

# **THE MISSING LINK**

The Global Fund and Financial Access to Health Care

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## **Introduction**

Despite the complexity of health care debates around the world, they all come down to a simple question: How can a health care system provide quality, affordable health services for all?

Enormous gaps between health “haves” and “have-nots” exist within and between countries, and the greatest injustices occur when easily preventable, manageable or curable illnesses go untreated, leading to unnecessary and unconscionable suffering and death. However, as we well know in the United States, the most technically advanced health care system in the world can crumble without a solid financial foundation: Health systems need to mobilize enough resources to provide quality care for all without bankrupting countries, businesses, families or individuals.

In the poorest countries of the world, where the total resources available for health are extremely limited from the individual level on up, this tension is even stronger. Rwanda is one of these countries: In 2007, its GDP per capita was \$866, and the country ranked 167th (out of 182 countries with data) on UNDP’s Human Development Index. Nevertheless, Rwanda has made astonishing progress in the 16 years since the 1994 genocide devastated the country and its people. In the health sector, key indicators have improved dramatically in recent years (see Table 1), in part thanks to the community-based health insurance system, known as *mutuelles de santé*. Rwanda has received hundreds of millions of dollars from donors since 1994, including US \$623,865,858 million in approved funding from the Global Fund to Fight AIDS, TB and Malaria (GFATM)<sup>i</sup>. Though Rwanda has faced challenges familiar to all recipient countries in balancing support from large disease-specific programs with support for the overall health system, it is one of the only countries that has received GFATM funding to support financial access to health care for all people in need, not just those affected by the target diseases.

**Table 1: Rwanda Health Indicators 1992-2007**

	1992	2000	2005	2007
Infant mortality (< 1 year)	85	107	86	62
Child mortality (< 5 years)	150	196	152	103
Antenatal care (1 <sup>st</sup> visit)	94%	92%	94%	96%
Skilled birth attendance	26%	31%	39%	53%
Total fertility rate	6.2	5.8	6.1	5.5
Contraceptive prevalence	13%	4%	10%	27%

Source: *Demographic and Health Surveys*

This briefing will examine Rwanda's experience with health mutuelles and with its Global Fund health system strengthening (HSS) grant, and look at the Global Fund's history and policies on supporting HSS, especially for health care financing. It will conclude with suggestions drawn from GFATM data and other sources on how countries can position themselves to mobilize GFATM money to support health care for a broad cross-section of people in need.

### **History of Mutuelles in Rwanda**

In the years after the 1994 genocide, health care services in Rwanda were free, with financing from donors and from government. User fees were reintroduced in 1996 in an effort to recover costs and reduce dependency, and by 1999 utilization had dropped to 0.2 consultations per person per year, down from 0.3 in 1997 and far below the WHO recommended average of 1 consultation per person per year. In 1999, the Ministry of Health started a pilot of mutuelles in three districts including 54 health centers. The USAID-funded Partnership for Health Reform, implemented by Abt Associates, provided technical and financial support for the pilot.<sup>ii</sup>

Each mutuelle is linked to a health center, and is managed locally and independently. The annual premium during the pilot phase was RWF 2,500 per family of up to seven members, with a copayment of RWF 100 per visit; this premium entitled members to the basic package of

health services at the health center, as well as transportation to a district hospital if needed and coverage for some hospital services. Results from the pilot suggested that mutuelle members had better access to care, with a visit probability of 0.45, compared to 0.15 for the uninsured in the pilot districts.<sup>iii</sup> In 2004, the GOR adopted a national policy of scaling up for mutuelles, and both numbers of mutuelles and membership coverage increased rapidly (Table 2).

*Table 2: Mutuelles and health care utilization in Rwanda, 1998-2009*

	<b>Mutuelle membership (national average)</b>	<b>Number of mutuelles</b>	<b>Consultation rate*</b>
<i>Target</i>	<i>100% by 2012</i>	<i>n/a</i>	<i>1</i>
1998	n/a	6	n/a
1999	n/a	59	n/a
2000	n/a	76	n/a
2001	n/a	76	.25
2002	n/a	76	.28
2003	7%	88	.31
2004	27%	226	.39
2005	44%	354	.47
2006	73%	392	.56
2007	75%	403	.65
2008	85%	408	.86
2009	86%	n/a	n/a

\*Average number of consultations per person per year

Source: Rwandan Ministry of Health

In 2007, Rwanda passed a law requiring every Rwandan to have health insurance. Options include: the government health plans (RAMA for civil servants and MIMI for military); government funding for special groups, including FARG for genocide survivors, people working for Gacaca traditional courts, and a prisoners' health fund; private insurance for those working in the formal sector or can pay on their own; or mutuelles, which is the only choice for the vast majority of poor people in rural areas. The mutuelle premium was set at RWF 1,000 per person per year. However, since about 57% of the Rwandan population is classified as very poor (living below the poverty line) and 37% in abject poverty<sup>iv</sup>, many cannot afford this seemingly minimal contribution. The RWF 100 co-pay at the time of service at health centers, and 10% of the bill at hospitals, is also prohibitive, or at least a strong disincentive to seeking care for many people.

The GFTAM is paying for around 900,000 of the poorest Rwandans under a \$33.9 million health system strengthening (HSS) grant awarded in 2005—one of only three standalone HSS grants that GFATM awarded under its onetime HSS window in Round 5.

### **Rwanda’s GFATM Grant for Health System Strengthening**

In its proposal for the Round 5 HSS grant, Rwanda argued successfully that, of the estimated three million consultations a year nationwide, about a third were related to malaria, 400,000 for cough and 300,000 to 600,000 for HIV-related diseases such as diarrhea and opportunistic infections. Moreover, the low consultation rate in the country suggested that the core problem was that the population does not interact with health services:

“This fact is caused by two underlying, fundamental problems:

- A large part of the Rwandan population is unable to pay for health services in case of need.
- Even if financial resources are available for health service consumption, in many cases the perceived quality of services does not justify the expense.”<sup>v</sup>

Or, as one observer put it, the Rwandan people and their health system were like an old married couple, living side-by-side but rarely speaking. “Thus,” the proposal continues, “it is indispensable to ensure financial access to health services and to gradually improve their quality in order to address the disease burden caused by the three target epidemics.”<sup>vi</sup> funding from

The project, titled “Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda”, has two objectives:

1. To improve financial accessibility to health care for the very poor, poor, people living with HIV/AIDS (PLWHA) and orphans
2. To strengthen and improve performance and quality of the health delivery system.

The main activity to fulfill the first goal was to finance mutuelle premiums for the very poor, for orphans and for PLWHA, and to co-finance premiums for people classified as poor (but not “very poor”). For the first three groups, the grant covered costs for both the minimum package of activities (health center services) and the complementary package of activities (district hospital

services). For the second goal, the project provided training and/or technical assistance to clinical, health service, supervisory, and administrative staff, as well as insurance providers; provided electricity to health centers; and undertook operational research.

In the first two years, the project performed well against targets for covering the very poor, orphans and PLWHA, covering nearly 900,000 people. For the co-financing for the poor, performance was less impressive against targets, covering about half of the expected number, or about 500,000 people, mostly because the amount budgeted for each subscription was found to be too low, so the number of beneficiaries had to be reduced.<sup>vii</sup> In addition, user satisfaction surveys conducted in 2005-2006 showed that 77.1% of users were satisfied with health center services, and 36.5% had seen improvement in health center services in the previous 12 months.<sup>viii</sup> In its grant performance report, the Global Fund called it “an innovative and partner supported approach towards improving health care access for poor people and other vulnerable groups such as orphans and people living with HIV/AIDS (PLWHA) through the funding of community-based health insurance schemes,” and gave the project a “go” for Phase 2.

There have been challenges. Most of those noted in a 2007 mid-term report had more to do with the mutuelle system or the health system itself, rather than to the grant<sup>1</sup>. The chief concern related to the grant is that the GFATM was apparently not enough to cover all of the people in need of a subsidy: Only an estimated 50% of people needing help were receiving subsidies for insurance coverage through all sources, including the GFATM.<sup>ix</sup> Concerns have also been expressed about sustainability. The current grant ends in December 2010, and while most observers expect another donor to pick up the mutuelle costs for those previously covered by the GFATM, questions remain as to how the system can be sustained as long as a significant

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<sup>1</sup> Much has been written about Rwanda's mutuelle system, but a full analysis is beyond the scope of this paper. For a more general discussion, see especially Kalk 2010 and Kalavakonda 2007.

percentage of the population cannot afford the RWF 1,000 per person annual premium, or the co-payments at time of service, which have been shown to be a significant barrier to utilization.

Whatever the challenges, it is clear that this grant provided access to health center services for many poor people. The midterm report cites as evidence for this the increase in utilization and coverage, and a decrease (from 40% to 20%) in OPD consultations. Focus group discussion (FGD) participants corroborated the data: “Quite a substantial number of participants in the FGDs mentioned that they had not visited the health center or the local hospital when they fell sick in the past, i.e., no insurance coverage. But, following membership in the *mutuelles* since January 2006 quite a good number have started frequenting the health centers.”<sup>x</sup>

In addition, Rwanda’s health indicators have improved considerably, as shown in Table 1, and the health utilization rate rose to 0.86 visits in 2008. In a January 2010 paper discussing the GFATM grant in depth, Kalk et al conclude:

Independently from these challenges, the experience gained tells a story of an intervention which rapidly improved equity of and access to health services with limited resources. As equity and access are widely recognised as two dimensions and as pillars of quality, this experience speaks in favour of attributing a prominent – if not a priority – role to health systems strengthening within GFATM-funded projects.

The success depicted here is still to be compared with the progress achieved through and with the efficiency of other – more disease-oriented – projects financed by GFATM. In the context of such a comparison, it might become a strong argument for broadening the Fund’s mandate and for subsequently transforming it into a ‘Global Fund for International Health Promotion’.<sup>xi</sup>

### **History of GFATM Funding for HSS**

The GFATM may not be a “Global Fund for International Health Promotion” yet, but over eight years and 10 rounds of funding, the GFATM’s support for HSS has expanded and become more and more explicit. In the early rounds, the types of HSS activities allowed in disease

components were limited. In its Round 5 call for proposals, issued in 2005, the Global Fund gave countries the option of applying for funding for separate HSS projects. Of 33 applications submitted, only three were funded, and only Rwanda's addressed financial access to health.

Cambodia's \$4 million grant is focusing on organization and management, mostly at the national level. Activities include: harmonization of Global Fund-financed programs with other national programs; strengthening of the Ministry of Health's procurement, logistics, storage and distribution systems for medicines and other medical supplies; curriculum development for health workers; and technical support and mentoring for the health system's operational districts.<sup>xii</sup> Malawi's grant (\$22.6 million) is being used primarily for human resources for health. Activities include: increasing the supply of highly skilled and motivated health workers, including Health Surveillance Assistants, laboratory staff, community nurses and clinical officers, among others.<sup>xiii</sup> These categories are more typical of HSS activities funded by the GFATM.

Round 5 was the only one for which HSS was a separate category. Rounds 6 and 7 allowed HSS activities within disease components, and Round 7 guidelines more explicitly encouraged "strategic action" on HSS within a disease component, as well as cross-cutting actions. By Round 7 the GFATM had also identified 15 broad categories of specific strategic actions for HSS<sup>2</sup>. At its 16th meeting (November 2007) the GFATM approved its current health system strengthening strategy, which encourages countries to include HSS activities in disease components, or in separate "cross-cutting" sections.

Round 10 guidance dispenses with lists of strategic actions, instructing CCMs to instead refer to the WHO building blocks. "Experience confirms that it is not appropriate to define specific areas

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<sup>2</sup>Governance; Strategic planning and policy development; Monitoring and evaluation; Coordination/partnerships; Community and client involvement; Policy research; Information systems; Health management; Health financing; Human resources; Essential medicines and other pharmaceutical products management; Procurement systems; Logistics, including transport and communications; Infrastructure (*does not include large-scale investments, such as building hospitals and clinics*); Technology management and maintenance.

for allowable health systems strengthening funding. This is because priorities differ between countries and are best determined based on the analysis of weaknesses in the health system, and knowledge of current national health sector strategies and available resources.”<sup>xiv</sup> It does, however, offer an “illustrative but not exhaustive” list of “What the Global Fund will support” which describes financing as activities:

To improve financial risk protection and coverage for those living with and/or affected by HIV, tuberculosis and/or malaria, and transparent and effective use of resources, actions that may be appropriate include: strengthening financial resource tracking systems for the three diseases; **actions to improve financial access to services, such as improving or expanding sustainable social insurance schemes to ensure access by key populations to essential services.** (emphasis added)<sup>xv</sup>

#### *National Strategy Applications: The First Learning Wave*

The Global Fund board also took first steps last year towards allowing countries to apply for funds through a “National Strategy Application,” or NSA. Under this model, countries could submit their existing national strategies for HIV/AIDS, TB or malaria as the basis for the application, and ask the GFATM to fill budgetary gaps in the national strategy not covered by other sources. At its 18<sup>th</sup> meeting, in 2009, the board decided to introduce the NSA approach through a “First Learning Wave” in which a limited number of countries would be asked to submit NSA applications. A total of 22 Country Coordinating Mechanisms (CCMs) were invited to apply, 19 submitted national strategy documentation for preliminary desk review by the Global Fund’s Technical Review Panel (TRP), and seven were invited to submit full applications. Of those, five were approved for funding; Rwanda won two of the five approved grants and China, Nepal and Madagascar each had one NSA funded<sup>xvi</sup>. Though the Rwanda grants are not yet signed, Rwanda was approved for \$213.8 million for its HIV/AIDS NSA and \$41 million for its TB NSA.<sup>xvii</sup>

Based on the TRP’s report on the First Learning Wave, the GFATM board approved a phased rollout for the NSA approach. At its April 2010 meeting, the board asked the secretariat “to

initiate a next NSA funding opportunity on a schedule that enables funding decisions to be made at the Board meeting in the fourth quarter of 2011, subject to availability of funding.”<sup>xviii</sup> Based on previous timelines, this suggests that a call for proposals would be made about six months before the board meeting.

Although two countries included cross-cutting HSS sections in their NSAs, neither of these was approved. The TRP reported that the separate HSS sections in their current form do not add value. “The NSA process may not be suited to accommodate a separate HSS section, but if this is desired, then detailed guidelines on how to develop such a section linked to an NSA should be developed and communicated to CCMs.”<sup>xix</sup> Rwanda did include HSS activities in its NSAs, though not in a separate cross-cutting section: The TB application includes funding for performance-based financing in health facilities, for various diagnostic equipment, including a CT scanner, and for implementation of the PAL approach and general infection control interventions, all of which have benefits beyond the TB-affected population. The HIV/AIDS NSA describes the intersections between the HIV/AIDS NSA and the country’s Health Sector Strategic Plan (HSSP), and includes a range of HSS activities. Most notably, the NSA application will finance mutuelle coverage for people affected by HIV, including orphans and vulnerable children (OVC), as well as at-risk groups such as sex workers and migrant workers. The NSA also includes activities to promote mutuelles at the community level and promote insurance coverage by employers in the formal sector.

*“Optimizing Synergies”: Global Fund support for Maternal and Child Health*

In the past several months, the GFATM has further broadened its support for HSS by explicitly stating that achieving its target Millennium Development Goal, MDG 6 combating HIV/AIDS, malaria and other disease, can only be approached through integration with MDGs 4 and 5

(reducing child mortality and improving maternal health). In its decision at its 21st meeting, the Global Fund board stated that: “the success of one MDG depends on progress on all others”, and continued:

The Board supports the efforts of countries to integrate MCH within their HIV/AIDS, TB and malaria programs, and strongly encourages CCMS to look at opportunities to scale up an integrated health response that includes MCH in their applications for HIV/AIDS, TB, malaria and HSS...

The Board encourages countries and partners, **as a matter of urgency**, to work together in the context of opportunities presented through grant reprogramming, Round 10, and changes to the Global Fund grant architecture to urgently scale up investments in MCH in the context of the Global Fund's core mandate...<sup>xx</sup> (emphasis added)

The current GFATM information note on HSS, dated May 2010, states that “applicants should not feel constrained to propose HSS interventions that improve the outcomes of the three diseases solely... Countries that fail to take advantage of this miss an important opportunity to develop strong health sector systems which benefit health outcomes beyond the three diseases.”<sup>xxi</sup>

## **Conclusions**

The Global Fund’s commitment to health system strengthening has become progressively stronger and more specific over the years since the onetime HSS window. Recent actions and statements by the GFATM on National Strategy Applications and support for MDGs four and five, as well as guidelines for Round 10 applications, strongly encourage countries to include HSS in their proposals. Advisors to countries, including WHO, have emphasized HSS in advice and toolkits for countries preparing Round 10 proposals. The GFATM’s current information note on HSS lays out the Fund’s rationale for supporting HSS:

“The Global Fund's major objective in providing funding for health systems strengthening is to increase overall impact of responses to the three diseases as well as other health MDGs. The Global Fund recognizes that supporting the development of equitable, efficient,

sustainable, transparent and accountable health systems furthers achievement of these objectives.”<sup>xxii</sup>

What is less clear is how financial access to health care fits into the GFATM’s frameworks.

Financing is mentioned less frequently in these guidelines than other HSS components such as human resources for health, even though it is explicitly listed as one of the areas the GFATM is willing to fund, and is one of the WHO’s six “building blocks” for HSS. The Global Fund explicitly bases its HSS support on these building blocks:

- Service delivery
- Health workforce
- Health information systems
- Medical products, vaccines and technologies
- Financing
- Leadership and governance<sup>xxiii</sup>

Only one of the six building blocks, financing, specifically covers financial access to health. Two others—equitable access to medical vaccines and technologies, and the somewhat vague category of service delivery—could also be linked to financial access.

The GFATM also has a long list of “program areas” that are assigned to each grant, but financing is not on the list. In fact, Rwanda’s HSS grant, among the only GFATM grants that addresses universal financial access to care, is assigned three “program areas” under HSS: service delivery, community systems strengthening, and procurement and supply management. Most HSS activities in disease components in Rounds 6 through 9 are for procurements systems, human resources (especially training), and coordination and harmonization efforts. When financial access is mentioned, it generally refers to access to care for people with HIV/AIDS, TB or malaria.

The Global Fund seems to be caught in the same confusion as many other actors when it comes to health systems strengthening and especially financial access: recognizing that HSS is

critical, it still has not evolved a clear understanding of what HSS means and how it should be described and measured. Despite this lack of clarity, the Global Fund has been moving steadily and surely in the right direction. This evolution presents a unique opportunity for countries to craft proposals that will respond to the Global Fund's stated goals in a way that also helps the Fund to refine its policies.

For countries trying to mobilize funds to provide financial access to health for their people, a careful analysis of the Fund's responses to previous HSS proposals can provide a useful guide to how to develop a convincing argument showing how HSS will improve outcomes for AIDS, TB and malaria. In addition, a number of stakeholders have provided guides, toolkits, advice, etc., for including HSS activities the current round. A selection of tips follows, roughly divided into four categories: Build a Case, Describe the Process, Follow the Directions, and Measure It.

### **Build a Case**

The most important aspect of a sound proposal is to describe a logical chain from financial access to the control of the three target diseases. GFATM is looking for a clear, logical, convincing, evidence-based argument as to how HSS activities will contribute to improving the disease-specific outcomes that form its mandate. For example:

- The HSS activities should respond directly and clearly to constraints and bottlenecks to effective HIV/AIDS, TB and malaria control that are identified in the disease-focused parts of the proposal. "Proposals often do not link their proposed HSS activities to the specific constraints identified in the analysis section of the proposal form."<sup>xxiv</sup>
- Proposals should show that the HSS activities are required in order to improve HIV/AIDS, TB or malaria services delivery, "but lie beyond the mandate of an individual programme, or could disrupt other priority services if implemented by one programme alone... Successful proposals have made a compelling case. However, in many proposals, the case has been superficial and unconvincing."<sup>xxv</sup>
- The proposal should show how the HSS activities will improve disease outcomes as well as broader health outcomes: "On the other hand, applicants should not feel constrained to propose HSS interventions that improve the outcomes of the three diseases solely. The TRP supports applicants to consider (as they have been encouraged to do so by the Global Fund Board) HSS interventions that impact on health MDGs more broadly.

**Countries that fail to take advantage of this miss an important opportunity to develop strong health sector systems which benefit health outcomes beyond the three diseases<sup>xxvi</sup>.**

- Previous HSS requests have focused on service delivery, but the Global Fund encourages applicants to address all six “building blocks” of the health system. **“The TRP sees both 'Financing' and 'Leadership and governance' as particularly important for performance within the health sector, as they encompass two key functions: equity and efficiency.** Applicants are thus encouraged to propose more balanced HSS interventions, based on country needs that cover a range of health system components.<sup>xxvii</sup>

## **Connect the Forest and the Trees**

The GFATM wants to see programs that are closely harmonized with existing national health policies and programs. The proposals should demonstrate an understanding of the complexity of the interconnected parts of a health system.

- The Global Fund recommends that HSS funding requests be based on a strong evidence base in the form of a country assessment (gap analysis) identifying constraints to effective performance of the health system and performance of existing interventions. “Strong HSS requests are based on such a gap analysis of a national health sector strategy which is supported by holistic needs assessment of the health system. This ensures that the proposed HSS interventions are based on analytical diagnoses of the underlying causes of health systems challenges and that the resulting funding request is clearly presented as being auxiliary to, and flowing from, a national health strategy.”<sup>xxviii</sup>
- The analysis of health system constraints and the proposal’s responses to them should address equity in health services. “The analysis should discuss “the structural arrangements between government and civil society in order to ensure equitable access to health services,” “the country’s priorities in strengthening the health and community systems to ensure equitable access to services for men and women,” and “whether certain groups may face barriers to access, such as women and girls, key populations, adolescents, or barriers arising from geographic, urban/rural or other location issues.”<sup>xxix</sup>
- Rather than requesting a “shopping list” of all theoretical HSS needs, “applicants are encouraged to base their HSS proposals on an understanding of the complex nature of the interactions between health systems components, functions, institutional and structural elements.”<sup>xxx</sup>
- The activities should fit with within overall national health policies, plans and strategies. “Many proposals have contained actions that appear to be planned in isolation of the wider health system. This makes it difficult for the TRP to judge the extent to which the proposed activities are part of a balanced approach that fits with overall national policy and strategy.”<sup>xxxi</sup>
- National strategies should meet international guidelines for sound national plans and strategies. The TRP review of National Strategy Applications provided valuable information on what the GFATM views as attributes needed for strong national strategies and plans. The attributes, drawn from the International Health Partnership working group on national strategies, are divided into five categories:

- Situation Analysis and Programming: Soundness of analysis/assessment underlying identification of the programming contained in the national strategy
- Process: Soundness of development/endorsement process of the national strategy
- Finance and Auditing: Soundness of financial/auditing framework and systems
- Implementation and Management: Soundness of arrangements and systems for implementing and managing the program contained in the national strategy
- Results, Monitoring and Review Soundness of review and evaluation mechanisms and how their results are used.<sup>xxxii</sup>

### **Describe the Process**

The WHO's "How to Make the Case" document emphasizes that "the **process** of proposal development is also a critical determinant of a strong proposal."<sup>xxxiii</sup> The Global Fund requires involvement of key HSS stakeholders in proposal development; they should ideally be members of the CCM. The CCM should recruit a range of health systems and cross-disease focused stakeholders: "In particular, the Global Fund encourages applicants to include stakeholders (including at least one non-government in-country representative with a focus on HSS and one government representative with responsibility for HSS planning) who are involved in the planning, budgeting and resource allocation processes for national disease programs and health system reform. The role of these stakeholders in the proposal that is submitted should also be explained."<sup>xxxiv</sup> "Moreover, in order to effectively address shared health systems barriers in a proposal, early collaboration between those preparing AIDS, TB and malaria components has also become important."<sup>xxxv</sup> This involvement should be clearly and explicitly described in the proposal.

### **Follow the Directions**

Successful HSS proposals share characteristics of other successful Global Fund proposals, which follow the GFATM's guidelines and respond thoroughly to the questions and requirements in the applications. Proposed activities should be clearly defined, and realistic and specific in

terms of cost, scale and timeline. “The TRP notes that successful HSS proposals ... focus on a manageable set of activities, not major sector reforms; they are judged to be realistic, and have clear objectives and budgets. Unsuccessful HSS proposals conversely contain actions considered too broad, too ambitious or too vague in terms of objectives, work plans and budgets.”<sup>xxxvi</sup>

The TRP also cited a lack of understanding among applicants on the difference between including HSS interventions in disease specific components or placing them as separate cross-cutting sections; applicants should review the requirements, decide which approach to take and provide a clear justification as to why it used a particular approach.

### **Measure It**

Indicators for health system strengthening are still evolving, and can be difficult to link to disease outcomes, but that link should be made as clearly as possible. “The Fund stresses that applicants must show a convincing link between proposed HSS interventions and outputs, and disease specific outputs.”<sup>xxxvii</sup> The Global Fund recommends using the toolkit for monitoring health system strengthening developed by WHO and the World Bank<sup>3</sup>.

### **Examples from Rwanda**

Given the success Rwanda has had with Global Fund grants, including HSS grants and components, it is often cited as a positive example; its Round 5 HSS proposal is still held up as a model. In its “Guide to Using Round 10 of the Global Fund to Fight AIDS, Tuberculosis and Malaria to Support Health Systems Strengthening”<sup>xxxviii</sup>, Physicians for Human Rights lists common features of the two largest approved Round 5 HSS grants:

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<sup>3</sup> [www.who.int/healthinfo/statistics/toolkit\\_hss/en/index.html](http://www.who.int/healthinfo/statistics/toolkit_hss/en/index.html)

- Strong links to reducing spread and impact of target diseases
- Strong health system analyses
- National commitment and interventions based on health strategies
- Strong chance of success
- Pro-poor and pro-marginalized populations
- Support from other development partners
- Address major obstacles

WHO's "How to Make the Case" document lists excerpts from four proposals that made strong cases linking identified challenges to proposed actions that required to improve health outcomes. The Round 5 HSS proposals from Rwanda and Malawi are both cited, with the note: "This example comes from a round 5 HSS proposal, but the line of argument used to make the case remains equally valid for Round 8, 9 and 10 proposals, despite there no longer being a stand-alone component." In Rwanda's proposal, the WHO states:

**The problem:** The proposal described how a lack of financial resources at the peripheral level of the health system meant health centres were charging user fees. It argued that this had contributed to a steady decline in service utilization over the last five years. Low service quality was also thought to contribute to low utilization by people with HIV/AIDS, TB or malaria .../...

**The response** addressed both of the identified constraints to demand for health care by those in need. It built on existing activities for which there were insufficient funds from other sources. ... It anticipated four outcomes from implementation of the proposal, including a 30% rise in service utilization, and includes HIV/AIDS, TB and malaria indicators as measures of progress... It said explicitly that the proposed approach had been "endorsed by all development partners in Rwanda, among them World Bank, UN agencies, bilateral partners and the Churches" .<sup>xxix</sup>

After its desk review of Rwanda's 2009 National Strategic Plan (NSP) for HIV/AIDS, the TRP asked for clarification on how the NSA links to the national 2009-2012 Health Sector Strategic Plan (HSSP). In its response, Rwanda painstakingly enumerated the HSSP's three strategic objectives and seven strategic program areas and gave a detailed description for each one of how activities carried out under the NSP contribute to achieving them. The response is too long (seven pages!) to be summarized in full, but the response for the strategic program area of ensuring "financial accessibility to health services for all and sustainable and equitable financing

of the health sector” is helpful. The proposal notes that by covering health insurance for people infected with and affected by HIV, as well as high-risk groups, “the NSP will make a significant contribution to achieving the HSSP objective of reaching universal insurance coverage from 85% to 100% of the population by 2012.”<sup>xi</sup>

Up to now, the Global Fund has had minimal experience supporting financial access to health. Countries preparing such proposals need to build a strong, logical argument that links its activities to outcomes for the three diseases that are the GFATM’s ultimate focus. A well argued case that responds to the Fund’s guidelines and takes previous lessons learned into account stands the best chance of not only winning funding for the country, but also of helping the fund and other major stakeholders strengthen their support for the “missing link” of financial access to health care.

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<sup>i</sup> The Global Fund to Fight AIDS, Tuberculosis and Malaria. Grant Portfolio, Rwanda Country Page. Accessed June 2010 at <http://portfolio.theglobalfund.org/Country/Index/RWN?lang=en#>.

<sup>ii</sup> Schneider P & Diop F (2004) Community-based health insurance in Rwanda. In: Health Financing for Poor People (ed. FS Preker & G Carrin) The World Bank, Washington, DC, pp. 251–274.

<sup>iii</sup> Schneider P & Diop F (2004) Community-based health insurance in Rwanda. In: Health Financing for Poor People (ed. FS Preker & G Carrin) The World Bank, Washington, DC, pp. 251–274.

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