma in the community.

As a result, separate health facilities for health workers, which can be sites for providing HIV services and meeting other health worker needs, have significant potential both to increase the number of health workers accessing HIV services and to improve health worker retention by demonstrating respect for these workers. In February 2006, the first Wellness Centre of Excellence for Health Care Workers was officially launched in Swaziland. The center will provide services to health workers including voluntary counseling and testing, AIDS and tuberculosis treatment, stress management, post-exposure prophylaxis, follow-up and home-based care, and prevention of mother to child transmission.⁶² This Centre is expected to serve about 6,000 health workers and their immediate family members and is based in Manzini, a major Swazi city. This and future centers to be supported by the Swaziland National AIDS Programme will address the many barriers to wellness services which health care workers now face allowing them to better fulfil their valued role in delivering health care.

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Supporting home and community caregivers

Community members have a tremendous potential to contribute to health care in their community, both helping to plug gaps created by the health worker shortage and by being a bridge between community members and the formal health system. They bring to the health system a deep understanding of the circumstances of their peers and a trusting relationship with their fellow community members. Peer counseling, treatment literacy, adherence counseling, and home caregiving are just several of the health services that community members can provide. To maximize their effectiveness and their ability to perform these services, they need support, including proper training, supervision and other support from formal health services, certain materials, adequate compensation, and in many cases, a career path.

Compensation takes on special significance given that many of those providing this care are themselves poor, which may prevent them from providing free services, as they must earn a living. Unleashing and fully supporting the potential of the community, including women and people with HIV/AIDS, is vital to the success of many HIV and other health programs.

Swaziland has recognized the need to support community members providing essential HIV-related service, and has begun to compensate community members who care for orphans and vulnerable children, receiving funds from the Global Fund's Round 4. Swaziland recognized that compensation is "crucial to ensure continued services to [orphans and vulnerable children] within the community," as it would help mitigate "the impact of poverty, drought and the loss of skilled labour on the ability of communities to take care of orphans." Compensation would be provided to community members "who take on additional responsibilities in caring for" orphans and vulnerable children.⁶³

Another program in Swaziland highlights that it is not enough to compensate caregivers – they must be compensated adequately. A recent news report stated that people providing home-based care to people living with HIV/AIDS receive only \$17 per month. This is too little to meet even the basic needs of caregivers; one reports that she must choose between using the allowance for lunch or for the bus ride to

⁶² Centers like this could also be sources of support and training on infection control.

⁶³ Swaziland's Round 4 HIV/AIDS proposal is available at:

http://www.theglobalfund.org/search/docs/4SWZH_820_0_full.pdf, at 42, 68. Much of this paragraph is quoted from the *Guidance to the Global Fund to Fight AIDS, Tuberculosis and Malaria and Support for Human Resources for Health* (pages 15), which Physicians for Human Rights produced in April 2005.

the patients she visits. Compensation levels must enable caregivers to meet their needs and perform their work effectively; the caregiver who must choose between the bus and lunch stated that “[t]he work is so hard I have no energy if I don’t eat.” Further, the level of compensation must correspond to the vital role of these mostly female caregivers.⁶⁴

Strengthening workforce in rural areas

Three strategies that have significant potential for increasing the number of health professionals in rural areas are providing a comprehensive set of incentives to health workers serving in rural areas, basing mid-level health workers in the communities that they serve, and recruiting future health professionals from these areas.

Incentives

Zambia has an effective incentive strategy for physicians who agree to serve for three years in rural areas. Incentives are slightly higher for those serving in areas identified as “very” rural. The package included a hardship allowance, an accommodation allowance, an education allowance for the doctors’ children, eligibility and some funding for post-graduate training, and eligibility for a loan. The early days of the program saw 39 recruited to serve in rural or very rural areas, and the success has continued.⁶⁵

When applying to the Global Fund for incentives, applicants are reminded that incentives should be well-defined, as should be the rural or other underserved regions where health professionals can serve to receive these incentives. With respect both to the nature of incentives and whom they cover, success is most likely if health professionals fully participate in developing the incentives schemes.

While needs will vary across countries, in general it is desirable that multiple categories of health professionals, not only physicians, receive these incentives. In most countries, severe health professional shortages in rural areas are not limited to physicians. Furthermore, limiting such incentives to physicians risks fostering frustration and resentment among other health professionals, such as nurses, who may feel undervalued and thereby actually become more likely to leave the public health services or the country.

Prioritizing community-based health workers

Community-based health workers have enormous potential for improving health services in rural areas, including for the Global Fund’s target diseases. This potential is beginning to be realized in Ghana, which has implemented a Community Health Planning and Services initiative, which includes training and deploying Community Health Officers. These health workers, who have approximately 18 months of training, typically serve several communities that total a population of about 4,500 people. They provide basic preventive and curative health services (including basic obstetric care but not midwifery level services). The Community Health Officers are based in the communities they serve. Two volunteers assist them in facility maintenance, client reception, security, and other facility-based duties, while a third community-based volunteer conducts disease surveillance and supports outreach visits by the Community Health Office. (The program would likely benefit from providing compensation to the volunteers, which could improve their retention.)

The program, which as of early 2006 had 310 Community Health Officers in 53 of Ghana’s most deprived districts, is already proving its impact. One district saw its childhood immunization rate triple, maternal

⁶⁴ “The Vital but Underestimated Role of Aids Caregivers.” *UN Integrated Regional Information Networks*, May 9, 2006. Available at: http://www.irinnews.org/report.asp?ReportID=53245&SelectRegion=Southern_Africa.

⁶⁵ 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; Office of the Global AIDS Coordinator, *Action Today, A Foundation for Tomorrow: The President’s Emergency Plan for AIDS Relief: Second Annual Report to Congress* (Feb. 2006), at 104. Available at: <http://www.state.gov/s/gac/rl/c16742.htm>.

and child mortality fall significantly, and the rate of tuberculosis defaulters drop from 73% to 0%. Other districts have experienced similar results.⁶⁶

Recruitment from rural areas

Another strategy that holds great promise is recruiting health professional students from rural areas, and covering any costs (such as through scholarships) that could impede their ability to complete their training. Health professional students from rural areas are much more likely to return to practice in rural areas. A study in South Africa, for example, found that medical graduates from rural areas were three to eight times more likely to practice in rural areas than medical graduates from urban areas.⁶⁷

Expanded role of mid-level and lay workers in AIDS treatment

An expanded role for middle level health workers (also known as paraprofessionals and auxiliary health workers) in AIDS treatment could speed ART roll-out in countries facing severe shortages of doctors and nurses. This innovation has enabled The AIDS Support Organization (TASO) to expand AIDS treatment in Uganda in spite of significant physician and nurse shortages. TASO employs Field Officers, who are mostly diploma and degree holders with a background in the social sciences and education fields, to carry out many tasks related to the delivery of anti-retroviral therapy, including checking for ART toxicity, opportunistic infections and unsafe behaviors; providing voluntary counseling and testing for family members; referring clients for medical care, and; checking adherence. The physician's role is limited to prescribing ART for new clients and caring for clients whom Field Officers have referred to them. The Field Officers receive four weeks of training and continuous professional development opportunities and other in-service training. Field Officers receive incentives including field and transportation allowances and refunds for their medical expenses. As of the end of 2005, TASO employed 89 Field Officers who were part of a team that also included medical and clinical professionals, community-based workers, and volunteers, and was providing ART to more than 5,000 people.⁶⁸

Supporting health worker safety

A significant contributor to health worker attrition in many countries is unsafe working conditions for health workers, and the resulting fear of health workers of occupational infection, including from HIV and tuberculosis. Yet few countries have prioritized safe working conditions or sought Global Fund money to improve working conditions, including ensuring that health workers are able to consistently practice universal precautions, have been vaccinated against hepatitis B, and have access to safer injecting devices. Protection against workplace infection from tuberculosis is similarly lacking. Implementing effective infection control programs – and so increasing workplace safety and helping to meet health workers' needs – will not only reduce workplace infections among both health workers and their patients, but also should improve health worker morale and contribute to health worker retention.

Further resources

For a broader overview of applying to the Global Fund, applicants may wish to review *The Aidspan Guide to Round 6 Applications to the Global Fund*, available through <http://www.aidspan.org/guides/index.htm>. This Guide includes an important section on lessons from previous rounds, which we strongly recommend that people involved in preparing proposals read. This website also has *The Aidspan Guide to Developing Global Fund Proposals to Benefit Children Affected by HIV/AIDS*.

⁶⁶ Information on the Community Health Officer program is from a draft report by the Capacity Project (<http://www.capacityproject.org>). Seth Acquah, Graeme Frelick & Richard Matikanya, *Community Health Officers and Volunteer Health Workers in Ghana* (draft) (Feb. 2006).

⁶⁷ Elma de Vries & Steven Reid, *Do South African Rural Origin Medical Students Return to Rural Practice?* (May 2003). Available at: <ftp://ftp.hst.org.za/pubs/research/ruralorigin.pdf>

⁶⁸ Information on TASO's use of Field Officers is from a draft report by the Capacity Project (<http://www.capacityproject.org>). Capacity Project, *Incorporating Lay Human Resources for Increasing the Accessibility to Antiretroviral Therapy through a Home-Based Approach in Uganda* (draft) (March 2006).

For perspective on how global health initiatives such as the Global Fund can be used to support health systems, see the WHO working paper on Opportunities for Global Health Initiatives in the Health System Action Agenda.⁶⁹ It is available at:
http://whqlibdoc.who.int/hq/2006/WHO_EIP_healthsystems_2006.1_eng.pdf.

An HSS Information Sheet will very soon become available at the Global Fund's own website, in particular the page that contains the Guidelines for Proposals, Proposal Form, and other documents for Round 6: <http://www.theglobalfund.org/en/apply/call6/documents/>.

The Global AIDS Alliance has produced *Integration of Sexual and Reproductive Health into HIV/AIDS Programming: Guide for Submitting HIV/AIDS Component Proposals to the Global Fund, Round 6 and Beyond*. It is available at:
http://www.globalaidsalliance.org/docs/Global_Fund_Round_6_HIV_and_SRH_Guide_FINAL_5.17.06.pdf.

⁶⁹ World Health Organization, Department of Health Policy, Development and Services, Evidence and Information for Policy, *Making Health Systems Work: Working Paper No. 4: Opportunities for Global Health Initiatives in the Health System Action Agenda* (2006).