



Copy → BH. JS. AP
PM. ASy.
EH, NG.

GLOBAL FUND COUNTRY CASE STUDIES REPORT

Author: Cheri Grace

Based on case studies conducted in Ghana, Kenya, Malawi, Uganda, and the Ukraine, during August and September 2002, by the following consultants:

Ghana: Dr. Mercy Bannerman

Kenya: Dr. Peter Mokaya

Malawi: Liz Ollier and Dr. Mercy Bannerman

Uganda: Dr. Peter Mokaya and Professor Salim Sohani

Ukraine: Rose-Marie de Loor

Final draft: January 2003

DFID Health Systems Resource Centre

27 Old Street

London EC1V 9HL

Tel: +44 (0) 207 253 2222

Fax: +44 (0) 207 251 9552

E-mail: enquiries@healthsystemsrc.org

Acknowledgements

This paper has been produced based on case studies conducted in five countries. We would like to express our gratitude to the Governments of Ghana, Malawi, Kenya, Ukraine, and Uganda for allowing us access to documentation and granting permission for numerous interviews.

We are particularly grateful to the interviewees who shared their views and time, including individuals from ministries, non-governmental, multi-lateral and bi-lateral organisations. The insights from these individuals and organisations contributed to a greater contextual understanding and assisted in the interpretation of findings.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
BCC	Behaviour Change and Communication
CCM	Country co-ordination mechanism
CCP	Comprehensive Country Proposal
DFID	Department for International Development
DOTS	Directly Observed Therapy Short-course
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, TB and Malaria
GPRS	Ghana Poverty Reduction Strategy
HDI	Human Development Index
HIPC	Highly Indebted Poor Country
HIV	Human Immunodeficiency Virus
HR	Human resources
HSRC	Health Systems Resource Centre
IDU	Intravenous drug user
ITN	Insecticide treated nets
LFA	Local Fiduciary Agent
MOH	Ministry of Health
NGO	Non-governmental organisation
OI	Opportunistic Infection
PLWA	Person living with AIDS
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnership
PR	Principal Recipient

PRSP	Poverty Reduction Strategy Paper
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
TRP	Technical Review Panel
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
USD	United States Dollars
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Contents

1	Executive Summary	7
2	Introduction	8
2.1	Purpose of study	8
2.2	Scope of the Study	8
2.3	Methods.....	8
2.4	Structure of the Report.....	8
3	Study country profiles	9
3.1	Ghana Proposal	9
3.2	Malawi proposal	11
3.3	Uganda proposal.....	11
3.4	Ukraine proposal	12
3.5	Kenya proposal	13
3.6	Summary of results of first round for countries included in the case studies.....	14
4	Findings and Recommendations	16
4.1	The Application Process.....	16
4.1.1	Short timeframes	16
4.1.2	Asymmetric access to information	16
4.1.3	Proposal format	17
4.1.4	Identifying realistic/appropriate financial parameters.....	18
4.1.5	Costing and budgeting	18
4.1.6	How was it decided whether to submit a combined proposal or multiple proposals (either divided amongst recipients or divided along disease lines)?	19
4.1.7	Eligibility criteria	20
4.1.8	Need for formal communication channels.....	20
4.1.9	Process of writing the proposal, including technical assistance.....	20
4.1.10	Appropriateness and consistency of criteria by which proposals were judged.....	22
4.1.11	Feedback after first round	23
4.2	Country Co-ordinating Mechanisms	24
4.2.1	CCM composition and process of formation	24
4.2.2	Clarity of CCM roles and responsibilities	24
4.2.3	CCM process since announcement of first round results.....	25
4.3	Compatibility with Country Health Systems.....	26

4.3.1	Compatibility with country-led development processes	26
4.3.2	Macroeconomic absorption.....	26
4.3.3	Absorption/capacity at micro level	26
4.3.4	Incentives for vertical programming	28
4.3.5	Performance monitoring	29
4.3.6	Financial infrastructure for implementation.....	30
4.3.7	Additionality.....	31
4.3.8	Crosscutting components.....	31
4.4	Equity/Pro-poor Focus	31
5	Appendix A: Terms of Reference.....	33

1 EXECUTIVE SUMMARY

This study was commissioned by the Department for International Development (DFID) Health and Population Department (HPD) and is based on the experiences of five countries in dealing with the Global Fund for AIDS, Tuberculosis and Malaria (GFATM). The study's aim is to better understand the challenges countries faced during the first round application process, the functioning of the country co-ordination mechanisms (CCM), the degree of compatibility of Global Funds with country-led development processes, and implications for the poor. General policy lessons, comparative experience, and consensus have been drawn out in this paper.

When the process for preparing and submitting proposals to the Global Fund was designed, it was recognised that revisions would be required, based on experience in the first round. Indeed, the country case studies undertaken for this report revealed specific examples of where revisions are needed, for example, the timeframes during the first round were too short, communication asymmetric across countries, and clarity lacking in the proposal format. Countries were also of the view that the criteria by which proposals were judged lacked appropriateness, clarity, and seemed to be inconsistently applied. The Technical Review Panel (TRP) feedback also needed to be more specific and more equitably distributed across countries.

The composition, inclusiveness and performance of the Country Co-ordinating Mechanisms also differed across countries. There was evidence of governance problems in one study country; GFATM will need to have policies in place to deal with such situations. Overall, there are steps the GFATM can take to help facilitate better performance and transparency for all recipient countries, including drafting a global CCM constitution for local adaptation and establishing guidelines for tendering processes, for use in countries where a bidding process is being used to vet proposals from implementing partners.

Compatibility of the Global Fund proposal with country-led development processes was variable across countries, seemingly more compatible where country-led processes were previously strong. The Global Fund was consistently viewed, in interviews, as being more disease than health systems orientated; countries are finding various ways to deal with this. All five countries initially developed a proposal that sought to obtain financing for unmet need in implementing or scaling up existing health service provision. However, in two of the five countries, external influence intervened, encouraging the countries to submit a substantially larger bid. Interviewees expressed doubt in capacity to implement the proposal in all study countries; human resources were seen to be the major constraint. Capacity for performance monitoring and infrastructure for financial management differs across countries. The process of trying to set up the latter had been a major pre-occupation in all the study countries during the time the case studies were conducted.

None of the countries studied had explicit policies regarding the criteria for rationing access to Anti-retroviral (ARV) therapy or whether ARVs (and the cost of the care that goes with their use) would be offered free, subsidised or at cost. Issues of equity and how Global Funds would affect the poor were consistently found to be neglected across the study countries.

2 INTRODUCTION

2.1 PURPOSE OF STUDY

In preparation for the GFATM Board meeting held in October 2002, DFID's Health Systems Resource Centre (HSRC) was commissioned to provide support to DFID's Health and Population Department advisors in preparing for the discussion at the Board meetings and for shaping DFID's position on key policy issues.

In this context, the HSRC was asked to conduct a series of country case studies, designed to draw out lessons learned and to understand some of the challenges applicant countries faced in the first round of the Global Fund. General policy lessons, comparative experience, and consensus views found during the case studies have been drawn out in this paper.

2.2 SCOPE OF THE STUDY

The country case studies were designed to capture the experiences of key stakeholders in country regarding the process of the application, proposal reviews and matters arising after a successful bid with respect to disbursement and implementation. The content and technical merits of each country's proposal were less of a focus, since the principal aim of the study is to inform future design and process.

2.3 METHODS

Countries were selected in consultation with HPD and DFID country advisors and the decision was based on such factors as proposal outcome, particular known issues of relevance to overall policy, and degree of willingness of the local CCM to support the study. Each study team reviewed relevant documentation, including the Global Fund proposal guidelines, the country proposal submitted during the first round, the overall results of the first round of proposals, and the TRP feedback sheets given to the country. A semi-structured approach using the format of the Terms of Reference (see Appendix A) was taken to ensure that key issues were covered. Each interview attempted to identify both processes which were felt by the interviewee to have been positive/worked well and those where difficulties were experienced. The results of the interviews in country were compiled under major thematic areas, and then, using manual 'cut and paste', compiled across countries. Compiling the results for all five countries under thematic headings allowed for general policy lessons, comparative experience, and consensus views to be drawn out.

2.4 STRUCTURE OF THE REPORT

It is assumed that readers have pre-existing knowledge about the GFATM, its objectives and processes. Thus this report is comprised of two sections: i) a snapshot of the **country context**, GFATM proposal submitted, and results obtained in the first round for each of the five study countries, ii) key overall **findings and recommendations** from the case studies, grouped into four categories and examined on a comparative, cross-country basis.

3 STUDY COUNTRY PROFILES

3.1 GHANA PROPOSAL

Following the first call for proposals for funding of the Global Fund to fight AIDS, TB and Malaria, Ghana submitted a proposal entitled **“Accelerating access to prevention, care, support and treatment for all persons affected by HIV/AIDS, Tuberculosis and Malaria.”**

Ghana has a population of 18.5 million, according to the census of 2000 with a projected population density of about 77 per square km which is very varied ranging from 897 in the Greater Accra region to 31 in the Upper West region which is also the poorest economically. Forty-six percent of the population is below the age of fifteen and fifty one percent of the population is female and life expectancy is currently at 58 years. In the year 2000, Ghana's GDP per capita was US\$390 with a GDP growth rate of 3.7%. As of the year 2001 the GDP growth rate was put at 4.2%.

In support of the governments' decision to opt for the Highly Indebted Poor Country (HIPC) Initiative, a Ghana Poverty Reduction Strategy (GPRS) is currently being finalized and will be the main development framework for the country over the next three years (2002-2004). .

Projected allocation of funds to the health sector in the GPRS for the year 2002 is 16% of total public expenditure. Governments budgeted per capita expenditure on health for the year 2002 which excludes private spending is US\$5, as against the Commission on Macro Economics and Health projection of US\$34 per capita per year. The budgetary allocation for the Ministry of Health is approximately US\$ 93.2m while the Ministry 's projected expenditure is US\$ 140million. Additional resources are therefore required to accelerate access to prevention; support and case management for all persons affected by HIV/AIDS, Tuberculosis, Malaria and other diseases to enable Ghana achieve the Mid- Decade Goals by 2015.

The 2000 national HIV prevalence rate in Ghana was estimated to be 3.0%, with projections for the prevalence rate of HIV/AIDS to increase to 4.7% by 2004 and 6.9% by 2009. The incidence of TB is on the increase with a total cumulative death from 1996 to 2000 of 2,328 (CFR). Malaria is hyper-endemic accounting for 44.5% of all outpatient illnesses, 36.9% of all admissions and 13.2% of all deaths with pregnant women and children under five years being the most vulnerable

The overall objectives for the three disease components being tackled by the Global Fund are, “To promote equitable access to prevention, care, support and treatment for all persons affected by HIV/AIDS, TB and Malaria, through strengthened partnerships between government, civil society and the private sector”. The proposal addresses all three diseases: HIV/AIDS, TB, and Malaria with the aim of interlinking them with the cross cutting issues of human resource development and increasing capacity for the efficient management and utilization of available resources for a strengthened health system that will deliver a package of services that is responsive to the particular needs of the poor.

All aspects of the proposal are linked to ongoing programmes and already articulated strategies. Each of the three components is backed by a Strategic Plan, which guided their activities.

The main objective for the HIV/AIDS component of the proposal is to promote equitable access to prevention, care, support and treatment for all persons affected by HIV/AIDS through strengthened partnerships between government, civil society and the private sector. Specific objectives of this HIV/AIDS component are largely derived from the gaps analysed from the HIV/AIDS National Strategic Framework.

The main objective of the TB component is to strengthen partnerships between government, civil society and the private sector to promote equitable access to prevention, care, support and treatment for all persons affected by TB. Specifically, the proposal seeks to increase the level of public/private partnership and expand health service provision for those infected with TB within the 2 largest metropolitan areas of Accra and Kumasi in the areas of case detection, treatment, monitoring and evaluation.

The Malaria component of the proposal's main objective is to promote equitable access to prevention, care, support and treatment for all persons affected by malaria through strengthened partnerships between government civil society and the private sector.

The total amount requested from the Global Fund to fill in the gaps of the existing national programmes over a five year period was approximately US\$ 38 million with the following breakdown HIV/AIDS - US\$14 million, TB- US\$5.5 million, and Malaria- US\$17 million. An initial amount of US\$ 10 million for 18 months in 2002-2003, comprised of US\$ 1 million for TB and US\$ 9 million for AIDS has been approved.

After the review of the first round call for proposals, two of the components of the Ghana proposal, namely AIDS and TB, were approved with a request for clarifications on a few issues while the malaria component was to be resubmitted for consideration. The TRP recommended a revision of targets and clarification of implementation issues for all the three components and specified the need for the inclusion of a Chloroquine sensitivity study and preventive malaria treatment for pregnant women in the malaria component.

Following further adjustments and clarifications made on the AIDS and TB components, the two components have been approved by the Global Fund for disbursement. The disbursement mechanism is now being worked out. At the time the case study was conducted, the Ministry of Health was selected to be the Principal Recipient and Price Waterhouse was selected as the Local Fiduciary Agent. An assessment of the Ministry of Health's financial management capacity was to be carried out prior to disbursement of the funds.

3.2 MALAWI PROPOSAL

The Malawi GFATM proposal '**An Integrated National Response to HIV/AIDS and Malaria**' addresses HIV/AIDS and Malaria prevention and treatment. Under the HIV/AIDS section, there are four components:

- Voluntary Counselling and Testing
- Prevention of Mother to Child Transmission
- Community Home Based Care and Treatment
- Management of Opportunistic Infections and Anti-Retroviral drugs

Under the Malaria section, one component, 'prevention', is included. Further, there are two crosscutting components:

- Health Systems Strengthening and Performance
- Management and Institutional support

For HIV/AIDS, the emphasis of the Integrated National Response is on care and support, which is linked to prevention strategies through the National Strategic Framework. In Malawi, prevention strategies include Behaviour Change and Communication (BCC), Voluntary Counselling and Testing (VCT), Control and Management of Sexually Transmitted Infections (STIs) including use of condoms, Blood Safety and Prevention of Mother-To-Child-Transmission (PMTCT). The pledged financial support for the National HIV/AIDS Strategic Framework is largely for preventive activities, thus the proposal focuses more on the gap, which is for treatment. The TRP approved \$284 million USD over five years for the HIV portion, pending certain revisions/clarifications were made to the proposal; \$19 USD million is budgeted for the first year. Twenty-five percent of the overall HIV budget is allocated to the purchase of ARVs and another 25% goes towards drugs to treat opportunistic infections. The TRP recommended that the malaria bid be revised and re-submitted to the TRP for consideration.

3.3 UGANDA PROPOSAL

Uganda has a population of 21,899,400 with a 8.3% prevalence of HIV/AIDS, 9050 cases/100,000 of Malaria and 170 cases/100,000 of TB. Uganda is classified as one of the highly indebted poor countries (HIPC). Uganda's GDP per capita is currently estimated at US\$330 and the average economic growth rate is 6.5% per annum. The proportion of the population living in absolute poverty is currently estimated at about 35% compared to 42% five years ago. The country is currently ranked 141 on the Human Development Index (HDI).

The Uganda proposal to the Global Fund to fight AIDS, TB and Malaria was entitled "**The Uganda Comprehensive Country Proposal (CCP) for Scaling up the National Response to HIV/AIDS, Tuberculosis and Malaria**". This proposal focused on funding gaps in the existing national plans for the three diseases. The additional **outcomes** expected from this proposal included:

- Strengthening the capacity of the health system to deliver services

- Scaling up on on-going cost effective interventions
- Supporting innovative interventions such as Home Based Management of Fever and the provision of anti retroviral (ARV) drugs
- And strengthening of Public Private Partnerships (PPP) in health care delivery

The main objectives for the HIV/AIDS component included: enhancing the prevention of STI/HIV, to strengthen care and support for people living with and affected by HIV/AIDS, and to build and strengthen the capacity at all levels to respond to the burden of HIV/AIDS. This was followed by specific objectives detailed in the proposal.

The main objectives for the TB component included: enhancing the prevention of TB, strengthening TB case management, and building and strengthening the capacity at all levels to respond to the burden of TB. This was followed by specific objectives detailed in the proposal.

The main objectives for Malaria component included: enhancing the prevention of Malaria, strengthening Malaria case management, and building and strengthening the capacity at all levels to respond to the burden of Malaria.

To undertake the above interventions, Uganda requested for a total of **US\$ 97 million** over 3 years. For year 1, a total of 22.7 million was requested, broken down as 15 million for HIV/AIDS, 14 million for Malaria and 4 million for TB. Although funds have not yet been released, the HIV/AIDS component was approved and recommended for funding, while the TB and Malaria components need to be re-submitted. The recommendations from the Technical Review Panel (TRP) were that, clarifications and additional information were required for all the three components, but specifically, the TB component of the project needed to be redrafted, spelling out the specific interventions proposed to be undertaken to achieve set targets. For the Malaria component, the TRP asked for more specificity about the number of people available to implement the proposal and a description of a plan for sustainability of the interventions.

3.4 UKRAINE PROPOSAL

Ukraine became a sovereign country in 1991. It has an estimated population of about 49 million. The first HIV case was registered in 1987, while 1994 is regarded as the first year of the epidemic (Balakireva et al, 2001). Between 1987 and 2001, 43,600 persons were infected. Two thousand nine hundred and seven (2,907) Ukrainians were diagnosed with AIDS, 1,473 died. The main route of HIV transmission is through injecting drugs and more recently also through heterosexual and mother to child transmission. A decrease in the proportion of HIV-positive drug users in the total number of HIV-infected individuals is further evidence of the starting move of HIV-infection into the general population. Experts in the field believe that governmental statistics do not reflect the real situation. The exact number of infections in the Ukraine remains unknown. Balakireva et al. estimate that the total number was 330-410,000 in 2001, that is, not less than 1% of the adult population.

The age group of 20-39 years is most affected amongst both men and women. The most affected regions are those in the east and south: Dnipropetrovsk, Donetsk, Odessa, Mykolaiv and the Crimea Autonomous Republic. According to the European Centre for AIDS Epidemiological Monitoring, Ukraine has the highest level of HIV infection in the WHO European Region.

The proposal from the Ukraine amounts to US \$92 million over the period 2002-2006, and aims at stabilising the current HIV/AIDS epidemic. It includes four components: Information & Education, Prevention among Vulnerable Groups, Care & Support and Monitoring and Evaluation. Sixty five percent of the budget is for the Treatment & Care component, about 11 % for prevention in vulnerable groups, and approximately 24% for the remaining two components. The Ukraine proposal was approved in the first round, pending resolution of certain clarifications. These included clarification about the three administrative layers, the capacity of the Ukrainian HIV/AIDS Foundation, unit prices used to calculate the budget (particularly for ARVs), selection of beneficiaries for ARV treatment, budgets for treatment and care as well as for TB treatment and target setting for the IDU component.

3.5 KENYA PROPOSAL

The Kenya Proposal to the Global Fund sought a total of US\$ 293.53 as additional funds, against an estimated commitment of US \$1.2 billion by Government, Civil Society, Private Sector and donors for AIDS, Tuberculosis and Malaria activities over the period 2002-2006. Out of the total funds requested, US\$ 179.37 was for HIV/AIDS activities, US\$ 102.25 for Malaria activities and US\$ 11.91 for TB activities.

The major categories of activities for which funds were requested included:

HIV/AIDS. The major activities included those which lead to scaling up of Prevention of Mother to Child Transmission (PMTCT) and VCT programme; increase in equitable access to STI and Opportunistic Infection (OI) prevention and treatment (TB included); increasing access to ARV for People Living with Aids (PLWA) in Kenya and developing systems to ensure the feasibility of these mainstream activities.

TB: The major activities included; Case-detection rate increase from 47% to 70% by 2006; achievement of 80% cure-rate of tuberculosis using the WHO DOTS strategy through sustained supply of high quality anti TB drugs in all health facilities by the end of 2006; Laboratory quality assurance establishment and achieving complete monitoring of drug resistance.

Malaria: The major activities for this component were those leading to a reduction of malaria related mortality by 30% among populations by 2006; through the provision of up to 80% of health facilities with uninterrupted quality assured anti-malarial drugs and ensuring that 60% of pregnant women and children under 5 years have access to insecticide treated nets (ITNs) by end of 2006.

The proposal submitted by the Kenya CCM was not funded during the first round. The key reasons for rejecting the proposal provided by the Technical Review Panel include:

For the HIV/AIDS component, the feedback included the fact that there was no work plan neither in the proposal nor in the attachments; that no strategies were described, that there was no indication on the nature or quantity of drugs they intended to buy and that there was no unit cost for budget calculation.

For the Malaria component, the feedback included the fact that the role of NGOs and other partnerships under the CCM was not clearly specified; there was no specification of which malaria activities had been covered by existing financial resources and consequent specification of which components would be covered by the Global Fund; details of budget needed to be provided as the budget requested was large and finally, need to provide an implementation plan and action programme.

For the TB component, the comments and specific observations included that the proposal did not mention activities, which would lead to increased detection and improved cure rate.

In view of the preceding feedback, the country was advised to submit a proper proposal. This was the summary recommendation.

Two Kenyan NGOs, Kenya Network of women with AIDS, and Sanaa Art Promotions, submitted proposals separately from the Kenyan CCM (with CCM endorsement) and were successful for the amounts of US\$ 220,875 and \$ 2,650,814 respectively.

3.6 SUMMARY OF RESULTS OF FIRST ROUND FOR COUNTRIES INCLUDED IN THE CASE STUDIES

The first round TRP gave five ratings to proposals submitted, as follows:

- Proposal/component recommended for funding with no minor technical or administrative adjustments
- Proposal/component recommended for funding needing more extensive adjustments
- Proposal/component recommended for funding, contingent on a re-review by the full TRP
- Proposal/component not recommended for funding, but encouraged to re-submit
- Proposal/component not recommended

For the countries included in this study, the following table summarises the results:

Disease	Country	Submitting body	TRP Rating	Total Grant \$USD
HIV	Ghana	CCM Ghana	Proposal/component recommended for funding with no minor technical or administrative adjustments	14,170,222
TB	Ghana	CCM Ghana	Proposal/component recommended for funding with no minor technical or administrative adjustments	5,687,055
HIV	Kenya	Kenya Network of women with AIDS	Proposal/component recommended for funding with no minor technical or administrative adjustments	220,875
HIV	Kenya	Sanaa Art Promotions (NGO Network)	Proposal/component recommended for funding with no minor technical or administrative adjustments	2,650,814
HIV	Ukraine	CCM Ukraine	Proposal/component recommended for funding with no minor technical or administrative adjustments	92,152,744
HIV	Malawi	CCM Malawi	Proposal/component recommended for funding needing more extensive adjustments	284,110,722
HIV	Uganda	CCM Uganda	Proposal/component recommended for funding needing more extensive adjustments	51,878,417
Malaria	Ghana	CCM Ghana	Proposal/component recommended for funding, contingent on a re-review by the full TRP	17,189,706
Malaria	Uganda	CCM Uganda	Proposal/component recommended for funding, contingent on a re-review by the full TRP	35,194,286
TB	Uganda	CCM Uganda	Proposal/component recommended for funding, contingent on a re-review by the full TRP	10,609,176
HIV	Kenya	CCM Kenya	Proposal/component not recommended for funding, but encouraged to re-submit	179,370,000
Malaria	Kenya	CCM Kenya	Proposal/component not recommended for funding, but encouraged to re-submit	102,250,000
TB	Kenya	CCM Kenya	Proposal/component not recommended for funding, but encouraged to re-submit	11,910,000
Malaria	Malawi	CCM Malawi	Proposal/component not recommended for funding, but encouraged to re-submit	22,136,585

4 FINDINGS AND RECOMMENDATIONS

4.1 THE APPLICATION PROCESS

4.1.1 Short timeframes

Countries universally felt that the timeframes for putting together the GFATM proposal had been too short, creating a multitude of problems.

The GFATM first round proposal submission deadline was placed in what is traditionally a busy time for most public sector organisations; for example, it coincided with the budget negotiation process in one country. The urgency of writing the GFATM proposal diverted senior technocrats and managers from their routine work. Had countries been aware in advance of the timeframe and also been aware that support and resources were available from international organisations such as the World Health Organisation (WHO), this diversion of senior capacity at a crucial time might have been avoided.

In some countries, input from non-governmental organisations (NGOs) and the private sector was not as inclusive as it could have been had there been more time for consultation. There was also not enough time to examine what level of funding was expected to be obtained from existing donor sources, so defining 'unmet need' in existing strategic plans was difficult, and consequently the GFATM requirement of 'additionality' hard to meet.

Despite the challenges, the countries that were successful in receiving funding seemed to share certain commonalities: having already reached consensus on the strategies for the three diseases during the development of national strategic plans; having relatively better access to information and guidelines (see the next section); and having the commitment of CCM members, task forces and proposal writers to put in long hours, making it possible to meet the deadlines.

- **Consideration should be given to scheduling the submission date for GFATM bids to a time outside the date that is common as the end of the financial year. (March)**
- **Countries should be aware in advance of the timeframe, the guidelines, and the support and resources available to develop a GFATM proposal**

4.1.2 Asymmetric access to information

Problems created by short timeframes were compounded by asymmetric access to information between countries.

On a formal, but very basic level, the mechanism whereby guidelines were made available via the Internet was felt to create problems for countries that do not have reliable communication systems. It was also identified that guidelines were only available in the English language, which was perceived as inequitable for a global bid (although it was noted that applications could be submitted in any of the six recognised United Nations languages).

On an informal, but more substantial level, there was suspicion that some countries had prior knowledge of the contents of the guidelines before they were officially released, whereas other countries were only vaguely aware of the creation of a Global Fund through information from previous summit meetings. The countries with better information were therefore felt to have had an unfair advantage in what was perceived to be a competitive situation that allowed only limited time for putting together proposals and for meeting deadlines.

Similarly, some countries had what was perceived to be an unfairly high number of opportunities to participate in Global Fund meetings and sub-committees, and at the same time, to be well represented at the international committees of the Global Fund, as compared to other countries. Interviewees from one such country stated that these opportunities, they believed, gave them a comparative advantage over other countries in terms of having a clear idea about the criteria of a successful proposal. They also felt that these opportunities/positions facilitated communication with the GFATM secretariat during proposal development.

Other countries had great difficulty in trying to get any kind of information from Geneva. The UNAIDS and WHO personnel, who provided technical support, did not appear to have additional knowledge of the processes involved. There was no desk officer, no email contact address and no dedicated telephone number.

- **Guidelines should be made available via a variety of channels, internet being one, and in a variety of languages**
- **An equitable, transparent process for accessing information must be put in place**
- **Opportunities to participate in GFATM Board level, Secretariat and sub-committee activities should be more equitable across countries.**
- **A need was expressed for a single liaison point of contact to be designated for each country applying for Global Fund support to answer questions and provide amplification and clarification. This needs to operate on a guaranteed response time.**

4.1.3 Proposal format

There were varying responses on the degree of specificity that should be required versus flexibility allowed for in the guidelines. On the one hand, it was felt that more detailed guidelines could streamline the proposal development process. On the other hand, guidelines that are too detailed could make it more tedious to adapt pre-existing proposals into a straightjacket format, and overly rigid guidelines could also inhibit local innovation. Specific views on these points follow in the next few sections.

- **A balance needs to be struck between the degree of specificity required versus flexibility allowed for in the guidelines.**

4.1.4 Identifying realistic/appropriate financial parameters

Countries had no indication of how often there would be an opportunity to bid, whether there would be a bid annually or biannually, or if there would even be an opportunity to bid every year. This created an incentive to go in for the first bid regardless of the time constraint, especially since the total purse was not disclosed.

In at least two of the five countries, there was extensive debate between stakeholders on the appropriate magnitude of the proposed bid. Rumours were rampant, external pressure was mounting to increase the proposal request, and inter-country consultation was limited due to the competitive nature of the bid. Conflicting ideas about appropriate financial parameters, and lack of official information led to much disagreement, rewriting and renegotiation of the proposal.

In three of the five study countries, the decision on the amount of funds to request was based on resource gaps within the medium term expenditure framework and strategic health development frameworks for the three diseases; these strategic frameworks had already been influenced by the Ministry of Finance, who placed the funding request within budget ceilings according to the macroeconomic situation in the country.

In one of the countries where there was extensive debate, the initial approach had been to request funds in line with what was needed to scale up the National HIV/AIDS plan. However, the regional office of an international organisation reportedly advised that it would be appropriate for that country to request almost five times more funding. Subsequently, the budget request was increased to five times the initial amount, and the country was successful in receiving the substantially scaled up funding.

- **It is suggested that both internal tensions and budget revision could have been avoided if the guidelines had been more explicit on the size of the resource package and some ceilings had been provided for bidding.**

4.1.5 Costing and budgeting

Some proposals contained an amalgam of financial estimates from a number of implementing partners and data sources, without a common costing methodology. Inflation rates differed, unit costs differed, and most significantly, assumptions about ARV costs differed. Whether generic or branded ARVs would be procured, for example, and at what unit costs, affected estimates extensively. No guidance was given to countries on these matters.

Proposal writers also found the GFATM budgeting tables to be ambiguous. For example, human resources could cover several elements including training, recruitment, supervision or incentives. At the same time, there was a separate column for training and supervision. Logistics and supplies could be used interchangeably with commodities and products and no specific details were given on what items were expected to fall under the various headings.

The costing process was extremely time consuming in situations where the costs had to be teased out of the integrated national plans and reconstituted into the GFATM

format. While some have suggested that the guidelines might usefully incorporate the elements of a standard costing model including assumptions that should be used, it also must be recognised that a strict model could prove tedious for those countries that need to transfer costs/budgets from existing strategic plans into GFATM formats.

- **While some have suggested that the Global Fund should develop clear and detailed technical guidelines on accounting / budgets to ensure a common understanding of budget lines and costing, it also must be recognised that a strict model could prove tedious for those countries who need to transfer costs/budgets from existing strategic plans into GFATM formats. At the least, assumptions used within proposals must be internally consistent, with implementing partners using standard assumptions, data sources, and methodologies. Proposals must be explicit in stating these assumptions.**
- **Assumptions used in calculating ARV and commodity prices should be particularly scrutinised by the TRP. The Global Fund should not proceed with funding before all relevant data on procurement and supply management, such as the achievement of competitive tendering, have been satisfactorily addressed.**

4.1.6 How was it decided whether to submit a combined proposal or multiple proposals (either divided amongst recipients or divided along disease lines)?

This was yet another area where the guidelines were found to be ambiguous. Some countries understood that one integrated proposal was required, consistent with the country's existing health sector strategic plans that adopt an integrated programmatic approach. Other countries were not very clear whether there should be one proposal for each disease entity or whether there could be a single proposal covering more than one disease and how these were to be linked up in the proposal.

The guidelines were also not felt to be clear on the issue of single country proposals as against multiple proposals from public, private or non-governmental agencies from the same country. Although countries were encouraged to present a coordinated country proposal through the CCM, there were options for other agencies to go it alone with justification, and various countries interpreted this differently.

The degree to which the NGO and private sector inputs to the proposal were clearly specified in the first round proposal differed by country. It would appear that some countries were penalised for not apportioning activities and budgets to implementing partners while other countries' proposals proved successful without such detail.

- **Clearer guidelines are needed regarding whether and how to split proposals along disease lines, or implementing partners.**
- **Guidelines must also stipulate the degree of specificity required when describing NGO and private sector inputs into the proposal.**

4.1.7 Eligibility criteria

The eligibility criteria were not perceived to be fair by some stakeholders. A criterion such as political commitment, using as a measure the contribution of Government financing to the proposal or the level of public spending on health, was perceived to place very poor countries at a disadvantage since their total national budget is already very limited.

Other countries thought that the eligibility criteria worked in their favour. Officials from one country, for example, felt that they had various competitive advantages in developing the GFATM proposal, one of which was clear political commitment on HIV/AIDS at ministerial level, as evidenced by financial contribution, the existence of a multi-sectoral inter-agency committee on HIV/AIDS, and a National Strategic Plan for HIV/AIDS.

Several countries tried to seek clarification on eligibility criteria from Geneva, and were unsuccessful, while other countries were successful in reaching someone who could clarify some of the ambiguities.

4.1.8 Need for formal communication channels

Communication was identified as a major theme, between the Fund and applicant countries as well as within countries. Distinguishing fact from fiction has been difficult due to the lack of formal accredited communication channels with the Global Fund. Many interviewees had the feeling, although difficult to substantiate, that some countries had benefited from earlier access to documents and information, giving them a competitive advantage.

Communication was equally a problem within countries. Because responsibility for both creation of the proposal and its implementation is shared across several organisations in most countries, there is a real need for formal systems. This is essential given that no one organisation will be able to work in isolation from all the multiple implementing stakeholders.

- **Consideration needs to be given to establishing formal internal communication methodologies both to produce a bid and to subsequently implement programmes.**
- **Equally, formal accredited channels of communication between countries and the Global Fund are needed.**

4.1.9 Process of writing the proposal, including technical assistance

External versus internal input

The proposal guidelines were unclear on the subject of external assistance. It was not clear the degree to which the proposals had to be 'home-grown', at one extreme, versus entirely new inventions, parachuted in from external experts, at the other extreme. Many countries were also not aware, when undertaking their initial submission, that there was support available to them from organisations such as the World Health Organisation and the United States Agency for International Development (USAID). Consequently, countries varied significantly in the degree to which internal versus external expertise was utilised in proposal development. Two

of the five countries did not use external expertise in the first round (one of which was unsuccessful in its bid). A third country used external, but local consultants familiar with the local context, but only to co-ordinate the process. Two of the five countries relied heavily on external inputs, receiving considerable expert technical advice from such organisations as the UNDP, UNAIDS, Harvard University as well as independent consultants.

There was a strong feeling that, in what was effectively a competitive bidding situation, there was an uneven playing field, as some countries were known to have had much more support and assistance from their technical support teams.

In countries where the proposal writing team relied heavily on the technical expertise of external interested bodies, there was a concern that the external advisors may not have the time (nor possibly the expertise) to rigorously examine the contextual appropriateness of all the technical inputs being proposed.

There was a related concern that the Global Fund proposal development process, rather than relying on parallel mechanisms for proposal generation, should rely more heavily on regionally generated plans, and in so doing, could serve as an opportunity/ tool to further improve local planning processes. Technical assistance (TA) could be provided to facilitate this.

- **It is advisable that programmes are developed around evidenced based research results or trials and that applicants are required to cite the evidence and show that the intervention was undertaken in a similar context.**
- **Formal communication should be given to countries regarding the use of external experts/input into proposal development. For example, the TA support (especially from United Nations agencies) that is available for proposal development should be made clear.**
- **If external input is used in proposal development, it is recommended that it be supplemented by an internal evaluation team who can ensure that the proposals put forward are i) based on research, ii) appropriate to the country context, and iii) deliverable within the infrastructure, resources and levels of expertise available.**
- **Consideration should be given to whether and how the GFATM application process could be leveraged as a tool to improve upon local planning processes.**

Within and across country consultation

Some countries took a more inclusive process to writing the proposal, holding workshops and delegating sections to task forces, and involving all stakeholders from the outset. Other countries felt that a more top-down, dictatorial approach was called for, with either a small group of government or external experts in the driving seat.

Inter-country consultation was virtually non-existent. There were fears that other countries, competing for the same funds, would steal ideas. Thus, the Global Fund has created a situation whereby the country with expertise in preparing a good proposal would not be interested in assisting other countries with weaker proposal development capacities.

4.1.10 Appropriateness and consistency of criteria by which proposals were judged

Common views across countries were that the TRP had not given due consideration to the country context, as well as disappointment that the proposal grading process had not been utilised as a development/learning opportunity. There also appears to be evidence that the criteria were not applied uniformly across countries.

Three general observations were made with regard to the context. First, there was a view that country based experience, as found in pilot programmes, for example, should be respected as the basis for projections and assumptions. In fact, it was felt that applicants should be required to cite evidence that an intervention will work within the context, by demonstrating that the intervention has been undertaken in a similar context. This is particularly important for bids relating to AIDs where international best practice is less clear-cut. This would assist the Technical Review Panel who, it has been suggested, has very limited time to evaluate the technical quality of bids. Without this approach, there is the possibility of developing technically sound proposals that nevertheless fail to adequately address structural, institutional, management or performance issues.

It was also mentioned that a key criteria of a successful proposal should be the degree to which a medical intervention for the disease fits into the overall existing health system, rather than a vertical diseases model. Third, there was a view that describing interventions and arrangements in a proposal is one thing, whereas proving they will work is another; this highlights the need for on-the-ground verification.

There was also a view that TRP review process missed a capacity building opportunity. If the review had been more of an interactive process rather than a scoring process, the applicant country would have been better able to improve their proposal with a view to executing a credible and long-term sustainable programme.

On the subject of consistency of criteria, it appeared that one country's proposal was penalised for not specifying the roles of non-governmental organisations and apportioning funds and implementing activities to implementing partners up front. This is especially interesting in light of the fact that two other countries in this study, which were successful, merely outlined potential activities, strategies and targets but did not define the implementing organisations for specific activities/programmes with budgets allocated. This would suggest that the judging criteria were not applied uniformly across countries.

- **The TRP panel should be comprised of health systems people as well as technical experts; 'on-the-ground' knowledge of the country context as well**

as the ability to verify the feasibility of proposal claims would also be valuable.

- The following tensions/issues require more consideration/direction from GFATM: i) the degree to which proposals should be integrated vs. disease specific, ii) how to handle cross-cutting issues/health systems capacity building, iii) to what degree implementing partners and their activities need to be specified, and iv) what degree of specificity is required for activities, budgets, monitoring arrangements, procurement systems/policies, and v) the degree to which the proposal should fit into the existing health system.

4.1.11 Feedback after first round

The TRP feedback was criticised along similar lines; it was found to be lacking in details, context and in providing opportunities for learning.

For example, several countries mentioned that the TRP's advice for areas for budget reduction would suggest a lack of knowledge of the country context. The composition of the TRP was faulted by many for this, with criticisms that the review panel was comprised primarily of theoreticians judging the technical quality of submitted proposals based on classroom knowledge, but without adequate knowledge of the reality on the ground. A related concern was the lack of health systems thinking by the TRP panel. The most distressing part of the TRP feedback for one country, for example, was the insistence that they must not only divide their proposal into three distinct disease entities, namely HIV/AIDS, Malaria and TB, but also, that they eliminate the "cross-cutting issues" that provided for an integrated health systems approach rather than a "disease specific vertical approach".

The quantity of the TRP feedback was thought to be scanty and the quality inadequate. Persons interviewed alleged that many of the TRP issues raised could be found in the supporting documents and so the impression was created that the TRP probably did not read the full proposal due to time constraints. Better quality feedback would have helped guide the country in improving their proposal and also would have helped alleviate the impression that the rejection of the proposal was more political than scientific.

A final criticism from one of the study countries related to the difficulty in obtaining clarification on the TRP feedback by phone or email. If looking comparatively at the countries' experiences in dealing with the TRP panel since the first round, there seems to be a great variation in the amount of interaction and feedback countries have had, with those countries who were more successful in the first round having more interaction. This potentially creates a negative spiral for those countries that were not successful.

- **More specific feedback would not only assure countries that rejections are legitimate and based on proposal weaknesses; it could also serve as a tool to improve the countries' capacity.**
- **Caution needs to be taken that positive and negative spirals are not set up, whereby countries that are initially successful receive better access to**

information and feedback from the Global Fund, while those who were not initially successful neglect to learn how to improve their bids.

4.2 COUNTRY CO-ORDINATING MECHANISMS

4.2.1 CCM composition and process of formation

In two countries, a new CCM was set up specifically because the Global Fund required it. In other countries, the CCM borrowed heavily from already existing bodies in place to co-ordinate inter-agency and inter-sectoral development initiatives.

Some CCMs are believed to be donor heavy, while others are perceived to be dominated by government. CCM membership was not generally selected on a skills basis, but rather, to represent specific constituencies. Whilst many members of the CCM are well versed in the health sector in general, this is not universally the case. This lack of understanding not only of technical issues but also of fundamental operations of the government tended to set back the timing when, for example, working group proposals were brought up for discussion in the enlarged group.

Some of the CCMs were also found to be rather unwieldy in size. Some countries dealt with this by hiring consultants to manage the co-ordination, others delegated proposal development tasks to working groups, and still others have instituted a 'CCM Secretariat' to serve as the CCM decision-making body.

The reception that NGOs have received, in participating in the CCM and proposal development, has differed across countries. Some NGOs interviewed would have liked to be invited onto the CCM in some countries; however there were examples of NGOs and members of the traditional sector who were invited were not very active. The NGOs in one country were allegedly met with paternalism initially, while another country, at the other extreme, was practically a model of inclusiveness. In a third country, collaboration between NGOs and the government had historically been limited; the CCM and proposal development process improved this collaboration for a time, only to regress again since having received approval by the Global Fund.

- **Whilst many members of the CCM are well versed in the proposal and the health sector in general, this is not universally the case. It will therefore be necessary to provide induction and capacity building to ensure that all members can participate fully and effectively.**
- **If the GLOBAL FUND ensures that all CCM members have access to the GFATM guidelines and TRP feedback without relying on the Internet, this would increase transparency and allow all members to participate fully in decision-making.**

4.2.2 Clarity of CCM roles and responsibilities

There is a lack of clarity about the role and responsibilities of CCM members. Many committees have a Terms of Reference, but no formal constitution to clarify how voting works, how meetings should be scheduled, etc. When observers attempt to participate in CCM debates, a constitution that clarifies such issues as agreement to

observers, their status and their ability (if any) to participate would be helpful here as well.

Although countries were encouraged to present a coordinated country proposal through the CCM, there were options for other agencies to go it alone with justification. There is a concern that this could confuse the role of the CCM further in its business of planning, coordinating and implementing the programme. The question also arises as to how realistic it is to expect the central coordinating mechanism, with its designated composition, to coordinate and endorse proposals that would not be incorporated into a main public proposal.

The view was expressed that the respective roles of the national AIDS councils, the Ministry of Health and the CCM need clarification to avoid confusion. There has been tension between these groups in most countries, with confusion over who was the more appropriate group for co-ordination, funding and monitoring.

In countries where the CCM is organising tenders for implementing partners, the mechanism by which the CCM should disseminate information to the bidders and judge the proposals is unclear. Equally, funding flows and how the CCM will support the implementation process after successful bids are also unclear. Some stakeholders suggest that the CCM should be limited to managing, steering and guiding the process, with independent bodies used for other activities.

- **There is a need for greater clarity regarding the roles and responsibilities of CCM members, especially between national aids authorities, the CCM and the Ministry of Health. A constitution is needed to clarify these roles as well as the role of observers, their status and their ability (if any) to participate in CCM debates. It is recommended that a CCM constitution be produced globally for local adoption/ modification.**
- **A need was expressed for the GFATM to define criteria and set up rules for the tendering process, in cases where implementing partners are being vetted through a tendering process.**

4.2.3 CCM process since announcement of first round results

Since the results were announced, the frequency of CCM meetings has increased in all countries in the study. Countries have been responding to TRP feedback and redrafting proposals, where necessary. All of the countries have been pre-occupied with setting up the required financial infrastructure. The time people need to spend on the GFTAM work is ongoing and not without its opportunity costs.

Two countries advertised in local dailies for implementing partners. A third country recently published a clarification on the procedure for NGO participation in implementation: any organization with an interest in partnering in the implementation of any activity in the proposal will be asked to submit plans for review by the Technical Sub Committee of the CCM.

In a fourth country, the period since the approval of the country co-coordinated proposal has been marked by lack of transparency and a move by the government to gain control of the decision-making process. Such governance problems are not

obvious by looking at the situation on paper; rather, it is the personal alliances, informal controls imposed, the decision-making and implementation model that give rise to concern in this country.

- **Given the time commitment and the need for capacity building, it has been suggested that the GFATM should provide basic funding for the preparatory phase of the country co-ordinated programme following approval of the proposal.**
- **The Global Fund Board should impose a moratorium on further activities in countries identified as having governance problems. A rigorous review and re-design of the internal processes and procedures would be required in this case.**

4.3 COMPATIBILITY WITH COUNTRY HEALTH SYSTEMS

4.3.1 Compatibility with country-led development processes

In some countries, the HIV bid was an attempt to add a treatment element to an existing prevention and care programme. In three other countries, the Global Fund Proposal sought to address funding and implementation gaps in existing policy and implementation frameworks, particularly the National Health Strategic Plans.

4.3.2 Macroeconomic absorption

Data was available for the two countries to show that the Global Fund resource package will be comfortably absorbed at a macroeconomic level. In one of these countries, the total Global Fund grant represents 2% of the 5-year health budget and the first year Global Fund grant comprises 3.5% of the 2002-2003 health budget.

A large portion (65%) of the second country's Global Fund budget has been allocated towards procurement of commodities from domestic manufacturers, which could prove inflationary. However, given the small percentage of the Global Fund budget relative to the overall health budget (Year 1 instalment of initial Global Funds is 1.2% of health budget), Global Funds should be easily absorbed at a macroeconomic level.

Data available for a third country did suggest potential macroeconomic absorption problems. The total per capita health expenditure in this third country is currently \$13 per head; government contributes \$2.8 to that figure. The Global Fund first year budget will provide a supplemental expenditure per person of about \$1, an increase of approximately 35% above government's annual health expenditure. Although the Ministry of Finance has approved the Global Fund proposal request as being within an acceptable budget ceiling, the Ministry of Finance has voiced caution about macroeconomic absorption, and more particularly, about the Ministry of Health's capacity to implement.

4.3.3 Absorption/capacity at micro level

Although macroeconomic absorption was achievable in the countries for which data was available, it is actually absorption at a microeconomic level that is the major worry. Sceptics point to the fact that basic services like immunization coverage remain low in many of the study countries, therefore, how will it be possible to provide additional AIDS, Malaria and TB services? Similarly, even if ARV drugs

were procured abroad and shipped into the country, timely distribution and access is likely to be an issue. Human resources were equally consistently raised as a concern. Human resources information and workforce projections were not included as part of the proposals in any of the study countries. It is evident that there are major shortfalls across all countries and high attrition rates resulting not only from dissatisfaction with terms and conditions of service but also as a direct result of AIDS/HIV related illness and death.

The opinions and suggestions that were forwarded as a solution to resolve the capacity and absorptive issues gravitated on the need to firstly receive the Global Fund resources and apply some of the funds to hire and develop requisite human resources and build the necessary capacity and capability. The flaw in this argument is the assumption that resolving human resource constraints can be achieved in the short term. Given the shortage of teachers in some countries, there has been a decline in the number of young people attaining academic levels appropriate for gaining entry to training in health careers; so the problems start upstream in the primary education system. There is also an increasing 'brain drain' with medical staff leaving to work in other, higher paying countries.

Not only are numbers of staff short, but the requisite skills are lacking as well. The level of monitoring and the intensity of counselling needed with anti-retroviral therapy, and the ability to deal effectively with side effects, demands very high skills within the human resource constraint.

In all study countries, much of the increase in service provision is expected to be fulfilled through the private and NGO sector. Implementing agencies have based their bids on scaling up what they are already doing in this case. The advantage of this approach is that agencies have some basis on which to estimate the capacity needed to deliver the larger programmes, thus this 'bottom-up' approach seems to be more believable than relying on government, which has a relatively more substantial human resource constraint and relatively less experience with HIV/AIDS in many countries.

It is clear that as things stand, the current infrastructure and availability of skilled staff may not be adequate to absorb Global Funds. Countries intend to apply these resources in building capacity and infrastructure to support the programme, however, a short-term resolution to the constraints is unlikely. Successful use of the private and NGO sector may help remedy the shortfall in capacity in the short term.

- **Data should be provided, in the proposal, on macroeconomic (how the GFATM funds sit within the wider resource picture) and micro-level (workforce projections, how skills will be upgraded in time) absorption. The latter should include workforce projection figures for the public, private and NGO sector (where relevant). This information should demonstrate not only that the proposed programme is deliverable but also that it will not impoverish other health sectors with staff migrating to this work.**

4.3.4 Incentives for vertical programming

The Global Fund is seen as being more disease oriented in outlook than systems oriented. For one, the call for proposals seems to have been directed at the Ministries of Health in most countries. This definitely influenced the way the proposals were written. Though disease and health systems are intertwined, some countries took a strong view that a cross cutting proposal should consider the health system as a whole. For example, there is some fear that the exclusion of a broader tuberculosis component in one country's proposal and the lack of focus in the country co-ordinated proposal on strengthening existing sexually transmitted disease programmes may indicate a vertical approach towards HIV/AIDS. Similarly, the inclusion of ministries of youth, sports and gender are recognised as being essential to a comprehensive HIV/AIDS programme.

Other concerns centered on the size of the Global Funds and the consequent risk of drawing away key implementers from already existing and on-going programmes to the overall detriment of national programmes. Still other concerns centre on the subversion of existing systems or country-led development efforts. The fear of verticalization in one country, for example, arises from the fact that earmarked funds within the sector wide approach (SWAp) are normally used to cover cross cutting issues such as the strengthening of district management capacity, quality assurance, training and supervision. However, GFATM funds in this country will have to go through earmarked support, despite the fact that they will be targeting specific disease programmes. In another country, the procurement choices that will be made due to the success of the Global Fund proposal risk undoing all the work that is being done to strengthen the capacity of the central medical stores.

Three countries expressed that efforts should be made to ensure that the Global Funds do not create incentives for a vertical project approach but rather that they complemented existing programme frameworks for the three disease entities namely HIV/AIDS, TB and Malaria National Strategic frameworks, which in turn are in harmony with the National Health Strategy and other sectoral policy frameworks for development. Interviewees from one country was particularly distressed about this point, given the insistence from the TRP panel that they must not only divide their proposal into three distinct disease entities, namely HIV/AIDS, Malaria and TB, but also, that they eliminate the "cross-cutting issues" that provided for an integrated health systems approach rather than a "disease specific vertical approach."

Contracting out to the private sector and NGOs was not viewed as a concern for these countries, however, since the roles of implementing partners would be in the context of the SWAp and/or in line with the national strategic plans. Most respondents were of the view that contracting out was a good thing in that apart from supplementing constrained government capacity in service delivery, it could bring greater efficiency and transparency, especially if used for financial or drug management. The only challenge this scenario poses is that of sustainability of this approach, if and once the Global Fund monies stop flowing.

The concern about implementing partners in three countries has more to do with the parallel process by which these organisations are being vetted and contracted. These

three countries have set up parallel mechanisms for appraising proposals from sub-recipients. The use of tenders for NGO implementers in the one of these countries, for example, bypasses existing co-ordination mechanisms at the regional and local level, such as the multi-sectoral inter-agency HIV/AIDS committees. The bidding process is creating a significant workload for NGOs, as well as for the CCM in assessing the proposals.

- **Efforts should be made to ensure that the Global Funds do not create incentives for a vertical project approach but rather that they complement existing programme frameworks for the three disease entities**
- **Several elements of the GLOBAL FUND application process should be re-examined based on the fact that they create incentives for a vertical disease approach. These elements include: the call for proposals which is directed at the Ministry of Health; the composition of the TRP and its judgement criteria which neglects a health systems approach; TRP feedback which recommends splitting proposals by diseases, and which drops cross-cutting or capacity building interventions**
- **GLOBAL FUND funded interventions risk drawing away key implementers from already existing and on-going programmes to the overall detriment of national programmes. This is especially true where the size of the Global Funds is large and the country's capacity is severely constrained. This further highlights the need to increase focus on absorption/capacity issues of applicant countries (see previous section).**
- **Contracting to the private and NGO sector can prove advantageous and sustainable, if placed within the context of the national strategic frameworks and well managed by government**
- **The process by which implementing partners are appraised, contracted and co-ordinated should rely on existing systems, where possible**

4.3.5 Performance monitoring

The issues with performance monitoring centre on the transaction costs and incentives to set up parallel monitoring systems, the capacity for monitoring, and the selection of a body responsible for monitoring.

Some countries indicated a desire to use existing monitoring and reporting systems, such as those based on MIS systems and surveys. However, some countries have less evolved systems for performance monitoring already in place. If the less monitoring-capable countries are to achieve the ambitious performance goals and rapid dispersal of resources, it seems the Global Fund programme could incentivise these countries to set up parallel monitoring systems.

Not only are the monitoring systems to be used a matter of debate, but also the organization responsible for doing the monitoring is questioned. Many countries see a role for the Local Fiduciary Agent (LFA) here, while others view the LFA as a fund flow mechanism only. Still others see the LFA as having a more substantial role in programme management, but if initiatives are to be delivered in an integrated

manner, then some form of programme planning and performance management system will need to require personal responsibility of key individuals to deliver agreed outcomes.

- **The process by which the performance of countries and implementing partners are appraised should rely on existing performance monitoring systems, where possible. Where existing systems are weak, GFATM support should be used as an opportunity to build and strengthen sustainable performance monitoring systems.**

4.3.6 Financial infrastructure for implementation

Every country in the study has been operating under the impression that it was the responsibility of the CCM to identify a suitable Local Fiduciary Agent (LFA) and Principal Recipient (PR). Some countries had already spent a considerable amount of time in making their selection and had begun making preparations. The issue of how to organise fund flows from the LFA to the PR and then from the PR to implementing partners has also been a major preoccupation of the CCMs recently.

One country has been working out quite an elaborate financial infrastructure for managing and disbursing Global Fund monies. They have 3 principal recipients, but have yet to be able to identify a LFA, having been refused by the World Bank and the UNDP.

Another country had made their LFA selection, only to be told afterwards that GFATM had unilaterally chosen Price Waterhouse for them. Most members of the CCM believe valuable time and resources are being wasted in sending a team down to reassess the financial systems and some very senior policy makers find it quite offensive to have an LFA imposed on the country. Stakeholders believe that it is imperative that the organization that is used as an LFA should have technical and sound knowledge of the issues involved as well as a clear understanding of the programme implementation details and the operational systems of the ministry.

Across countries, non-government study respondents expressed concern about patronage and several drew particular attention to the need for close monitoring of the funds by the Global Fund Board. Many respondents from international organisations and NGOs said they would like Global Fund assistance in making the preparatory and implementing process democratic and transparent. There was also a view that the GFATM should produce clear guidelines about functions of bodies that were to deal with GFATM funds.

- **It seems likely that identification of a suitable LFA may be a delaying factor in implementation and it may be appropriate to incorporate prior identification in future guidelines and to clarify whether the Global Fund secretariat or country CCMs are responsible for this.**
- **Many respondents from international organisations and NGOs said they would like Global Fund assistance in making the preparatory and implementing process democratic and transparent. There was a view that the GFATM should produce clear guidelines about functions of bodies that were to deal with GFATM funds.**

- **The financial infrastructure used for Global Funds should take into consideration existing country systems and processes.**

4.3.7 Additionality

In three of the five countries, Global Fund amounts requested will fill in unmet needs of the budget. Existing donor and government funding will not be substituted or re-allocated. The delay in the disbursement of the Global Fund monies will only slow down any expansive activities, but all the existing programmes will continue to run.

This is not the case with a fourth country. Although it is not clear yet which organizations and what specific programmes will receive funding in this fourth country, all respondents thought that the money from the Global Fund, together with the expected loan from the World Bank for HIV/AIDS programmes, would affect donor policy with regards to HIV/AIDS, so that the country would be less likely in the future to receive funding from other donors.

4.3.8 Crosscutting components

Some level of disruption of implementation strategies is expected to occur in countries where funds for one component may be released earlier than those for a component that was not successful during the first round, and where these disease components are well integrated, sharing cross-cutting components or systems building elements.

Other countries felt that the disbursement of funds for the three disease programmes at different times will not create any problems because the proposals requested for additional funds to fill in gaps in programmes which would be implemented regardless of the proposal being successful.

Still other countries were disappointed when crosscutting activities were rejected by the TRP, in situations where they were listed as separate line items not attributed to one disease specifically. This would create an incentive for countries to 'hide'/bundle crosscutting and health systems development budget items within each disease programme in the future.

4.4 EQUITY/PRO-POOR FOCUS

While there has been a drastic reduction in the prices of ARVs from initial levels, they are still not affordable to the average lesser-developed country government or individual consumer. None of the study countries had a thoughtful answer for how to resolve the inevitable dilemma that will result when a scarce supply of ARV drugs arrive on the scene, funded by Global Funds. None of the countries have explicit policies regarding the criteria for rationing access, and whether ARVs (and the cost of the care that goes with their use) would be offered free, subsidised or at cost.

One country has at least considered the issue. In response to feedback from the TRP, this country decided that 2000 patients will receive the Global Fund ARVs free of cost. This translates to providing free care for 2 patients per county. It would be very difficult to establish criteria to be used to identify the 2 patients per county. While Ministry of Health and the AIDS Commission in this country feels that it would be the responsibility of the community to identify 2 patients, some critics feel

that this policy could end up excluding the powerless and poor, especially women. The justifiable fear is that, politically well-connected people might get selected to benefit from the free treatment.

Many of those interviewed talked 'around' this sensitive and unclear issue. In one country, Ministry officials continually referred to 'international protocols for selecting patients based on viral load and survival chances', whilst refusing to answer to the fact that there would be too many people who would qualify for ARVs based on this criteria when compared with the ARVs that will be available. In another country, officials talked about 'improved resource allocation to poor areas and groups, redistribution of health workers to deprived and needy areas, and cost effective interventions and improved outreach' as measures targeted to bridge the equity gaps. But the government in this country has yet to come out clearly with a position on who will get ARVs and whether they will be free, subsidized, or provided at cost to the patients.

- **Increased focus needs to be given to issues of equity in evaluating proposals. Countries who have pro-poor policies in place for the use of the Global Funds should be evaluated favourably by the TRP. Monitoring frameworks should explicitly test the degree to which these policies are serving the poor in practice. ARV prices achieved through open and transparent tendering systems, and the composition of the beneficiaries, should be monitored in all countries.**

5 APPENDIX A: TERMS OF REFERENCE

Global Fund to fight AIDS, TB and Malaria

DFID HSRC Support to HPD/HPG (2002)

Country Case Studies: Ukraine

Terms of Reference

With reference to the Draft overall Terms of Reference for support from DFID HSRC, a specific set of tasks and outputs have been identified as a first stage in support to HPD/HPG following the first GFATM Board Meeting in April in Washington.

The work will involve preparing information and briefings for the HPD in preparation for the next GFATM Board meeting planned for October 2002. The DFID HSRC will provide support to DFID's HPD advisor in preparing for the discussion at the Board meetings and for shaping DFID's position on key policy issues.

Country Case Studies

To inform this process, HPD would like to carry out a set of case studies in 5 countries to review how the process has worked. Countries will be selected in consultation with advisors and based on such factors as proposal outcome and known particular issues of relevance to overall policy (as described below).

Issues that need to be considered in all 5 countries include the process by which proposals were developed, absorption/capacity issues, integration with country-led development processes and effectiveness of country coordination mechanisms. Questions in each of these categories include the following:

Process by which the proposal was developed

1. How were decisions made about i) the amount to request ii) the timeframe to request (i.e. one year, three years, and five years)? Were you aware of the financial envelope (i.e. total Global Fund resources) you were bidding against, and if so, how was this communicated to you? Were there any communications to you, formal or informal, about what percentage of the Global Fund resources it would be appropriate to ask for? How much disagreement was there between stakeholders on this issue? How were disagreements resolved?
2. How did the country level players perceive GFATM priorities and objectives and did they experience any pressure to alter their priorities around:
 - The balance between funding to commodities versus systems support/capacity building
 - Prioritisation of diseases or geographic areas

→ Other

3. If so, where did the pressure come from?
4. How was it decided whether to submit one, combined proposal or multiple proposals (either divided amongst recipients or divided along disease lines)? Did you receive any communications, formal or informal, as to which would be preferable? How much disagreement was there between stakeholders on this issue? How were disagreements resolved?
5. How clear were the eligibility criteria and other guidelines? If unclear, what attempts were made to clarify issues? What was the result of these attempts?
6. What sort of difficulties did the proposal writers and CCM experience when it came to timing of the first round of applications? Can the respondent think of examples of how ongoing work priorities and human resources were managed/reshuffled due to the 'extra' workload of developing the Global Fund proposal?
7. Were the evaluation criteria used by the Technical Review Panel (TRP) clear to you, to the CCM and to the writers of the proposal? Do you think that the criteria were appropriate? What revisions would you recommend?

Absorption/capacity

1. What level of confidence does the respondent have that the country will be able to absorb the amount of funds requested from the Global Fund in the first round?

Micro level absorption

2. What sort of difficulties does the respondent foresee when it comes to, for example, i) human resource constraints: [would suggest the consultant looks at HR capacity, perhaps as indicated by percentage of current vacant posts and what sort of numbers of staff can realistically be added by X date, given the years it takes to educate nurses/doctors etc.]
3. ii) Drug procurement and distribution capacity/security? iii) Also, if patients are expected to pay for ARV drugs, then you might look at the average projected cost of ARV therapy as compared with an average civil servants salary or as compared with the per capita GDP.

Macro level absorption

1. [Would suggest that the consultant meets with finance people and/or IMF/World Bank to collect the following information and any other information relevant to determining absorption capacity at the country level]

Projected 2002 (or 2003, whichever is most relevant) annual health budget or projected health expenditure in US \$m	(You can probably get this info from the Medium Term Expenditure framework)
---	---

Initial Global Funds (total) to be received	
-Commodities portion	
- The rest	
Initial Global Funds (total) as % of annual health budget	
Year 1 instalment of initial Global Funds to be received as a % of annual budget	

2. Were absorption/capacity issues discussed during proposal development? What opinions/suggestions were given to try and resolve these capacity/absorption issues? How confident is the respondent that the proposal adequately addressed these issues (or, conversely, does he/she feel that it remained a weakness in the proposal and could have been better handled?)

Integration with country-led development processes

3. Please tell us about the ongoing health/development processes in your country (examples: SWAPs, PRSPs, decentralisation). To what degree is the proposal compatible with these on-going country development processes – the overall reform environment and policy context of reforms? What level of importance was this compatibility given in the development of the proposal, and (if important) how were links with these processes ensured in practice? What kind of disagreements/debates occurred about this compatibility (or lack of it) during the proposal development process?
4. Where the country was successful in the first round, where are the funds located? Who has control over them and who will decide how they are used? How will the money be channelled through different levels of the health/finance system? Will it be possible to track the spending of GFATM funds separately in the financial management reporting system (e.g. will they be within or outside a common financial pool)? Is the country implementing an independent financial monitoring system for GFATM funds?
5. Will GFATM funds have any effect on other sources and levels of funding? Will it attract additional funds? Will it substitute for existing (donor or MoH) funding?
6. Has the timing of arrival/non-arrival of funds had any effect on the planning and implementation process?
7. Who participated in development of the performance targets/objectives to be used for programmes implemented with GFATM money? What positive or negative effect could the targets have on service delivery? Will trying to

achieve the targets have positive or negative impact on other services? (which ones?)

8. How will MoH/CCM assess that performance targets have been met? What monitoring systems will be used at local level? Will these be part of the routine monitoring, or will it require setting up new monitoring systems?
9. Are there any examples of how the Global Fund proposal will create incentives for a vertical project approach? For contracting out certain services? In the respondent's view, what will be the likely effect of these approaches on sustainability, equity, and efficiency of service provision?

Effectiveness of country coordination mechanisms

1. How clear were the guidelines for CCM composition? How were decisions made about appropriate membership for the CCM? Were there stakeholders/groups who were asked to join, but were not interested? Were there stakeholders/groups that thought they should have been members who were not asked to join? In the latter case, why were they not asked to join and who was making these decisions? Were the CCM members seen as neutral players supporting the country, or were some or all seen as coming with their own agendas? What are the structural relationships of CCM members with the operational groups who would be implementing programmes with Global Fund money?
2. To what degree does the respondent feel that the proposal would have had a different outcome had the CCM membership been different?
3. To what degree did the CCM membership actually affect the proposal content? Who were the actual writers of the proposal? (MoH? Other ministries?, levels of seniority) How did they work together in practice? How often were the results of their work submitted to others for comments/approvals? Who were the 'others' that the document was circulated to for comments/approvals? What kind of technical consultancy input went into the proposal development at country level (disciplinary background? perceived quality of consultancy input? How long were they in-country/familiar with the context?)

Other

1. How clear was the Global Fund concept/requirement of 'additionality'? Do you think this was addressed adequately in the proposal? If not, how will it be dealt with in subsequent proposals?
2. Regarding the process since the results of the first round have been announced, could you tell us about i) the helpfulness/relevance/specificity of feedback received; ii) how the CCM process has worked since the results have come in (frequency of meetings, changing composition of the CCM, discussion content, delegation of tasks) iii) how decisions were made about revising/redrafting the proposal – who was assigned to do what?, and iv) if

the proposal was successful, how is the CCM working differently than before in the context of starting to implement the work programme?

3. How do CCM members perceive the balance of 'ownership' of GFATM between the country level, the donors, the central GFATM structures or other bodies?

Ukraine specific issues (for the consultants' attention)

1. We need to get a lot more detail on how the budgeting was done: what unit costs were used (especially for drugs)/ what studies did the unit costs come from? Were the unit costs used consistently throughout the proposal? Why do the TB costs jump from year to year? What kind of difficulties did the people developing the budget have? What kind of guidelines were there for unit costs they should use?
2. Need to get pay particular attention to the CCM composition and working relationships – how it was formed, how it has worked in practice, and which groups are more active than others [perhaps it would be possible for the consultants to see CCM minutes from meetings?]
3. Need to pay particular attention to how NGOs have been incorporated into the CCM and will be incorporated into implementation.
4. Several points of feedback from the TRP related to clarifications needed re: the budget. What is the CCM's understanding of how it is supposed to go about clarifying these issues? Is securing funds dependent upon satisfactory clarification of these points (or rather, is funding unconditional)? If the budgets need to be revised (for example, if it is found that the wrong unit costs were used for drugs) then what is the CCM's understanding re: how budget revisions would occur?
5. On the issue of absorption/capacity, the consultants may need to be a little creative in the appropriate metrics to use to illustrate to what degree this is an issue for the Ukraine. The form that capacity constraints take in the Ukraine may differ from the example metrics listed above (HR, distribution systems) which are likely to be issues in African, very low income country contexts.

Methodology

The consultants will be provided with a copy of i) the country proposal submitted during the first round, ii) the overall results of the first round of proposals, and iii) feedback sheets given to that country. This information should be read prior to starting interviews, and is provided in order to give the consultants a sense of perspective regarding the strengths and weaknesses of the proposal. This information is confidential and should be shared with no one else. A list of CCM members is provided in the country proposal.

In country, the consultants will start with a briefing in the DFID offices, followed by interviewing members of the CCM and other groups (NGOs, if relevant) who submitted first round proposals to the Global Fund. As time allows and as

appropriate for each country, the consultants will also interview other stakeholders who would have information on the questions outlined above. HSRC will attempt to set up interviews with some of the CCM interviews, but the consultants will also be responsible for setting up some of the interviews.

Report format

The report format should begin with a brief description of the country's first round Global Fund proposal (focus of the proposal, main activities for which funding was requested, amounts requested over what time periods), whether the proposal was successful and a summary of the TRP feedback given to the country.

The report should then roughly follow the categories outlined above, answering the questions as well as describing other issues identified by respondents. In addition to focusing on the difficulties experienced by each country, the consultants should pay particular attention to the incentives created by, for example, Global Fund eligibility criteria/CCM composition/application process/monitoring and evaluation process. Of particular interest are examples where the Global Fund creates incentives to undermine or side-step systemic, country-led reforms; where incentives for a vertical project approach or contracting-out are created; or where incentives are created to redeploy resources with either a negative or positive effect on equity, technical and/or allocative efficiency.

The consultants should also take a view, where possible, as to various options/strategies the Global Fund can take to resolve the difficulties countries have experienced as well as alter incentive structures, in cases where the incentives created are unproductive.