Twenty-Second Board Meeting
Sofia, Bulgaria, 13-15 December 2010

GF/B22/13

For decision

For information

REPORT OF THE TECHNICAL REVIEW PANEL AND THE SECRETARIAT ON ROUND 10 PROPOSALS

PURPOSE:

1. This report outlines the Technical Review Panel's (TRP) funding recommendations on Round 10 proposals. It also summarizes the Secretariat process to determine eligibility, the TRP membership and proposal review methodology and its recommendations and lessons learned arising from the Round 10 proposal review process.

PART 1: INTRODUCTION

1.1 The Technical Review Panel (TRP) met from 16-30 October 2010 to review the technical merit of Round 10 proposals. The meeting was chaired by Dr Bolanle Oyeledun, with Mr Shawn Baker and Dr George Gotsadze serving as Vice-Chairs.

1.2 This report is structured as follows:

Part 1: Introduction

Part 2: TRP Funding Recommendations on Round 10 Proposals

Part 3: Secretariat Report on Eligibility Determinations

Part 4: TRP Membership and Proposal Review Methodology

Part 5: Recommendations and Lessons Learned from the Round 10 Proposal Review

1.3 This report should be read in conjunction with the following Annexes:

Annex 1: List of Eligible Round 10 Proposals Reviewed by the TRP, Classified by Recommendation Category;

Annex 2: List of all Eligible Proposals Reviewed by the TRP, ordered alphabetically by Applicant;

Annex 3: List of all ineligible Applicants in Round 10 and the Secretariat's Screening Review Panel Justifications;

Annex 4: Round 10 'TRP Review Forms' for all Disease Proposals Reviewed by the TRP, together with the full text of all proposals;

Annex 5: Detailed Analysis of Round 10 Outcomes; and

Annex 6: Round 10 TRP Membership.

1.4 Annex 1 is provided with this report. Annexes 2 to 6 are provided on a confidential basis in electronic format as supplementary information to Board members.

1.5 Shortly after the 22nd Board Meeting and the Board's funding decisions on Round 10, all eligible proposals, regardless of their recommendation, will be published on the Global Fund's website. In accordance with the Global Fund's documents policy (GF/B16/2), TRP Review Forms will not be published on the website[1].

[1] Stakeholders wishing to obtain copies of the TRP Review Forms should contact the applicants directly.

PART 2: TRP FUNDING RECOMMENDATIONS ON ROUND 10 PROPOSALS

2.1 For Round 10, the TRP reviewed funding requests totaling **US$ 4.33 billion over two years and** US$ 11.35 billion over five years[2]. This represented 150 disease proposals with 28 attached cross cutting health systems strengthening (HSS) requests[3].

2.2 A total 2-year upper ceiling (Phase 1) of **US$ 1.73 billion**[4] is being recommended by the TRP. The overall success rate of Round 10 proposals, including HSS requests, is 53 percent. The TRP funding recommendations to the Board on Round 10 proposals are listed in Annex 1 of this report. The recommendations are presented by TRP recommendation category[5] and have not been ranked according to the Round 10 prioritization criteria[6]. Table 1[7] below summarizes the funding recommendations by disease components and separate cross-cutting HSS requests (Sections 4B/5B). Of 28 submitted cross-cutting HSS requests[8], 11 (39 percent) were recommended for funding[9] with a two year upper-ceiling of US $ 127.6 million. In nine instances both the disease component and the HSS request are being recommended for funding and in two cases only the HSS request is being recommended.

Table 1: Summary of funding recommendations, including HSS requests

Disease proposal	Number received	Number recommended for funding	Success Rate	2-year upper ceiling recommended (in million US$)	Share of total 2-year upper ceiling recommended	5-year upper ceiling recommended (in million US$)	Share of total 5-year upper ceiling recommended
HIV (including s.4B HSS)	78	34	44%	809	47%	2,232	47%
Tuberculosis (including s.4B HSS)	48	26	54%	340	20%	936	20%
Malaria (including s.4B HSS)	24	19	79%	583	34%	1,555	33%
Total	**150**	**79**	**53%**	**1,733**	**100%**	**4,723**	**100%**

Resubmissions from Round 9

2.3 Applicants that received a 'Category 3' rating by the TRP in Round 9 were encouraged to submit a revised proposal (disease or cross-cutting HSS request) in a subsequent Round, taking into consideration the TRP comments. Of the 150 proposals reviewed by the TRP, a total of 64 re-

[2] The Phase 1 and five-year demand figures include only new funding – this means that, in the case of the twelve consolidated disease proposals submitted in Round 10, already approved and committed funds under existing grants forming part of the consolidation were excluded.
[3] As with Rounds 8 and 9, applicants could submit a request for 'HSS cross-cutting interventions' (Section 4B/5B of the proposal form) as a separate part (not component) of one disease proposal.
[4] As some proposals requested funds in Euros, this report, including relevant annexes, uses the 1 December 2010 OANDA interbank exchange rate to translate Euro funding requests to US dollars.
[5] http://www.theglobalfund.org/documents/trp/TRP_TOR_en.pdf
[6] Decision Point GF/B21/17.
[7] Cross-cutting HSS requests have been excluded from the total number received and recommended as they are not separate components.
[8] Disease proposals in many cases also included interventions to support health systems strengthening that were not presented as separate sections 4B/5B of the proposal form. This information is not summarized in the table above.
[9] According to the TORs of the TRP, the TRP can recommend for funding either i) the whole disease proposal, including the HSS request; or ii) the disease-specific part, excluding the HSS request; or iii) only the HSS request if the proposed interventions materially contribute to overcome health systems constraints to improve HIV, tuberculosis and/or malaria outcomes.

submissions were received and the overall success rate of re-submissions was 64 percent for disease proposals and 55 percent for cross-cutting HSS requests.

Round 10 Most at Risk Populations Reserve

2.4 At its 21st Meeting, the Board approved, for Round 10 only, a funding reserve for HIV proposals for Most at Risk Populations[10]. The dedicated Most at Risk Populations reserve was open to both single and multi-country applicants, and ensures that the Global Fund continues to present opportunities for most at risk populations from all regions of the world, particularly those in 'upper-middle' and 'lower-middle' income countries.

2.5 Round 10 HIV applicants addressing the needs of most at risk populations could therefore either submit a *regular* HIV proposal focusing partly, predominantly or only on most at risk populations, or submit an HIV proposal focusing only on most at risk populations through a 'dedicated Most At Risk Populations reserve'.

2.6 Applicants submitting a proposal under the Most at Risk Populations reserve were restricted to a Phase 1 funding request of US$ 5 million and of US$ 12 million over five years, with collective limits of $75 million and $200 million for two years and five years respectively. The dedicated Most at Risk Populations reserve also has its own rules for prioritization, in the event that there are insufficient resources available to finance all TRP-recommended proposals submitted through this reserve[11].

2.7 A total of 25 proposals[12], with a two-year funding request of US $ 104.1 million, were reviewed under the dedicated Most at Risk Populations reserve. The TRP is recommending 12 proposals, with a two-year funding request of US $ 46.9 million, for funding.

Table 2: Summary of recommendations related to Most at Risk Populations funding requests

Income Level	Number received	Number recommended for funding	Success Rate	2 year upper ceiling requested (in million US$)	2-year upper ceiling recommended (in million US$)	Value Success Rate	Share of total recommended 2-year upper ceiling of funding
Lower-middle income	11	4	36%	43	14	34%	31%
Upper-middle income	7	5	71%	28	20	72%	43%
Mixed*	7	3	43%	33	12	37%	26%
Total	**25**	**12**	**48%**	**104**	**47**	**45%**	**100%**

* Refers to Multi-Country and Regional Organization applicants which include countries of different World Bank income classifications.

Transition to new Grant Architecture

2.8 One of the major areas of change under the new grant architecture is the way that countries apply for new funding. Round 10 afforded applicants the option to apply for new funding using a consolidated disease proposal which identifies new funding being requested but also includes ongoing grants for the same disease. While voluntary in Round 10, this approach to requesting new funds will be mandatory starting with Round 11.

[10] Decision Point GF/B21/DP18.
[11] The rules of prioritization for the dedicated Most At Risk Populations Reserve are set out in the Annex to Decision Point GF/B21/DP18.
[12] Of the 25 applicants, 18 were submitted by Country Coordinating Mechanisms (CCMs) and 7 by Regional Organizations. Of the 12 recommended proposals, 9 are from CCMs and 3 from Regional Organizations.

2.9 A total of 12 consolidated proposals were reviewed by the TRP of which 8 were recommended for funding. Consolidated proposals were received for tuberculosis (8 applications, 7 recommended) and HIV (2 applications, 1 recommended) components only.

Decision Point GF/B22/DPXX:

1. ***The Board approves, in principle, all the Round 10 proposals recommended for funding by the Technical Review Panel (TRP) as "Category 1", "Category 2" and "Category 2B", subject to the below provisions.***
2. ***The Board approves for funding for an initial two years all those Round 10 proposals focusing on Most-at-Risk Populations for HIV/AIDS, which have been submitted under the dedicated reserve referred to in Decision GF/B21/DP18 and recommended for funding by the TRP, subject to paragraphs 5, 6 and 7 below.***
3. ***The Board approves for funding for an initial two years those Round 10 proposals recommended for funding by the TRP which have:***
   a. ***a composite score of [X or X or X] based on the criteria referred to in Decision GF/B21/DP17 (as indicated in List A of GF/B22/XX); and***
   b. ***a composite score of [X] and have been prioritized for funding as of this date based on the ranking mechanism set out in the Annex to this Decision (as indicated in List A of GF/B22/XX),***

   subject to paragraphs 5, 6 and 7 below.
4. ***The remaining Round 10 proposals recommended for funding by the TRP that have a composite score of [X,X,X] based on the criteria referred to in Decision GF/B21/DP17 (as indicated in List A of GF/B22/XX) will be approved for funding for an initial two years***
   a. ***through Board confirmation by email as the remaining funds allocated for funding Round 10 proposals become available up to 31 March 2011, under the terms of the Comprehensive Funding Policy (as amended for Round 10 as per the terms of GF/B21/DP19); and***
   b. ***subject to the ranking mechanism set out in the [Annex] to this Decision and paragraphs 5, 6 and 7 below.***
5. ***The applicants whose proposals are recommended for funding as 'Category 1' (as indicated in Annex 1 of GF/B22/13) shall conclude the TRP clarifications process, as indicated by the written approval of the Chair and/or Vice Chair of the TRP, not later than eight weeks after the applicant's receipt of notification in writing from the Secretariat of the Board's decision.***
6. ***The applicants whose proposals are recommended for funding as 'Category 2', including the subset of proposals identified as 'Category 2B' (as indicated in Annex 1 of GF/B22/13), shall:***
   a. ***provide an initial detailed written response to the requested TRP clarifications and adjustments by not later than six weeks after the applicant's receipt of notification in writing by the Secretariat of this Board decision; and***
   b. ***conclude the TRP clarifications process, as indicated by the written approval of the Chair and Vice Chair of the TRP, not later than three months from the Secretariat's***

receipt of the applicant's initial detailed response to the issues raised for clarification and/or adjustment.

7. *As required under the Income Level and Cost Sharing Policy, the lifetime grant amount of approved Round 10 proposals that will be implemented in Upper-Middle Income Countries ("UMI Proposals") shall be subject to a collective maximum limit of 10% of the lifetime grant amount of all Round 10 approved proposals. The Board notes that this limit will be applied at the time of approving additional commitments for approved Round 10 UMI Proposals.*
8. *The Board declines to approve for funding those proposals recommended by the TRP as 'Category 3', as indicated in Annex 1 of GF/B22/13. These applicants are encouraged to re-submit a proposal in a future funding round after major revision of the proposal.*
9. *The Board declines to approve for funding those proposals recommended by the TRP as 'Category 4', as indicated in Annex 1 of GF/B22/13.*
10. *The Board notes the TRP's request to have additional financial analysis support as part of the clarifications process and requests the Secretariat to make the necessary arrangements.*

The budgetary implications of this decision are estimated at approximately USD 100,000 for financial analysis support.

Notes:

- *This decision point is presented in draft form and will be revised at the Twenty Second Board Meeting to include the composite scores of proposals that have been approved for funding in accordance with the criteria set out in Decision GF/B21/DP17. If there are insufficient assets available to approve all proposals which have been assigned the same composite score according to such criteria, it would be preferable for the Board to approve a ranking mechanism to further prioritize which of these proposals should be approved for funding, as indicated in paragraphs 3 and 4 above.*
- *This decision point has been drafted on the basis of existing policies as they relate to determining the assets available for approving Round 10 proposals for funding up to 31 March 2011.*
- *This decision point has been drafted on the assumption that measures to restrict the amount of funding committed for Round 10 approved proposals, such as those applied in the two previous rounds (and NSAs), will not be applied.*

PART 3: SECRETARIAT REPORT ON ELIGIBILITY DETERMINATIONS

Round 10 Application Materials

3.1 A number of important changes were made to the Round 9 Proposal Form, based on consultations and input from technical partners, Secretariat personnel and the Portfolio and Implementation Committee (PIC) that oversaw the approval of the application materials.

3.2 Principal among the changes were those enabling the submission, on a voluntary basis, of consolidated applications. This is an important step in the transition to single streams of funding within the context of the new grant architecture.

3.3 Other changes to the Round 10 application materials, reflecting previous Board Decisions that had yet to be incorporated, included: Gender Equality and Sexual Orientation and Gender Identity Strategies; TB/HIV collaborative activities; enhancing the Global Fund's response to HIV/AIDS through the prevention of mother-to-child transmission (PMTCT); private sector/in-kind donations; community systems strengthening; and pharmacovigilance. Additional emphasis was placed on 'value for money' and technical assistance. Round 10 guidance materials were updated accordingly and included twelve new information notes.

3.4 Application materials, information notes, frequently asked questions and links to guidance documents from technical partners were featured (in multiple languages) on the Global Fund website. Applicants were encouraged to contact the Secretariat (through the Proposals Inbox[13]) for any question related to Round 10. As with previous Rounds, the Global Fund Secretariat did not provide any technical assistance to applicants for proposal development.

Proposals received

3.5 A total of 166 proposals from 117 applicants were received by 20 August 2010[14], including 28 cross-cutting health systems strengthening parts (sections 4B/5B of the proposal form).

3.6 Applicants were encouraged to submit proposals in the United Nations official language that they most commonly work in. In Round 10, there were a large number of applicants who submitted proposals in a language other than English[15]. As in Round 9, applicants from Russian speaking countries preferred to submit proposals in English. Francophone and Spanish-speaking applicants continued to submit proposals mostly in French and Spanish respectively. No applications were received in Arabic or Chinese.

Screening for eligibility and completeness

3.7 The Round 10 proposal screening process took place from August to October 2010. A total of 24 proposals officers were assigned to different regions based on their experience and language skills, and worked closely with applicants to ensure that all necessary documentation was available for both the Screening Review Panel and the Technical Review Panel.

3.8 In order to ensure that the Screening Review Panel had the most complete information, many applicants were required to provide clarifications. For the most part, the clarifications requested were in relation to the following minimum requirements:

[13] Email: proposals@theglobalfund.org. Between the launch and the closing date of the Round 10 Call for Proposals, the Secretariat received approximately 240 requests for further information and/or guidance.
[14] This number includes 5 applicants which submitted only parts of the Global Fund proposal form or a Microsoft Word document as their funding request and identified themselves as undefined or as a 'CCM'. The applicants were reviewed by the Screening Review Panel of the Secretariat and were considered ineligible.
[15] Twenty-one applicants submitted either the full proposal or a part (i.e. one component) of it in French, eleven in Spanish, and two in Russian.

i. open, transparent and documented process to solicit and review proposal submissions;

ii. transparent and documented process to nominate the Principal Recipient; and

iii. where appropriate, evidence of the application of an adequate conflict of interest plan with respect to the selection of Principal Recipients.

3.9 The Global Fund's Screening Review Panel applied the same principles used for Rounds 6 to 9 to determine eligibility and compliance regarding the minimum requirements for grant eligibility. The CCM team of the Secretariat will, as it did for Rounds 7 to 9[16], release a detailed report of the outcomes of the Screening Review Panel process for Round 10 applicants, including lessons learned and best practices. Table 3 provides a comparison of the outcomes across the last five Rounds.

Table 3 – Outcome of Secretariat Screening Review Panel on Eligibility: Rounds 6 to 10

Applicant Type	Round 10		Round 9		Round 8		Round 7		Round 6	
	Total applicants	Eligible applicants	Total applicants	Eligible applicants	Total applicants	Eligible applicants	Total applicants	Eligible applicants	Total applicants	Eligible applicants
CCM	92	87	93	88	88	88	80	77	96	93
Sub-CCM	2	2	3	2	3	3	3	2	1	1
RO	14	12	8	8	8	3	5	5	10	9
RCM	3	3	3	3	3	2	1	1	1	1
Non-CCM	6	1	14	0	23	2	21	3	36	4
Total	**117**	**105**	**121**	**101**	**125**	**98**	**110**	**88**	**144**	**108**
Percentage eligible	**90%**		**83%**		**78%**		**80%**		**75%**	

[16] http://www.theglobalfund.org/documents/ccm/Screening_Review_Panel_Report_Round_9.pdf

PART 4: TRP MEMBERSHIP AND PROPOSAL REVIEW METHODOLOGY

Round 10 TRP Membership

4.1 Membership of the Technical Review Panel for Round 10 is provided in Annex 6 and consisted of 43 experts. For Round 10 there were 13 members serving for the first time on the TRP; all were recruited through the 2010 TRP replenishment process[17].

4.2 The Round 10 meeting was chaired by **Dr Bolanle Oyeledun,** a cross-cutting expert from Nigeria. **Mr Shawn Baker,** a cross-cutting expert from the United States of America, and **Dr George Gotsadze**, also a cross-cutting expert, from Georgia, served as the two Vice-Chairs. Following the Board's decision to amend the TRP's Terms of Reference[18], the TRP Chair and Vice Chairs were not assigned to small review groups but rather rotated among the review groups to provide support and were dedicated to other aspects of the TRP meeting.

4.3 The full replenishment of the TRP Support Group was completed in August this year. The recruitment of 105 new experts was approved by the Board, following the recommendations of the PIC and the Executive Director of the Global Fund[19]. Of these experts, nine were appointed as Permanent Members, commencing their terms from Round 10, and 20 appointed as Alternate Members. For Round 10, the TRP had to call upon nine Alternates to serve for Round 10 due the availability of Permanent TRP Members.

4.4 The Board decided to permit, on an exceptional basis for this Round, existing permanent TRP members to serve more than four Rounds to ensure that a sufficient pool of experienced TRP members were available to draw on for Round 10.[20] The Board also decided, following the recommendation of the PIC Sub-Working Group, to pilot a TRP mentoring program for Round 10. The PIC Sub-Working Group selected three experts (one in each disease) from implementing countries, who showed strong potential as TRP members. These experts were invited to participate in the first week of the Round 10 review process.

4.5 At the end of the Round 10 clarifications process, twelve 'TRP Permanent Members' will complete their term of service. The TRP and the Secretariat would like to acknowledge the contributions of **Dr Martin Alilio (cross-cutting expert, Tanzania), Peter Barron (cross-cutting expert, South Africa), Dr François Boillot (cross-cutting expert, France), Dr Assia Brandrup-Lukanow (cross-cutting expert, Germany), Dr Josef Decosas (cross-cutting expert, Germany), Dr Blaise Genton (malaria expert, Switzerland), Dr Ruth Kornfield (HIV expert, USA), Dr Andrew McKenzie (cross-cutting expert, South Africa), Dr Lílian de Mello Lauria (HIV expert, Brazil), Dr William N. Okedi (cross-cutting expert, Kenya), Dr Gladys Antonieta Rojas de Arias (malaria expert, Paraguay), and Dr Nêmora Tregnago-Barcellos (HIV expert, Brazil) and to sincerely thank them for their time and commitment to the Global Fund.**

Addressing potential conflicts of interest and safeguarding the independence of the TRP

4.6 The TRP Chair continues to apply strict rules to ensure compliance with the Global Fund's Policy on Ethics and Conflict of Interest[21] and to safeguard the independence of the TRP. These rules were updated and strengthened prior to the Round 10 meeting, to reflect amendments to the

[17] The recommendations of the Portfolio and Implementation Committee (PIC) and Executive Director of the Global Fund regarding the full replenishment of the TRP were presented to the Board in the report entitled, 'Technical Review Panel – 2010 Members And Support Group Replenishment'; Decision Point B21/EDP/18.
[18] Decision Point, GF/B21/DP7.
[19] Decision Point B21/EDP/18.
[20] Decision Point, GF/B21/DP8.
[21] Refer to the Global Fund's 'Policy on Ethics and Conflicts of Interest': http://www.theglobalfund.org/documents/policies/PolicyonEthicsandConflictofInterestforGlobalFundInstitutions.pdf.

TRP's Terms of Reference. The revised safeguards applied with respect to the review of proposals are as follows[22]:

i. A TRP member shall recuse himself or herself from reviewing a proposal submitted by a single country applicant, if the TRP member:
   a. is a national of the applicant country;
   b. otherwise has a significant link with the applicant country, if he/she has lived in the country for more than one year in the past ten years;
   c. is employed by an organization that is a potential beneficiary of funding if the proposal is approved (e.g. as a Principal Recipient, Sub-recipient or technical assistance providers); and

ii. The TRP Chair may require a TRP member to recuse himself/herself from the review of a proposal if:
   a. it has been submitted by a multi-country applicant and the TRP member is a national of one of the applicant countries or otherwise has a significant link with one of the applicant countries if he/she has lived in that country for more than one year in the past ten years; or
   b. the TRP member is employed by an organization that has assisted in the development of that proposal.

In addition to the above safeguards, the rules also include a one-year "cooling-off" period, upon completion of service, which requires former TRP members to restrict themselves from assisting countries in Global Fund proposal development or from participating on Country Coordinating Mechanisms (CCMs) or other mechanisms[23].

TRP meeting modalities

4.7 The Round 10 TRP meeting was held in Evian-les-Bains, France. An induction session for new TRP members was organized by the TRP leadership to introduce Global Fund policies, architecture, TRP review modalities as well as internally agreed practices. The session also involved a mock proposal review.

4.8 The Secretariat also provided updates on key Global Fund policies and strategic initiatives, such as value for money, transitioning to a single stream of funding (new architecture), and performance-based funding.

4.9 Different to recent Rounds, technical partners were invited to the meeting for a morning of technical briefings. These meetings built on written technical briefs provided by partners to the TRP, as well as teleconference calls between TRP focal points and technical partners that took place one week prior to the meeting. The TRP welcomed this approach, which allowed for more meaningful, engaged discussions on issues that would be relevant to the TRP's imminent review of proposals. The TRP also signaled its desire to continue the post Rounds-based meeting debriefing session for technical partners, which was introduced in Round 9, as a means for communicating information regarding technical matters identified during the proposal review process. The TRP has also expressed a desire to engage with a wider range of partners as part of its pre and post review meetings.

[22] Please see the revised Ethics and Conflict of Interest Guidelines for TRP Members at: http://www.theglobalfund.org/documents/trp/TRP_CoI_Guidelines.pdf
[23] The TRP continues to apply this practice adopted in early Rounds.

4.10 A mini-retreat was organized midway through the TRP Round 10 meeting in order to discuss issues relating to the TRP's activities since Round 9, its engagement with the Board and its Committees, and TRP work streams supporting the Secretariat. In addition, the TRP discussed emerging themes of the Round 10 review process. This approach was deemed very constructive and useful.

4.11 The final meeting day provided an opportunity for TRP members to confirm Round 10 recommendations made throughout the meeting, discuss the overall review process, including internal TRP matters, as well as lessons learned and recommendations for future Rounds.

Proposal review methodology

4.12 The key features of the TRP's review included:

i. working in small groups (two disease experts and two cross-cutters typically for each day) to review no more than two disease proposals a day;

ii. small group meetings for preliminary recommendations before a daily TRP plenary;

iii. partial parallel plenary sessions were held on three days. The sessions were chaired either by the Chair or one of the Vice-Chairs;

iv. TRP funding recommendations finalized through daily TRP plenary sessions, during which the TRP agreed on the rating and the wording of TRP Review Forms (Annex 4); and

v. a final plenary, for TRP discussion of the overall review process, consistency between findings and the confirmation of funding recommendations.

4.13 Where the TRP had difficulty in reaching consensus in plenary sessions, the case was re-examined by the small review groups, in light of the plenary discussions, and if necessary by two fresh reviewers. Decisions would eventually be made after full discussion at subsequent plenary sessions. As with previous Rounds, this process was found to be very effective.

4.14 Per its Terms of Reference, the TRP did not take into account the availability of funds during the proposal review process. Also mandated by the TRP Terms of Reference, each disease proposal was reviewed as a whole. However, for the first time in a Rounds-based review, the TRP was provided with greater flexibility to remove of a limited set of elements of the proposal (not subject to appeal) of an otherwise technically sound proposal as part of the recommendation for funding, which resulted in up-front budget removals for some recommended proposals[24]. Further budget amounts have been queried by the TRP and may lead to further reductions prior to completion of the clarification process.

4.15 The TRP's review focused on: i) soundness of approach; ii) feasibility; iii) potential for sustainability and impact; and iv) the corresponding criteria[25] as defined in the TRP Terms of Reference. There is no predefined 'rating methodology' or allocation of quantitative scores for proposal review. Rather, the TRP draws on its collective experience to make a judgment on the technical merit of the proposal. This is a complex process, but one that ensures that there is appropriate consideration of country and/or regional context.

4.16 To be consistent with the Board's decision on health systems strengthening, the TRP did not review proposals that included cross-cutting HSS requests as two distinct funding applications. The TRP could recommend for funding either both parts of the disease proposal (i.e. the disease

[24] See Part 5 of this Report for more information on the removal of a limited set of elements.
[25] Terms of reference of the Technical Review Panel, Attachment 1 "Proposal Review Criteria", http://www.theglobalfund.org/documents/trp/TRP_TOR_en.pdf. In addition, these criteria are included in the Guidelines for Proposals for every Round.

component and the HSS request), one part, or neither. Applicants who submitted a cross-cutting HSS request with their disease proposal receive one TRP Review Form with comments relating to both proposal parts.

4.17 In addition to proposal documents, TRP members were also provided with the following documents:

i. Secretariat documentation on existing grants (Grant Performance Reports, Grant Scorecards, Country Reports by disease[26], and previous TRP review forms for Rounds 5-9, RCC Waves 1-8 and the Final Re-submissions Wave, and the First Learning Wave of the National Strategy Applications);

ii. epidemiological data provided by UNAIDS and WHO (including malaria and tuberculosis country profiles, 2008 UNAIDS progress reports and epidemiological facts sheets); and

iii. where applicable, other relevant documents from Donors.

4.18 Following the success of the Round 9 pilot, the TRP had access to off-site external financial analysis support for Round 10. Nine financial experts and one procurement expert, from existing Local Fund Agents reviewed over a two-week period proposal budgets requesting approximately more than US$ 50 million over five years, as well as all consolidated proposals. Such proposals represented 47 percent in number and 86 percent in value of all Round 10 proposals reviewed[27]. These reviews were independent of the TRP's own review and their findings were provided for the TRP's consideration. The TRP reviewed the findings of the financial experts in conjunction with the full proposal documentation. The TRP valued this element of the review process. Financial Experts were also available remotely during the Round 10 review meeting to respond to clarifications and ad-hoc requests for support. In addition the TRP has requested that the services of external financial experts be made available as part of the clarifications process.

4.19 The TRP was requested to pay particular scrutiny to the issue of value for money. This topic formed part of the Secretariat briefings in advance of the review process. The TRP was made aware of the new guidance provided in the Round 10 guidelines and the new questions in the proposal form. In addition, the TRP was briefed on the ability to selectively recommend a subset of a proposal's components. Both of these are commented upon by the TRP in the next section (see paragraphs 5.9 to 5.13). The Secretariat will be incorporating this Round 10 feedback (as well as that from applicants) to further improve the way both applicants and TRP consider value for money in future funding rounds.

4.20 The TRP provides reasons for their funding recommendations in the 'TRP Review Form' which is sent to each applicant. Detailed explanations for the funding recommendation are provided and, where appropriate, separated into major and minor weaknesses. In the case of Category 1, 2 and 2B proposals, weaknesses include issues that must be addressed during the clarification process. In the case of Category 3 proposals, weaknesses include issues that would have to be addressed in a re-submission.

[26] In response to previous TRP recommendations, the Secretariat provided the TRP with specific Country Report per disease during its review. The report provided consolidated programmatic and financial information about the performance and achievements of the portfolio of Global Fund grants and collated and aggregated information from Grant Performance Reports (GPRs) and contained an overview of country statistics, the Global Fund portfolio and key results for the three diseases; an overview of overall financing, usage of funds and detailed results for the disease-component; and an overview of the performance of each Global Fund grant, including financial performance and programmatic achievements.

[27] In Round 9, proposal budgets requesting more than US$ 100 million over five years were reviewed by financial experts.

PART 5: RECOMMENDATIONS AND LESSONS LEARNED FROM THE ROUND 10 PROPOSAL REVIEW

INTRODUCTION

5.1 This part documents the lessons learned by the Technical Review Panel (TRP) during their review of Round 10 proposals and provides recommendations for Applicants, the Global Fund Board, Partners and the Secretariat for consideration in future Rounds. **Recommendations are presented in bold text.**

GLOBAL FUND ARCHITECTURE AND POLICIES

Consolidated Disease Proposals

5.2 In Round 10 applicants had the option of submitting a consolidated disease proposal. Overall, the experience with consolidated proposals was positive in that they allowed the TRP to better understand how the new funding request fits within the context of the existing grants in that disease area. This made it easier to judge both the added value and the additionality of the proposal. In particular the TRP found helpful the way in which applicants presented their existing service delivery areas (SDAs) and indicated the changes (new, removed, or expanded) from existing grants.

5.3 The TRP would like to emphasize that submitting a consolidated proposal presents the opportunity for reprogramming, where warranted, based on lessons learned from past implementation.

5.4 As consolidation moves forward, it will be important for the Global Fund to ensure that information regarding previous consolidations and transitions to single streams of funding are presented in a logical manner to allow the TRP to have a clear picture of existing and future consolidations.

5.5 Applicants that submitted strong consolidated funding requests were careful to build on lessons learned and successes achieved during their current grant implementation. They did a good job of identifying weaknesses of their existing programs and modified the proposed program going forward in order to achieve improved performance. Strong consolidated proposals also clearly distinguished between continuation of existing activities and the implementation of new activities.

The TRP recommends that the Consolidated Proposal application process be further enhanced and simplified, building on the lessons learned during Round 10 recognizing that it provides many benefits for more holistic consideration of programs.

Round 10 Dedicated Most at Risk Populations Reserve

5.6 The dedicated reserve for most at risk populations was a new initiative for Round 10. The inclusion of, and focus on most at risk populations within HIV proposals, however, has always been regarded by the TRP as a critical aspect to the technical merit of proposed interventions. The TRP has commented on this consistently in past Rounds and has been disappointed by the relatively low prioritization given to most at risk populations.

5.7 Overall, the quality of focus on these populations was greatly enhanced in the proposals submitted under this funding reserve in Round 10, suggesting that this mechanism provided an appropriate incentive for applicants to focus on these groups. Of the 25 proposals submitted under

this funding reserve, the TRP is recommending 12 of these and this represents a comparatively higher success rate than the HIV proposals in general (48 percent versus 41 percent).

5.8 There were also some notably high quality proposals submitted in the general funding category that had a very strong focus on most at risk populations. This could suggest that all Round 10 applicants, regardless of their choice of HIV proposal type, were appropriately made more aware by the Board's message and Secretariat information notes on this topic. This initiative most likely resulted in a better prioritization of interventions focused on those that are most at -risk of being infected.

Given this relatively positive experience, the TRP recommends the Most at Risk Populations Reserve established for Round 10 be reviewed by the Board for replication and possible expansion in future discussions of access to funding policies, including prioritization.

Value for Money

5.9 As set out in their Terms of Reference, the TRP has consistently considered value for money as an important proposal review criteria. The TRP considers effective cost of service delivery, opportunities for efficiencies, and ensures that countries have the requisite capacity, skills and resources to deliver on agreed outcomes. The budget and budget assumptions are also scrutinized for reasonableness. The TRP notes that the definition and understanding by applicants of the value for money concept is often not the same across all countries despite the fact that the Round 10 guidelines and the revised form provided some guidance on this.

5.10 In its review of Round 10 proposals the TRP worked to 'un-pack' the over-arching concept of value for money in a practical way in order to ensure a consistent approach, while recognizing the critical importance of country context. From the overall proposal review criteria, the TRP assessed value for money in the context of how a proposal makes a compelling case for investment in terms of how well suited the proposed goods and services are to make a difference in the fight against the three diseases and effect positive change in the health systems. In particular, the TRP considered:

i. Given the disease (or health systems) situation and local context, as presented in the proposal, whether the proposed activities correspond to what needs to be done (technically sound) and reflect appropriate priorities.

ii. If the activities reflect what needs to be done, whether the proposal suggests to undertake them in an **effective** way. When considering effectiveness, the TRP considered 'how' (i.e. the substance of what is proposed to be done) interventions are to be undertaken. The TRP looked at whether the activities are well designed to achieve the desired outcomes and impacts, whether they are coherent and needs-based, and whether, according to the TRP, they will be sustainable over time.

iii. Once the TRP considered whether the applicant was proposing to undertake an appropriate response and in an effective way, the TRP considered whether this would be done efficiently. When considering 'efficiency', the TRP considered this in the terns of whether what was being proposed was contemplated at the appropriate cost[28]. To determine the 'efficiency' of the interventions and activities, the TRP reviewed the different cost elements of the proposal, including but not limited to unit costs, training activities, salary support, etc.

[28] Cost efficiency simply means minimum input (i.e. minimum cost) for a given output, or maximum output for a given input; for the TRP it is the former. Note that "output" is used in the same sense as in applications, and is different from impacts and outcomes.

iv. Upon reviewing in detail the budgeted costs, the TRP also examined whether the additionality criterion had been met.

5.11 With regards to value for money, the TRP would like to emphasize that this concept remains and will continue to remain an important parameter for assessing proposals. However, the TRP notes that the new questions related to value for money introduced in the proposal form in Round 10 were not useful for its review purposes. Lessons learned from the review of this section indicate that countries did not fully comprehend what was required of them and could not provide clearly articulated answers to these sections. Some applicants did not provide enough information especially in relating strategies and activities to unit costs, budget assumptions, and additionality in their applications to enable the TRP to understand why investing in their application would represent good value for money.

The TRP recommends that for Round 11, the value for money concept be addressed by asking applicants to justify, per service delivery area, the technical appropriateness of the approaches being proposed and to provide the evidence upon which this is based. In addition, applicants should be required to demonstrate that the most effective interventions are being proposed at the lowest cost, (i.e. in the most efficient way). The TRP recognizes that there may be situations in which the interventions proposed are not at the least possible cost, but that a higher cost could be justified by the applicant based on appropriateness, effectiveness and/or sustainability.

Removal of a limited set of elements: Up-front removals

5.12 In Round 10 the TRP had greater flexibility to recommend a proposal for funding conditional upon the removal of a limited set of elements - the removal of which is not subject to appeal. Previously the TRP was only permitted to do this in the Rolling Continuation Channel (RCC). The TRP notes that it was not always practical or constructive to remove specific elements without the benefit of clarifications from the applicant. In certain cases (totaling approximately US $ 96.5 million over the proposal life time), the TRP decided to remove technically unsound elements; in others it may do so, but wishes to seek clarifications before doing so.

5.13 The ability of the TRP to propose the up-front removal of specific elements was found to be especially challenging with consolidated proposals. There was concern about the effect and implications of the removal of activities that had been approved in a previous Round.

The TRP welcomes the new flexibility to remove a limited set of elements from a proposal and recommends that it be maintained, recognizing however that the removal of such elements may only be effectively done at the clarification or grant consolidation stage. In addition the TRP recommends the Secretariat provide clearer guidance to both applicants and the TRP on the removal of specific elements from consolidated proposals for Round 11.

Under-spending and Unsigned/Recently Signed Grants

5.14 At the 21st Board meeting, as part of its decision on Round 10 prioritization[29], the Board requested the (TRP) to 'review data on significant under-spending of existing grants as part of its formal recommendation process (such data to be provided by the Secretariat)'.

5.15 The TRP has consistently considered progress on implementation of existing grants. One of the proposal review criteria specifically requests the TRP to consider if applicants have demonstrated successful implementation of programs previously funded by international donors (including the Global Fund), and, where relevant, efficient disbursement and use of funds.

[29] Decision Point GF/B21/DP17.

5.16 For Round 10, the TRP continued to consider under-spending of existing Global Fund grants, as well as undisbursed amounts, during its review. The main source of information regarding under-spending was the Grant Performance Report (GPR) and the Country Specific Report provided by the Secretariat. However, the TRP notes that these documents did not always indicate the extent of, or reasons for, any under-spending in a particular grant. This was particularly true in the case of recent grant consolidations.

5.17 The TRP also continues to see proposals from applicants recently approved with grants that are not yet signed, or that have grants with significant amounts of under-spent funds. While acknowledging some circumstances may justify applicants presenting requests for additional funding, the TRP renews its concern about new applications being made when lessons on implementation have yet to be drawn from active grants. As with Rounds 8 and 9, the TRP did not usually recommend for funding a proposal to continue, scale-up or alter an existing program that had not yet reported progress beyond a few months or had not yet been signed.

The TRP wishes to reiterate again to the Board the need to address this issue urgently before the next round. The TRP strongly recommends that the Board clearly define the rules for applying for new funds on a repeat basis, especially in situations where countries have an unsigned grant or are in the early stages of a recently signed grant, with the intent of reducing the frequency of applications from countries that have been recently approved for funding. Should the Board decide to implement eligibility restrictions based on funding history, the TRP would encourage a broader and flexible approach to reprogramming.

The TRP recommends that the Secretariat work with the TRP to improve the presentation of information on under-spending and undisbursed funds prior to Round 11 to allow for the TRP to adequately assess this.

Regional and Multi-Country Proposals

5.18 In Round 10 the TRP recommended five (HIV proposals) out of 15 eligible multi-country and regional proposals (seven HIV Most at Risk Populations, five HIV, two tuberculosis and 1 malaria). The recommended proposals clearly demonstrated the value-added of a multi-country and/or regional approach. The TRP continues to question the value-added of most multi-country and regional proposals. As with Round 9, the TRP questions the relevance of including service delivery interventions in these proposals as this may contribute to the creation of parallel systems in country. For the TRP to recommend a multi-country or regional proposal there must be a compelling case for a regional approach as there is a risk of duplicating national activities. The TRP notes that in most cases these proposals fail to demonstrate value for money and include significant funds for salaries which are not sustainable.

The TRP recommends that the Global Fund provide better guidance for these applicants and stipulate the conditions under which a multi-country or regional proposal is considered appropriate.

GENERAL RECOMMENDATIONS

Grant Performance Reports

5.19 The TRP continues to rely on Global Fund GPRs as the main source of programmatic and financial data on existing Global Fund grants, but notes again the significant variability in the quality, completeness and relevance of GPRs.

The TRP recommends that GPRs be more consistently completed, with necessary level of detail, across the grant portfolio. This issue is of particular importance for grants with large amounts of unspent funds.

5.20 In response to the TRP's concern regarding the limitations of GPRs to provide a holistic view of all Global Fund grants in given country for a particular disease, the Secretariat provided the TRP with country specific reports per disease which consolidated programmatic and financial information about the performance. The TRP welcomed this attempt to provide a more holistic picture.

The TRP recommends that the practice of preparing country specific reports be continued and strengthened.

Performance and Evaluation Frameworks

5.21 As with previous Rounds, the TRP found performance frameworks, as presented in disease and cross-cutting HSS requests as well as those existing in current Global Fund grants, to be weak and requiring further improvement. Performance frameworks continue to focus largely on process and output indicators, and in general lack appropriate outcome and impact indicators. For those programs that propose outcome indicators, insufficient attention is paid to the quality of the interventions (e.g. quality of care, or quality of prevention services, etc.). Rather, indicators typically focus on aspects of coverage.

5.22 In particular as the Global Fund transitions to periodic reviews in the new grant architecture, the TRP maintains that program evaluations should be better incorporated into the national programs – both as part of measuring outcomes/impacts and as a basis for funding requests for continuation and/or scale up of the interventions.

5.23 The current Performance Framework model does not provide sufficient information to serve as an evaluation framework for national programs supported by the Global Fund. In advance of Round 11, the TRP is supportive of the work underway to establish requirements for applicants to incorporate an evaluation framework at the proposal development stage. This should ensure that evaluation activities (program reviews, surveys, operational research, technical assistance, etc.) are integrated into the program and are adequately resourced in the budget request or funded by other donors.

During grant negotiations, the TRP recommends the Secretariat continue to improve the rigor of performance frameworks by ensuring that these contain fewer process and output indicators and focus instead on outcome and impact.

The TRP also supports the introduction of more detailed guidance as part of the application materials to support the requirement of a comprehensive evaluation framework from the applicants.

Funding of Human Resources

5.24 The TRP notes that significant funding is requested for human resources. The TRP sees the issue of staff compensation and performance incentives as an important issue. The TRP is concerned that the way this issue is currently addressed within the Global Fund financing framework potentially leads to mismanagement, 'internal brain drain', and potential destabilization of the rest of the health care system.

The TRP recommends that urgent action be taken by the Board and the Secretariat to develop and to avail to countries strict rules on human resource compensation, based on countries' national standards and documented policies, prior to the launch of Round 11. The TRP

welcomes the guidance now available in the Guidelines for Budgeting in Global Fund Grants, but notes that this was not available in time to inform the Round 10 applications[30].

The TRP also recommends that further policy developments in this regard should be made in collaboration with countries and partners to ensure harmonization and relevance.

5.25 The TRP noted that requests for capacity development and pre-service training often failed to provide clear justification for how it will contribute to addressing priority program needs and the broader needs of the health system.

The TRP recommends that applicants provide a retention mechanism/policy with particular attention paid to programs supported by the Global Fund; and a description of how it fits with a broader human resource development policy.

5.26 Many applications request funds for training without sufficient demonstration of program-level impact. While training indicators are often reflected in terms of process/outputs, the TRP encourages applicants to measure the change that is achieved through the contributions of these numerous trainings by including more robust impact indicators.

The TRP recommends that proposal guidelines clearly state that all in-service training requests be based on a training needs assessment and include a plan for a training impact assessment. The TRP further recommends that impact indicators be included to measure the effect of training efforts.

5.27 With respect to occupational health and safety, the TRP strongly encourages applicants to incorporate measures in their proposals to ensure occupational safety of health workers with respect to blood borne and air borne infections, according to internationally accepted standards.

Role of United Nations Agencies

5.28 The TRP continues to support local capacity development and is concerned about the role and the increasing number of UN agencies being nominated as Principal and Sub-Recipients (PRs and SRs). The TRP notes that in some instances UN agencies continue to remain as PRs and SRs after many Rounds. In its experience, the TRP finds that using UN agencies as SRs may create parallel systems, fail to build local capacity and not represent value for money. The TRP recognizes the important role played by UN agencies in terms of providing technical assistance to countries in the development and implementation of strategic approaches, as well as proposal development support.

The TRP recommends that applicants provide strong justification in their proposal in cases where UN agencies are nominated as either PRs or SRs. In situations where a UN agency is proposed as a PR, a clear plan should be developed to transition responsibilities to a local PR.

Number of Sub-Recipients

5.29 The TRP notes with concern the proliferation of SRs in Global Fund grants. As each Sub-Recipient has its individual overhead costs, the TRP is concerned that the amount of funding going towards Sub-Recipient overheads may not represent good value for money. With an increasing number of Sub-Recipients, coordination challenges also increase.

The TRP recommends that applicants provide strong justification in their proposal on the selection and number of its nominated SRs, and clearly describe coordination mechanisms that will be put in place to ensure effective coordination and value for money.

[30] http://www.theglobalfund.org/documents/core/guidelines/Core_BudgetingInGlobalFundGrants%20_Guideline_en.pdf

Technical Assistance

5.30 The TRP notes that the new technical assistance section of the proposal form may have increased the awareness on this topic by Round 10 applicants. However, it notes that in general there is a lack of local technical assistance providers being put forward. Countries seem to look internationally for technical assistance, while many in-country partners may have the necessary knowledge and skills.

The TRP recommends that applicants propose the use of local technical assistance providers in future proposals as this may represent better value for money. Where there are no suitable local providers, the TRP notes that it may be appropriate to engage with UN agencies for technical assistance, rather than contracting them as Sub-Recipients.

5.31 The TRP notes that in many proposals there was confusion among applicants regarding what constitutes technical assistance and what constitutes contracted out services.

The TRP recommends that future proposal guidelines provide more detailed guidance on what constitutes technical assistance.

Translations

5.32 The TRP notes with concern that the quality of translations of proposals provided to the TRP in Round 10 was of lower quality than in Round 9. The sub-optimal quality of translations did not hinder the proposal review process as the TRP has the requisite language skills among its members to enable review of the original language documents submitted and in most instances TRP members with the necessary language skills were assigned to small groups to review translated proposals in their original language.

The TRP recommends the Secretariat takes additional measures to improve the quality of translations. Applicants are also encouraged, where feasible, to provide their own translation.

RECOMMENDATIONS ON FINANCIAL ISSUES

Financial Gap Analysis and Cost-sharing

5.33 As part of its review, the TRP looks at complementarity and additionality. An important tool for this assessment is the financial gap analysis presented in the proposal form. The TRP notes that too often applicants fail to present a robust and accurate financial gap analysis giving rise to difficulty in validating the information, and its reliability. The TRP also recognizes the challenges that applicants face in presenting future donor commitments within the financial gap analysis.

The TRP recommends that Technical Partners provide support to countries, in advance of Round 11, in developing clear, detailed and evidence-based financial gap analyses for the diseases and health sector when appropriate. This could include, but would not be limited to, supporting countries with costed national strategies and strategic plans, as well as forecasting pipelines from national and donor sources, among others. The TRP also urges donors to provide as much forward looking information as possible.

5.34 The TRP strongly feels that the current cost-sharing method (as presented within the financial gap analysis table) is impractical and does not elicit the type of information required.

The TRP recommends that the financial gap analysis table and cost-sharing table and related guidance be re-designed to help applicants understand the cost-sharing requirements. However, the TRP recognizes that this should only occur after the Board makes a final decision on the review of the Global Fund's eligibility criteria and cost-sharing requirements. Furthermore, the TRP would recommend the exploration of possible methods to hold

applicants/grant recipients accountable for compliance with cost-sharing requirements at the time of proposal submission and throughout the grant life cycle.

Financial Analysis Support to TRP

5.35 As with Round 9, the TRP was provided financial analysis support for its review of budgets. For Round 10, financial analysts reviewed all budgets whose lifetime request was approximately US $ 50 million or above, as well as for all consolidated proposals, which represented 47 percent of the proposals reviewed and 86 percent of the entire Round 10 proposal lifetime value requested.

5.36 The TRP again welcomed this support and overall remains extremely positive on the ability of these experts to provide an extra level of scrutiny to proposal budgets.

The TRP recommends that for Round 11 all proposal budgets, irrespective of the amount, be reviewed by external financial experts, since smaller funding requests may still have significant issues. The TRP also requests access to additional financial analysis support during clarifications for complex cases.

Budgets

5.37 The TRP notes with concern the disappointing quality of many proposal budgets which often lack the necessary detail, clarity and accuracy. In particular the TRP would like to emphasize to applicants that a well-written budget should clearly state and disclose unit cost assumptions. In Round 10, a small number of applicants submitted their budget using the WHO Costing Tool. Overall the TRP found that the tool provided for better accuracy and presentation of required information. Should the tool be made available for future Rounds, additional improvements are required. Should applicants not provide unit costs for certain items, strong justifications should be provided.

The TRP makes the following recommendations for changes in the proposal form and guidelines in order to support improved budget submissions:

i. **A standardized budget template should become mandatory;**

ii. **The proposal guidelines should include more detailed instructions on the classification of cost categories;**

iii. **Better guidance should be provided to applicants on unit costs; the breakdown of lump sums into their component parts; and also how to classify cost items within the various cost categories;**

iv. **The budget and work plan should be separate documents, but should be cross-referenced; and**

v. **The request for budget information should be consolidated within the proposal form so that it only appears once, with related summary sheets in order to avoid confusion and inconsistencies.**

The TRP also recommends a mechanism be developed by the Secretariat to ensure greater budget clarifications during eligibility screening, recognizing that this may have resource and timing implications for the Secretariat.

Unit Price References

5.38 As remarked in the disease specific sections below, the TRP notes with concern the significant variability in the unit and procurement costs of commodities presented in proposals. Worthy efforts were made in Round 10 to improve resources available to applicants and the TRP on international price references. The TRP commends the efforts of partners in providing this

guidance. However, it is important that the guidance be further developed and shared with countries by partners with significant technical inputs to enable countries to utilize the tools more effectively.

The TRP recognizes the challenge in developing guidance that takes into account regional and country differences in the existing price and market variability. The TRP encourages the Secretariat to continue its work with technical partners to develop useful tools in this area, particularly in light of positive advancements with the Global Fund's Price and Quality Reporting Mechanism (PQRM) that could be leveraged to support applicants' ability to align proposed prices with current practice.

TECHNICAL QUALITY OF PROPOSALS: GENERAL RECOMMENDATIONS

Pharmacovigilance

5.39 The TRP welcomed the additional guidance provided to applicants on pharmacovigilance. How applicants responded to this depended on the disease component. For tuberculosis proposals, the TRP noted that overall the information provided improved in this Round, but in most cases proposals did not include sufficient budgets to fund capacity building for pharmacovigilance. Although most malaria applicants mentioned pharmacovigilance, it was not clearly elaborated in most cases.

The TRP recommends that guidance and technical assistance be provided to applicants as this is a cross-cutting issue.

Behavior Change Communication (BCC)

5.40 With respect to behavior change communication (BCC) interventions, the TRP notes many proposals request funding for BCC interventions without providing or demonstrating sufficient evidence of program-level impact in a given country context. The TRP acknowledges the challenges inherent in designing appropriate BCC interventions and encourages partners and applicants to propose pilot approaches before going to scale on BCC interventions.

The TRP recommends that proposal guidelines clearly state that BCC requests must be based on a needs assessment, evaluation/lessons learned from pilots where applicable, and must include a plan for a BCC impact assessment.

5.41 Regarding the measurement of BCC interventions, the TRP notes that in general applicants tend to only include output indicators.

The TRP recommends that applicants should use appropriate evaluation approaches and impact indicators to measure the change in behavior and awareness.

Gender and Sexual Orientation

5.42 It is clear that more guidance is required for applicants to better understand how to address gender inequality as part of their proposed interventions. Proposals should not appear to 'compartmentalize' gender in a dedicated section of the Proposal Form; rather this should be integrated and mainstreamed throughout the proposal (in particular within the proposal strategy section and linking with performance framework with the help of carefully selected indicators).

The TRP recommends that the Global Fund, with support from Technical Partners, provide guidance to applicants on areas that can be considered within programmatic components to applicants and the proposal form and guidelines be modified in this respect. The TRP also recommends that the Board and Secretariat send a message to applicants that failure to

undertake a gender analysis prior to developing interventions may compromise the success of proposals.

5.43 As noted above in paragraph 5.2, the TRP notes a significant increase in Round 10 proposals appropriately focused on people who are marginalized due to sexual orientation, gender identity, or consensual sexual behaviours. This could suggest that the Global Fund's sexual orientation and Gender Identities (SOGI) Strategy[31] has provided an important framework for applicants and partners to develop proposals to target groups who are particularly underserved, including men who have sex with men and transgender people.

5.44 While there were several proposals from Regional Organizations that focused on special needs of men who have sex with men, transgender people and commercial sex workers, the TRP notes that there were no country-level applications submitted as non-CCM proposals in response to the special provisions afforded to proposals whose activities focus on socially marginalized and or criminalized groups at heightened risk (see Action 4 of the SOGI Strategy).

Stigma and discrimination

5.45 The TRP is concerned with the limited inclusion in proposals of existing human rights instruments and measures to address stigma and discrimination. The TRP maintains that issues of stigma and discrimination must be addressed together and complementary to gender. As demonstration of their commitment to this issue, applicants should include interventions (and the necessary budget) to address stigma and discrimination rather than making token mention of these within the proposal text. The TRP also urges applicants to address the criminalization of key and vulnerable populations where applicable, and to demonstrate the role of civil society organizations in the social de-criminalization of these populations.

The TRP recommends that the Board and Secretariat send a message to applicants that failure to provide a complete and appropriate discrimination analysis as part of their proposal may compromise its quality.

Given the significant influence of the Global Fund, the TRP recommends that the Office of the Executive Director and the Board leverage this influence at the global level and in specific national contexts where there is a clear discrimination against vulnerable populations. This includes addressing legal environments that criminalize vulnerable populations.

TECHNICAL QUALITY OF PROPOSALS: DISEASE-SPECIFIC RECOMMENDATIONS

HIV/AIDS

5.46 In Round 10, 41 percent[32] (or 32 out of 78 proposals) of HIV proposals were recommended for funding by the TRP. This success rate is similar to the success rates from Rounds 8 and 9.

Most at Risk Populations

5.47 To ensure that an enabling environment is created for the HIV interventions for which funding is requested, the TRP encourages countries to reflect strategies for most at risk populations in their HIV national strategies as this may influence the extent to which interventions will be operationalized.

5.48 The TRP notes that different key populations should be targeted at different stages of the HIV epidemic as key populations change during the course of an epidemic and this should be

[31] http://www.theglobalfund.org/documents/publications/other/SOGI/SOGI_Strategy.pdf

[32] This number excludes cross-cutting Health Systems Strengthening (HSS) requests and represents purely the disease component success rate.

considered by applicants. In addition, the TRP cautions applicants to ensure that most at risk populations are not stigmatized as disease drivers but rather offered support as vulnerable and underserved groups.

The TRP recommends that future applicants provide more contextual information regarding most at risk populations, including but not limited to surveillance data or special survey reports addressing these populations as appropriate.

WHO PMTCT regimen: Use of Options A and/or B

5.49 Many Round 10 HIV proposals considered the July 2010 guidelines issued by World Health Organization (WHO) on PMTCT (preventing mother-to-child transmission) and on HIV and breastfeeding. The TRP found that applicants did not always clearly present the country context when describing the preferred treatment regimen selected. Applicants also did not always demonstrate their ability to conduct CD4 monitoring. The TRP also notes that applicants should clearly describe how health care workers will be trained to implement the selected option, as well as describe how existing country guidelines on the provision of anti-retroviral (ARV) prescription policies will impact on the implementation of the selected regimen.

The TRP recommends that WHO provide clearer guidance to help countries make better informed decisions on which option to adopt based on their local context as well as to support sound transition planning. Future proposals should also clearly demonstrate the country capacity to implement its preferred option.

Adherence to anti-retrovirals

5.50 With an increasing number of persons receiving ARV therapy, the issue of treatment adherence is of particular importance to the TRP. The success in increasing ARV therapy coverage brings with it the challenge of ensuring adherence in the long-term. The TRP recommends that applicants include within proposals a focus to improve and sustain adherence beyond two years after the commencement of ARVs, particularly in symptomless patients who are placed on ARVs. Adherence strategies and components need to be reflected in national policy documents in order for them to be sustained.

The TRP recommends that applicants increasingly consider the use of community approaches to improving adherence to ARVs and include within their proposals support for technical assistance for monitoring data on ARV adherence.

Reproductive Health and Contraceptives

5.51 The TRP recognizes that in many countries there exist systemic challenges affecting appropriate integration between sexual reproductive health and prevention of mother-to-child (PMTCT) services. The TRP encourages the integration of family planning interventions into HIV care and treatment programs as part of a larger reproductive health program. It also strongly supports equality of treatment of HIV positive women with respect to their reproductive choices. So while the TRP recognizes that requests for contraceptive commodity procurement may be warranted in certain countries, proposals should demonstrate that funds being requested are not replacing traditional family planning donors (e.g. UNFPA and the US Government), address the interactions between anti-retrovirals and contraceptives and include an analysis of current family planning commodities, utilization and uptake in existing service delivery points on a country by country basis.

The TRP recommends the Global Fund provide clear guidance to applicants regarding when and under which circumstances the Global Fund will consider funding contraceptive commodity procurement.

Hepatitis C Virus

5.52 The TRP reviewed several proposals that included funds for the treatment of Hepatitis C and recommended one proposal for funding subject to clarifications. The TRP is concerned that currently available therapy for the treatment of Hepatitis C (Interferon and Ribavirin) is generally not accessible to the estimated 170 million people living with chronic Hepatitis C. Furthermore, evidence suggesting effectiveness of the combined treatment is limited; the treatment is often poorly tolerated in combination with ARV, needs to be closely supervised and presents operational challenges with treatment access and adherence. More effective and better tolerated regimes are expected to come on the market within a short period of time. Applications for funding of treatment using the present regime will only be recommended by the TRP after close scrutiny of the country context, including well-documented evidence that Hepatitis C treatment and funding is available to the general population and that funding from the Global Fund is to fill-in the gap for HIV infected individuals. Applicants should be required to supply this information in their proposal.

The TRP therefore recommends that Global Fund resources be used at this time to increase the evidence base for the need of Hepatitis C treatment (e.g. prevalence surveys), create awareness and increase prevention efforts (e.g. through supporting methadone substitution and needle exchange program, as well as focusing on infection control in health care setting and blood transfusion safety, which would also benefit prevention of other blood-borne diseases) and support advocacy for access and affordability of new Hepatitis C treatments as they become available. Clearer guidance to applicants in this regard is recommended. The TRP urges partners (UNITAID and Clinton Foundation) to explore possibilities with pharmaceutical industry to see how treatments can be made more affordable.

Orphans and Vulnerable Children- Supplemental Feeding

5.53 Considering that malnutrition amongst orphans and vulnerable children - as reflected by poor child growth and poor micronutrient status is very common and near universal, the TRP recommends that funding requests for the provision of food supplements and/or appropriate micronutrient supplements for orphans and vulnerable children not be targeted by disease status to ensure that all such children in any given facility or community receive the appropriate services.

The TRP recommends that the Global Fund continue to support targeted food and/or micronutrient supplements for undernourished children, on a case-by-case basis, and that such proposals demonstrate linkages with other food support programs to avoid the politicization of such programs (e.g. applicants could consider integration with sustainable livelihoods and income-generating activities and programs).

HIV and TB Collaboration

5.54 TRP is pleased to acknowledge an increase in the number of TB and HIV proposals that have taken note of the Board decision and adequately reflected TB/HIV collaborative efforts. There were, however, a number of proposals that did not address sufficiently TB/HIV co-infection and collaborative activities.

The TRP recommends that the Secretariat and partners continue to communicate the Board decision to applicants and to emphasize the importance of reflecting TB/HIV collaborative activities in the TB and HIV proposals, unless compelling reasons exist not to do so.

MALARIA

5.55 While there were fewer malaria proposals in Round 10, they had the highest success rate with 79 percent of proposals (19 out 24) recommended for funding. The TRP applauds the strategy

focus taken by the malaria applicants and technical partners that reflects a focus on those countries with a compelling case for funding.

Assumptions for malaria episodes

5.56 The TRP noted during its review that the assumptions made for malaria episodes suffered huge variations between assumptive cases and confirmed cases.

The TRP recommends that as countries scale up parasite-based diagnosis, case load data be adapted with a clear indication of how the assumptions made adjust the data.

Insecticide and drug resistance studies

5.57 The TRP noted that not all applicants mentioned the monitoring of insecticide resistance in their vector control programs.

The TRP recommends that applicants ensure that insecticide resistance monitoring accompanies all vector control programs within their proposal.

Programming needs assessment for commodities and unit costs

5.58 The TRP noted that overall applicants did not provide sufficient information within their proposal regarding their programming needs assessment for commodities. In addition, significant variability was found in the unit and procurement costs of commodities within malaria proposals.

The TRP recommends a table be provided to applicants in the Proposal Form to present the commodities required for each service delivery area and that Technical Partners assist applicants in providing this information. The TRP also recommends that the Secretariat works with Technical Partners to develop a comprehensive and standardized list of average costs and reference prices for these commodities.

TUBERCULOSIS

5.59 The success rate of tuberculosis proposals was 54 percent with 26 out of 48 proposals recommended for funding.

Management of Childhood Tuberculosis

5.60 The TRP noted that a number of proposals included broad reference to the management of childhood tuberculosis and included procurement of tuberculin and pediatric formulations of drugs. However, many proposals failed to include comprehensive strategies for childhood TB diagnosis or management of pediatric cases and the role of pediatricians was not routinely described.

The TRP recommends that applicants who include interventions for the management of childhood tuberculosis provide this information as part of their proposal submission in order to allow for the TRP to adequately assess the request.

Cost of Surveys

5.61 In addition to providing a global price list of all of the equipment that is normally requested within tuberculosis proposals, the TRP requests that WHO provide price ranges for drug resistance surveys, prevalence surveys, Knowledge, Attitudes and Practice (KAP) surveys, etc.

Advocacy, Communication and Social Mobilization (ASCM)

5.62 As with Round 9, the TRP noted that ACSM components included in tuberculosis proposals were not strategic, nor were strategies well elaborated. Applicants tended to include a 'laundry list' of activities without the evidence to support the chosen interventions. The TRP also notes that the involvement of community partners was still not well developed within Round 10 proposals.

Technical Partners are requested to work with applicants to improve this component and to provide detailed guidance. In addition, applicants are encouraged to build the capacity of community partners in ASCM interventions.

Laboratory and diagnostic networks and Quality Assurance

5.63 As with Round 9 proposals, a primary weakness in Round 10 proposals was the lack of clear rationale for the selection of laboratory diagnostics, the lack of strategic planning for the introduction of new diagnostics (for example, GeneXpert), and the fact that only a small number of applicants included diagnostic algorithms. The TRP is concerned that the inclusion of new diagnostics often is not accompanied by clear indication of how and where they used and how quality assurance would be maintained. The TRP noted that although the inclusion of plans for quality assurance of laboratories improved in Round 10, it is still not consistently included in all proposals.

5.64 In addition, while only a few applicants included the consideration of x-rays as a valuable tool within the diagnostic algorithm, the TRP recommends that Technical Partners provide guidance to applicants on when to use x-ray technology and on the appropriate use of digital x-ray.

5.65 In its review of Round 10 proposals, the TRP noted that plans for decentralizing microscopy are frequently extreme and need to be more rational. The existing WHO guidelines may not be sufficient.

The TRP recommends that Technical Partners work with applicants to ensure that robust and appropriate plans for the introduction of new technologies is provided, as well as the routine inclusion in proposals of comprehensive laboratory quality assurance plans. It also notes that applicants would benefit from better guidance on the appropriate use of x-ray technology as well as decentralization of microscopy, particularly to explore options for reaching remote areas and hard-to-reach populations while maintaining the quality of diagnostic services.

Management of Multi-Drug Resistant Tuberculosis (MDR-TB)

5.66 The management of multi-drug resistant tuberculosis (MDR-TB) is rapidly expanding at the global level and resources needs are constantly increasing. Currently, the Global Fund support for MDR-TB management is conditional upon Green Light Committee (GLC) approval and technical assistance, in order to ensure technically sound MDR-TB related activities and procurement of high quality, low cost second line anti-TB drugs.

5.67 The rapid scale-up and evolvement of MDR-TB management toward programmatic implementation may contemplate a transition away from the GLC. In case the transition from GLC is endorsed, the TRP expresses concerns on how this will affect the quality and effectiveness of MDR-TB programs. In addition, if countries do not implement appropriate MDR-TB management measures, the TRP is concerned about the possible growth of Extensively Drug Resistant Tuberculosis (XDR-TB).

5.68 The TRP is concerned that without GLC monitoring and rationalization of the pace of scale-up of MDR-TB components based on program performance, the assessment of MDR-TB program implementation within Global Fund supported programs will be particularly challenging. In Round 10 many applicants proposed rapid scale-up of MDR-TB and the TRP based its recommendations and comments considering GLC's role and technical assistance. In future, without the GLC, the Global Fund will need to ensure that quality is being monitored (e.g. treatment outcomes of MDR-TB patients) prior to approval of further scale-up.

The TRP recommends that, in case the transition from GLC is approved, the Global Fund works with Technical Partners to ensure that a new policy, including quality assurance of second line drugs, is adopted.

5.69 The TRP noted that some applicants are already implementing the 9-month regimen for MDR-TB (not endorsed by WHO-GLC so far). In general, the TRP recommends that countries change to the GLC-endorsed regimens. However, the TRP notes that the switch to GLC-recommended regimens may not be necessary if preliminary data on the 9-month regimen show good treatment outcomes. As more guidance on this is required, the TRP encourages Technical Partners (including but not limited to WHO) to develop regional recommendations on alternative regimens, conditional on careful monitoring of results.

The TRP notes that in many proposals the approach to screening and follow-up of MDR-TB patients was not sufficiently described (in particular: diagnostic algorithm, rationale of use of new technologies, etc.) and recommends that in the future Technical Partners work with applicants to ensure that these issues are adequately addressed.

Operational Research

5.70 The TRP notes that operational research is often absent or inadequately elaborated in the proposals and that this is a missed opportunity to strengthen the proposals and address bottlenecks in service delivery. Often, proposals clearly describe the bottlenecks to progress and this provides the basis for operational research questions that seem obvious but are not proposed.

The TRP recommends that Technical Partners work with applicants to help translate programmatic constraints and identified bottlenecks into relevant operational research to support research implementation and to formulate programmatic changes based on research results.

Practical Approach to Lung Health (PAL)

5.71 The TRP notes that while Round 9 included a significant amount of activities for PAL, these were largely lacking in Round 10. It is not evident to the TRP that consistent guidance is provided to applicants.

The TRP recommends that Technical Partners ensure that clear and consistent guidance is provided on this topic.

Patient Support

5.72 The TRP notes that there was an increase in the proposed levels of patient support in Round 10, often without the evidence to substantiate the need for or the type of support proposed. Without any evidence of impact, these budget requests were not recommended by the TRP.

The TRP recommends that all requests for patient support include supporting evidence to allow for the TRP to assess the feasibility and impact of such activities.

Prisons

5.73 The approach to working in prison settings was not well presented by most applicants. Applicants require support to ensure collaboration with other ministries (Justice, Interior, etc.) working with prisons. While the TRP commends the consideration of prison settings within Round 10 proposals, overall the plans did not appear well designed or comprehensive which makes feasibility questionable.

Technical Partners are encouraged to provide more guidance and best practices examples to applicants on working effectively in prison settings.

HEALTH SYSTEMS STRENGTHENING (HSS)

5.74 Discussions with Technical Partners leading up to the Round 10 TRP review highlighted the fact that proposals to strengthen health systems submitted to the Global Fund, regardless of whether these interventions are ultimately incorporated into the disease proposal or submitted under the specific section of the proposal form (section 4B/5B), do not receive the same level of support from Technical Partners as do efforts to develop the disease-specific proposals.

5.75 Interactions between TRP and the WHO during pre-briefings indicated that in addition to improving mechanisms to finance HSS interventions, it is equally important to reflect on how this should be most effectively planned. TRP experience and current thinking in WHO suggest that the WHO "building blocks" do not make suitable SDAs for articulating funding support for HSS interventions. This lesson learned is of particular importance for advancing the Health System Funding Platform currently under development.

5.76 Despite this, the TRP notes an encouraging trend in Round 10 proposals towards increased synergy between disease specific and health system strengthening interventions, as well as the incorporation of innovative healthcare funding mechanisms aimed at achieving universal coverage.

In light of the opportunity afforded by the Health Systems Funding Platform (HSFP) to the Global Fund and partners to enhance the approach to HSS, the TRP urges the Secretariat and partners (WHO, GAVI and World Bank) to ensure that lessons learned from the various stakeholder experiences to date with HSS be fully leveraged to improve guidelines to countries, to simplify the application materials, and that adequate provision for technical support is made available to HSS applicants prior to the launch of Round 11.

List of Eligible Round 10 Proposals Reviewed by the TRP, classified by recommendation category

PROPOSALS RECOMMENDED FOR FUNDING BY THE TRP								
No.	**Applicant type**	**Applicant**	**Income level (from Annex 1 in Round 10 Guidelines)**	**WHO Region**	**Global Fund Regional Team**	**Disease**	**TRP Recommended* Phase 1 Upper ceiling (2 Years)**	**TRP Recommended* Lifetime Upper ceiling (Up to 5 years)**
CATEGORY 1 HIV MARPs PROPOSALS								
1	CCM	Macedonia (Former Yugoslav Republic)	Lower-middle	EURO	EECA	HIV MARPs	€ 2,825,259	€ 9,407,934
Sub-Total: Category 1 HIV MARPs Proposals in EURO							**€ 2,825,259**	**€ 9,407,934**
Total: Category 1 HIV MARPs Proposals in US$							**$ 3,691,074**	**$ 12,291,044**
CATEGORY 2 HIV MARPs PROPOSALS								
2	CCM	Georgia	Lower-middle	EURO	EECA	HIV MARPs	€ 3,105,210	€ 8,860,077
Sub-Total: Category 2 HIV MARPs Proposals in EURO							**€ 3,105,210**	**€ 8,860,077**
3	CCM	Argentina	Upper-middle	AMRO	LAC	HIV MARPs	$ 4,933,812	$ 12,500,000
4	CCM	Kazakhstan	Upper-middle	EURO	EECA	HIV MARPs	$ 2,404,755	$ 12,449,062
5	CCM	Panama	Upper-middle	AMRO	LAC	HIV MARPs	$ 4,202,744	$ 10,273,513
6	CCM	Peru	Lower-middle	AMRO	LAC	HIV MARPs	$ 4,999,999	$ 12,499,997
7	RO	REDTRASEX	Mixed	AMRO	LAC	HIV MARPs	$ 4,328,974	$ 12,496,279
8	CCM	Uruguay	Upper-middle	AMRO	LAC	HIV MARPs	$ 3,953,375	$ 9,572,417
Sub-Total: Category 2 HIV MARPs Proposals in US$							**$ 24,823,659**	**$ 69,791,268**
Total: Category 2 HIV MARPs Proposals in US$							**$ 28,880,476**	**$ 81,366,562**
CATEGORY 2B HIV MARPs PROPOSALS								
9	RO	ISEAN-HIVOS	Mixed	WPRO	EAP	HIV MARPs	$ 4,767,802	$ 12,473,395
10	CCM	Malaysia	Upper-middle	WPRO	EAP	HIV MARPs	$ 4,672,630	$ 12,405,288
11	RO	MENAHRA	Mixed	EMRO	MENA	HIV MARPs	$ 3,209,492	$ 8,352,698
12	CCM	Syrian Arab Republic	Lower-middle	EMRO	MENA	HIV MARPs	$ 1,723,169	$ 3,396,722
Total: Category 2B HIV MARPs Proposals in US$							**$ 14,373,093**	**$ 36,628,103**
Total: Category 1, 2 and 2B HIV MARPs Proposals in US$ Equivalent							**$ 46,944,644**	**$ 130,285,709**

No.	Applicant type	Applicant	Income level (from Annex 1 in Round 10 Guidelines)	WHO Region	Global Fund Regional Team	Disease	TRP Recommended* Phase 1 Upper ceiling (2 Years)	TRP Recommended* Lifetime Upper ceiling (Up to 5 years)
CATEGORY 1 PROPOSALS								
13	CCM	Angola	Low er-middle	AFRO	SA	Malaria	$ 40,435,549	$ 111,239,055
14	CCM	Timor-Leste	Low er-middle	SEARO	EAP	HIV	$ 6,798,682	$ 14,254,688
Total: Category 1 Proposals in US$							**$ 47,234,231**	**$ 125,493,743**
CATEGORY 2 PROPOSALS								
15	CCM	Afghanistan	Low	EMRO	SWA	Tuberculosis, incl. CCHSS	€ 16,132,533	€ 23,330,719
16	CCM	Armenia	Low er-middle	EURO	EECA	Tuberculosis, disease only	€ 3,310,881	€ 8,881,651
17	CCM	Djibouti	Low er-middle	EMRO	MENA	Tuberculosis	€ 2,461,552	€ 6,080,117
18	CCM	Georgia	Low er-middle	EURO	EECA	Tuberculosis	€ 7,695,603	€ 21,727,729
19	CCM	Macedonia (Former Yugoslav Republic)	Low er-middle	EURO	EECA	Tuberculosis	€ 2,901,528	€ 6,112,713
20	CCM	Mali	Low	AFRO	MENA	Tuberculosis	€ 8,053,957	€ 13,773,341
21	CCM	Senegal	Low	AFRO	WCA	Malaria	€ 21,650,781	€ 62,865,723
22	CCM	Senegal	Low	AFRO	WCA	Tuberculosis	€ 6,335,035	€ 17,460,725
Sub-Total: Category 2 Proposals in EURO							**€ 68,541,870**	**€ 160,232,718**
23	RO	APN+	Mixed	WPRO	EAP	HIV	$ 1,200,000	$ 3,000,000
24	CCM	Congo (Democratic Republic)	Low	AFRO	EAIO	Malaria	$ 73,922,870	$ 185,122,386
25	CCM	Eritrea	Low	AFRO	EAIO	HIV, incl. CCHSS	$ 20,818,140	$ 59,897,311
26	CCM	Indonesia	Low er-middle	SEARO	EAP	Tuberculosis, incl. CCHSS	$ 47,727,271	$ 157,544,680
27	CCM	Iran (Islamic Republic)	Low er-middle	EMRO	SWA	Malaria	$ 9,363,548	$ 19,578,464
28	CCM	Jordan	Low er-middle	EMRO	MENA	Tuberculosis	$ 2,078,829	$ 4,666,284
29	CCM	Kenya	Low	AFRO	EAIO	Malaria	$ 49,979,579	$ 138,370,324
30	CCM	Kyrgyz Republic	Low	EURO	EECA	HIV	$ 11,207,840	$ 41,480,486
31	CCM	Lao PDR	Low	WPRO	EAP	Tuberculosis, disease only	$ 3,255,999	$ 12,887,910
32	CCM	Liberia	Low	AFRO	WCA	Malaria, incl. CCHSS	$ 28,698,063	$ 68,892,692
33	CCM	Mongolia	Low er-middle	WPRO	EAP	Tuberculosis, incl. CCHSS	$ 3,696,354	$ 9,052,049
34	CCM	Morocco	Low er-middle	EMRO	MENA	HIV	$ 14,672,516	$ 43,597,649
35	CCM	Morocco	Low er-middle	EMRO	MENA	Tuberculosis	$ 5,014,439	$ 10,795,334
36	CCM	Namibia	Low er-middle	AFRO	SA	Tuberculosis	$ 12,524,672	$ 32,994,241

No.	Applicant type	Applicant	Income level (from Annex 1 in Round 10 Guidelines)	WHO Region	Global Fund Regional Team	Disease	TRP Recommended* Phase 1 Upper ceiling (2 Years)	TRP Recommended* Lifetime Upper ceiling (Up to 5 years)
37	CCM	Nepal	Low	SEARO	SWA	HIV	$ 16,150,553	$ 57,273,249
38	CCM	Papua New Guinea	Low	WPRO	EAP	HIV, incl. CCHSS	$ 23,419,727	$ 46,697,052
39	RO	REDCA+	Mixed	AMRO	LAC	HIV	$ 2,366,057	$ 9,229,855
40	CCM	Sao Tome and Principe	Low	AFRO	WCA	HIV	$ 1,279,852	$ 2,476,713
41	CCM	Sierra Leone	Low	AFRO	WCA	Malaria	$ 23,255,609	$ 62,649,856
42	Non-CCM	Somalia	Low	EMRO	MENA	Malaria, incl. CCHSS	$ 39,333,002	$ 84,550,325
43	CCM	South Africa	Upper-middle	AFRO	SA	HIV	$ 128,481,275	$ 302,717,719
44	CCM	Sudan North	Lower-middle	EMRO	MENA	HIV	$ 21,944,538	$ 61,919,606
45	Sub-CCM	Sudan South	Lower-middle	EMRO	MENA	Malaria	$ 26,486,653	$ 98,618,453
46	CCM	Swaziland	Lower-middle	AFRO	SA	Tuberculosis	$ 11,202,195	$ 39,004,228
47	CCM	Thailand	Lower-middle	SEARO	EAP	HIV	$ 15,398,249	$ 42,088,572
48	CCM	Thailand	Lower-middle	SEARO	EAP	Tuberculosis	$ 12,344,773	$ 31,716,829
49	CCM	Uganda	Low	AFRO	EAIO	Malaria	$ 53,167,057	$ 155,963,673
50	CCM	Uganda	Low	AFRO	EAIO	HIV, CCHSS part only	$ 17,917,965	$ 25,251,193
51	CCM	Uganda	Low	AFRO	EAIO	Tuberculosis	$ 10,391,585	$ 24,757,129
52	CCM	Ukraine	Lower-middle	EURO	EECA	HIV	$ 95,842,099	$ 305,535,421
53	CCM	Uzbekistan	Low	EURO	EECA	HIV	$ 9,519,645	$ 14,828,347
54	CCM	Zambia	Low	AFRO	SA	HIV	$ 102,851,986	$ 259,216,608
55	CCM	Zanzibar (Tanzania)	Low	AFRO	EAIO	Tuberculosis	$ 2,633,434	$ 5,912,925
56	CCM	Zimbabwe	Low	AFRO	SA	Malaria	$ 14,550,666	$ 24,960,569
Sub-Total: Category 2 Proposals in US$							**$ 912,697,041**	**$ 2,443,248,133**
Total: Category 2 Proposals in US$ Equivalent							**$ 1,002,243,923**	**$ 2,652,585,000**
CATEGORY 2B PROPOSALS								
57	CCM	Burkina Faso	Low	AFRO	WCA	HIV, disease only	€ 38,993,903	€ 97,448,392
58	CCM	Cameroon	Lower-middle	AFRO	WCA	HIV	€ 30,200,540	€ 97,411,942
59	CCM	Cape Verde	Lower-middle	AFRO	WCA	Malaria	€ 968,724	€ 1,414,366
60	CCM	Mali	Low	AFRO	MENA	Malaria	€ 24,827,735	€ 94,873,243
61	CCM	Niger	Low	AFRO	MENA	Tuberculosis, incl. CCHSS	€ 19,035,383	€ 42,226,096
Sub-Total: Category 2B Proposals in EURO							**€ 114,026,285**	**€ 333,374,039**

No.	Applicant type	Applicant	Income level (from Annex 1 in Round 10 Guidelines)	WHO Region	Global Fund Regional Team	Disease	TRP Recommended* Phase 1 Upper ceiling (2 Years)	TRP Recommended* Lifetime Upper ceiling (Up to 5 years)
62	CCM	Angola	Low er-middle	AFRO	SA	HIV	$ 25,877,952	$ 68,884,971
63	CCM	Bangladesh	Low	SEARO	SWA	Tuberculosis	$ 11,677,496	$ 98,543,757
64	CCM	China	Low er-middle	WPRO	EAP	Malaria	$ 5,830,102	$ 15,704,363
65	CCM	Colombia	Low er-middle	AMRO	LAC	Tuberculosis	$ 5,390,584	$ 11,271,656
66	CCM	Eritrea	Low	AFRO	EAIO	Tuberculosis	$ 7,316,801	$ 22,815,431
67	CCM	Ghana	Low	AFRO	WCA	Tuberculosis	$ 31,897,744	$ 77,418,445
68	CCM	Guinea	Low	AFRO	WCA	HIV, incl. CCHSS	$ 20,877,516	$ 56,875,437
69	CCM	Guinea	Low	AFRO	WCA	Malaria	$ 32,046,938	$ 46,625,648
70	CCM	Honduras	Low er-middle	AMRO	LAC	Tuberculosis	$ 6,030,951	$ 12,402,425
71	CCM	Kenya	Low	AFRO	EAIO	HIV	$ 93,376,285	$ 345,103,871
72	CCM	Liberia	Low	AFRO	WCA	Tuberculosis	$ 2,862,226	$ 16,061,899
73	CCM	Pakistan	Low	EMRO	SWA	Malaria, disease only	$ 23,395,667	$ 51,516,709
74	CCM	Russian Federation	Upper-middle	EURO	EECA	Tuberculosis	$ 63,472,958	$ 126,926,245
75	Non-CCM	Somalia	Low	EMRO	MENA	Tuberculosis	$ 14,213,393	$ 58,380,928
76	CCM	Sudan North	Low er-middle	EMRO	MENA	Malaria	$ 61,256,082	$ 182,841,841
77	CCM	Thailand	Low er-middle	SEARO	EAP	Malaria	$ 32,500,432	$ 78,378,690
78	CCM	Timor-Leste	Low er-middle	SEARO	EAP	Malaria	$ 7,170,680	$ 22,349,915
79	CCM	Vietnam	Low	WPRO	EAP	HIV, CCHSS part only	$ 42,102,165	$ 86,636,150
Sub-Total: Category 2B Proposals in US$							**$ 487,295,972**	**$ 1,378,738,381**
Total: Category 2B Proposals in US$ Equivalent							**$ 636,266,204**	**$ 1,814,276,626**
Total: Category 1, 2, and 2B Proposals Recommended for Funding in US$							**$ 1,685,744,359**	**$ 4,592,355,369**
Total: Category 1, 2, and 2B Recommended for Funding in US$, inlcuidng HIV MARPs proposals							**$ 1,732,689,003**	**$ 4,722,641,079**

PROPOSALS NOT RECOMMENDED FOR FUNDING BY THE TRP								
No.	**Applicant type**	**Applicant**	**Income classification**	**WHO Region**	**Global Fund Regional Team**	**Disease**	**Requested Phase 1 Upper ceiling (2 Years)**	**Requested Lifetime Upper ceiling (Up to 5 years)**
PARTS OF CATEGORY 1, 2 OR 2B PROPOSALS NOT RECOMMENDED FOR FUNDING								
Ref. 16	CCM	Armenia	Low er-middle	EURO	EECA	Tuberculosis, CCHSS part	€ 1,180,614	€ 2,159,904
Ref. 57	CCM	Burkina Faso	Low	AFRO	WCA	HIV, CCHSS part	€ 10,272,650	€ 24,384,963
Sub-Total: Parts of Category 1, 2 or 2B Proposals not recommended for funding in EURO							**€ 11,453,264**	**€ 26,544,867**
Ref. 31	CCM	Lao (People's Democratic Republic)	Low	WPRO	EAP	Tuberculosis, CCHSS part	$ 8,155,754	$ 17,158,018
Ref. 73	CCM	Pakistan	Low	EMRO	SWA	Malaria, CCHSS part	$ 15,199,740	$ 21,594,900
Ref. 50	CCM	Uganda	Low	AFRO	EAIO	HIV part	$ 55,834,292	$ 217,300,859
Ref. 79	CCM	Vietnam	Low	WPRO	EAP	HIV part	$ 45,071,739	$ 188,864,423
Sub-Total: Parts of Category 1, 2 or 2B Proposals not recommended for funding in US$							**$ 124,261,525**	**$ 444,918,200**
Total: Parts of Category 1, 2 or 2B Proposals not recommended for funding in US$ Equivalent							**$ 139,224,701**	**$ 479,597,879**
CATEGORY 3 PROPOSALS								
80	CCM	Armenia	Low er-middle	EURO	EECA	HIV MARPs	€ 2,328,230	€ 4,817,816
81	CCM	Azerbaijan	Low er-middle	EURO	EECA	Malaria	€ 1,880,538	€ 3,571,100
82	CCM	Benin	Low	AFRO	WCA	HIV	€ 11,286,254	€ 21,692,352
83	CCM	Benin	Low	AFRO	WCA	Tuberculosis	€ 993,858	€ 2,274,009
84	CCM	Central African Republic	Low	AFRO	WCA	HIV, incl. CCHSS	€ 29,077,778	€ 64,570,395
85	CCM	Chad	Low	AFRO	MENA	HIV	€ 31,801,787	€ 94,985,597
86	CCM	Chad	Low	AFRO	MENA	Tuberculosis, incl. CCHSS	€ 11,599,749	€ 22,450,241
87	CCM	Congo	Low er-middle	AFRO	WCA	HIV	€ 4,674,974	€ 9,978,943
88	CCM	Cote d'Ivoire	Low	AFRO	WCA	HIV, incl. CCHSS	€ 57,632,004	€ 133,432,755
89	CCM	Guinea Bissau	Low	AFRO	WCA	HIV, incl. CCHSS	€ 26,167,631	€ 63,815,647
91	CCM	Niger	Low	AFRO	MENA	HIV	€ 30,335,989	€ 73,945,907
90	CCM	Niger	Low	AFRO	MENA	Malaria	€ 72,627,052	€ 130,641,962
92	CCM	Togo	Low	AFRO	WCA	HIV	€ 6,280,885	€ 16,083,684
Sub-Total: Category 3 Proposals in EURO							**€ 286,686,729**	**€ 642,260,408**

No.	Applicant type	Applicant	Income classification	WHO Region	Global Fund Regional Team	Disease	Requested Phase 1 Upper ceiling (2 Years)	Requested Lifetime Upper ceiling (Up to 5 years)
93	RO	ASICAL	Mixed	AMRO	LAC	HIV MARPs	$ 4,827,281	$ 11,149,346
94	CCM	Azerbaijan	Lower-middle	EURO	EECA	HIV MARPs	$ 3,546,724	$ 12,466,986
95	CCM	Belize	Lower-middle	AMRO	LAC	HIV MARPs	$ 2,602,746	$ 6,722,026
96	CCM	Botswana	Upper-middle	AFRO	SA	HIV	$ 47,926,893	$ 137,642,491
97	CCM	Botswana	Upper-middle	AFRO	SA	Tuberculosis	$ 10,828,604	$ 25,258,210
98	CCM	Brazil	Upper-middle	AMRO	LAC	HIV MARPs	$ 5,000,000	$ 12,500,000
99	CCM	Burundi	Low	AFRO	EAIO	Tuberculosis	$ 4,830,351	$ 13,212,893
100	CCM	Cambodia	Low	WPRO	EAP	HIV	$ 23,124,597	$ 47,452,279
101	CCM	Cambodia	Low	WPRO	EAP	Tuberculosis, incl. CCHSS	$ 47,313,760	$ 132,570,309
102	CCM	Congo (Democratic Republic)	Low	AFRO	EAIO	HIV	$ 111,533,674	$ 295,297,357
103	RO	ECSA	Mixed	AFRO	SA	Tuberculosis	$ 3,322,054	$ 14,593,861
104	CCM	Ethiopia	Low	AFRO	EAIO	Malaria, incl. CCHSS	$ 97,848,890	$ 245,989,480
105	CCM	Ethiopia	Low	AFRO	EAIO	HIV	$ 88,149,150	$ 176,458,326
106	CCM	Ethiopia	Low	AFRO	EAIO	Tuberculosis	$ 21,107,334	$ 82,169,387
107	CCM	India	Lower-middle	SEARO	SWA	HIV	$ 21,412,956	$ 61,404,090
108	CCM	Kyrgyz Republic	Low	EURO	EECA	Tuberculosis	$ 3,842,777	$ 5,659,777
109	CCM	Lesotho	Lower-middle	AFRO	SA	HIV	$ 29,594,699	$ 65,273,286
110	CCM	Madagascar	Low	AFRO	EAIO	HIV, incl. CCHSS	$ 46,050,649	$ 110,739,971
111	CCM	Malawi	Low	AFRO	SA	HIV	$ 164,254,176	$ 561,450,164
112	CCM	Maldives	Lower-middle	SEARO	SWA	HIV MARPs	$ 2,880,814	$ 8,044,746
113	CCM	Mauritius	Upper-middle	AFRO	EAIO	HIV MARPs	$ 2,870,148	$ 12,435,364
114	RCM	Meso	Mixed	AMRO	LAC	HIV	$ 7,868,536	$ 23,214,775
115	CCM	Moldova (Republic)	Lower-middle	EURO	EECA	HIV MARPs	$ 3,849,298	$ 12,491,713
116	CCM	Mozambique	Low	AFRO	SA	HIV	$ 54,163,105	$ 131,214,912
117	CCM	Mozambique	Low	AFRO	SA	Tuberculosis	$ 25,407,092	$ 69,822,783
118	CCM	Nicaragua	Lower-middle	AMRO	LAC	Tuberculosis	$ 4,106,578	$ 8,247,665
119	RCM	OECS	Mixed	AMRO	LAC	HIV	$ 3,112,877	$ 9,059,745
120	CCM	Peru	Lower-middle	AMRO	LAC	Tuberulosis	$ 15,481,203	$ 29,837,075
121	CCM	Peru	Lower-middle	AMRO	LAC	Malaria	$ 2,835,863	$ 7,741,937
122	RO	REDLACTRANS	Mixed	AMRO	LAC	HIV MARPs	$ 4,994,209	$ 12,500,000

No.	Applicant type	Applicant	Income level (from Annex 1 in Round 10 GuideLownes)	WHO Region	Global Fund Regional Team	Disease	TRP Recommended* Phase 1 Upper ceiling (2 Years)	TRP Recommended* Lifetime Upper ceiling (Up to 5 years)
123	CCM	Sierra Leone	Low	AFRO	WCA	Tuberculosis, incl. CCHSS	$ 34,333,373	$ 77,234,629
124	CCM	Sri Lanka	Lower-middle	SEARO	SWA	Tuberculosis, incl. CCHSS	$ 11,845,852	$ 25,088,859
125	Sub-CCM	Sudan South	Lower-middle	EMRO	MENA	Tuberculosis	$ 16,374,061	$ 50,114,047
126	CCM	Swaziland	Lower-middle	AFRO	SA	HIV	$ 34,723,593	$ 89,609,304
127	CCM	Tajikistan	Low	EURO	EECA	Tuberculosis	$ 49,913,253	$ 115,418,678
128	CCM	Tajikistan	Low	EURO	EECA	HIV	$ 20,521,257	$ 64,745,498
129	CCM	Tanzania (United Republic)	Low	AFRO	EAIO	HIV	$ 50,880,157	$ 113,178,230
130	CCM	Tanzania (United Republic)	Low	AFRO	EAIO	Tuberculosis	$ 33,201,781	$ 68,786,103
131	CCM	Timor-Leste	Lower-middle	SEARO	EAP	Tuberculosis	$ 2,706,769	$ 9,661,901
132	CCM	Tunisia	Lower-middle	EMRO	MENA	HIV MARPs	$ 4,144,950	$ 12,499,365
133	CCM	Yemen	Low	EMRO	MENA	HIV, incl. CCHSS	$ 14,565,766	$ 32,312,943
134	CCM	Zimbabwe	Low	AFRO	SA	HIV, incl. CCHSS	$ 118,402,303	$ 342,054,472
135	CCM	Zimbabwe	Low	AFRO	SA	Tuberculosis	$ 12,193,205	$ 25,507,117
Sub-Total: Category 3 Proposals in US$							**$ 1,268,493,358**	**$ 3,368,832,099**
Total: Category 3 Proposals in US$ Equivalent							**$ 1,643,036,724**	**$ 4,207,916,546**

No.	Applicant type	Applicant	Income classification	WHO Region	Global Fund Regional Team	Disease	Requested Phase 1 Upper ceiling (2 Years)	Requested Lifetime Upper ceiling (Up to 5 years)
CATEGORY 4 PROPOSALS								
136	CCM	Bosnia & Herz.	Lower-middle	EURO	EECA	HIV	€ 2,800,310	€ 5,497,810
137	Sub-CCM	Russian Federation	Upper-middle	EURO	EECA	Tuberculosis	€ 20,170,145	€ 36,360,264
Sub-Total: Category 4 Proposals in EURO							**€ 22,970,455**	**€ 41,858,074**

No.	Applicant type	Applicant	Income level (from Annex 1 in Round 10 Guidelines)	WHO Region	Global Fund Regional Team	Disease	TRP Recommended* Phase 1 Upper ceiling (2 Years)	TRP Recommended* Lifetime Upper ceiling (Up to 5 years)
138	RO	AMREF	Mixed	AFRO	EAIO	Tuberculosis	$ 29,868,200	$ 63,996,437
139	CCM	Belize	Lower-middle	AMRO	LAC	Tuberculosis	$ 2,823,065	$ 5,960,681
140	RO	CONGA	Mixed	AMRO	LAC	HIV MARPs	$ 4,506,212	$ 12,451,594
141	CCM	Dominican Republic	Lower-middle	AMRO	LAC	HIV MARPs	$ 4,950,940	$ 12,496,996
142	CCM	Ghana	Low	AFRO	WCA	HIV, incl. CCHSS	$ 499,428,723	$ 1,420,138,447
143	RO	GLIA	Mixed	AFRO	EAIO	HIV MARPs	$ 4,873,647	$ 12,499,735
144	CCM	Guyana	Lower-middle	AMRO	LAC	Tuberculosis	$ 486,607	$ 1,050,801
145	RO	HIVOS-SA	Mixed	AFRO	SA	HIV	$ 12,130,614	$ 36,066,771
146	CCM	Mongolia	Lower-middle	WPRO	EAP	HIV	$ 2,218,185	$ 7,248,739
147	RCM	MOZIZA	Mixed	AFRO	SA	Malaria	$ 12,322,727	$ 28,043,158
148	CCM	Namibia	Lower-middle	AFRO	SA	HIV	$ 15,248,614	$ 44,292,453
149	CCM	Nigeria	Low	AFRO	WCA	HIV, incl. CCHSS	$ 97,491,288	$ 383,708,645
150	Sub-CCM	Sudan South	Lower-middle	EMRO	MENA	HIV	$ 65,528,320	$ 135,697,425
Sub-Total: Category 4 Proposals in US$							**$ 751,877,142**	**$ 2,163,651,881**
Total: Category 4 Proposals in US$							**$ 781,887,012**	**$ 2,218,337,580**
Total: Proposals Not Recommended for Funding in US$**							**$ 2,564,148,437**	**$ 6,905,852,005**

* TRP Recommended upper ceilings correspond to the maximum amount being recommended to the Board. In fourteen instances, the TRP Recommended upper ceilings are less than the funding amount requested by the applicant because the TRP is recommending the removal of certain elements from the proposal (APN+ H, Armenia T, Eritrea H, Eritrea T, Ghana T, MENAHRA HIVMARPs, Pakistan M, Papua New Guinea H, Papua New Guinea H (including HSS), Senegal T, Somalia T, Syria H MARPs, Thailand M, Timor-Leste M, Zambia H). In eight instances the funding ceiling has been adjusted to take into account already existing funds included in consolidated disease proposals that are recommended for funding (Bangladesh T, Eritrea T, Lao PDR T, Mongolia T, REDCA+ H, Senegal T, Somalia T, Swaziland T).

** Including the parts of category 1, 2 and 2B proposals not recommended for funding.

*** Proposals in EURO - the OANDA exchange rate effective at 1 December 2010 - 1 USD = 0.76543 EURO [Due to an administrative error, this has been corrected subsequent to the Board decision.]

Global Fund Regional Teams

EAP	East Asia and Pacific
EA	East Africa & Indian Ocean
EECA	Eastern Europe & Central Asia
LAC	Latin America & The Caribbean
MENA	Middle East & North Africa
SA	Southern Africa
SWA	South West Asia
WCA	West and Central Africa

Applicant Types

CCM	Country Coordinating Mechanism
RCM	Regional Coordinating Mechanism
RO	Regional Organization

Key for multi-country proposals

1 - RO	APN+ - Bangladesh, Indonesia, Lao (Peoples Democratic Republic), Nepal, Pakistan, Philippines, Viet Nam
2 - RO	REDCA+ - Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama
3 - RO	RedTraSex - Argentina, Bolivia, Brazil, Chile, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay
4 - RO	ISEAN-HIVOS - Indonesia, Malaysia, Philippines, Timor-Leste
5 - RO	MENAHRA -Afghanistan, Bahrain, Egypt (Arab Republic of), Iran (Islamic Republic of), Jordan, Lebanon, Libya, Morocco, Oman, Pakistan, Syrian Arab Republic, West Bank and Gaza [Due to an administrative error, this has been corrected subsequent to the Board decision.]
6 - RO	ASICAL - Argentina, Bolivia (Plurinational State), Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay
7 - RO	ECSA - Zambia, Zimbabwe
8 - RCM	Meso - Belize, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama
9 - RCM	OECS - Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and Grenadines
10- RO	REDLACTRANS - Argentina, Bolivia (Plurinational State), Brazil, Chile, Colombia, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay
11- RO	AMREF - Burundi, Ethiopia, Kenya, Tanzania (United Republic), Uganda
12- RO	CONGA - Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama
13 - RO	GLIA - Burundi, Congo (Democratic Republic), Kenya, Rwanda, Tanzania (United Republic), Uganda
14 - RO	HIVOS-SA - Lesotho, Mauritius, Namibia, South Africa, Swaziland
15 - RCM	MOZIZA - Mozambique, South Africa, Zimbabwe

Annex 5

GF/B22/13

ANALYSIS OF THE TRP'S ROUND 10 FUNDING RECOMMENDATIONS

Part 1: Introduction

1.1 This annex provides additional analysis of the overall recommendations of the Technical Review Panel in Round 10. This includes:

Part 2: an overview of Round 10 outcomes;

Part 3: a comparison of Round 10 with prior Rounds;

Part 4: an analysis by WHO regional classification;

Part 5: an analysis of budgeted expenditure for Phase 1 by cost category; and

Part 6: additional analysis on various themes, including cross-cutting health systems strengthening (HSS) requests (Section 4B); community systems strengthening (CSS); TB-HIV co-infection; and dual track financing (DTF).

1.2 **Table 1** provides a summary of the number of proposals reviewed and recommended by the TRP. In Round 10, the TRP reviewed 150 disease proposals. Of these, 28 proposals included a cross-cutting HSS request. On the whole, the TRP therefore reviewed 178 parts (150 disease and 28 distinct HSS requests).

1.3 Requests for health systems strengthening support could be made within a disease part of the proposal or, in the case of cross-cutting health systems strengthening, by either integrating within a disease part or by attaching a distinct health systems strengthening part to a disease proposal ('HSS request' in section 4B/5B).

1.4 When a proposal is composed of a disease part and a HSS request, the TRP can recommend for funding both parts; or the disease part alone; or the HSS request alone. If both or either of the parts are recommended for funding, the related proposal is considered as recommended for funding in the analyses presented below. This accounts for the higher success rate observed for proposals than for individual parts.

Table 1 - Summary of the number of proposals and parts reviewed and recommended for funding by the TRP

	Number reviewed	Number recommended for funding	Success rate
Proposals	150	79	53%
Parts (disease and cross-cutting HSS (s.4B) requests)	178	88	49%
Disease only	150	77	51%
Cross-cutting HSS (s.4B) requests only	28	11	39%

1.5 As applicants are allowed to apply for funding either in US dollars or in Euros, this analysis uses the OANDA exchange rate of the first day of the month of issue of this report.[1] There may be changes in the overall US dollar equivalent totals at the time the Board makes its funding decision. This will not impact individual proposals as they are approved in their original currency.

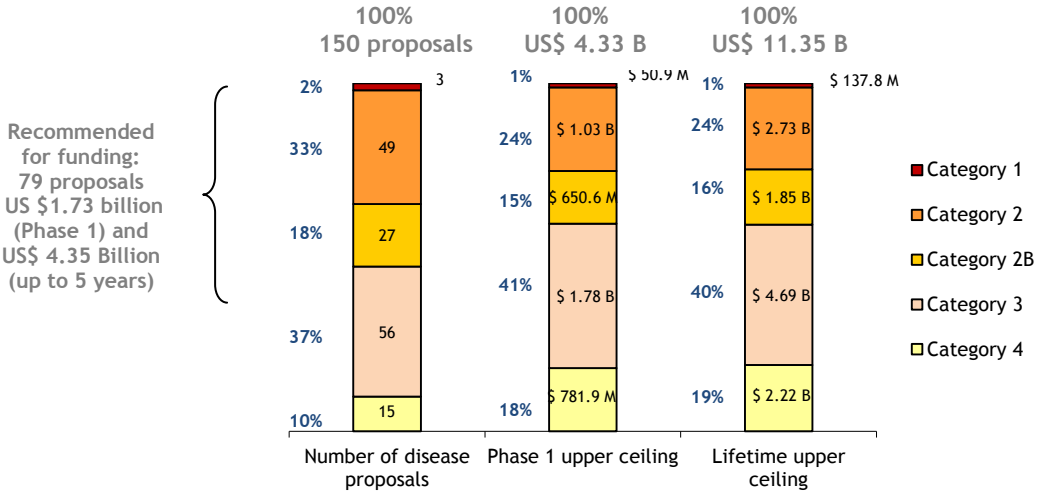
1.6 The comparative analysis across the Rounds does not include final outcomes (i.e. the successful outcome of an appeal), but rather TRP recommendations to the Board following the review meeting.[2] It should also be noted that this analysis is based on Rounds 1 to 10 and does not include funding recommended through the Rolling Continuation Channel or the National Strategy Application (NSA) First Learning Wave.

[1] This report uses the 1 December 2010 OANDA interbank exchange rate for the conversion of Euro funding requests in United States dollars (http://www.oanda.com/currency/converter/).
[2] If applications were reclassified following a successful appeal (i.e. 18 successful appeals across all Rounds) or, if for any reason a grant was not signed (i.e. 6 instances across all Rounds), these have not been reflected in this analysis.

Part 2: Overview of Round 10 outcomes

2.1 Round 10 is the third largest Round, both in terms of the number of proposals and the amount of funding being recommended by the TRP. In total, 79 proposals are recommended for funding by the TRP with a Phase 1 upper ceiling budget of US$ 1.73 billion (in Round 9 this amount was US $ 2.2 billion prior to TRP clarifications and efficiency reductions). **Figure 1** below shows the distribution of proposals by TRP recommendation category[3] and provides the breakdown by recommendation category of the two-year and five-year funding upper ceilings.

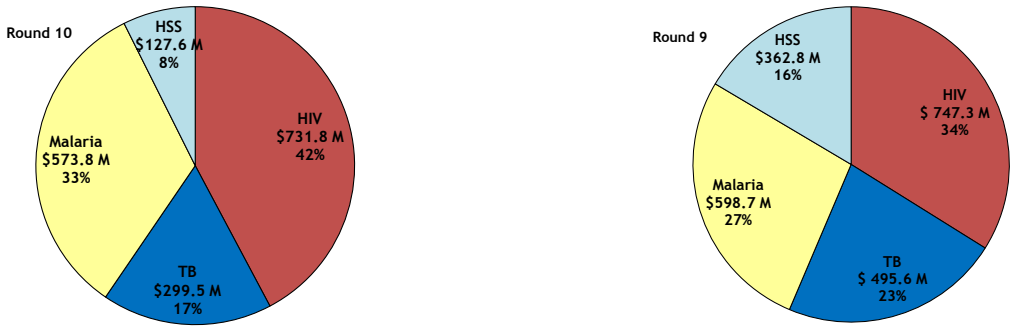
Figure 1 - Distribution of proposals and of upper-ceiling budgets by TRP recommendation category



Analysis by disease component

2.2 **Figure 2** illustrates the distribution of recommended demand of US$ 1.73 billion across the three diseases and cross cutting health systems strengthening requests.

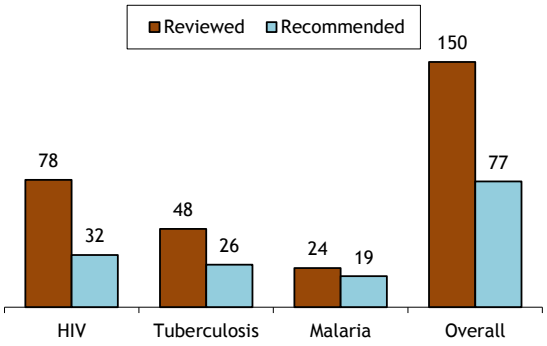
Figure 2 - Breakdown of Phase 1 upper-ceiling budgets of recommended proposals by disease and HSS



2.3 **Figure 3** illustrates the number and proportion of disease parts recommended for funding in Round 10 (excluding cross-cutting HSS requests) per disease and overall. **Figure 4** provides a similar analysis for the distinct HSS requests, indicating the disease proposal to which they are attached. In each case, the Round 8 and 9 success rates are provided for comparison.

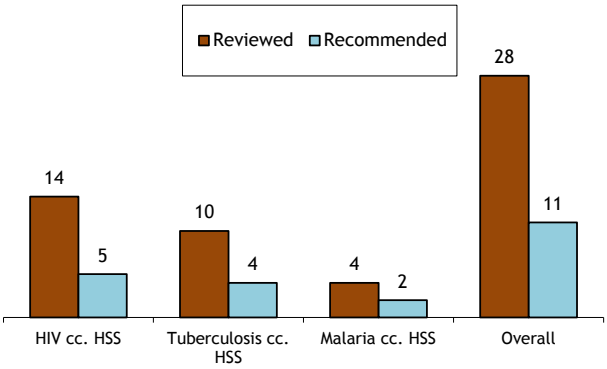
[3] Category 1 - Recommended for funding with no or only minor clarifications;
Category 2 - Recommended for funding provided that adjustments and clarifications are met within a limited timeframe. This also includes the subset of recommended 'Category 2' proposals which have been classified as 'Category 2B' proposals;
Category 3 - Not recommended for funding in its present form but encouraged to submit a revised version of the same proposal, taking into account the issues raised by the TRP, for consideration in the next Round of proposals;
Category 4 – rejected.

Figure 3 - Number of disease parts recommended for funding, by disease and overall



	HIV	Tuberculosis	Malaria	Overall
Round 10 Success rate	**41%**	**54%**	**79%**	**51%**
Round 9 Success rate	41%	59%	55%	50%
Round 8 Success rate	40%	49%	68%	49%

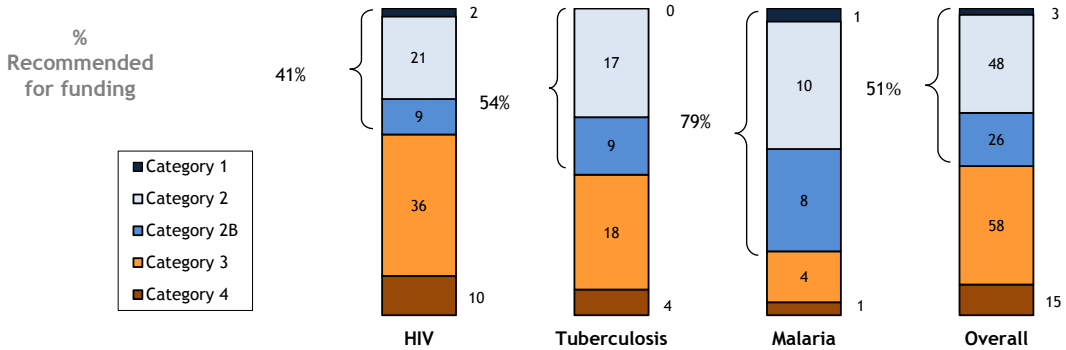
Figure 4 - Number of HSS cross-cutting requests recommended for funding (attributed to the host disease proposal



	HIV cc. HSS	Tuberculosis cc. HSS	Malaria cc. HSS	Overall
Round 10 success rate	**36%**	**40%**	**50%**	**39%**
Round 9 Success rate	52%	43%	50%	50%
Round 8 success rate	56%	50%	50%	53%

2.4 **Figure 5** shows the number of disease parts in each TRP recommendation category by disease, as well as the proportion that are recommended for funding.

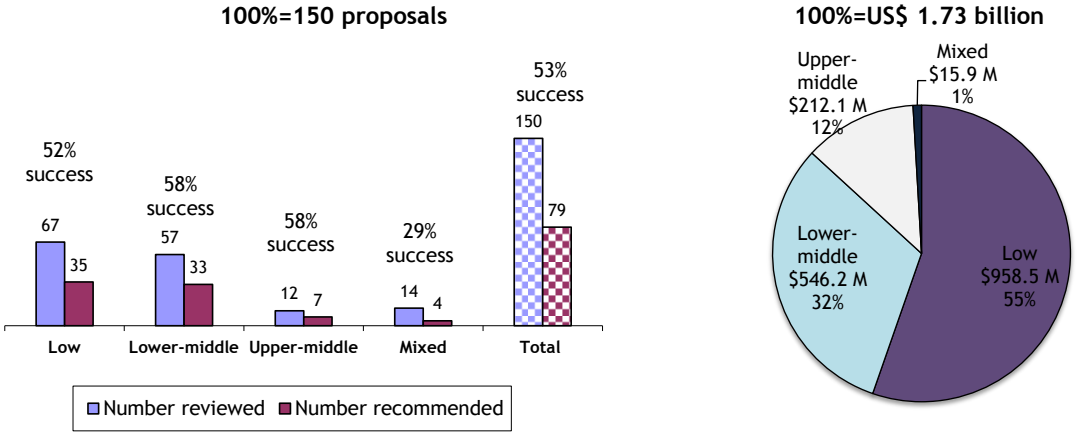
Figure 5 - Number and proportion of disease parts by TRP recommendation category and by disease



Analysis by income level classification[4]

2.5 **Figure 6** shows the number and proportion of proposals recommended for funding according to the applicant's income level, and the corresponding two-year upper ceiling recommended for funding.

Figure 6 - Success rates of proposals and distribution of Phase 1 upper-ceiling budgets recommended for approval, by income level



2.6 Relative to Round 9, there has been a marked decrease in the share of recommended funding for 'low' income countries while 'lower' and 'upper-middle' income countries have increased their share. In Round 10, the 'low' income countries' share of the total two-year upper-ceiling budget recommended for funding by the TRP is 55 percent (Round 9; 71 percent), 'lower-middle' ' 32 percent (Round 9; 24 percent) and 'upper-middle' income countries 12 percent (Round 9; less than 4 percent).

2.7 Recommended funding for countries classified as 'upper-middle' income, with a continued increase (from less than 1 percent in Round 8 to 4 percent in Round 9) in the last three Rounds, accounts for 10.3 percent of the recommended five-year funding in Round 10 which is just outside the limits set by the Board (10 percent of funding).[5]

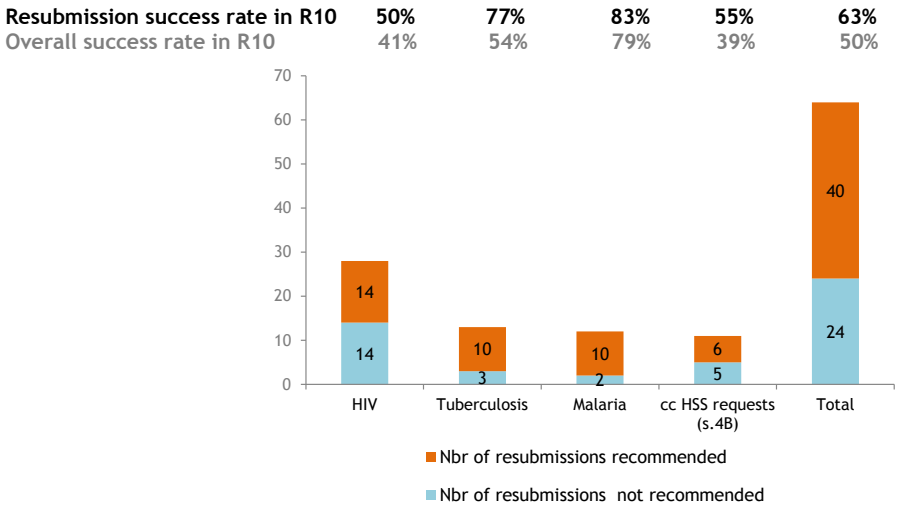
Round 10 re-submissions

2.8 In Round 10, 64 of the proposals reviewed by the TRP were re-submitted Round 9 Category 3 proposals or parts of Round 9 Category 1, 2 or 2B proposals that were not recommended for funding. **Figure 7** shows that, as in Round 9, the success rate of re-submissions is higher than the average success rates achieved across all disease parts.

[4] The income level classification used by the Global Fund can be found in annex 1 to the Round 10 guidelines. For Round 10, it is based on the World Bank's income level classification at 1 March 2009. Countries moving up from the 'low-income' to the 'lower-middle income' category or from the 'lower-middle income' to the 'upper-middle income' category benefit from a "one year grace period" according to which they are classified by the Global Fund based on their earlier World Bank income level classification. As regional proposals include countries with different income level classification these proposals have been labelled as "mixed" in this analysis.

[5] Global Fund funding for programs that will be implemented in 'upper-middle' income countries will be limited to 10 percent according to Board Decision GF/B16/DP18.

Figure 7 - Success rates of resubmissions (disease parts) and overall success rates of disease parts (re-submissions and new submissions combined)



Round 10 dedicated reserve for HIV proposals targeting most at risk populations

2.9 At its 21st Meeting, the Board approved, for Round 10 only, a funding reserve for HIV proposals for Most at Risk Populations (MARPs)[6]. The dedicated Most at Risk Populations reserve was open to both single and multi-country applicants, and ensures that the Global Fund continues to present opportunities for most at risk populations from all regions of the world, particularly those in 'upper-middle' and 'lower-middle' income countries.

2.10 Round 10 HIV applicants addressing the needs of most at risk populations could therefore either submit a *regular* HIV proposal focusing partly, predominantly or only on most at risk populations, or submit an HIV proposal focusing only on most at risk populations through a 'dedicated reserve' for these groups.

2.11 A total of 25 proposals for the HIV dedicated Most at Risk Populations reserve were reviewed by the TRP, of which twelve (48 percent) are recommended for funding. The success rate of proposals submitted through the dedicated reserve is higher than *regular* HIV proposals with 20 recommended HIV proposals out of 53 submitted (38 percent).

2.12 All proposals submitted through the dedicated reserve and reviewed by the TRP submitted funding requests that were within the Board-set Phase 1 and Lifetime upper limits of US$ 5 million and US$ 12.5 million respectively. The TRP recommended upper ceiling for the HIV proposals submitted through the dedicated reserve for Most at Risk Populations amounts to US$ 46.9 million for the initial two years and US$ 130.3 million for the proposal term (also within the maximum overall reserved funding of US$ 75 million for the initial two years and US$ 200 million for five years).

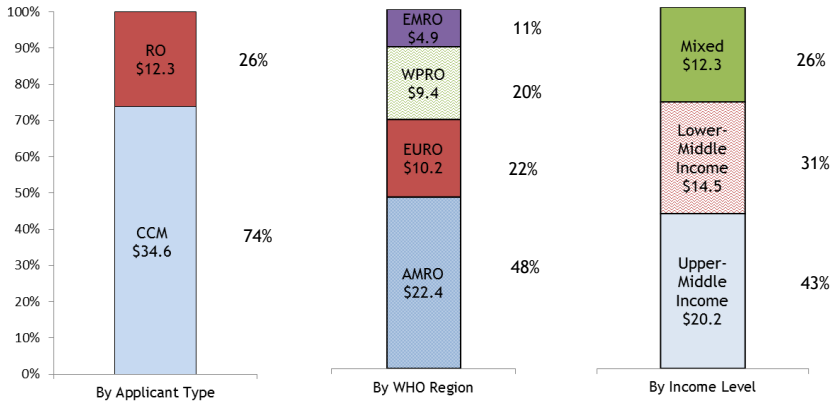
2.13 **Figures 8, 9 and 10** below show the distribution of the recommended two-year funding amount for the dedicated Most at Risk Populations reserve by applicant type, WHO Region and country income level respectively.

[6] Decision Point GF/B21/DP18.

Figure 8 - Phase 1 recommended funding for HIV MARPs by applicant type

Figure 9 - Phase 1 recommended funding for HIV MARPs by WHO Region

Figure 10 - Phase 1 recommended funding for HIV MARPs by income level



Round 10 consolidated disease proposals

2.14 In view of the transition to the new grant architecture, applicants were given the option to transition to the single stream of funding in Round 10 by submitting a consolidated disease proposal. As shown in **Table 2**, twelve consolidated disease proposals were submitted (ten for tuberculosis, two for HIV and none for malaria), of which eight (67 percent) are recommended for funding.

Table 2 - Success rate of consolidated disease proposals

Consolidated disease proposal	Number reviewed	Number recommended for funding	Success Rate	2-year incremental upper-ceiling recommended (in million US$)	5-year incremental upper ceiling recommended (in million US$)
HIV	2	1	50%	2	9
Tuberculosis	10	7	70%	58	262
Total	**12**	**8**	**67%**	**61**	**270**

Applicants who have not previously received funding from the Global Fund (for a specific disease)

2.15 If the Round 10 HIV proposals of Malaysia and Uruguay are approved by the Board, as recommended by the TRP, these applicants would receive funding from the Global Fund for the first time (both submitted HIV proposals through the MARPs reserve). In addition, the following applicants will receive funding for a specific disease for the first time: Panama and Syria for HIV and Cape Verde for malaria and Colombia for tuberculosis. Four regional applicants would also receive funding from the Global Fund for the first time[7].

[7] APN+, MENAHRA, REDTRASEX and ISEAN-HIVOS.

Part 3: Comparison of Round 10 with prior Rounds

3.1 **Figure 11** shows the proportion of proposals recommended for funding by the TRP across Rounds 1 to 10. This shows that the success rate achieved in Round 10 is comparable to that in Rounds 8 and 9. **Figure 12** shows the proportion of five-year upper-ceiling budgets for proposals recommended by the TRP across Rounds 1 to 10. Note, however, that initial commitments are only made for the first two years of recommended proposals.

Figure 11 - Proportion of proposals recommended for funding by the TRP across Rounds 1 to 10

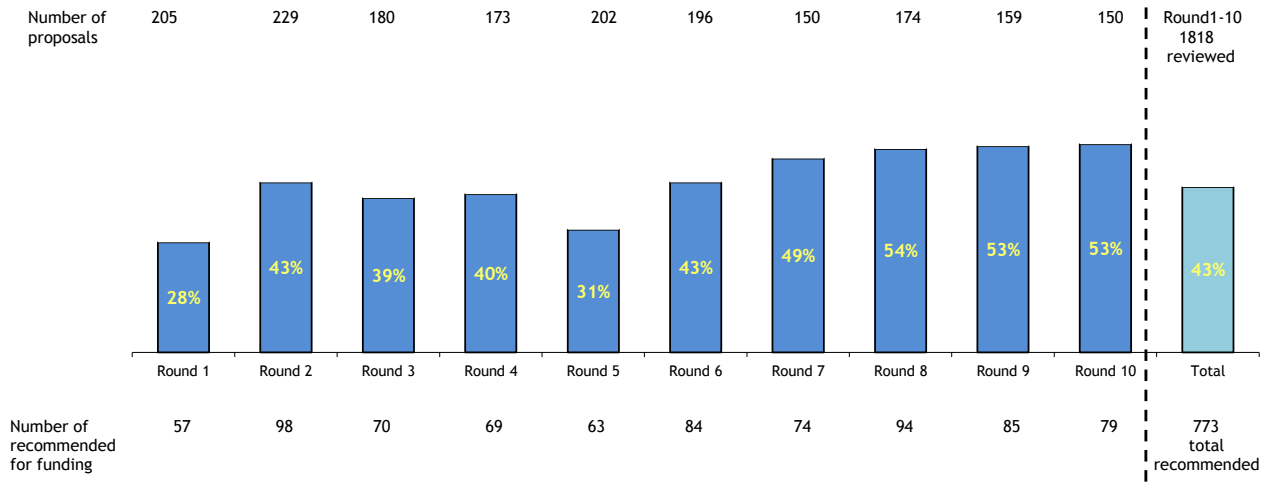
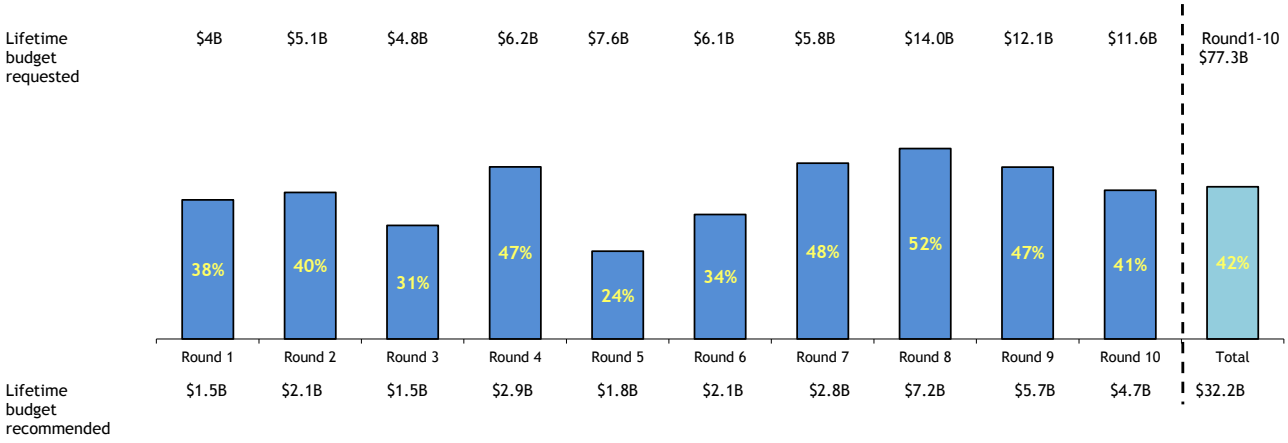


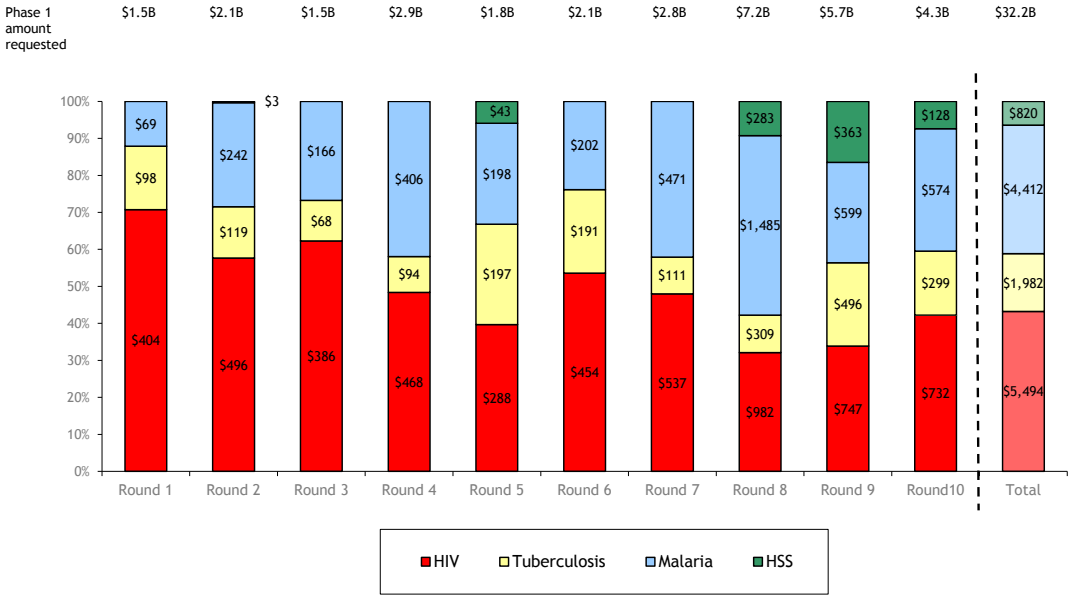
Figure 12 - Proportion of 5 year upper ceiling budgets for proposals recommended by the TRP across Rounds 1 to 10



3.2 **Figure 13** illustrates the proportion of total Phase 1 upper-ceiling budgets recommended by the TRP across Rounds 1 to 10 linked to HIV, tuberculosis and malaria disease parts and HSS requests[8].

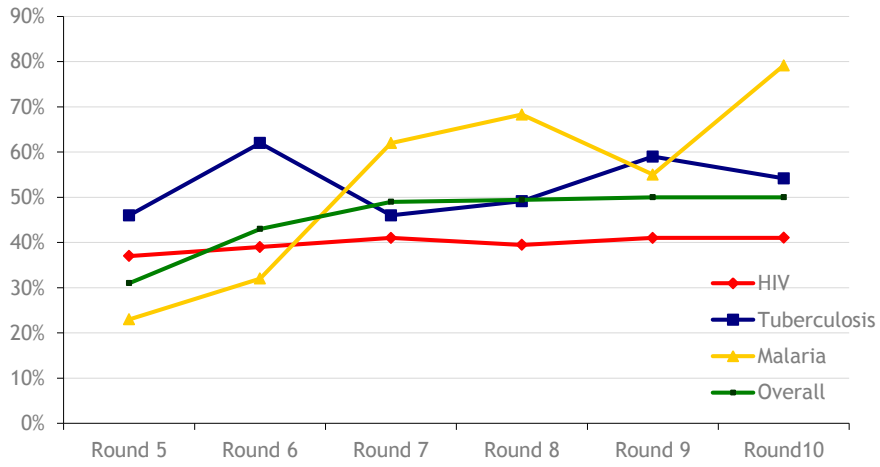
[8] There was a separate HSS funding window in Round 5 only. In Rounds 8, 9 and 10, applicants could apply for distinct cross-cutting HSS interventions (s.4B) as part of the disease proposal. In both Rounds, the TRP could recommend for funding either the whole proposal or only the disease part or the distinct cross-cutting HSS request (s.4B, 5B).

Figure 13 - Distribution of Phase 1 upper-ceiling TRP recommended budgets by disease and HSS Rounds 1 to 10 (in million US$)



3.3 The success rates for each disease in recent Rounds are shown in **figure 14**. This graph shows that the success rates for HIV disease parts remain steady and consistently lower than the success rates achieved by tuberculosis and malaria. In three of the last four Rounds, malaria has had the highest success rate among the three diseases.

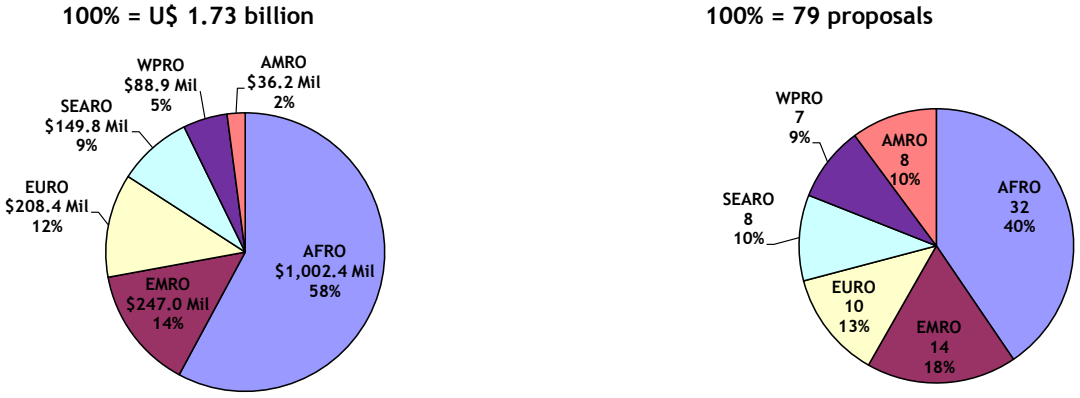
Figure 14- Success rates by disease from Rounds 5 to 9



Part 4: Analysis by WHO region

4.1 **Figure 15** shows the proportion of proposals recommended for funding and the overall Phase 1 upper-ceiling budgets by **WHO region**.

Figure 15 - Proportion of recommended proposals and Phase 1 upper-ceiling budget (in million US$ and percentage) by WHO region



4.2 As in prior Rounds, the largest proportion of recommended proposals (40 percent) and related funding (58 percent) is directed to the **WHO AFRO region**. These proportions are similar to those in Round 9.

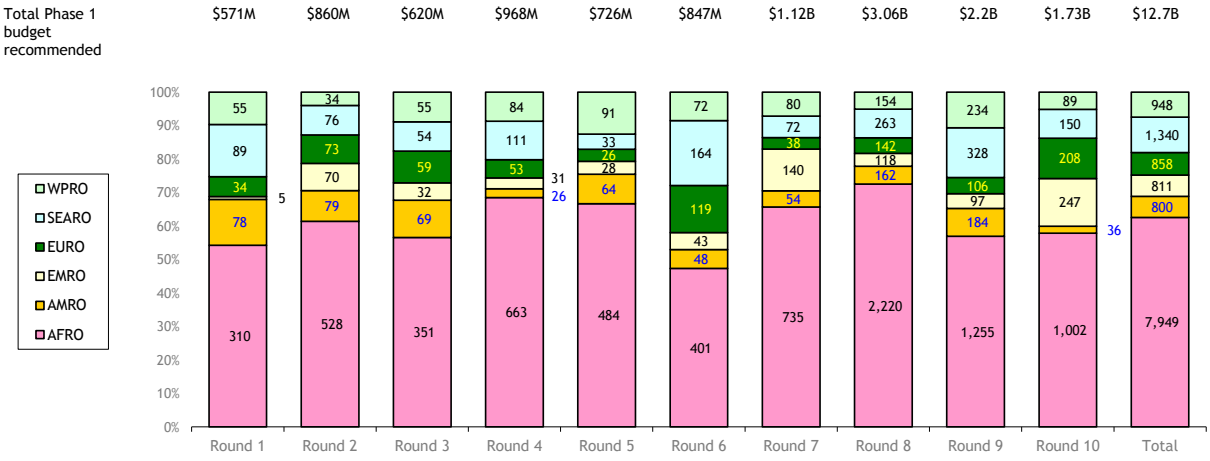
4.3 Success rates vary between WHO regions and across Rounds as shown in **Table 3.** The success rates of proposals coming from EMRO and WPRO both increased significantly compared to recent rounds.

Table 3 - Success rate of disease proposals by WHO region

Round	AFRO	AMRO	EMRO	EURO	SEARO	WPRO
Round 5	30%	38%	15%	43%	16%	59%
Round 6	38%	24%	28%	65%	52%	77%
Round 7	51%	45%	59%	36%	35%	59%
Round 8	53%	31%	58%	50%	53%	58%
Round 9	47%	53%	27%	57%	67%	50%
Round10	41%	38%	73%	50%	64%	63%

4.4 **Figure 16** illustrates the breakdown by region of the total Phase 1 upper-ceiling budget for TRP-recommended proposals across Rounds. In terms of value, although AFRO benefits from the largest proportion of the recommended funding, this proportion is less than in Round 8 and similar to the share in Round 9. The regions of EMRO and EURO show an increased proportionate share of recommended funding.

Figure 16 - Distribution of the Phase 1 upper-ceiling budget for proposals recommended by the TRP by WHO region (in million US$)

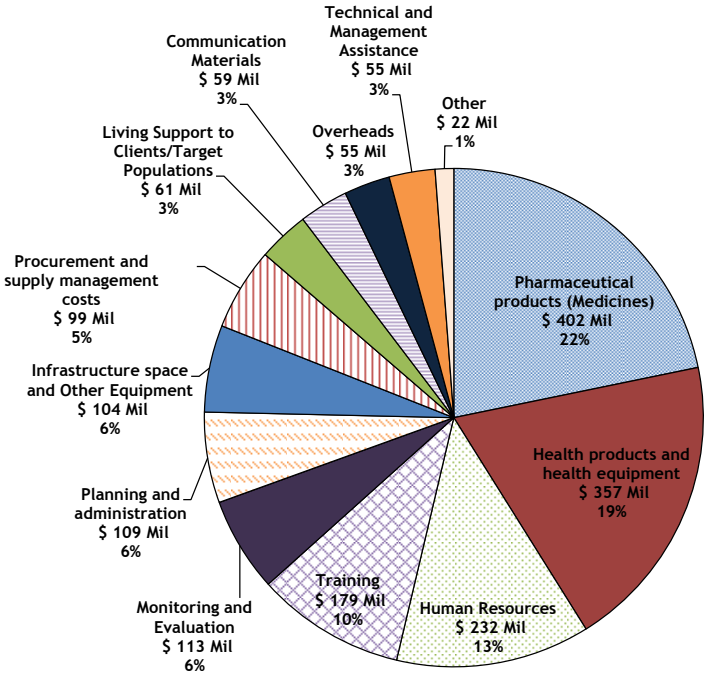


Part 5: Budgeted expenditure for Phase 1

5.1 **Figure 17** shows the planned expenditure by cost category over the initial two years of funding for the 79 proposals recommended for funding.

Figure 17 - Distribution by cost category of the Phase 1 upper-ceiling budget for recommended proposals including cross-cutting HSS requests (US$)

100% = US$ 1.85 billion[9]



5.2 In Round 10, there was a substantial increase in the funding requested for 'Pharmaceutical products (Medicines)' compared to Round 9:, this cost category represents 22 percent in Round 10 (US$ 402 million) compared to 13 percent of the total Phase 1 upper-ceiling budget (US$ 290 million) in Round 9. There are no other substantial changes across the other cost categories.

5.3 The distribution of budgets across cost categories by disease is summarized in **Table 4**. This table includes data on disease parts only (excluding cross-cutting HSS requests). This allows a comparison across diseases on items such as the proportion of the total budget allocated to the procurement of pharmaceutical products (medicines).

Table 4 - Distribution of Phase 1 upper-ceiling budgets by cost category and disease (cross-cutting HSS requests excluded)

[9] This total includes already approved and committed funds under the eight consolidated disease proposals recommended for funding, as well as, in fourteen instances, those elements identified and removed by the TRP from otherwise technically sound proposals recommended for funding by the TRP. This is the reason for the difference from the $1.73 billion total recommended amount.

Component / Cost category	HIV/AIDS		Tuberculosis		Malaria		Total Phase 1 upper-ceiling (Disease proposals only)
	HIV Total Phase 1 recommended upper-ceiling (in S$ million)	%	Tuberculosis Total Phase 1 recommended upper-ceiling (in US$ million)	%	Malaria Total Phase 1 recommended upper-ceiling (in US$ million)	%	
Communication Materials	18	2%	14	4%	25	4%	58
Health products and health equipment	81	11%	28	7%	234	40%	343
Human Resources	121	16%	53	14%	39	7%	213
Infrastructure space and Other Equipment	25	3%	22	6%	19	3%	66
Living Support to Clients/Target Populations	22	3%	32	8%	7	1%	61
Monitoring and Evaluation	31	4%	38	10%	37	6%	107
Other	16	2%	2	1%	5	1%	22
Overheads	23	3%	14	4%	16	3%	53
Pharmaceutical products (Medicines)	274	36%	83	22%	45	8%	402
Planning and administration	37	5%	19	5%	44	7%	99
Procurement and supply management costs	26	4%	15	4%	54	9%	96
Technical and Management Assistance	23	3%	11	3%	9	2%	43
Training	55	7%	50	13%	50	9%	155
Disease Total	**753**	**100%**	**381**	**100%**	**585**	**100%**	1,719

Part 6: Additional analysis

This part presents a preliminary analysis of a number of areas of particular interest in Round 10 proposals.[10]

Health Systems Strengthening requests (Section 4B)

6.1 In Round 10, as in the last two Rounds, applicants had the possibility to apply for health systems strengthening support, either within a specific disease component or as a distinct cross-cutting section attached to a disease component (section 4B/5B).

6.2 The following analysis refers to cross-cutting HSS requests only, and therefore represent only a part of all requests for HSS support presented by applicants. **Table 5** summarizes requested and recommended funding for cross cutting HSS parts with the Round 9 comparison. This table shows that the success rates in terms of both the number of HSS requests recommended for funding and of US dollar amounts in Round 10 are significantly less than those in Round 9.

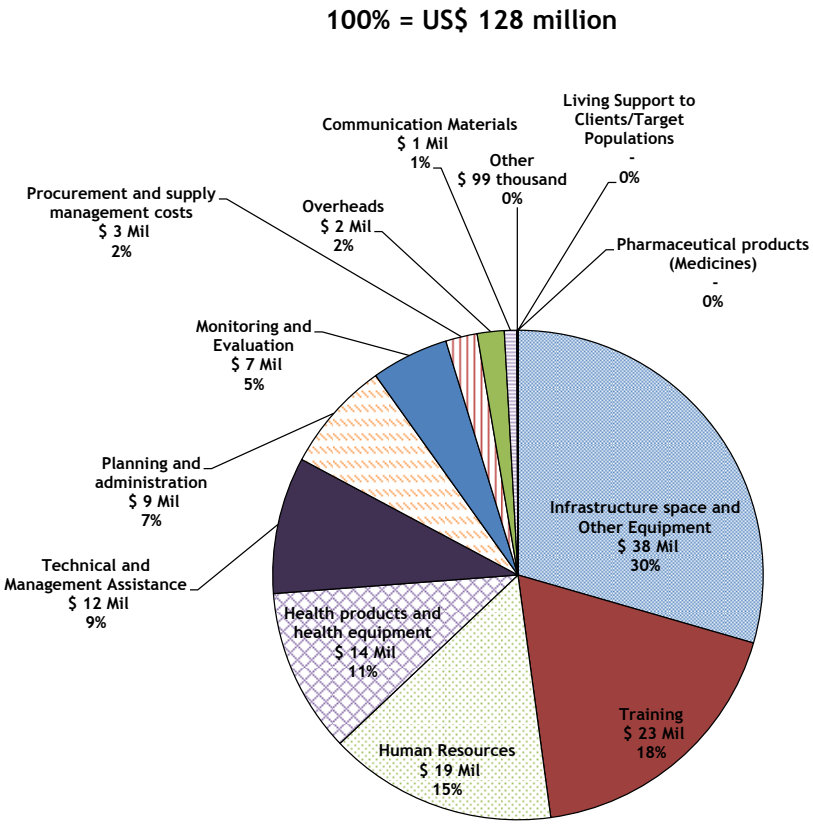
Table 5 - Requested and recommended Phase 1 upper ceilings in Rounds 9 and 10

Round	Number reviewed	Number recommended	Success rate of HSS requests	Requested Phase 1 upper-ceiling (million US$)	Recommended Phase 1 upper- ceiling (million US$)	Percentage recommended out of total Phase 1 upper ceiling requested
Round 9	34	17	50%	672	363	54%
Round 10	28	11	39%	461	128	28%

6.3 **Figure 18** presents a breakdown by cost category of the Phase 1 upper-ceiling budgets for cross-cutting HSS requests recommended for funding.

[10] See footnote 9.

Figure 18 - Distribution by cost category of the Phase 1 upper-ceiling budget for recommended cross-cutting HSS interventions (s.4B/5B) (million US$)



Community systems strengthening

6.4 In Round 10, for the first time, applicants could refer to the Community Systems Strengthening (CSS) Framework to include support for CSS in their disease proposals or cross-cutting HSS funding requests. The framework provides a detailed description of the CSS rationale and core components. It includes a number of recommended CSS indicators to enable measurement of progress in community systems strengthening over time.

6.5 Sixty-five of the 150 disease proposals (43 percent) as well as six of the twenty-eight cross-cutting HSS requests (21 percent) reviewed by the TRP included CSS interventions for a total funding request of US$ 251 million for Phase 1 and US$ 623 million over the proposal term. Funding requested for CSS interventions represents six percent of the overall 2-year and 5 percent of the overall 5-year funding requested in Round 10.

6.6 Of the proposals and parts that include CSS, 27 out of 65 disease proposals (42 percent) and one of six cross-cutting HSS requests (17 percent) are recommended for funding. The total 2-year and 5-year recommended upper-ceiling for funding for CSS interventions amount to US$ 60 million (3 percent of total 2-year recommended amount) and US$ 145 (3 percent of total lifetime recommended amount) respectively.

TB/HIV collaborative activities

6.7 At its 18th meeting in November 2008, the Global Fund Board stressed the importance of activities to fight TB/HIV co-infection and recommended that all countries applying for TB or HIV funding incorporate TB/HIV collaborative activities in their proposals[11]. TB/HIV guidelines

[11] GF/B18/DP12

based on the WHO-endorsed strategy were made available to applicants prior to the Round 9 and Round 10 call for proposals.

6.8 In Round 10, 48 tuberculosis and 78 HIV proposals were reviewed by the TRP. Of these, 66 proposals (39 tuberculosis and 27 HIV) included TB/HIV collaborative activities, representing just over half (52%) of all tuberculosis and HIV proposals reviewed. Total funding requested for TB/HIV collaborative activities amounted to US$ 294 million, representing 3 percent of the combined funding requested for tuberculosis and HIV.

6.9 Thirty-seven of the 66 proposals (56 percent) with TB/HIV collaborative activities were recommended for funding by the TRP. Of these, 24 are tuberculosis proposals and 13 HIV. The total recommended 5-year amount for TB/HIV collaborative activities is US$ 104 million, representing 3.5 percent of 5-year upper ceiling recommended for tuberculosis and HIV.

Dual track financing

6.10 At its fifteenth meeting, the Global Fund Board encouraged applicants to routinely nominate both government and non-government Principal Recipients (PRs) in Global Fund proposals ("dual-track financing"). [12]

6.11 Of the 150 proposals received in Round 10, 52 (35 percent) are proposing to implement dual-track financing (DTF). Slightly more than half of the proposals with DTF are recommended for funding (27 of 52; 52 percent). **Figure 19** below shows the comparison with Round 9 of the number of proposals with DTF received and the number of proposals with DTF recommended for funding.

6.12 The distribution of all nominated PR by Sector of activity in Round 10, with a comparison between all proposals received and proposals recommended for funding, is shown in **Figure 20**. As in previous rounds, the majority of nominated PRs (57 percent) continue to be from the public sector (GOV).

Figure 19 - Round 9 and Round 10 comparison of number of proposals with DTF

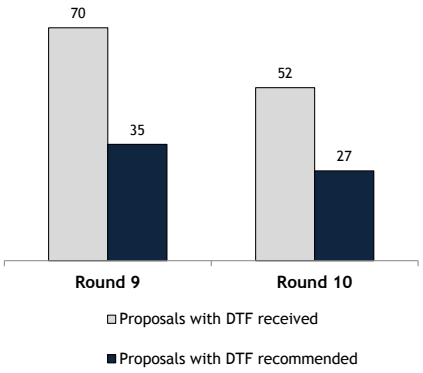
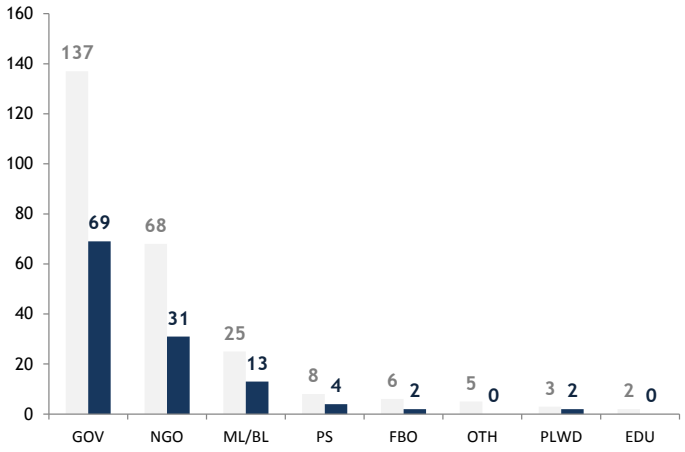


Figure 20 - Number of nominated PRs per Sector for proposals reviewed and recommended proposals



(GOV – Government; NGO – Non-government organization; ML/BL – Multilateral/bilateral partner; PS – Private Sector; FBO – Faith-based organization; PLWD – Organization/network of people living with HIV/AIDS; or OTH – Other)

[12] Decision Point GF/B16/DP14

Technical Review Panel (TRP) Round 10 Membership

Category	No.	Surname	First name	Gender	Nationality	Rounds served 1	2	3	4	5	6	7	8	9
Chair	1	Oyeledun	Bola	F	Nigeria									
Vice Chair	2	Baker	Shawn	M	USA									
Vice Chair	3	Gotsadze	George	M	Georgia									
	1	Tregnago Barcellos	Nemora	F	Brazil									
HIV/AIDS (9) Members	2	Kornfield	Ruth	F	USA									
	3	Lauria	Lilian de Mello	F	Brazil									
	4	Bobrik	Alexey	M	Russia									
	5	Mazaleni	Nomathemba	F	South Africa									
	6	Nyenwa	Jabulani	M	Zimbabwe									
	7	Chitwarakorn	Anupong	M	Thailand									
	8	Mills	Stephen	M	USA									
Alternate	9	Van Praag	Eric	M	Netherlands									
Alternate	10	Hawken	Mark	M	New Zealand									
	1	Genton	Blaise	M	Switzerland									
Malaria (5) Members	2	Rojas De Arias	Gladys Antonieta	F	Paraguay									
	3	Talisuna	Ambrose	M	Uganda									
	4	Adeel Adbel-Hameed	Ahmed Awad	M	Sudan									
	5	Lyimo	Edith	F	Tanzania									
	1	Hanson	Christy	F	USA									
Tuberculosis (6) Members	2	Bah-Sow	Oumou Younoussa	F	Guinea									
	3	Hamid Salim	Abdul	M	Bangladesh									
	4	Bonsu	Frank Adae	M	Ghana									
Alternate	5	Tadolini	Marina	F	Italy									
Alternate	6	Itoda	Ichiro	M	Japan									
	1	Decosas	Josef	M	Germany									
	2	Alilio	Martin S.	M	Tanzania									
	3	McKenzie	Andrew	M	South Africa									
	4	Boillot	Francois	M	France									
	5	Brandrup-Lukanow	Assia	F	Germany									
	6	Barron	Peter	M	South Africa									
	7	Okedi	William	M	Kenya									
	8	Ayala-Öström	Beatriz	F	Mexico/UK									
	9	Heywood	Alison	F	Australia									
	10	Le Franc	Elsie	F	Jamaica									
	11	Rose	Tore	M	Norway									
	12	Leal	Ondina	F	Brazil									
	13	Rabeneck	Sonya	F	Ireland/Canada									
	14	Dusseljee	Jos	M	Netherlands									
	15	Nagai	Mari	F	Japan									
	16	Khodakevich	Lev	M	Russia									
	17	Surjadjaja	Claudia	F	Indonesia									
	18	Blok	Lucie	F	Netherlands									
Alternate	19	Hafiz	Rehan	M	Pakistan									
Alternate	20	Andina	Michele	F	USA									

Key:

Serving TRP Members for R10
TRP Members serving half R10
Rounds served
Rounds not served

In total: 44 TRP members