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Tracking the Global Fund in four countries:

an interim report

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NOTE TO THE READER:
The authors encourage the wide dissemination of this draft report to all study country stakeholders, as well as other interested national and international agencies. We welcome comment and feedback on this draft. This document has been submitted for comment to Country Co-ordination Mechanism (CCMs) in all four study countries; the Global Fund Secretariat; the Monitoring, Evaluation, Finance and Audit Committee (MEFA) of the Global Fund; and the study funders.

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GLOSSARY[2]

Country Coordinating Mechanisms (CCMs): country-level partnerships that develop and submit grant proposals to the Global Fund; and then monitor implementation, if proposals are funded. CCMs are intended to be multi-sectoral, involving broad representation from government agencies, NGOs, community- and faith-based organizations, private sector institutions, individuals living with HIV, TB or malaria, and bilateral and multilateral agencies.

Technical Review Panel (TRP): an independent panel of disease-specific and cross-cutting health and development experts that review the technical merit of applications. The TRP may recommend to the Board that proposals be funded without condition, approved conditionally, resubmitted, or not approved.

Principal Recipient (PR): a local entity nominated by the CCM and confirmed by the Fund as legally responsible for programme results, monitoring and evaluation, and financial accountability in a recipient country. Once the Board approves a proposal, the Secretariat negotiates and signs a two-year grant agreement in which disbursement of funds to the PR is based on the achievement of measurable results, i.e. performance-based funding. There may be multiple public and/or private PRs in a country.

Local Fund Agent (LFA): an independent professional organisation, which is contracted by the Global Fund to assess the capacity of the Principal Recipient to assume financial and programmatic accountability, prior to signing a grant agreement. Subsequently the LFA provides independent oversight and verification of progress and financial accountability. To date, LFAs include PriceWaterhouseCoopers, KPMG, United Nations Office for Project Services (UNOPS) and Crown Agents.

[2] Definitions of key Global Fund structures in this glossary are taken from Global Fund, Questions & Answers: <http://www.globalfundatm.org> and 'The Global Fund to Fight AIDS, Tuberculosis, and Malaria. A Partnership to Prevent and Treat AIDS, Tuberculosis and Malaria, prepared May 12, 2003.

ABBREVIATIONS

ARV	Antiretroviral drug
ART	Antiretroviral treatment
CBO	Community-based organisations
CCM	Country Co-ordination Mechanism
DOTS	Directly Observed Treatment Short course (for TB)
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHI	Global Health Initiative
LFA	Local Fund Agent
LSHTM	London School of Hygiene and Tropical Medicine
MAP	Multi-Country AIDS Program (of the World Bank)
MoF	Ministry of Finance
MoH	Ministry of Health
NAC	National AIDS Council (or Commission)
NGO	Non Governmental Organisation
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PPP	Public Private Partnership
PR	Principal Recipient
PS	Permanent Secretary (of a ministry)
SWAp	Sector Wide Approach
TRP	Technical Review Panel
VCT	Voluntary Counselling and Testing

1. INTRODUCTION

1.1 Interim report

This is an interim report describing the processes of introducing the Global Fund (GF) in four sub-Saharan African countries: Mozambique, Tanzania, Uganda, and Zambia. The report is a preliminary cross-country synthesis of the views of country-level stakeholders, in response to a widely expressed need for rapid and early findings to inform ongoing GF implementation. This was phase 1 of a two phase study, conducted from late April to early July 2003. Cross-country and individual country reports, incorporating an analysis of key documents, will be produced at the end of the study, mid 2004.

Respondents' views and opinions are subjective. However, triangulation of the views of representatives of the major constituencies in each country (137 interviews were conducted) adds weight to findings and conclusions. The findings are cross-sectional, based on views expressed by respondents in interviews ranging from a half to two hours in length, and were supported by observation of several meetings. Recall biases are likely, in that respondents were sometimes reporting on events that occurred up to 16 months previously, when countries started the application process for round 1 grants. Also, country GF structures and processes have continued to evolve since this first phase of field work was completed.

The GF is an innovative global initiative, which has made a major financial commitment to help countries tackle three diseases – HIV/AIDS, malaria, and tuberculosis (TB) – which are having a devastating impact world-wide, especially in the poorest countries. The aim of the interim report is to provide early insights into country processes, rather than make firm conclusions and recommendations to policy makers at this stage.

The GF is at an early stage of development, so it is too soon to evaluate its effectiveness and impact. However, it is hoped that a review of early processes and country concerns about future implementation will provide useful insights, especially for countries receiving GF support. The findings reported here (on which feedback is welcomed) will inform subsequent field work in late 2003 and early 2004.

Report Structure[3]

Section 1 continues with a brief **background** on the Global Fund, the study and a description of study design and methods.

Section 2 is a **summary** of findings and lessons learned, questions and issues that require further clarification. These are grouped into themes around experiences of the application processes, the functioning of Country Coordination Mechanisms (CCMs), and issues that have arisen in establishing principal recipient (PR), local fund agent (LFA), and communication processes. Country views are summarised on the fit of the GF with country systems; and concerns around implementation, once GF funds have arrived in-country.

[3] Note section 4 – **Conclusions** – provides a short overview of key messages emerging from the interim findings.

Section 3 presents **interim study findings**, which include selected quotations from country respondents, organised into the same themes as section 2. Differing views – within and between countries – are highlighted.

Section 4 presents some provisional overall **conclusions**.

Annex A contains a set of **tables** summarising relevant country data, information on country applications in rounds 1, 2 and 3, CCM composition and the number and categories of respondents interviewed.

1.2 Global Fund Background[4]

The *Global Fund to Fight AIDS, Tuberculosis & Malaria* is an international financing mechanism established in January 2002 to attract, manage and disburse additional resources to countries to control these diseases. As of July 2003, a total of US$2.6 billion had been pledged for the period 2002 to 2004, with further pledges of US$2.1 billion for 2005 to 2008.

Countries secure GF resources via a grant application system. There have been three application rounds[5] to date: March 2002, September 2002, and May 2003. Ninety three countries were approved to receive almost US$1.5 billion over two years for Rounds 1 and 2. By August 2003, 70% of these approved countries had signed grant agreements and around US$113 million had been disbursed. So far, sub-Saharan Africa has been approved for the largest proportion of funds, most of it earmarked for HIV/AIDS activities.

The Global Fund headquarters is located in Geneva. The GF consists of a Board (18 voting and 5 non-voting members), supported by a Secretariat and four committees. Country level structures include the Country Co-ordination Mechanism, Principal Recipient(s), and the Local Fund Agent (see glossary and GF website: http://www.globalfundatm.org).

1.3 Study Background

In late 2002, four bilateral donors – Development Cooperation Ireland (DCI), the Danish Agency for Development Assistance (DANIDA), the United Kingdom Department for International Development (DFID), and the Netherlands Directorate-General for International Cooperation (DGIS) – commissioned a team from the London School of Hygiene and Tropical Medicine (LSHTM) to conduct a study, with national collaborators, of the early country-level processes of the Global Fund. The study objectives are:

(1) to synthesise government and other country stakeholders' perspectives on the preparation of countries' applications to the GF, the functioning of CCMs and GF implementation processes at the country level.
(2) to identify lessons learnt and make recommendations on the coordination of the GF and other global health initiatives with existing country-level systems and processes.

[4] This section is based on information from the Global Fund website <http://www.globalfundatm.org>
[5] The deadline for round 3 grant applications was 30 May 2003. The outcome of this round was not known during preparation of this report.

The study, which runs from April 2003 to July 2004, is tracking GF implementation in four countries: Mozambique, Tanzania, Uganda, and Zambia. These countries were purposively selected and are not intended to be representative of all countries receiving GF support. Criteria determining country selection were: significant levels of disease burden for HIV/AIDS, TB and malaria; ministries of health (MoH)[6] in all four countries have indicated support for the study; the countries all have instigated sector wide approaches (SWAps) and are hosts to other global health initiatives; and bilateral donors funding the study have had long-standing partnerships with national governments.

1.4 Study design and methods

This is a descriptive qualitative study, combining: semi-structured interviews with a broad range of stakeholders in each country (senior government policy makers, representatives of bilateral and multilateral agencies, faith-based groups, non-governmental organisations (NGOs) and community groups); non-participant observation of CCM and other meetings of country partners; and a review of relevant documentation, which will be included in a final report. It is called a tracking study as the focus and direction of the study are determined by the pace and phase of GF implementation in each country.

Interviews have been conducted by two researchers from the LSHTM, often in conjunction with a country counterpart, using an interview guide to steer discussion. Interviews, in the first phase of field-work, were conducted over a 4-5 week period in each country, from late April to early July 2003. An average of 34 interviews was conducted in each country, ranging from 26 in Tanzania to 43 in Mozambique, including an average of 65% of CCM members (Table 5). Data recording was by note taking during interviews, with a minority tape recorded. Notes were typed up after interviews. Following field work, a coding framework was devised, based on a content analysis of interview transcripts.

[6] In this report, the term ministry of health (MoH) is used across the four countries, including Zambia where there is a Ministry of Health and a Central Board of Health.

2 SUMMARY OF FINDINGS[7]

2.1 Application Processes

Decision to apply

- Government-led – the motivation was the possibility of additional funds.
- Countries submitted round 1 proposals because of fear of "the well going dry" (i.e. GF resources might run out).
- Governments were either optimistic, or reckoned they would learn from the experience.
- Donors tended to be more sceptical.

Round 1 proposal selection and development

- A six week deadline meant hurried and intensive proposal preparation.
- Some countries used it as opportunity to develop/adapt existing disease control policies and strategies.
- There were different approaches in different countries – from centrally-controlled to participative.
- Within-country technical support was used.

Rounds 2 and 3

- Lessons learned from round 1 meant that in some cases there was better use of working groups, covering the three diseases and cross cutting systems issues. One country attempted to be more inclusive.
- There was more use of external technical assistance – while useful, this may have detracted from lesson-learning and development of proposals that fitted with the country context.

Proposal format and guidelines

- These were brief but not sufficiently clear in round 1.
- They were more detailed by round 3 in response to country requests for better guidance and GF's need for more information; but were now more time-consuming to complete.

Technical review panel feedback

- There were mixed views about content – with more concerns around process.
- There was difficulty in getting detailed feedback from TRP in round 1 – the source of these communication problems (between Geneva and countries, or within countries) was unclear.
- Requests for clarification from the TRP were difficult to manage and required frequent communication between CCMs and Geneva.

Benefits of the application process

- A wide range of stakeholders were involved working with MoH and national AIDS council (NAC)[8]: different line ministries, NGOs, civil society, faith-based and private sector organisations.

[7] The section headings used in this *Summary of findings* correspond with those used in Section 3 – *Findings.*

- Applications were successful (in rounds 1 and/or 2) in all four countries.
- In some countries, it promoted country ownership, in others trust-building between constituencies.
- The process stimulated planning across three priority diseases.
- The process catalysed policy and strategy development.

Costs of the application process

- Transaction costs were low for governments – mainly covered by donors, though these resources needed to be solicited.
- Opportunity costs were generally perceived as high but it was difficult to identify the exact nature of the other activities which were delayed or omitted due to a focus on the GF. Views may have been influenced by the outcome of applications.

Provisional Issues / Lessons

◊ Timely financial and material support from different donors facilitated proposal preparation.

◊ A balance between inclusivity and keeping the CCM 'lean' was difficult to achieve – it was helped by working groups.

Question

Can proposal formats be more flexible, to allow countries to submit existing, costed systems-strengthening and disease-control plans?

2.2 Country Coordination Mechanisms

Setting up CCMs

- They were established in a hurry as a GF condition.
- NAC was not seen as an ideal vehicle – being disease specific – but it provided the closest fit.
- Selection of representatives from the different constituencies had to be done quickly – it was controlled by government in three of the four countries.
- Self-selection by constituencies was seen as a positive development in one country.
- Selection of representatives was easier where there were existing umbrella bodies and networks.
- There was difficulty in finding suitable and acceptable representatives from NGO and private sector.

CCM composition

- Constituencies represented on CCMs were broadly similar across countries.
- CCMs expanded in response to demands for additional constituency representatives.
- Balance – some felt that CCMs were skewed towards government and HIV/AIDS.

[8] In some countries this body is called a council, in others a commission; the term national AIDS council (NAC) is used as a generic term throughout the report.

- High level political representation on CCMs provided credibility within government.

Representation and Participation

- CCM constituency composition was representative, but within-constituency consultation and feedback were poor due to: lack of time, lack of resources, lack of consultation mechanisms, poor communication, irregular attendance at meetings, ideological differences within constituencies, delegating attendance to junior staff, and work overload.
- There was a rapid turnover of individuals representing key constituencies, e.g. line ministries.
- Delayed notice of meetings and distribution of documents impaired participation.
- Participation of the different constituencies was considered good in some countries and less so in others, where government was seen as dominating meetings.
- Country representation at the global level (Geneva) would benefit from stronger regional networking across recipient countries.

Communication

- Internal communication problems such as a lack of notice of meetings and last minute access to documentation compromised CCM members ability to attend and participate in CCM discussions.
- External communication problems with the GF secretariat were reported as initially poor but improved over time – difficulties were ascribed to GF secretariat constraints and communication constraints in countries.
- There was uncertainty about where communication breakdowns occurred, whether between GF and countries, or within countries.

Provisional Issues / Lessons

◊ Where constituencies are not already formally organised into umbrella groups or networks, they may welcome support and assistance to form and strengthen representative bodies.

◊ Where it occurred, the self-selection of constituency representatives onto the CCM appeared to be preferred by constituency membership.

◊ There is some evidence of a recognised need and will to tackle some of the obstacles to representation – for example, one donor had offered to fund the strengthening of an NGO communication infrastructure.

Questions

How to rationalise planning processes and meetings to reduce workload on key decision makers (an issue that also arose under 'systems fit')?

What are the avoidable causes of delayed or lack of communication between CCM members?

What are the avoidable barriers to effective participation on CCMs, while recognising the need for government-led and owned processes?

What lesson-learning has there been between recipient countries and how well is regional representation working at the global level?

2.3 Post Approval Structures and Processes

CCM function and fit

- There was uncertainty around the function of the CCM after proposals were submitted and grant agreements signed, notably around CCM relationship with Principal Recipients (PRs).[9]
- There was a lack of clarity about the 'fit' between the CCM and NAC in some countries – the NAC was sometimes seen as having greater legitimacy with tensions in some countries over the control and use of resources for HIV/AIDS control.

Principal recipient

- There were concerns about the capacity of some proposed / selected PRs to carry out their functions.
- There was reluctance or concern about taking on the role of PR or sub-recipient in disbursing funds to multiple NGOs, many with limited capacity.

Local fund agents

- There were mixed views about the need for the LFAs but little contention over the companies selected.
- There were concerns among LFAs about some implementing agencies' abilities to fulfil reporting and financial requirements.

Pace of disbursement

- Initial expectations of rapid access to resources had not been met because of slow disbursement of funds to countries.[10]
- People expected that disbursement within countries would also be slow.

Provisional Issues / Lessons

◊ There was and continues to be a need for timely dissemination of guidelines on evolving GF structures and processes to CCM members.

◊ Countries may adopt different models or approaches to embedding CCMs within existing and evolving partnership structures – CCM legitimacy may grow over time as its function becomes clearer.

◊ Building capacity of PRs and sub-recipients to fulfil roles and responsibilities is an urgent need, which donors and other country partners may wish to address.

[9] Such uncertainties reflected a pervasive problem for many CCM members of keeping pace with evolving GF structures and lack of guidelines earlier in the process.

[10] Note, the tracking study countries may not be representative of sub-Saharan African (SSA) countries with regard to pace of disbursement.

Questions

How can CCMs, established as a condition for the GF, be integrated into country policy and partnership organisational structures, notably around HIV/AIDS?

How best can countries and GF manage raised expectations of rapid funding if disbursement to and within countries is slower than anticipated?

What are the advantages / disadvantages of different PR models (single or divided along constituency lines)?

What will be the consequences if PRs are unable to meet milestones for disbursement?

Will there be adverse consequences for other programmes and activities if senior MoH managers are diverted to manage GF-specific activities?

2.4 Systems Fit [11]

Global Fund and country systems

- Perceived positive features of the Global Fund:
  - ⇒ a country-led process that gives countries more autonomy.
  - ⇒ promotes public private partnerships, involving NGOs, civil society and the private for-profit sector.
  - ⇒ can be used to fill funding gaps
- Perceived negative features:
  - ⇒ too disease focused and might also divert attention from other health priorities.
  - ⇒ could undermine systems and systems strengthening.
  - ⇒ might mean setting up parallel funding, reporting, monitoring and evaluation systems.
- There was confusion around whether or not GF funds could be channelled through the SWAp – only some respondents were aware that this was now permissible.
- There were concerns that GF funds might not be additional.

[11] Respondents' views around the fit of the Global Fund with existing systems were speculative, as GF systems were not yet in place in countries. Concerns around global health initiatives and implementation are also general systems issues, not unique or specific to the Global Fund. Hence, provisional issues/lessons and questions are not identified here.

Global Health Initiatives and country systems

There was a range of new global health initiatives (GHIs) around HIV/AIDS arriving in all four countries, e.g. World Bank's MAP programme, and the Clinton Foundation (the latter present in two of the study countries). The potential concerns and features were:

- A burden for governments having to engage in parallel negotiations with different global health initiatives (GHIs).
- A lack of lesson learning across GHIs.
- New global initiatives start being prescriptive and gradually learn to adapt to country contexts.
- All new money is generally welcomed by governments, where systems are resource-starved.
- Government capacity needs to grow to cope with multiple international financing initiatives.

2.5 Challenges to implementation

Management and disbursement

- There would be low capacity, especially among small NGOs, for meeting GF requirements for fund management – including quarterly reporting.
- There was a 'crisis of expectation' and suspicion within constituencies because of slow disbursement of funds. This needed to be managed.

Delivering antiretrovirals

- The criteria for ARV access were not clear – would AIDS activists, rural dwellers, the poor, and women benefit?
- There were concerns around lack of capacity of health systems to deliver ARVs, leakage of ARVs into the private sector, and lack of sustainability of drug supply.

Absorption capacity and pressure to spend

- Absorption capacity (ability to spend well) was not high among some government bodies and some NGOs.
- There was a culture of ineffective spending among some organisations – too many workshops were held and too many guidelines produced.
- There is a need to target spending towards those who are doing service delivery.

Human resource bottlenecks

- There was a lack of adequate numbers of staff for service delivery, due to staff attrition from AIDS; and low salaried government staff leaving for better paid NGO and donor jobs.
- Building health worker capacity, especially for ARV delivery, would take time.

3 FINDINGS

3.1 Application processes

This section describes the processes and experiences in the four countries in putting together and submitting proposals in rounds 1, 2 and 3; country interactions with the GF, and respondents' perceptions of the costs and benefits of the application process. As the GF has been an evolving and learning process – for countries and the GF – differences between the three rounds are highlighted. Country experiences of the application processes related to the application rounds where proposals were submitted: Zambia (round 1), Tanzania (rounds 1, 2 and 3), Mozambique (rounds 1 and 2), Uganda (rounds 1, 2 and 3) – see Table 2 in Annex A.

3.1.1 Decision to apply

Countries learnt about the establishment of the GF at different times. In all countries, the decision to apply was government-led. Preparation in three countries started in late 2001, and in the fourth after the formal call for proposals in January 2002. The deadline for submission was 10 March, less than six weeks after the launch of the Fund.

Factors influencing a decision to submit a round 1 proposal varied between countries. Country-level political pressure to apply and "fear (that) the well would go dry," i.e. that GF funds would run out, were motivating factors for all four countries to submit a first round proposal. In one country, a long-standing relationship between the MoH and international NGOs stimulated early collaboration in developing proposals. Bilateral donors in another country advised postponing a submission to a later round, in view of the short time-frame. Government responded:

> "When we voiced our intention to put in an application, the Excellencies [Ambassadors] and general donor community were openly against it. Their view was that (the country) was doing this before it was ready and couldn't do it. It was our view that we would work into the night to put an application together and that, given our experience with health reforms, we had learnt good lessons and had systems in place to make this work."
>
> *[MoH]*[12]

3.1.2 Round 1 proposal selection and development

The tight time-frame for submission was experienced by all countries as extremely demanding. In round 1, there were different approaches to preparing proposals. In two countries, there was a national call for proposals; and in the other two, the proposals were written by working groups.

[12] Respondents cited in this report have been grouped into *constituencies* or categories: ministry of health – 'MoH'; 'other line ministries' (which includes national AIDS councils); 'multilateral' agencies, such as WHO, UNAIDS, UNICEF; 'bilateral' donors; 'NGO'. The category 'other' covers other constituencies on CCMs, which included faith-based groups, academia, technical assistants, media, and the traditional sector. This interim report does not specify in which of the four countries respondents were located.

In one country, a national meeting was called to approve the recently constituted CCM. Proposals were invited and seventeen were received, screened, and ranked by a CCM technical review committee. Four were selected – one for malaria and three that were later combined into one proposal for HIV/AIDS. One respondent's recall of the process was:

> "It (the GF) came as a surprise. … We got called by WHO and the Ministry (of Health) … we were busy preparing for the MAP (World Bank's Multi-Country AIDS Program)… we were trying to come up with a strategic HIV/AIDS framework … I could see government leaving everything … time was very tight … it was too hurriedly done … I couldn't understand what was a CCM, it was all confusion." *[Multilateral]*

In a second country, proposals were invited separately by the MoH, the national AIDS council (NAC) and by a NGO umbrella group. Twelve proposals on HIV prevention were received; all were combined into a single proposal by an editor appointed by the NAC, who also had responsibility for combining additional proposals for TB, malaria and HIV treatment, as they were received.

In a third country, technical working groups were convened by the MoH, supported by specialists from a longstanding donor-funded project, who then drafted separate proposals around the three diseases, coordinated by a team of local consultants. The assessment of the final proposal, by a local consultant who coordinated the application process, was that "the document was not technically the best, but the best in terms of political consensus and the time involved." A senior member of the MoH took the lead in the preparation of a single comprehensive proposal in the fourth country, with support from technical staff. In the latter two countries, which had not solicited proposals from a wide range of stakeholders, large national consultative meetings were held early in the process of writing the applications. Outputs from these meetings were incorporated into the drafts. A MoH malaria specialist recalled:

> "I heard about the Global Fund via the RBM (Roll Back Malaria) network – that is, heard its name but not what it meant. The proposal writing started before the request came from Government. We took advantage of what was there already, e.g. documentation written for RBM plus worked on the partnership angle because of the demand for multi-sectoral involvement. Locally there was scant information on the Fund. … we used our common sense." *[MoH]*

In two countries, bilateral donors thought proposals were insufficiently developed and requested delays immediately prior to submission. Both proposals were submitted at the request of government. One was successful and one not.

3.1.3 Rounds 2 and 3

In round 2, countries adopted different approaches to proposal selection and development. In two countries, which were encouraged by the GF to resubmit, the CCMs decided to submit elements of previously unsuccessful proposals. In one of these, technical working groups were formed – combined of staff from MoH, NAC and technical assistants – who reworked the round 1 integrated

proposal as separate disease-specific proposals. In the second country, a similar approach was adopted, using external technical assistance in addition to local consultants, supported by cross-cutting groups to address systems-wide issues such as human resources and finance. At that point, a core group secretariat was established to support the CCM around technical and administrative issues.

> "The overall process was better as we appointed a core group which summarised points of progress from all the technical groups to the CCM. However, it was not easy as most participants in the working groups were not engaged full-time and the two consultants who came from WHO had a tough time coordinating the efforts. It was an improvement on the first round." *[Multilateral]*

In a third country, in a deliberate effort to improve inclusivity, the CCM invited proposals for round 2 around an integrated theme. Thirty nine proposals were received by the secretariat, which they short listed down to 20. Representatives of the 20 organisations worked over a six week period, facilitated by a team of international management consultants, to develop one overall proposal covering HIV and TB. Those involved reported it to be a positive participatory process. The application was unsuccessful. However, the country revised and resubmitted it in round 3. A core group of ministry staff, technical assistants, and organisation representatives were supported in the round 3 resubmission by one external consultant. Government and multilateral respondents referred to the consequences of considerable use of external technical assistance in the previous round:

> "Use of consultants in the second round left a vacuum. We need a mix of international and local, as until now we don't own this (application) process at all, although we have learnt some lessons." *[MoH]*

The other country that submitted a third round proposal out-sourced preparation of a new HIV/AIDS proposal to international consultants. Observations and respondents' views of third round proposal preparation processes in these two countries will not be reported at this stage.

3.1.4 Proposal format and guidelines

Proposal formats and guidelines from the GF evolved considerably over the three rounds. Round 1 information and guidelines from the GF were generally perceived as unclear, notably on how many years and on levels of funding that could be applied for. The format and guidelines for round 2 proposals were perceived as clearer by some respondents in two of the three countries that applied. However, by round 3, countries were encountering difficulties with successive revisions of the guidelines, which generated additional work. For example, new requirements on tax exemption and procurement processes had been introduced by round 3. Respondents said:

> "Processes are very confusing with differing versions of proposals from one round to the next. Experience in previous rounds does not necessarily help you with the current round." *[Other]*

> "Information flow and guidelines [in round 1] were poor – [budget] ceilings were not known – an emerging problem is that guidelines are now too detailed – the application form is a document in itself – there is a lack of linkage between the guidelines and the forms." *[MoH]*

At the time of the third round, bilateral donors in two countries were critical about the increased workload involved in proposal preparation. This illustrates the difficult balancing act faced by the GF in responding to demands for detailed guidance, while needing to keep the application process simple.

> "The application forms … should be a 3 page paper accompanied by annual operation plans and corollary costs and 3 year rolling plans which can identify funding gaps. We are putting people through too many hoops and spending far too long on this, when we should be reinforcing the system." *[Bilateral]*

> "It (the GF) was a good idea at first, but has become increasingly bureaucratic over time, with any residual value lost in the added layers between each round. The increased requirements incorporate everyone's (every agency's) pet agenda at the international level." *[Bilateral]*

3.1.5 Technical review panel feedback

Views on technical review panel (TRP) feedback related to both content and process of feedback; and are likely to have been influenced by the outcome – a request for minor modifications, major modifications, or re-submission in a subsequent round. Views varied within and between countries. There were generally positive comments about the content of TRP feedback in a country whose round 1 proposal was successful:

> "In my view, the TRP did a very good job – the questions that came back, including on budget, made sense." *[Bilateral]*

However, there was dissatisfaction expressed by all constituencies with the round 1 outcome in a country that had submitted an integrated, systems-building proposal to cover the three diseases. For example, one respondent said:

> "The reviewers may not have understood decentralisation … Our combined proposal was split into separate parts (at the request of the TRP). There was unease about this amongst the development partners who favoured systems strengthening … a view that the application was weakened." *[MoH]*

TRP responses to round 1 proposals were reported in two countries as 'scant' and lacking in detail. In two countries, some respondents reported that feedback on some proposals was never received. However, it was not clear if feedback had not reached the countries; or had been received but not passed to the relevant technical persons. Countries often expressed more dissatisfaction about the feedback process than about the content:

> "There has been a lack of clear information around TRP decisions and the first round rejection could have been done more kindly, perhaps by recognising efforts/inputs." *[Bilateral]*

There were fewer comments made about TRP feedback following round 2, which may indicate greater satisfaction. However, countries reported that dealing with TRP requests for clarification, following submission, was difficult and time-consuming. Respondents in two countries stated:

> "The main difficulty is trying to explain the intricacies of country context and the (human resource) plan in a series of e-mails to Geneva." *[MoH]*

> "It wasn't that the questions weren't legitimate but they (the TRP) need to consolidate their requests for information." *[Multilateral]*

3.1.6 Benefits of the application process

There were, to varying extents, some generally-held positive views of the GF application process in all four countries. Firstly, it brought together around the table different ministries and a range of other country stakeholders with a commitment – but different approaches to disease control. Secondly, it promoted planning across the three priority diseases. Thirdly, where national policies and strategic plans for the diseases had not been developed, the GF process catalysed and helped move the development of these up the agenda. A typical comment in one country was:

> "We benefited by the proposal writing process in that national players were brought to the table and motivated by the potential of big resources. There was strong leadership – not domination – shown by MoH." *[Bilateral]*

In one country, there had been little contact and considerable distrust between the bilateral donor and NGO communities, up to and during round 1 proposal preparation. Subsequently, there was reciprocal attendance by constituency representatives at each other's meetings and a more co-ordinated process in preparing a later application. This country's round 1 proposal process was generally seen as chaotic. However, most respondents viewed it as having been a learning exercise that contributed to a much more coherent and coordinated process in round 2:

> "The process of going through round 1 in such a disorganised way had benefits in that it challenged accepted ways of working and raised open discussions around access to ARVs (antiretroviral drugs), human rights issues, selection of priority groups e.g. people living with AIDS, social sector staff, pregnant women etc, which were more thoroughly and systematically explored in round 2." *[Bilateral]*

In another country, where there was strong government leadership and an inclusive process, many respondents reported a high level of country ownership, consultation, and participation. A successful application was a source of national pride. However, in some countries, mistrust persisted between government and civil society groups, notably NGOs. This mistrust stemmed from a perception, expressed by some NGO respondents, that there was often lack of transparency around budgets and they were suspicious of governments' intentions around disbursement. An important benefit was that, in all four countries, applications in round 1 and/or 2 were successful.

3.1.7 Costs of the application process

Transaction costs for the countries were probably low, in that technical support and funding to support proposal preparation were solicited by CCMs and often provided by bilateral and multilateral agencies. One donor funded a first round national consultative process. An example of donor support in one country was:

> "People/agencies pulled together – UNAIDS provided work space, computers were provided by UNFPA and CDC." *[Multilateral]*

Respondents in all countries reported that there were large opportunity costs in round 1, in that senior ministry officials and technical staff were diverted from routine activities for several weeks to lead and support the drafting process. Many vivid comments were made to illustrate the intensity of the work-load and its impact on staff. However, it was not possible to establish, up to 17 months later, what (if any) opportunities were foregone, i.e. the nature of other activities delayed, postponed or omitted altogether, as a result of involvement in proposal preparation. Perceptions around the application process were partly determined by the outcome. For example, in a country whose round 1 proposal was approved:

> "It was a very intensive work time involving a huge number of people – some of whom where sceptical – it was stressful but also exciting." *[Other]*

A CCM member in another country viewed participation in the application process as too demanding and that full engagement was not feasible because of other commitments:

> "There are too many activities and it's always the same people whether it's HIV, Malaria or TB…..there are deadlines with too little notice – sometimes proposals are thick…..and there are competing demands." *[Other]*

The experience of round 1 provoked different country responses in later rounds. One country perceived the opportunity cost-benefit ratio as having been too unfavourable, which appeared to explain – at least in part – why it contracted out a later round proposal to external consultants. Increased use of external technical assistance, paid for by donors, helped to reduce costs to countries in rounds 2 and/or 3.

3.1.8 Lessons learned

In the three countries that submitted proposals in two or more rounds, lesson-learning between rounds was variable. CCMs tried different strategies in successive rounds. Better structuring and use of working groups – and notably more use of external technical assistance – were a consistent feature in all three. Lack of capacity, lack of time, concerns about the opportunity costs on government / senior MoH staff, and a desire to improve upon earlier round application processes were cited as reasons for using external consultants. Their use, however, was perceived to contribute to lack of 'country ownership' and to detract from proposals being adapted to the health systems context of the countries (this issue of GF 'fit' with country systems is reported later in section 3.4).

> "(External) technical staff were contracted to help the GF application but they were not familiar with a systems approach. Consequently the programme was designed with an inappropriate vertical perspective – there needs to be a systems perspective in technical considerations." *[Bilateral]*

Features that facilitated proposal preparation processes were the existence of national policies and strategic plans, which could then be adapted to the GF proposal format. Their absence, more often around HIV/AIDS, was a major constraint. Strong political and senior level leadership and involvement, a CCM that was both inclusive and lean, technical working groups for the three diseases, and strategic use of long-term country-based technical assistants were identified as key features to success in one country. Its approach was summarised by a senior MoH respondent:

> "We identified key stakeholders in each of the disease areas (HIV/AIDS, TB and Malaria), as well as other areas such as Finance. We had a working group in each area and we looked at the guidelines and credentials specified by the Fund for CCMs – People Living with HIV/AIDS, Faith Based Organisations, NGOs, line ministries that needed to be involved (e.g. Education) and other groups like youth and community development. We were careful to keep the group lean, so that we could move forward. We were running to a very tight deadline and we invited people we felt would contribute. People met twice a week. There was a lot of inter-communication outside of these meetings." *[MoH]*

3.2 Country Coordination Mechanisms

This section describes the processes of establishing CCMs, selection of members and how CCM composition and structures evolved. Respondents highlighted issues and difficulties around representation within the different constituencies, participation at meetings, and communication within countries and with the GF secretariat.

3.2.1 Setting up CCMs to "the dangle of dollars"

A country co-ordination mechanism (CCM) [13], which was a new organisational entity, was established in each country, as this was a GF requirement for proposal submission. Pre-existing organisations such as the national AIDS council (NAC), present in all 4 countries, was not considered an appropriate national co-ordination vehicle for different reasons in different countries: the NAC was disease specific, had insufficient capacity, or was not chaired by a senior government official – a GF requirement for CCMs. The CCM's initial function – to prepare proposals – was clear: "the CCM was formed in response to the dangling of dollars," said one respondent. At this stage, there was an urgency to get structures in place:

> "The first CCM meeting was set up entirely to meet conditions of the GFATM; i.e. it is multisectoral, and the selection of members and secretariat was done in a hurry." *[Other line ministry]*[14]

[13] In some countries, the title was adapted.

[14] Ministries other than MoH, such as Education, Finance, etc., also including NAC.

In three countries, CCM formation was led by government. In spite of reservations about the suitability of NAC, it provided the core structure or framework for the formation of the CCM in three of the countries, with other disease components grafted on. In one country, MoH and NAC separately identified potential constituency groups and invited them to join the CCM. The fourth country adopted a more consultative and participatory process for CCM formation. An interim secretariat was formed, composed of NAC, the three disease programme officers and several multilateral agency representatives, which prepared a shortlist of potential CCM members. Candidates from this list were then formally selected and endorsed at a public meeting of more than 50 stakeholders drawn from a wide range of constituencies. In all countries, CCMs were established during the course of round 1 proposal preparation.

The process of selecting representatives from the different constituency groups was not straight-forward, especially when selecting from the NGO and private sector communities. Given the tight timeframe, a centrally controlled process of selecting representatives, which was the case in three countries, was viewed as pragmatic, if not ideal in one country; whereas, in a second country, the CCM was perceived as a process that had been forced on government:

> "We should have done better on this – we [the government] chose. It would have been better for groups to choose. However, we got a 100% response from those that were invited." *[MoH]*

> "(The CCM is) a 'carpet (i.e. shotgun) wedding'; participants are forced to work together." *[Other line ministry]*

In one of the countries where constituencies were more active in selecting their own representatives the process was viewed as real progress:

> "Up until the Global Fund process most people were hand-picked, but we talked to the Minister and suggested that constituencies nominated their own representatives to increase legitimacy; and this genuine process of consultation and selection of members to the CCM is now almost normal, and thus makes it difficult to hand-pick participants." *[Multilateral]*

Faith-based groups, bilateral and multilateral agencies had the least difficulty in providing representatives, as they usually had established umbrella bodies, networks, or could agree representation processes. Where weak or non-existent, the process of setting up CCMs encouraged NGOs to organise or strengthen existing umbrella bodies, so as to ensure constituency representation. For example, an international NGO in one country, active in HIV/AIDS control, took the lead in forming an umbrella body to represent the NGO community on the CCM. CCM Chairs were all senior government officials (see Table 3), demonstrating political endorsement at a high level. However, endorsement was not always translated into a high level of involvement in CCM processes (see 3.2.3).

3.2.2 CCM composition and support structures

Table 3 shows the composition of CCMs by mid 2003, which included broadly similar constituency groups across countries. There was consensus among

respondents that the important constituencies were all represented. With the exception of one country, CCMs had expanded through increasing the number of representatives per constituency, resulting in a near doubling in size in two countries. There was no clear pattern to expansion across countries. Most additional members were from government line ministries, NGOs, or organisations representing People Living with HIV/AIDS. Reasons for expansion were either because constituencies complained that their positions were not being adequately represented, or as a deliberate attempt by CCMs to be more inclusive and/or strengthen particular constituency voices. The strategy of CCM expansion to improve inclusivity and representation was not considered a panacea, as reported by one respondent:

> "Regarding CCM composition, representation of actual players on the ground could be better – however, you cannot represent everybody, and a lean and small group is quicker for making decisions. The use of sub-committees is also viable. To enlarge the CCM to improve representation is contentious because it means the CCM could be inefficient." *[Other]*

There has been a turnover of individuals representing constituency groups on CCMs, with a high of 50% in one country since its inception, which could have had a negative effect on group cohesion and institutional memory. Such turnover and lack of continuity was not necessarily peculiar to CCMs and may have been symptomatic of a wider climate of institutional instability. For instance, in one country, the composition of the NAC had changed significantly four times in two years; and there had been five changes of Minister of Health in a 3.5 year period.

Whereas the constituencies represented on the CCMs were viewed as appropriate, comments were made about the balance between government and non-government, the disease mix, and political versus technical mix. By mid 2003, around 40% of CCM members represented government, including MoH and other line ministries (Table 3). Where government representation on the CCM was particularly high, there was recognition, even by government officials, that:

> "The public sector is over-represented. There is a need to make more contact with the private sector, and there is ministerial encouragement to do so. Civil society is also under represented." *[MoH]*

CCMs were viewed as political bodies, where high level ministry representation could provide political clout. However, there was tension around the balance and representation of the three priority diseases, with many representatives – of NGOs, multilateral agencies and line ministries – having a strong HIV/AIDS focus, which contributed to a perception of 'disease imbalance'. Senior MoH and technical advisers responsible for malaria expressed concerns that lack of representation on CCMs could have a negative effect on subsequent implementation of funded activities.

CCM support structures for managing the administrative workload have evolved in the four countries. By mid 2003, two had secretariats – in one, the NAC played this role, and in the second, it included representatives from NAC,

multilaterals and senior disease control staff. In a third country, five permanent technical working groups, and a 'core-group' provided technical and administrative support. In the fourth, the CCM secretary was primarily responsible. In one country, the secretariat was seen as an effective way of providing support, but possibly side-lined the CCM which was not sufficiently *au fait* with evolving GF processes. In another country, the secretariat was seen as having limited capacity for providing support to the CCM.

3.2.3 Representation

CCM members are representatives of constituency groups. Representation was defined by one CCM member as:

> "a responsibility to engage and participate in programme and resource allocation decisions, to lobby and influence other members about issues important to their constituency, and to serve as a 'go between' between the CCM and their constituency group." *[NGO]*

There were contrasting views, within and between countries, with regard to the quality of representation on CCMs. Whilst CCM members acknowledged that efforts had been made to secure representatives from the different constituencies, there was a high degree of consensus across countries (with some notable exceptions) that constituency consultation was often poor, hindered by a lack of time, resources, poor communication infrastructure, lack of consistency in attendance at CCM meetings, ineffective delegation and work overload:

> "There is no email/telephone at the level of provincial and district groups….they [fellow constituents] get information late. Groups in (the capital city) have an advantage. We exchange information at provincial youth forums when they occur and when we get opportunity. It is difficult for me to get their view." *[NGO]*

> "The CCM consists of individuals – there are no structures for within-constituency representativeness and consultation." *[Multilateral]*

> "In terms of academic consultation – I am too busy to do it and there is no administration support for it." *[Other]*

In most countries, dissatisfaction with representation was explained by the different 'ideological' positions of constituency members, and a belief that the CCM representative would not fully represent constituency views at the CCM. Such problems were often solved by expanding the CCM. For example, in one country a representative of bilateral donors supporting the sector wide approach (SWAp) was added, where the current bilateral donor representative was from an agency not participating in the SWAp.

Government in another country was described by donors as "not engaged" and senior officials frequently delegated CCM attendance to junior line officials. Bilateral and multilateral agencies were reported as dominating these meetings, with government representatives reluctant to speak out:

> "I don't know how my PS (Permanent Secretary) reports back to the rest of the ministry, and I usually receive no clear instructions to speak at meetings, so I just attend." *[Other line ministry]*

Rapid turnover within ministries may have impaired senior level engagement. For example, in one country a PS representing a line ministry on the CCM, who had been in post for several months, stated that he did not know what the Global Fund was, nor had he heard of the CCM.

There were also reports of effective representation. A recently formed NGO umbrella body in one country received much praise from other NGOs for its efforts to represent and feedback to its constituency. Efforts were also made to improve representation – a bilateral donor in one country proposed to fund communication networks for NGOs; whilst in another country a donor offered funds to "extend the reach of the CCM."

Respondents in three countries reported potential conflicts of interest, where organisations were involved in decision-making about fund allocation and at the same time were potential recipients of funds. NGOs and the for-profit private sector were mentioned in this regard.

3.2.4 Participation

In one country, informants described levels of participation by constituency representatives in terms of a confidence to speak out and express a different view to that of other CCM members as good. Attendance was regular and consistent, reasonably equal between constituency groups, and discussions were mostly robust and open. In two countries, some (non-government) representatives viewed meetings as overly dominated by government and not truly participative:

> "It feels like a government CCM, not a country coordinating mechanism. There is an imbalance of power in favour of (government) which is talking only on behalf of government, and not listening to civil society…. Civil society is not willing to talk openly." *[NGO]*

Reluctance to speak out was not confined to civil society and NGO constituencies:

> "It should be the CCM, not the Chair of the CCM, that makes decisions… It's not like a partnership…...a real partnership where things are being discussed and challenged…It's a signing ceremony group." *[Multilateral]*

> "My experience with the CCM has been that it has some useful and powerful members (e.g. bilaterals and multilaterals) that could make contributions but people seem to restrict and hold back from challenging government pronouncements." *[Other]*

At a practical level, the ability to engage and participate in CCM discussions and decision making was also determined by an ability to speak the language. The use of English during CCM meetings and in completing proposals initially

impaired participation of local NGOs and civil society representatives in one country:

> "The main issue is that English is not our first language, so initially we had many problems participating fully in CCM meetings and also the forms are all in English. Even the Minister speaks English, as do the visiting consultants. We cannot influence the processes." [*NGO]*

3.2.5 Communication

Communication problems – within countries and between CCMs and the GF – were widely reported. Internal communication problems were reported by representatives of all constituencies in all countries, in that many CCM members complained of lack of advance notice of meetings; and that documents were not circulated to them in-time.

> "All rounds have had less than 48 hours to review drafts. NGOs and Government often don't have email/paper/toner, and may not have read the documentation. Further, the concept of meeting to review here is different, as (participants) will often only review docs after the review meeting where decisions have already been made." *[Multilateral]*

> "My diary is already full – and then there is short notice to attend a meeting or read a proposal … regarding the HIV proposal I didn't read it." *[Other]*

In addition, CCM membership and distribution lists had not always been updated. Inadequate communication had consequences for CCM members because it meant they were either unable to attend meetings or not able to fully participate in discussions and decision-making. Logistical problems, sheer lack of time and work overload were factors that impaired communication and thereby participation. However, these may not fully explain last minute communications.

Respondents in two countries remarked that communication with the GF secretariat was initially difficult; and many felt it had improved over time. Improvement came with the appointment of dedicated country portfolio managers, and more regular telephone and email contact. There was also a growth in understanding at the country level of GF's operating constraints. For example, one interviewee observed that initial communication was a "nightmare," but following a visit to Geneva, he better understood the issues of skeleton staffing and time pressures on the GF secretariat.

Where problems were identified, it was not possible to determine if communication failures were due to external or internal (within country) breakdowns. Lack of clarity at the country level about GF expectations also meant that countries spent time discussing new entities, such as selection of the LFA, only to find that that these decisions did not lie within their remit. In one country, a visit by a portfolio manager who explained the processes around grant signing was reported to be highly "illuminating." Earlier there had been much confusion around grant signing in two other countries. CCM members sometimes speculated that senior government officials on the CCM might know more than them.

Communication problems were recognised by country respondents as not necessarily a one-way street – difficulties encountered by the GF secretariat were acknowledged:

> "GF itself was irritated in the lead up to the signing of the agreement. The portfolio manager was trying to make arrangements to visit and there was no response from (us). The reason for this incommunicado was structural – there was email breakdown as people shifted office." *[Multilateral]*

There was also a perceived need to strengthen communication pathways between countries and GF regional representatives:

> "Problems with information flow between GF and countries may partly be our responsibility. Communication between countries and our regional representatives (Uganda and South Africa) is not as it should be. We participate via our reps in GF decision making and this should be better communicated at country level. There are no mechanisms and systems for doing this. This is starting to improve – it may be something you wish to investigate." *[MoH]*

3.3 Post grant approval: structures and processes

Once country proposals were approved for funding, the role of the CCM needed to evolve and new entities – principal recipients (PRs) and local fund agents (LFAs) – were established. Countries were about to or were already grappling with these processes during the course of the field work in May and June 2003. This section focuses on some of the main issues raised that could affect future implementation; and on respondents' concerns about the pace of disbursement.

3.3.1 CCM function and fit

While there was clarity around the initial purpose of the CCM – to prepare proposals – there was often uncertainty in countries around its subsequent function. There were tensions with regard to how it fitted with existing partnership structures, notably in the 'fit' with the NAC in all four countries. There were also uncertainties about the relationship of the CCM with other new GF entities, such as the PR:

> "The role of CCM is not clear after signing. What is our role? We haven't come together since the signing – what will we be talking about when we meet? We don't control resources. PRs are answerable to the GF – it is not clear what the CCM's role is. PRs are not accountable to the CCM." *[NGO]*

Some senior CCM members were often clearer than others were about its direction. In the words of one senior government official, the functions of the CCM included "coordination, preparation, steering, monitoring progress, and obtaining results." Absence of guidelines for CCMs, or failure to disseminate them widely, was a cause of uncertainty with regard to their post-application roles in countries whose proposals had been approved.[15]

[15] 'Guidelines on the Purpose, Structure and Composition of Country Coordination Mechanisms, June 4 2003' have been produced by the Global Fund.

There were conflicting views about the relationship between, and relative importance of, the NAC and the CCM; and, in the words of one respondent, "there is a need to discuss whether NAC or CCM is 'supreme' in terms of co-ordinating GF." Usually, the NAC had been established through legislation and some respondents viewed it as having greater legitimacy than the CCM.

> "I think there's an issue of governance/fiduciary regarding the CCM. NAC has a channel of governance – the secretariat reports to the Council/Board of NAC, which has its own committee structure; and this in turn reports on a quarterly basis to the cabinet." *[Other line ministry]*

Others saw the CCM as having a broader remit than the NAC, covering three diseases, and benefiting from stronger technical involvement from the MoH:

> "We saw CCM as broader than NAC, needing multi-sectoral representation including malaria. Also, NAC doesn't want to do implementation and be responsible for handling money." *[NGO]*

The GF would provide large levels of funds for HIV/AIDS control, which was creating (or re-opening) tensions in all countries between the NAC and MoH over roles and control of funds.

3.3.2 Principal recipient

Debate by country stakeholders over the selection and number of principal recipients (PRs) was very time-consuming.[16] Debate was around capacity of (proposed) PRs, control over new funds, and the challenge of channelling funds to multiple NGOs. There were also concerns about how the PR concept would impact on efforts to harmonise systems for disbursing and managing development funds (a corner-stone of the SWAp). "Jockeying for position" to be lead agents or sub-recipients (i.e. agencies or organisations that receive funds and implement activities) was also reported. Table 4 summarises the identity of PRs and status of approval in the four countries, at the time this report was being drafted. Changes occurred after the field work and further changes may take place.

The principal concern of respondents was around the capacity of PRs to undertake their roles. There were mixed views about the suitability of government bodies as PRs. They were seen by NGOs as slow and excessively bureaucratic, already over-burdened by existing responsibilities. The selection of a PR for civil society provoked most discussion in one country, where there were conflicting views. Some viewed the proposed PR as not having the capacity for this role; whereas others viewed this as a new mechanism which, if successful, would provide a new channel for disbursing funds to civil society. An accounting firm had been contracted to build its capacity. Lack of clarity about the relative responsibilities of Finance and line ministries in two countries, which were later resolved, resulted in delays in grant-signing.

[16] 'Fiduciary Arrangements for Grant Recipients, July 1 2003', produced by the GF, address some of these issues.

Mechanisms for channelling funds to sub-recipients (organisations including NGOs who would use these funds to deliver services) were not yet clear to CCMs; and the proposed systems for channelling funds had not been tested. All countries reckoned that one of the biggest challenges would be in disbursing funds to multiple NGOs. A large national NGO in one country had refused the invitation to become a lead agent, not wishing to be responsible for managing disbursement to smaller NGOs. In another, a representative of a proposed government PR expressed its concerns:

> "If we start to open all these accounts here we will not survive – all (potential sub-recipients) have different accounting and reporting procedures and timelines. Even though we are the first public sector organisation to have external audit, it will not help." *[Other line ministry]*

3.3.3 Local Fund Agent

LFAs have been appointed in all four countries (Table 4). Opinions at country level were divided around the need for a LFA. In one country, the general view was that it would help increase accountability; whereas, in another, respondents perceived the requirement as an unwanted, additional structure that would duplicate current monitoring systems. The choice of firms as less contentious, in that these were in-country offices of international firms who would therefore have some familiarity with the country contexts. LFAs were clear about their roles, which one reported as: assessing the role of the PR in terms of financial capacity and accountability; monitoring and reporting back to GF on progress related to quarterly targets; and making final assessments at the end of project funding.

A LFA representative reported that it was contracting consultants to help with programme assessment, it would not authorise disbursement releases if it had concerns, and it was exchanging lessons learned with LFAs in other countries. Two LFAs were asked if they foresaw potential conflicts of interest, if a fund recipient was, or had pre-existing connections with, an implementing body. Both responded that these could be mitigated through a declaration of interest, but that these would be difficult to monitor and were probably unavoidable. In a country, where a member of the LFA had agreed to join the management steering committee overseeing implementation of one of the funded components, some respondents expressed concerns about a potential future conflict of interest with regard to the LFA's independent monitoring role.

The principal problems that LFAs anticipated were around procurement processes and reporting, especially in getting reports from implementing agencies in the field, essential for further disbursements. One LFA expressed concerns that a government PR was over-stretched and under-staffed. Donors recommended that, although the GF saw itself as purely a financing mechanism, with the LFA as the "eyes and ears of the Fund in-country," GF should draw more on existing country oversight systems, such as health sector committees composed of the MoH and its partners, for monitoring future performance.

3.3.4 Pace of disbursement

As of May-June 2003, two countries had received some funds (Table 2). However, unfulfilled expectations of rapid fund disbursement were still widely viewed as problematic, more so in countries where proposals had been approved early. Whilst the GF was acknowledged as not slow compared to other funding mechanisms, frustration was growing. Reasons for slow disbursement were not clear to CCM and non-CCM members alike. Government respondents stated:

> "I thought money would be available by the first quarter of this year (2003). There is no money yet and a request had to be made to (a named donor) to bridge-fund the purchasing of malaria drugs." *[MoH]*

> "Fast disbursement so far has not happened. GFATM has changing information needs and this makes it difficult and frustrating for countries as more keeps being requested. … GF has distracted us from 'business as usual' for a year." *[MoH]*

In one country, the first instalment had been disbursed and had arrived in country within three months of grant sign-off, but remained largely unspent five months later. This was attributed to delays in setting up country oversight mechanisms, and to an under-estimation of the time required to set up a complex new system. A country view was that the GF was experiencing similar problems and delays:

> "There will, probably will be delays as we need dialogue with districts and need to procure (commodities)… We may not be off the ground before Christmas 2003 – the GF took some time to set up their processes too." [*MoH]*

An additional communication problem at the country level was that many people were unclear about how GF resources would be disbursed within countries. One national programme manager, who would not be responsible for disbursing funds, reported receiving a "box full" of applications from various groups at the district and community level, requesting GF funds. NGOs, who had most welcomed the GF as a potential source of rapid funding, expressed the greatest frustration:

> "If I had known how long all of this would take, I would have sought other sources of funding. ... We need to see the money now. We have (named donor) money in the interim. … It is very difficult – to be straight – re-working this detailed plan for GF as we are already committed to other projects. We just couldn't wait. I'm worried when the contract will come and how the finances will flow quarterly via the PR." *[NGO]*

As in the case of the TRP process, some senior government staff were reflective, acknowledging the constraints experienced by the GF and the need to address these:

> "Grant processing and fast disbursal – I think the GF secretariat is too thin and, because of this, the secretariat can't process. There needs to be some thought about how to manage the secretariat." *[MoH]*

Another reason for slow disbursement appeared to be around additional GF requirements for procurement. In one country, an initial procurement assessment was reported to have deemed the country's systems to be acceptable. However, further delays had occurred. In defence of the Fund, a donor in this country mentioned that repeated GF requests for a national procurement plan had been unfruitful.

3.4 Systems fit

This section reports respondents' perceptions around the 'fit' of proposed GF systems and processes with evolving and established country systems. It continues with a synthesis of views on GF, in the light of other new and anticipated global health initiatives (GHIs), and a perceived need at country level to harmonise them.

3.4.1 Global Fund and country systems

An objective of the tracking study has been to assess how well the GF fits with existing funding mechanisms and processes in the four countries. Three countries were already operating and the fourth was developing a SWAp to channel government funds through a common pool/fund. Some bilateral donors, who had been focusing their efforts over several years on general systems strengthening, had strongly held and sometimes critical views about the country fit of the GF. Others – government, multilaterals and NGOs – generally took a more pragmatic and positive view of the potential systems effects of the GF, expressing more concern about feasibility of implementation (see section 3.5).

Government and NGO respondents were most positive, viewing the GF as potentially providing an additional source of funds that would support intersectoral activities, public private partnerships (PPPs), and NGO and private sector interventions. It could help plug gaps in financing the provision of antiretroviral drugs (ARVs), other drugs, voluntary counselling and testing (VCT) and prevention of mother to child transmission (PMTCT). NGOs perceived that the channelling of funds through a SWAp was preventing funds from reaching them:

> "There is a big gap in HIV/AIDS funding at the moment; the process of expanding the under-manned NAC and developing the SWAp has delayed funding to NGOs. There are many capable NGOs out there with capacity to do something, if you have to wait for the system to improve, without trying first, people will die in the interim." *[NGO]*

> "GF is a PPP (public private partnership) challenge. …. The aim is rapid disbursement but it's starting from scratch with disbursement to private sector and NGOs. … GF opportunities represent a better drug supply. …. it may also foster new partnerships between government and civil society and government and the for- profit sector. ... the terrain is open." *[Multilateral]*

Compared to other donor initiatives, government respondents perceived the GF to be a more autonomous, country controlled process and source of funding;

and represented an alternative to other funds that were seen as more donor-controlled.

> "The beauty of the process from a country perspective is that it is country led. We haven't had that level of autonomy before to decide which interventions we want, which systems to use and how we wanted to strengthen ourselves. …. The benefit of the Fund is the autonomy it offers, as well as bringing people together in a participatory way." *[Other line ministry]*

One senior MoH official suggested that GF funds could be used to fill "the health financing gap." This implied an expectation (or hope) that GF funds would be truly additional. However, a NGO representative in another country was sceptical:

> "They [other donors] won't pull back on funding – they are diplomats. They will not be forthright and say we're cutting or giving less, and us as beggars can't say 'why are you giving us less?' It is not diplomatic. They [the donors] will ask what is the Fund giving, and (they) will give the rest. In this way budgets are cut" *[NGO]*

Concerns about possible negative effects of the GF were most frequently articulated by bilateral donors, but also by government respondents in all four countries. Some thought it would distort country policy priorities, for example by promoting a shift towards urban curative care, especially if ARVs were introduced, and away from poverty reduction strategies targeted at the rural poor. Many saw the GF as a vertical disease-specific programme (in one country, it was officially termed a "project"), which could draw the country's focus away from systems strengthening:

> "Of course these are important diseases but a health sector has to deal with other problems such as diarrhoea. … (This country) has a Minimum Health Care Package – the ideal approach would have been: 'this is what is being covered – this is the gap – GF resources can fill the gap.' However, this was seen as too generic." *[Bilateral]*

> "A focus on disease neglects the system…..systems do matter…..A lot more gets into the system through the budget system. Vertical programmes are demanding and we prefer an integrated approach….I think it is a distortion to take a disease approach – there needs to be much more attention to system strengthening." *[MoH]*

There was often confusion in countries around whether and how GF could be harmonised with existing funding mechanisms, for example whether or not GF resources could be channelled through a SWAp common pool or fund.[17] Within countries, respondents had different views. Some had believed this was possible and others not. In one country, a consultant supporting preparation of a second round application informed the CCM that such a mechanism would

[17] A GF Guideline now states: "Where Sector Wide Approaches (SWAps) or other similar arrangements exist for pooled donor funding, Country Coordinating Mechanisms may use these arrangements as long as accountability systems are in place that will allow for transparent and reliable reporting of results and financial transactions and balances." p 6 of *Fiduciary Arrangements for Grant Recipients, July 1 2003*.

not be accepted by the GF. The outcome of subsequent discussions involving a GF portfolio manager, government, and bilateral donors was that funds could in fact be channelled through an existing AIDS common fund. A respondent in a second country reported that GF had shown flexibility in acceding to its request:

> "We wanted to use GF to strengthen our systems and capacity but the Fund saw this as too broad. Now they are learning to be more flexible. We operate a SWAp in the health sector – GF money will now go through SWAp – this has been agreed." *[MoH]*

The other main systems concern, which was expressed by government and donor respondents in all countries, was that they believed that the GF wanted parallel planning, monitoring, and reporting systems; and that the proposed systems would be too onerous on countries.

> "Now GFATM has said it is OK to disburse some of the money through the SWAp. It will go through the basket but will have separate district indicators. It creates additionality in reporting. There are already 18-20 indicators for monitoring and evaluating the Health Strategy and these are used to report to the Health Sector Committee…There are also problems with how GFATM fits with the planning cycle. For example, GFATM wants 6 month and 2 month plans… this is not our planning timeframe." [*Bilateral]*

Respondents in three countries were of the view that the increased workload, if recipients and sub-recipients had to submit quarterly reports as a condition for disbursement, would over-stretch fragile health systems.[18] A donor view was that "GF's drive for results-based disbursement would encourage irrational management decisions, with a fixation on short term gains at the expense of dealing with systemic weaknesses in the general infrastructure and management systems." However, others held a different view, believing performance assessments would provide "a fair reflection of good use." Concerns were expressed by two respondents, around current capacity and the time required to embed new mechanisms within country systems:

> "Quarterly disbursement will be a disaster – we need a better system than this. I just hope that sub-recipients will be able to send accurate returns quarterly." *[Multilateral]*

> " I think things will pan out like a biological 'S curve' – initially there'll be a lot of stuff going on under the surface (mechanisms developed, hiring etc) before any logarithmic growth phase can happen…….There'll be a learning phase between people in country and the GF." *[Other]*

[18] A GF Guideline states: "Unless another agreement regarding the *disbursement period* is reached between the Global Fund and a Principal Recipient, the Fund normally expects PRs to submit their *Disbursement Requests and Progress Updates* on a quarterly basis, usually within 45 days after the PR's fiscal quarter, at least for the first year of the grant period." : p. 7 of *Guidelines for Performance-Based Funding, July 1 2003.*

3.4.2 Global Health Initiatives and country systems

A criterion in the selection of countries in this tracking study was that they were implementing SWAps and poverty reduction strategy processes. It quickly became apparent in field work in all four countries that policy makers were grappling with a range of new and forthcoming global health initiatives (GHIs), focussing on HIV/AIDS control. These included initiatives that preceded the GF, such as the World Bank's Multi-Country AIDS Program (MAP) in all four countries;[19] the Clinton Foundation, which plans to fund ARV provision and was being negotiated in two of the study countries, in parallel to negotiations with the GF;[20] and some senior level respondents were aware that a new U.S. 'President's Initiative' had been announced, which they believed would focus on the provision of ARV drugs to African countries.

Multilateral advisers and senior government respondents wanted to see greater lesson-learning across similar initiatives, so that mistakes would not be repeated. Senior donors stated that too much of the previous two years had been spent developing plans for MAP, GF and Clinton. Countries were having difficulty in coordinating planning around these parallel initiatives, having to revise agreed plans when the next initiative came along.

> "The Global Fund has to be seen in the light of what has been going on in the last 2 years. It has taken that long for Government to negotiate the MAP process." *[Bilateral]*

> "We spent 7 months last year on GF and 8 months on the Clinton Foundation, 3 months on MAP, now TAP is coming – it is not surprising we talk of capacity shortfalls." *[Bilateral]*

Comparisons were made between the different GHIs, sometimes favourable and sometimes unfavourable to the GF. Each was perceived as coming in with its own conditions; and initially with a prescriptive approach. Sooner or later, each was learning to adapt its approach to the constraints of the country's system. Governments welcomed new sources of funding into resource-starved countries. According to one senior MoH official, "all initiatives are canvassed (by government) in the hope (of) a positive result. This is a tremendous hidden workload." A senior government respondent encapsulated a view shared by governments across the four countries:

> "We need greater capacity for monitoring international initiatives and how we use new knowledge. We must adjust our strategies – not every 4 or 5 years – but as required to respond appropriately. However this will require more flexibility in international bilateral and multilateral financing institutions."
> *[Other line ministry]*

[19] < http://www.worldbank.org/afr/aids/map.htm >
[20] < http://www.pgaf.org/newsletter/issue01/clinton_partnership.html >

3.5 Challenges to implementation

Respondents were asked to suggest challenges, major obstacles, and optimal strategies for implementation. Answers were necessarily speculative, perhaps reflecting fears more than hopes. All countries envisaged that difficulties encountered in preparing proposals would be compounded in moving to implementation at the district and community level, in terms of coordination, forging partnerships, and building capacity. One respondent predicted:

> "In terms of supervising implementation, this will be even more complex than proposal preparation – the challenge will be to ensure that each ministry uses the funds in collaboration with a number of organisations and coordinating many activities across many directorates." *[Other line ministry]*

The major concerns were around management constraints at all levels, the challenges around ARV delivery; and low absorptive capacity and the danger of poor use of funds. Human resource weakness was a cross-cutting issue and likely "bottleneck" in terms of limited staff capacity and numbers.

3.5.1 Management and disbursement

Countries were concerned about lack of capacity and management weaknesses at the central level, which first needed to be addressed. In May and June 2003, management systems for GF implementation were only beginning to be put in place in two countries, where initial disbursements of funds had been received. There had been early delays, which people feared might mean that GF milestones, which they had been told were essential for further disbursement, would not be met. Respondents questioned district readiness and sometimes district capacity. For example, one bilateral donor stated:

> "AIDS interventions offer relatively huge amounts of money to the district/community level, relative to what districts are used to. There is limited capacity for planning, budgeting, implementation; (and) massive demands are made on (that) limited capacity." *[Bilateral]*

There was much greater concern around the capacity of small NGOs and community based organisations (CBOs), alluded to in 3.3.2. Some did not have bank accounts and, as stated by the representative of a large NGO: "CBOs can't read or write – how will they access funds?" Weak monitoring systems and lack of capacity among NGOs, essential for tracking the disbursement and utilisation of funds, were reported in three countries. In one country that was implementing a World Bank MAP programme that had begun disbursing funds to districts and communities, a multilateral adviser who was familiar with the programme stated:

> "… (Monitoring) reports have not been forthcoming, and it's a replenishment programme, so if you don't have reports you don't get money. So they're bankrupt….[*When asked why reports were not forthcoming?"*]: maybe the reporting mechanisms, maybe the volume of reports, maybe the people don't have the capacity to do these reports or have to do too many other reports as well. …. So, in addition to this mechanism they have just added another mechanism parallel to this … there will now also be the Global Fund."
>
> *[Multilateral]*

Delays in getting management, procurement and monitoring systems in place – some of the reasons cited for delays in the arrival and disbursement of GF funds – were contributing to what was reported as a "crisis of expectation" in most countries, which would need to be managed. There had been a lot of media coverage, when grants had been approved. A representative of people living with AIDS reported that people were now anxious that "MoH or MoF (had) diverted funds." One PR reported:

> "People are aware there is money and there are problems of expectation. Now people are wondering 'where is the money?' and 'are they sitting on the money?' It's tricky … we have no money. Our strategy is to keep quiet."
>
> *[PR]*

3.5.2 Delivering antiretrovirals

Absence of national ARV drug treatment policies and lack of transparent and equitable criteria on who should get ARVs were a major concern in the three countries who had submitted proposals with these as a large component. There were criticisms in the national media in one country about decisions taken at national level about access to ARVs. In other countries, representatives of people living with AIDS were concerned that their members would be overlooked – "it depends whose ear you have"; and that the poor, women and people living far away from treatment centres would be disadvantaged. Strategies for expansion of the number of ARV sentinel sites and decisions around the use of subsidies, co-payment, and exemptions – to enable people obtain ARVs – had not yet been worked out:

> "There is a need to come out with clear cut criteria on ARVs and how to cater for those who don't have money. (The teaching hospital is) giving ARVs. None of our members, who characteristically are poor and uneducated, are receiving that treatment." *[NGO]*

> "An important issue is ARVs – the tricky issue is how to implement – there is a need to know priorities – who gets it first? As AIDS activists we should benefit – we have fought and fought for others – there is a need to keep the light burning. …. The policy needs to be clear – no loopholes – criteria transparent. This will help with expectations." *[NGO]*

> "My concern is how do we ensure gender disparities are taken into account…...the gender linkages are very weak and have not been addressed or strongly built into the GF application…..more women are affected by HIV/AIDS. …… If implementation does not take into account gender disparities the whole essence of fighting HIV/AIDS will be lost**."**
>
> *[Other line ministry]*

Low technical capacity for delivering ARVs; unreliable drug distribution systems that could allow ARVs leak into the private sector; and uncertainties around future sustainability, once people had been started on treatment, were some of the concerns of country respondents. Some doubted the feasibility and others the sustainability of antiretroviral treatment (ART):

> "We cannot get people to adhere to a six months DOTS or chloroquine regime; so how will we manage to get people to take ARVs (safely) for life?" *[Bilateral]*

> "We need to ask how long will GF be around? This is a big threat….ARVs have to be taken for life. Government may be in a problem here. Has GF ignored the issue of sustainability?" *[NGO]*

3.5.3 Absorption capacity and pressure to spend

Low absorption capacity and ability to spend well, both at central and district levels, was a problem reported in all four countries, notably by bilateral donors. Respondents cited recent examples of incomplete or almost no 'spend' at all, often on HIV/AIDS control programmes. The alternative to money being returned to the funder or to treasury unspent – reported to be common-place – was the pressure to spend it quickly. Such pressure had already resulted in the diversion of funds to non-intended areas and promoted what one respondent described as "an endemic culture of undisciplined spending, operating on a 'use and replace' philosophy." The term "push(ing) money out of the door" was used in one country to describe this. Poor use, more than risk of misappropriation of funds, was seen as a potential threat to the goals of the GF:

> "You get a group of people together who are badly paid and… you can't blame them for this. And it's like, "We've got a million dollars, what are we going to spend it on?" "Oh, I think we should have a workshop to discuss this"; and it's…you know, the Global Fund stuff, I think it's writ large….." Oh well, we must improve the guidelines here and there"…..and also the nature of project funding is to have discrete activities with a start and a finish and a supposedly easily identifiable output in terms of… you know, 2,000 guidelines here, or a workshop there." *[Bilateral]*

> "I hope we stick to focusing on results that are measurable and that it is not just workshop after workshop. … it's the same people/faces no matter the topic of the workshop and it's not the people who do the leg work. It's important to have attendance determined by the concept of the workshop and not by the sitting allowance/remuneration." *[MoH]*

A view from one respondent was that absorptive capacity was not a problem, or at least should not be used as a pretext for slowing down disbursement:

> "I have a different view – this country has huge absorption capacity – it's like a sponge. If districts know what resources they have, it's easy for them to put money in the gaps. … There are structures out there to absorb GF – all of it! The response is at district level, home based care." *[Other]*

In two countries respondents recommended that additional funds should be targeted towards improving public sector pay (see 3.5.4), though this was believed to be contrary to GF guidelines. Procurement and purchase of ARVs could also absorb large levels of funds. However, risks associated with procurement raised concerns, with lack of transparency or the potential for corruption through irregular tendering practices mentioned in three countries. One respondent was of the opinion that the problem of absorption capacity was ultimately about human resources:

> "[Absorption capacity] will be low – limiting factor is personnel…..the money is not enough to meet the need and yet structures to manage the money will not be able to absorb it." *[Other]*

3.5.4 Human resource bottlenecks

Human resource limitations – inadequate numbers and capacity of staff – were reported as probably the biggest obstacle to implementing GF-funded programmes for the three diseases. NGO, bilateral, ministry and multilateral respondents in one country all drew attention to an absolute shortage of staff at the service delivery level. Reasons given were: attrition due to health workers dying of AIDS and leakage of staff to better paid jobs.

Government and multilateral respondents reported leakage or "poaching" of ministry staff to better paid NGO jobs. In one country, an estimated 2000 new staff would be needed to implement GF and Clinton Foundation plans alone.

> "TB is the main opportunistic infection in (named country), and follow-up for TB requires specific experience, we will try to get around this problem by filling the gaps with retired or unutilised staff. …. Currently more than 10% of TB staff nationally have died and have not been replaced… We will need 150-250 more people, The TRP response said no - only top-up training of existing staff was allowed, so we dropped this component. There is a real risk here as TB HIV positive staff are dying from AIDS." *[MoH]*

NGO and bilateral donor respondents reported staff shortages due to unfilled positions in NGOs, who were therefore unable to spend the funds they received:

> "Our greatest problem is one of personnel: we already have unfilled vacancies in (named NGO), but we will be required to sign the code of conduct to indicate that we will not further deplete the public sector of staff. But the reality is, where am I going to get people?" *[NGO]*

In a second country, donors recognised that they themselves were also compounding the problem of staff attrition from the public sector. In most countries, low public sector salaries and lack of incentives were seen as a major obstacle to staff retention and GF implementation at all levels:

> "There's a fundamental problem in Africa that good people in government are poached by donors like ourselves. Donors hire the best at higher salaries and this drains governments. How do (governments) get qualified people and keep them? There's the issue of salaries." *[Bilateral]*

> "Motivation and development of staff is an issue – GF will not top up on government salaries. People will be expected to do more for same – my staff will leave." *[MoH]*

Low or inadequate capacity, especially for managing technically complex interventions such as ARVs but also in generic management skills, was the second major human resource weakness. GF funds could help to address capacity weaknesses through training, but it would take time.

4 CONCLUSIONS

This section starts with some **caveats** with regard to interpretation of the study findings. and then presents some provisional **conclusions**. Feedback to the authors is welcomed, as this will help inform the next phase of the study.

4.1 Caveats

1. An interview guide was used to explore respondents' views on a range of issues, selected by the research team as potentially important. The topic guide was based on a review of unpublished reports and web-based discussions during 2002 and early 2003. However, respondents were also encouraged to talk about any other issues they felt important.
2. Respondents' views as reported to the field workers will have been influenced by their access to information, their interpretation, and their recall of events that happened up to 18 months previously. However, many of the findings concur with those in an earlier report.[21]
3. Despite the large number (an average of 34 per country) and the wide range of respondents interviewed, it was not possible to interview all of the relevant senior level government staff in every country.
4. The focus of the study has been circumscribed so as to provide a country voice and perspective on the Global Fund. The perceptions of country-level respondents, notably around interactions with the Global Fund, provide only one side of the picture. This report does not present the perspective of the Global Fund.
5. Field work, which was conducted in the four countries over a period of two months during May and June 2003, provides only a snap shot of an evolving process. New guidelines to countries have been developed by the Global Fund and are footnoted below.[22]
6. These four sub-Saharan African countries may not be representative of countries receiving Global Fund support, which limits the generalisability of findings.

[21] GAO. Global Health, Global Fund to Fight AIDS, TB, and Malaria Has Advanced in Key Areas, but Difficult Challenges Remain. US General Accounting Office, May 2003.

[22] Guidelines on the Purpose, Structure, and Composition of Country Coordinating Mechanisms, June 4 2003.
Guidelines for a Principal Recipient's Monitoring and Evaluation Plan, July 1 2003.
Guidelines for Annual Audits of Program Financial Statements, July 1 2003
Fiduciary Arrangements for Grant Recipients, July 1 2003.
Request for Feedback on Global Fund Policy Documents, July 14 2003.
Guidelines for Performance-Based Funding, July 1 2003.

4.2 Provisional conclusions

- There is a great desire within countries to see the Global Fund work and *achieve its goals*. Governments – ministries of health, national AIDS councils, other line ministries – and their country partners have already invested much energy and effort to that end.

- The Global Fund is a new entity that has had positive effects already, notably in bringing *new partners* – NGOs, civil society, faith-based and private sector organisations – into a common forum for planning for the control of three diseases.

- Countries used different strategies in *proposal preparation*. Reliance on external technical assistance can reduce perceived opportunity costs, but may also reduce country ownership and result in proposals that are not cognisant of country systems and contexts.

- *Representation* of the different constituencies on the CCMs has been a challenge. It requires partners to be willing to represent the interests of their members; and to have the necessary resources and systems for consulting and communicating with them.

- *Communication* problems between countries and the Global Fund, and also within CCMs, are pervasive in all countries, which directly impact upon the effective functioning of CCMs. Examination of the causes of poor communication and development of strategies to improve communication effectiveness are required.

- Global Fund systems and processes have continued to rapidly evolve and countries have not always been able to keep abreast of these new developments. Lack of *guidelines*, earlier in the process, has led to considerable uncertainties within CCMs.

- Health systems in countries long-starved of resources are still weak. Introduction of the Global Fund has helped to highlight longstanding *systems weaknesses*. Interactions between countries and the Fund have enabled some countries to allocate these resources through existing systems strengthening channels.

- The need for *harmonisation* is a key message – *harmonisation of funding flows*, financial management systems and planning processes within countries. The Global Fund promises relatively huge levels of funds to countries that are operating a range of mechanisms to channel government and donor funds. Flexibility, and above all co-ordination on the part of new and long-standing funders, is necessary.

- There is a need for *lesson-learning* across new and existing initiatives that bring resources into country systems, both to identify reasons where funding flows and disbursement have been slow or have stalled and to learn from successful models.

- CCMs are new entities and there have been tensions with regard to their organisational fit and function within overall *national AIDS authority frameworks*. If countries can manage these tensions, supported by a coordinated approach on the part of new and longstanding donors, there is a greater likelihood that much needed resources for AIDS prevention, treatment, and care will be used effectively.

- *Additionality* – collecting and disbursing additional funds to countries – is intended as a cardinal feature of the Global Fund. Countries are hopeful, but also sceptical of donor intentions and commitment to additional development assistance.

- Countries report that the Global Fund is demonstrating growing flexibility and willingness to allow its funds be channelled through existing budgetary mechanisms. They wish that it and other new global funding initiatives would support countries in developing *harmonised systems for reporting, monitoring, and evaluation.*

- Countries are using what are new entities for managing fund disbursement, notably P*rincipal Recipients* and *sub-recipients*. These are frequently untested structures and systems, which may take time to function effectively, resulting in delays in disbursing funds to support service delivery.

- The demands attached to performance based funding could be hugely exacting on the capacity of fund recipients, government, and non-government alike. *Building capacity* – and agreeing to systems that do not overstrain that capacity – is essential, if donor expectations of accountability are to be realised.

- The Global Fund has had a high profile and generated high expectations in countries, including expectations of rapid funding that would enable people living with HIV/AIDS get access to antiretroviral drugs. Countries need assistance in *managing expectations*.

- Lack of country *policies around ARVs*, notably on equitable access and sustainability, was a major concern in countries. AIDS activist organisations feared that their members, rural dwellers, women, and the poor would get overlooked.

- The findings in this interim report ended with country concerns about the *human resource bottleneck* – shortages of trained health workers, underpaid and sometimes de-motivated public sector staff. While shedding little new light on these obstacles to implementing interventions for the control of HIV/AIDS, TB and malaria, it adds a country voice.

ANNEX A

Table 1: Health and population by country

	Mozambique	Tanzania	Uganda	Zambia
Population Size (millions)[1]	19,286,000	32,793,000	21,143,000	8,976,000
Urban Population (% of total, 2001)[2]	33.2	33.2	14.5	39.8
% Population > 60 yrs plus [1]	5.1	4.1	3.2	3.4
Life expectancy at birth[2] (years; both sexes)	39.2	44.0	44.7	33.4
Infant mortality rate [2] (per 1,000 live births)	125	104	79	112
HIV prevalence[2] (%, 15-49 years, 2001)	13.0	7.83	5.0	21.52
TB prevalence[2] (per 100,000 people, 2001)	125	212	187	445
Malaria prevalence[2] (per 100,000 people, 2001)	18,115	1,207	46	34,204
Adult literacy rate[2] (%, age 15 years plus)	45.2	76.0	68.0	79.0
Estimates of total expenditure on health for 1997 (% GDP)[2]	5.8	4.8	4.1	5.9
Annual GFATM budget per capita ($USD)[3]	1.61 (5 yr average)	0.25 (3year average)	1.52 (3 year average)	4.27 (5 year average)

[1] Source: The World Health Report 2000. Health Systems: Improving Performance. World Health Organization, Geneva.
[2] Source: Human Development Report 2003. Millennium Development Goals: A Compact Among Nations to End Human Poverty. http://www.undp.org/hdr 2003/
[3] Calculated as a annual average on total amounts requested for approved applications.

Table 2: Summary of GFATM applications by round in study countries*

Round 1 Application (application deadline: 10th March 2002)												
	Mozambique			**Tanzania**			**Uganda**			**Zambia**		
	HIV/AIDS/ TB treat.	**HIV prevent.**	**Malaria**	**HIV/AIDS**	**TB**	**Malaria**	**HIV/AIDS**	**TB**	**Malaria**	**HIV/AIDS**	**TB**	**Malaria**
Application content by disease component (v)	v	v	v	v	-	v	v	v Integrated proposal	v	v	v	v
Amount applied for by disease ($USD) & Grant Duration	154.4m	43.1m	45.8m	5.4m	-	19.8m	51,878,417 3 years	9,058,221 3 years	35,783,000 3 years	92,847,000 5 years	59,846,000 5 years	39,274,000 5 years
Grand total applied for ($USD)	**243,543,923**			**25,227,716**			**96,719,638**			**191,967,000**		
Notification of Application Outcome (date)	May 2002			May 2002			May 2002 (to confirm)			May 2002 (to confirm)		
Outcome (TRP Grade 1-4)[1]	3	3	3	2	-	1	1	3 ?	3?	2?	2?	2?
Number of Grant agreements per disease component	-	-	-	1	-	1	1			4	3 ?	2?
Grant Agreement Signed (Y/N) – *'Yes'* specify date	-	-	-	Y Jul 2003	-	Y Nov 2002	Y Feb 2003			Yes (3/4) March 2003 & May 2003		
Grant Amount ($USD agreed for 2 years)				5,400,000 over one year	-	11,959,076	36,314,892			21,214,271[a] 6,614,958[b] ? c		
Start Date (for initial 2 year contract)				09/07/03?		01/12/02	15/3/03			1/4/03[a.b] ZNAN?		
End Date (for overall grant)				08/07/03?		31/12/2007 ? As in actual grant, but it's a 3 yr programme …	14/3/06			31/3/08[a,b]		
First disbursement received by Country (Y/N) – *'Yes'* specify date	-	-	-	N	-	Y Feb 2003	Y May 2003 ?			Y[a,b] (check) ZNAN?		

* Sources: GFATM country applications, signed grant agreements and GFATM communications

[1] TRP recommendations are graded 1-4: 1=recommended for funding with no or minor modifications, 2=recommended for funding providing clarifications are met within a limited timeframe, 3=not recommended for funding in its present form but strongly encouraged to resubmit, 4= not recommended for funding

[a] Amount awarded to Central Board of Health as one of four Principal Recipients in Zambia

[b] Amount awarded to Churches Association of Zambia as one of four Principal Recipients in Zambia

[c] Amount awarded to Zambia National Aids Network as one of four Principal Recipients in Zambia

Table 2: Summary of GFATM applications by round in study countries * (cont.)

Round 2 Application (application deadline ?27th September 2002)												
	Mozambique			Tanzania			Uganda			Zambia		
	HIV/AIDS	TB	Malaria	HIV/AIDS	TB	Malaria	HIV/AIDS	TB	Malaria	HIV/AIDS	TB	Malaria
Application content by disease component (v)	v	v	v	v (Integrated)		-		v	v	-	-	-
Amount applied for by disease ($USD) & Grant Duration	109.3m	18.1m	28m	212.2m		-		9,058,221 3 years	35,783,000 3 years			
Grand total applied for ($USD)	155,594,941			212,224			44,841,221					
Notification of Application Outcome (date)	?			?			?					
Outcome (TRP Grade 1-4)[1]	2	2	2	3		-		2?	2?			
Grant Agreement Signed (Y/N) – *'Yes'* specify date	N	N	N	-	-	-		N	N			
Grant Amount ($USD agreed for 2 years)								-	-			
Start Date (for initial 2 year contract)								-	-			
End Date (for overall grant)								-	-			
First disbursement received by Country (Y/N) – *'Yes'* specify date	N	N	N	-	-	-		-	-			

* Sources: GFATM country applications, signed grant agreements and GFATM communications

[1] TRP recommendations are graded 1-4: 1=recommended for funding with no or minor modifications, 2=recommended for funding providing clarifications are met within a limited timeframe, 3=not recommended for funding in its present form but strongly encouraged to resubmit, 4= not recommended for funding

Table 2: Summary of GFATM applications by round in study countries* (cont.)

Round 3 Application (application deadline 30th May 2003)													
	Mozambique			Tanzania			Uganda			Zambia		
	HIV/AIDS	TB	Malaria	HIV/AIDS	TB	Malaria	HIV/AIDS	TB	Malaria	HIV/AIDS	TB	Malaria
Application content by disease component (v)	-	-	-	v (Integrated)			v (incl. orphans /vulnerable children)	-	-	-	-	-
Amount applied for by disease ($USD) & Grant Duration	-	-	-	?85m+ 5 years		-	158.5m (?) 3 years					
Grand total applied for ($USD)				**?85m+**			**158.5m (?)**					
Notification of Application Outcome (date)	-			?			?					
Outcome (TRP Grade 1-4)[1]	-	-	-			-	-					
Grant Agreement Signed (Y/N) – *'Yes'* specify date	-	-	-	-		-	-					
Grant Amount ($USD agreed for 2 years)							-					
Start Date (for initial 2 year contract)							-					
End Date (for overall grant)							-					
First disbursement received by Country (Y/N) – *'Yes'* specify date	-	-	-			-	-					

* Sources: GFATM country applications, signed grant agreements and GFATM communications

[1] TRP recommendations are graded 1-4: 1=recommended for funding with no or minor modifications, 2=recommended for funding providing clarifications are met within a limited timeframe, 3=not recommended for funding in its present form but strongly encouraged to resubmit, 4= not recommended for funding

Table 3: Composition of Country Co-ordination Mechanism by Country[1]

	Mozambique (n=13)	Tanzania (n=29/30)	Uganda (n=28)	Zambia (n=21)
Ministry of Health	2	1	4	1
Government – Other Ministries	4	10	9	5
NGO & Community-Based Organisations	2	10	3	3
Private-For-Profit	1	?2/3	2	1
People Living With HIV/AIDS	1	1	3	1
UN/Multilateral Agencies	1[2]	1[2]	3	2
Bilateral Agencies	1[2]	3	2	2
Academia	0	0	1	2
Faith Based Organisations	1	2	1	2
CCM Chairperson (specify sector/position)	Minister of Health (included in above)	Permanent Secretary, Prime Minister's Office (additional to above)[3]	Director General, Ministry of Health	Permanent Secretary, Ministry of Health[4]
Other (specify)	Plus 'core' group of 10 active advisers, drawn from above constituency groups. NAC acts as main contact point for GFATM	Plus 'secretariat' of 9 active advisers, mainly multilateral/technical/academic. NAC acts as main contact point for GFATM		1 (Traditional Healers & Practitioners) 1 (Private Media Association) Plus the National Aids Council as the Secretariat to the CCM

[1]Sources: Interviews and application forms

[2] Rotating seats

[3] There has been one change in CCM Chairmanship in Tanzania since its inception

[3] There has been one change in CCM Chairmanship in Zambia since its inception

Table 4: Principal Recipients & LFA by Country for Approved GFATM Applications

	Mozambique	Tanzania	Uganda	Zambia
PR identified (Yes/No/In Progress)	In progress (Rd 2)	Yes (Rd 1)	Yes (HIV/AIDS, Rd 1) In progress (TB, Rd 2) In progress (Malaria, Rd 2)	Yes
Number of PRs per country		2	1	4
Identity of PR(s)	1. MoH (via transitional Swap for HIV/AIDS treatment, malaria and TB) 2. NAC (HIV prevention)	1. MoH (malaria) 2. MoF (HIV/AIDS)	Ministry of Finance, Planning & Economic Development for	1.Central Board of Health (CBOH) 2. Ministry of Finance (MoF) 3. Churches Association of Zambia (CHAZ) 4. Zambia National Aids Network (ZNAN)
PR formally approved by GFATM	No	Yes (date?)	Yes, Feb 2003?	3 out of 4 PRs approved CBOH and CHAZ March 2003?, ZNAN May 2003? MoF to be approved
LFA identified (Yes, No /In Process)	Yes	Yes	Yes	Yes
Identity of LFA	PwC Business Advisory	PwC Business Advisory	PwC Business Advisory	PwC Business Advisory

Table 5: Phase 1 interviews conducted by country[1]

	Mozambique	Tanzania	Uganda	Zambia
Total individuals interviewed	**43**	**26**	**35**	**33**
Government: cross-sectoral	5	5	4	6
Government: health	8	6	8	2
NGOs (national and international), faith, private sector and community-based organisations[2]	14	2	9	8
Academics			2	1
Technical Agencies (e.g. WHO, CDC)			3	4
Principal Recipients				3
Local Fund Agent	-	1	1	1
Bilateral agency representatives	8	7	4	7
Multilateral agency representatives	8	5	4	1
Percentage of CCM interviewed	85%	30%	73%[3]	71%
Percentage of Secretariat/Core group interviewed	80%	90%	CCM Secretary interviewed (no Secretariat)	The two members of the Secretariat were interviewed
Direct observation	Yes, 2-day joint review and donors meeting	Yes, round 3 proposal process over 2½ weeks and CCM meeting	Yes, 1 CCM Meeting & a UN/Bilateral Meeting	-

[1] Phase 1 interviews covered a combination of CCM members and non-CCM members
[2] Includes representatives from traditional healers and media
[3] Denominator used in this calculation was 26 CCM members – the two newly appointed representatives of people living with HIV/AIDs were not included