Eighteenth Board Meeting
New Delhi, India, 7 – 8 November 2008

GF/B18/10
Revision 2[1]

Decision

REPORT OF THE TECHNICAL REVIEW PANEL AND THE SECRETARIAT ON ROUND 8 PROPOSALS

OUTLINE:

This report presents to the Board:

1. the Technical Review Panel's (TRP) funding recommendations on Round 8 proposals;
2. analysis on a number of key policy initiatives introduced into the Global Fund's proposals processes commencing from Round 8; and
3. recommendations of the TRP arising from the Round 8 proposal review process.

[1] Revision 1 introduces:
   i. The effect of the 1 November 2008 exchange rate movement for Euro: US$ conversions for Round 8 proposals denominated in Euro currency at the time of submission; and
   ii. A new Part 3 in Annex 5, providing detailed analysis on cross-cutting health systems strengthening requests submitted by 45 applicants within one of their disease specific Round 8 proposals ('HSS requests').

Changes from the original version of this report (issued on 10 October 2008) are identified by *shaded italics* consistent with prior Rounds.

[2] Revision 2 introduces prioritization for category 2 proposals

PART 1: INTRODUCTION

1. The Technical Review Panel (TRP) met to review the technical merit of Round 8 proposals from 25 August 2008 until 5 September 2009. This report presents, together with other information, the TRP's funding recommendations on Round 8 disease proposals. Continuing from Round 7, the Chair for the TRP meeting was Professor Peter Godfrey-Faussett, and the Vice Chair was Professor Indrani Gupta.

2. In close proximity, the TRP (differently constituted) reviewed for technical merit proposals submitted in Wave 4 of the Rolling Continuation Channel (RCC). The TRP has reported to the Board, concurrently with the delivery of this report, on the TRP's funding recommendations for Wave 4 RCC proposals. Common lessons learned are included in this report.

3. This report addresses the following topics:

Items for Board Decision:

i. TRP recommendations on funding for Round 8 eligible proposals (Part 2).

Items for Information:

i. Secretariat report on Round 8 eligibility determinations (Part 3);
ii. Round 8 TRP meeting proposal review methodology (Part 4); and
iii. TRP membership in Rounds 8 and 9 (Part 6).

Items for Board input:

i. Lessons learned and issues for discussion and endorsement by the Board, including common lessons learned from the TRP's review of Wave 4 RCC proposals (Part 5).

Index of Annexes

4. This report should be read in conjunction with the following Annexes (*emphasis in **bold** added to indicate those Annexes which are attached in paper format*):

Annex 1: List of all eligible proposals reviewed by the TRP, ordered alphabetically by applicant.

Annex 2: **List of all eligible disease proposals reviewed by the TRP, classified by the category in which they are recommended by the TRP to the Board.**

Annex 3: List of all applicants determined ineligible in Round 8 and the Secretariat's Screening Review Panel justification for that determination.

Annex 4: Round 8 'TRP Review Form' for all disease proposals reviewed by the TRP, together with the full text of each eligible applicant's application for funding.

Annex 5: **Detailed analysis on the TRP's funding recommendations for Round 8 disease proposals, with comparisons across prior Rounds** *(formerly comprising 'Part 4' in the TRP's reports to the Board for prior Rounds*).

Annex 6: **Round 8 TRP membership**.

5. Annexes 2, 5 and 6 are provided with this report. Consistent with earlier reports of the TRP and Secretariat on proposal review recommendations, the other annexes are provided to Board delegations for consideration in electronic form via CD-Rom by reason of the significant volume of the materials. Annexes 2 and 4 may be most relevant to Board delegations in their consideration of the decision point presented in part 2 below for consideration at the Eighteenth Board meeting over 7 to 8 November 2008.

6. Consistent with the Board's decision to ensure that applicants receive preliminary information about the TRP's Round 8 funding recommendations (GF/B17/DP23), the Secretariat will, not later than 17 October 2008, provide each applicant with the relevant notification letter. The letter will clearly state that the notification comprises preliminary notice only, and does not constitute a final decision of the Global Fund on funding, which may only be taken by the Board. The preliminary notification will include the 'TRP Review Form' for each disease proposal, to: facilitate early planning for a possible re-submission in Round 9 (for disease specific proposals not recommended for funding); provide information on reasons for rejection ('Category 4'); or, subject to Board approval and availability of funds, grant negotiations and signature (for 'Category 1', 'Category 2', and 'Category 2B' proposals).

7. Subject to outcomes at the Eighteenth Board, all eligible proposals (whether recommended for funding or not) will be published on the Global Fund's website as soon as practicable after the Board's decision on funding[2].

8. For ease of reference, each new part of this report commences on a separate page, according to the following index:

[2] This arises from operation of the Global Fund's documents policy (GF/B16/2). TRP Review Forms are not 'public documents' under this policy and are sent direct to applicants, but not otherwise published by the Global Fund. Stakeholders wishing to obtain access to the TRP Review Form for a particular country should contact the CCM direct.

PART 2: TRP FUNDING RECOMMENDATIONS TO THE BOARD **Decision**

1. Annex 2 lists, for the 174 eligible Round 8 disease proposals reviewed by the TRP, the TRP's recommendations to the Board. These recommendations are presented in the categories in which the TRP is authorized to make recommendations to the Board, as set out in the document entitled 'Terms of Reference of the Technical Review Panel' (TRP TORs, GF/B17/DP5)[3]. At the request of the Secretariat at the commencement of the Round 8 proposal review meeting, a number of 'Category 2' proposals assessed to be technically sound by the TRP were identified as 'Category 2B' proposals, comprising a sub-set of 'Category 2' proposals.

2. In Round 8, the TRP recommends for funding 54 percent (94) of the 174 eligible disease proposals. Table 1 below summarizes the overall funding recommendations of the TRP, separated by disease.

Table 1 – Summary of Round 8 TRP recommendations for proposals recommended for funding

Disease Proposal	Number recommended for funding	Within disease success rate	2 Year Upper Ceiling all Recommended (US$ millions)	Percent of 2 Year Upper Ceiling Budget	5 Year Upper Ceiling all Recommended (US$ millions)	Percent of 5 Year Upper Ceiling Budget
HIV (including s.4B HSS)	37 of 76	49%	1,164	38%	3,334	46%
Tuberculosis (including s.4B HSS)	29 of 57	51%	327	11%	914	13%
Malaria (including s.4B HSS)	28 of 41	68%	1,568	51%	2,927	41%
TOTAL	**94 of 174**	**54%**	**3,059**	**100%**	7,175	100%

3. The combined maximum two year upper ceiling recommended to the Board for approval of approximately US$*3,059* million is significantly higher than the equivalent funding recommendation in Round 7 (US$ 1,119 million). The overall rate of proposals being recommended for funding (54 percent in Round 8) also exceeds any prior Round (Round 7 being next most successful for applicants at 49 percent, Round 6 at 43 percent overall, and Round 5 at 31 percent overall).

4. Table 1 presents each disease proposal as a complete part, including the requests for cross-cutting health systems strengthening (HSS requests) that were submitted under the relevant disease specific part. How the TRP approached the review of the HSS requests, lessons learned, and recommendations to the Global Fund, are addressed, respectively, in part 4 and part 5 of this report.

5. As a summary, the TRP reviewed *45* distinct HSS requests that were submitted in Round 8 as part of a disease specific proposal. This review was undertaken with regard to the Terms of Reference of the TRP, permitting the TRP to recommend for funding[4]:

i. The whole disease proposal, including the HSS request; or

ii. The disease specific part <u>not</u> including the HSS request; or

iii. Only the HSS request, if the interventions in that part of the proposal materially contribute to overcoming health systems constraints to improved HIV, tuberculosis, and/or malaria outcomes.

[3] As approved at the Fifteenth Board Meeting (GF/B15/DP36). Refer to paragraph 35 and Attachment 1 of the TRP TORs.
[4] Refer to the Board decision entitled 'Strategic Approach to Health Systems Strengthening' (GF/B16/DP10), and the TRP TORs at paragraph 32.

6. There were eight instances where the TRP recommended only the HSS request, and not also the disease specific part of the proposal. For the other 37 cases:

i. in 17 instances both the disease specific part and the HSS request were recommended together;
ii. in seven instances only the disease specific part was recommended; and
iii. in 13 instances, neither the disease part nor the HSS request were recommended for funding.

7. In all cases, each proposal that included a HSS request continued to be given one TRP recommendation only even where the HSS part was, in effect, 'selected out' as is possible under the RCC proposal process. *Part 4 of this report discusses this approach further*.

8. The two year upper ceilings of HSS requests were relatively modest compared to the overall funding requested by the 174 eligible disease proposals, with an average of US$ *13.4* million per HSS request (although there was considerable variation in funding requests).

9. Table 2 below summarizes the overall funding recommended for HSS requests. Health systems support was also requested in many of the disease proposals, and also in the disease specific part of a proposal that included a HSS request. The table below does not seek to summarize these requests.

Table 2 – Summary of HSS requests, as a proportion of the overall amount requested and recommended

	Requested	Recommended	Percent
2 Year Upper Ceiling	US$ 603 million	US$ 283 million	46%
Number of HSS requests	45	25	56%

10. Relevant to the TRP's two year upper ceiling funding recommendation of Category 1 and Category 2 (including Category 2B) proposals, table 3 below identifies, at the time of issue of this report to the Board[5], the cumulative amounts which the Board is being recommended to fund based on application of the funding priority principles set out in the document entitled 'Comprehensive Funding Policy'[6].

[5] This report was first released to the Board on 10 October 2008 (GF/B18/10). *This revision 1 was issued on 3 November 2008, impacting each of the tables and figures that contain financial data regarding the TRP's recommendations for funding.* The Global Fund uses the United National official exchange rate for the conversation of EURO funding requests into their US$ equivalent. It is noted that the change (downward) between the date of the TRP review, and *the release of the 1 November 2008 exchange rate was approximately US$ 100 million.*.

[6] As amended at the Fifteenth Board Meeting (GF/B15/DP27).

Table 3 – Summary of two year upper ceiling funding recommended by the TRP, by Category, and prioritization of proposals

Funding Category	Number of Proposals	2 Year Upper Ceiling US$ (millions)	Cumulative 2 Year Upper Ceiling (US$ millions)	EURO amount as part of US$ ** (millions)
1	**16**	**452**	**452**	**49**
2	**51**	**1,854**	**2,306**	**433**
2B Total	**27**			
Composite index 8	6	443	**2,749**	15
Composite index 6	6	99	**2,848**	60
Composite index 5	8	125	**2,974**	48
Composite index 3	7	85	**3,059**	4
	2B Sub-total	**753**		**127**
All recommended	**94**	**3,059**	**3,059**	**609**

11. The TRP's recommendation to the Board to approve 94 Round 8 disease proposals relates to 68 individual countries. A majority of these countries (69 percent; n=48) have one disease proposal that is recommended for funding by the TRP. In 25 percent of cases (n=17), the TRP is recommending two disease proposals, and in the residual 6 percent of cases (n=4), the TRP is recommending all three disease proposals for funding.

12. As set out in Annex 2, and for the reasons identified by the TRP in the respective 'TRP Review Form' for these proposals (Annex 4), none of the five eligible multi-country proposals were recommended for funding. This report addresses that outcome in part 5 below.

13. Most of the applicants (93 percent) whose disease proposals are recommended by the TRP to the Board in Round 8 already receive support from the Global Fund (for the same or another disease). How the TRP takes into account the past performance of existing same disease grants (or other disease grants within the country, if the same Principal Recipient is being recommended and there are significant implementation challenges reported in supporting documents), is addressed in part 5 below.

14. Subject to Board approval, Round 8 would add five new countries as single country beneficiaries of Global Fund financial support[7]. These countries, and the disease proposals recommended for funding in Round 8, have been extracted below from Annex 2 for ease of reference:

i. Cape Verde (*HIV*);
ii. Democratic Peoples Republic of Korea (*tuberculosis and malaria*);
iii. Fiji (*tuberculosis, including the HSS request*);
iv. Mauritius (*HIV*); and
v. Solomon Islands (*HIV HSS request only, and tuberculosis*).

15. Annex 5 of this report provides significantly more detail on the TRP's recommendations by disease, with information provided on trends, and the regional breakdown of funding

[7] Some of these countries benefit, directly or indirectly, from the implementation of interventions supported through multi-country Global Fund grants in the relevant regions.

recommendations. *Specific analysis regarding the nature and scope of HSS requests is set out in part 3 of that annex.*

Decision Point 1:

1. ***The Board approves for funding for an initial two years, subject to paragraphs 3 to 5 below, those Round 8 proposals recommended for funding by the Technical Review Panel (TRP) as 'Category 1' [and 'Category 2' (excluding 'Category 2B' proposals)], as listed in Annex 2 to the Report of the Technical Review Panel and Secretariat on Round 8 Proposals, (GF/B18/10).***

2. ***The remaining Round 8 proposals recommended for funding by the TRP and identified as 'Category 2B' proposals in Annex 2 will be approved for an initial two years, subject to paragraphs 4 and 5 below, as follows:***

   i. through Board confirmation by email (or, if appropriate, at the Nineteenth Board Meeting), as funds become available under the terms of the Comprehensive Funding Policy;

   ii. based on the composite ranking of such proposals in compliance with Board's decision entitled 'Prioritization in Resource Constrained Environments' (GF/B8/2, p. 13), and the Board's decision to introduce, commencing from Round 8, a one-year grace period regarding country income level changes between consecutive years for the purposes of determining eligibility for funding (GF/B16/DP18);

   iii. not later than 31 July 2009.

   In the interim, the Board requests the Secretariat to proceed with the TRP clarifications and the LFA assessments with respect to those proposals.

3. The applicants whose proposals are recommended for funding as 'Category 1' 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.

4. The applicants whose proposals are recommended for funding as 'Category 2' (including the subset of proposals identified as 'Category 2B') shall:

   i. provide an initial detailed written response to the requested TRP clarifications and adjustments by not later than six weeks after receipt of notification in writing by the Secretariat to the applicant of this Board decision; and

   ii. 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.

5. All proposals that are approved for funding by the Board under paragraph 1 or 2 are (or will be) approved by the Board on the basis that the funding amounts requested in these proposals, as identified in Annex 2 in the column entitled "Phase 1 Upper ceiling (2 years)", are maximum upper ceilings that are subject to revision during the TRP clarifications and grant negotiations processes, rather than final approved Phase 1 grant amounts.

6. The Board declines to approve for funding those proposals recommended by the TRP as 'Category 3' proposals as indicated in Annex 2 in GF/B18/10. The Board encourages such applicants to resubmit a revised version of the same proposal in Round 9.

7. The Board declines to approve for funding those proposals recommended by the TRP as 'Category 4' as indicated in Annex 2 to GF/B18/10.

This decision does not have material budgetary implications.

PART 3: SECRETARIAT REPORT ON ELIGIBILITY DETERMINATIONS **Information**

Background events

1. At its 9th Meeting[8], the Portfolio Committee approved the Secretariat's Round 8 Proposal Forms and Guidelines for Proposals. The Portfolio Committee endorsed recommendations for the inclusion of new material focused on: encouraging applicants to have an increased focus on gender issues; improving CCM capacity to consider health systems strengthening constraints; and bringing focus to community systems strengthening as a sub-set of what could be included in health systems strengthening requests for proposals. The Portfolio Committee also endorsed a new separate 'multi-country' Proposal Form and Guidelines.

2. The Round 8 call for proposals was issued on 1 March 2008, and closed on 1 July 2008.

3. As in Round 7, the Secretariat provided significant guidance to applicants during the four month proposal development timeframe. The Secretariat ensured that information shared with applicants focused on how to complete forms, where to find additional guidance, and how to contact partners for technical assistance. Consistent with existing principles underlying Global Fund support during proposal preparation, countries were not informed by Secretariat personnel on the content of proposals.

4. In summary, the Secretariat's support consisted of the following:

i. **The release of single topic *'Round 8 Fact Sheets*'** for six new policy initiatives. Applicant and partner feedback is that the six official United Nations language 'fact sheets' were a useful and targeted tool to stimulate discussion on topics such as: community systems strengthening; why scaling up gender sensitive responses is important, particularly in HIV settings; and, how to ensure that only cross-cutting health systems strengthening interventions were included in HSS requests in appropriate disease specific proposals;

ii. **Increased circulation of Secretariat responses to proposal development questions**, through use of multi-lingual online facilitators on MyGlobalFund.org; and

iii. **Participation in an increased number of partner Round 8 'road shows'**. These included meetings specifically focused on the inclusion of gender, community systems strengthening, and integrated HIV/reproductive health strategies into Round 8 proposals. As with Round 7, partners scheduled these meetings in a way that facilitated mid-term proposal development peer review processes. The Global Fund commends its partners for their commitment to the financing of country attendance at these meetings, and the collaborative way in which the meetings have been held.

Proposals received

5. The Global Fund received 125 funding applications at the closing date of 1 July 2008. As noted above, 45 of these disease proposals included, as a distinct part of one of the diseases, a request for support for health systems strengthening cross-cutting interventions (HSS requests).

[8] Refer to the document presented at the Seventeenth Board meeting and entitled 'Report of the Portfolio Committee' (GF/B17/5, Part 4).

6. The addition of HSS requests as a 'distinct part' of a disease proposal substantially increased:

i. The time taken to screen proposals for completeness: The Round 8 screening team (comprised of 18 persons) was, typically, dealing with two separate budgets, two separate 'Performance Frameworks' (*indicators for performance measurement*); two separate work plans; two separate budget summary tables; and often, variations in the accuracy of calculations between the two 'parts' of the one disease proposal;

ii. Country response time to clarifications: Applicants requesting funding for one or more of the three diseases and health systems strengthening cross-cutting interventions through s.4B requests were similarly dealing with an additional version of these documents; and

iii. Proposal collation time in advance of the TRP meeting.

7. In Round 8, the Global Fund saw an increase in the number of proposals submitted in a language other than English. This was particularly so for French and Spanish proposals. No applications were received in Arabic or Chinese. There were also a number of proposals that were received from applicants in English, although Spanish or French is the dominant language in the applicant's country. In a very limited number of cases, the TRP observed that the self-translation of some proposals was poor.

8. The Secretariat has continued to work with its translation companies to improve quality. Applicants are encouraged to submit proposals in the United Nations official language that they are most commonly working in, rather than English. Wherever possible, the Secretariat would encourage partners in regional offices to support quality translations of applicant proposals (if requested to do so), by providing access to the translation services that they rely upon.

Screening for eligibility and completeness

9. The Secretariat undertook the Round 8 proposal screening during August 2008.

10. The Global Fund's Screening Review Panel, with Secretariat Senior Executive membership, conducted the review of disease proposal eligibility. To ensure objective decisions are taken, no member of the Country Proposals team has a decision making role on determinations of compliance with the minimum requirements for applicant eligibility.

11. Applying the same principles that were reported for the Round 6 and Round 7 eligibility screening outcomes, the Secretariat took its decisions on compliance with the Global Fund's minimum requirements for grant eligibility as reported in table 4 below.

Table 4 – Outcome of Secretariat Screening Review Panel determination on Eligibility: Rounds 5 to 8

Applicant Type	Total Applicants Round 8	Eligible Applicants Round 8	Total Applicants Round 7	Eligible Applicants Round 7	Total Applicants Round 6	Eligible Applicants Round 6	Total Applicants Round 5	Eligible Applicants Round 5
CCM	88	88	80	77	96	93	90	89
Sub-CCM	3	3	3	2	1	1	1	1
RO	8	3	5	5	10	9	9	2
RCM	3	2	1	1	1	1	3	3
Non-CCM	23	2	21	3	36	4	64	3
Total	125	98 (84%)	110	88 (80%)	144	108 (75%)	167	98 (59%)

12. Increasingly, country context is an important aspect in the Screening Review Panel's determination of whether an applicant is determined as having met the minimum standard of eligibility. As for Round 7, clarifications were required of a large number of applicants. Most specifically, this was in the areas of how applicants are:

i. Transparently considering the selection of a technically sound Principal Recipient or Principal Recipients for each disease proposal; and

ii. Transparently calling for, and then evaluating (preferably with reference to criteria that have been circulated amongst the public), suggestions for inclusion in the one country/regional proposal.

13. Countries that were not previously determined compliant with the minimum CCM requirements, made a particular effort to demonstrate compliance with the requirements for Round 8. This was also seen in those situations where the applicants were applying for funding for the first time.

14. The CCM team within the Secretariat, as for Round 7[9], will release a detailed report on the work and outcomes of the Secretariat's Screening Review Panel. This report will outline areas for ongoing focus by applicants, with a particular focus on country coordinating mechanisms (CCMs). It will also provide further guidance to countries on *best practice* examples as they develop proposals.

15. In a limited number of instances, the CCM's decision to continue the role of a 'well performing' incumbent Principal Recipient was given as the reason for not implementing dual track financing. However, criteria for that 'selection' were not routinely provided. **The Secretariat strongly encourages applicants, and partners working with them, to develop a set of criteria relevant to the country context, that enables all Principal Recipient selections to be merit based, whether selecting between differing entities in the same sector, or across sectors**.

Round 9 re-submissions

16. As noted in part 1, in Round 9, the Board is encouraging applicants to re-submit a revised version of the same Round 8 proposal that was not recommended for funding (and classified as 'Category 3'). To facilitate a streamlined re-submission process, the Global Fund will release, by 17 October 2008, a specific 'Frequently Asked Questions' for re-submission proposals. This FAQ will clarify that proposals which are re-submissions of the same Round 8 proposal, but amended to address weaknesses, will be screened by the Global Fund in a manner consistent with the more streamlined RCC proposal screening approach. That is, the focus will be on what has changed from the Round 8 proposal, and how stakeholders were involved, rather than requiring full public calls for proposals.

17. All potential applicants in Round 9 (including those re-submitting an amended version of the same disease proposal as Round 8) are strongly encouraged to work with partners, the Global Fund Secretariat, and specifically the Global Fund cluster working in that region, to understand fully the minimum requirements for eligibility, including the minimum level of documentation that is required to demonstrate compliance with those requirements.

[9] The Round 7 report entitled '**CCM Requirements: Lessons Learned: Round 7**', on the Round 7 Screening Review Panel outcomes, including lessons learned for countries, is available on the Global Fund's website at: http://www.theglobalfund.org/documents/ccm/Report_on_the_Screening_Review_Panel-Round7.pdf

PART 4: TRP PROPOSAL REVIEW METHODOLOGY **Information**

1. As reported for Rounds 6 and 7, key features of the TRP's review of the 174 disease proposals in Round 8 included:

i. maintenance of the structure of the TRP dividing the workflow into, approximately, 20 disease proposals for review during each of the nine days of proposal review;

ii. TRP members working in small groups (two disease experts and two cross-cutters typically for all days of proposal review) to review the disease proposal, Grant Performance Report data and other supporting documents;

iii. the small group presenting a preliminary recommendation to a daily TRP plenary;

iv. the TRP's recommendation on funding being finalized through daily TRP plenary sessions, during which the TRP sought to agree on the overall wording of the TRP Review Form (Annex 4); and

v. in addition, on the final TRP plenary for proposal review (Thursday 4 September 2008), TRP discussion of the overall review process and confirmation that it was comfortable with its recommendations for funding on all disease proposals reviewed.

2. Where consensus was noted to be more difficult to reach in the daily plenary, proposals were re-reviewed. This took place in, reduced from earlier Rounds, 3 percent (n=5) of cases. In such situations, at least two additional TRP members, one disease expert and one cross-cutter, reviewed the proposal, focusing on the specific issues that had been raised in the first plenary. The proposal was then discussed further, on a day which facilitated the TRP members having sufficient time to review the supporting documents (for example, Grant Performance Reports of the Secretariat for existing grants). As in earlier Rounds, this process of additional expert review was found to be highly effective in more difficult reviews.

3. The entire review process took no account of the availability of funds for the Round. The TRP's review was based on relevance, technical merit, feasibility, and likelihood of effective implementation. The TRP's analysis of lessons learned and recommendations in this regard, are set out in parts 4 and 5 below.

4. To help manage an increasing volume and complexity of work, at the same time that the TRP is, appropriately, being requested to provide greater specificity in the reasons for its funding recommendations, Round 8 also saw the TRP use a number of new approaches in its review of the 174 disease proposals. This included:

i. **drawing on an increased number of cross-cutters compared to earlier Rounds**: Annex 6 of this report reveals the increase in the cross-cutter pool compared to earlier Rounds. This facilitated, especially in disease proposals with HSS requests, the cross-cutter taking on the 'primary reviewer' role. A disease expert always retained a prominent role in the group of, usually, four TRP members; and

ii. **piloting the use of parallel review sessions**: On the two days that this was piloted, a sub-set of the TRP, under the leadership of the TRP Chair, reviewed and made funding recommendations on tuberculosis and malaria proposals where the applicant submitted only one or both of these diseases, but not also HIV. Another sub-set, under the leadership of the Vice Chair, reviewed and made funding recommendations on those funding applications which included only a HIV disease proposal. In the very limited situation where consensus on the funding recommendation could not be achieved, the relevant disease proposal was adjourned for further discussion amongst the full TRP on a subsequent day, as is discussed in paragraph 2 of this part 4 above.

Determining between a 'Category 2B' and 'Category 3' recommendation

5. The TRP's TORs identify, under three 'headings', 18 criteria which the TRP considers when reviewing each disease proposal[10]. Inevitably (and appropriately), the Global Fund's country-driven focus means that not all disease proposals carry interventions that enable consideration of each of the criteria. Equally, it is appropriate that there is no particular 'rating methodology' required to be used by the Board, which seeks in some way to apportion a quantitative score to what has been presented. 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 appropriate regard is had to the country context presented in the proposal.

6. As overall guidance to the Board on what influences the decision between a recommendation to fund ('Category 2B') or not ('Category 3'), the following comprise the minimum fundamental pre-requisites for a recommendation for funding:

i. a disease proposal that is based upon and responds directly to the current, documented, epidemiological situation;

ii. a coherent strategy that flows in a consistent order throughout the proposal – with the implementation plans (s.4.5.1) having the same objectives, program areas ('Service Delivery Areas'), and interventions/activities as are stated in the budget, the work plan, the 'Performance Framework';

iii. a robust gap analysis, both programmatic and financial, that accounts for the full extent of existing resources (including those planned and/or reasonably anticipated based on past practice) and not merely signed arrangements;

iv. clear and realistic analysis of implementation and absorptive capacity constraints (whether disease specific or broader health systems) that relate directly to the in-country social, environmental and other contexts;

v. logical strategies to address capacity constraints, whether through the existing funding application, or through other domestic or partner supported initiatives (which are also subject to performance assessments and adjustments);

vi. implementation arrangements that recognize and respond to the need to broaden service delivery channels to multiple sectors to achieve universal access to prevention, treatment, and care and support services for people most affected;

[10] In addition, these criteria are set out in the Guidelines for Proposals for every Round for ease of applicant reference.

vii. demonstrated effort to address the more challenging drivers of, especially, the HIV epidemic in ways that will have a meaningful impact on preventing further infections;

viii. a clear plan for how to monitor activities and evaluate the impact of interventions;

ix. a budget that is sufficiently detailed to allow the costs of activities to be assessed;

x. a workplan that makes clear the timing and sequencing of activities and responsibilities for each activity; and

xi. planned outcomes (included as indicators in the 'Performance Framework') that address and respond to current epidemiological data, and demonstrate that the incremental investment of additional Global Fund resources will improve disease specific and broader health outcomes for those most at risk.

7. Together, these demonstrate to the TRP that the applicant has a clear need for the additional resources, and has planned its funding request in a way that will supplement and strengthen in-country responses to the three diseases. Addressing weaknesses in earlier 'Category 3' proposals is also an important, but not determining factor, as to whether a proposal is recommended for funding.

8. **Of concern, Round 8 saw too many proposals being presented to the TRP where there was no recent assessment of the epidemiological situation in the country**. This was especially so for countries who, for example, had last applied for the same disease in or before Round 4. In these situations, the Round 8 proposal appeared to be a request for 'continuation' of an earlier grant without any re-evaluation of the appropriateness of the earlier strategies.

9. **This same concern is also noted in proposals presented to the TRP through the RCC**. In its review of Wave 4 RCC proposals, the TRP was presented with a number of applications that seek continuation of funding without demonstrating the ongoing appropriateness of the earlier strategy. Performance under the underlying qualifying grant may have been rated as strong according to the indicators that were set for that grant some years earlier. However, in very recent years there have been advances in disease strategies, and what constitutes an appropriate response, and this necessitates that countries reconsider whether continuing the same unchanged strategy is technically sound. This is so even if the earlier 'performance' has been the basis on which the grant qualifies to make a request for continued funding.

Partner briefings and Secretariat support

10. The Round 8 TRP meeting was held in a venue outside of Geneva. This resulted in a decision that partner briefings (with a specific focus on changes in technical recommendations, or new developments) would be provided to the TRP, through its portal, in advance. This was a welcome development. The TRP met in four groups (one for each disease and one for cross-cutters) to discuss the documentation provided through the portal and to raise any points for discussion arising from their experience both within previous TRP meetings and more broadly. This allowed consensus to be reached on several areas of debate, and ensured that the first day's discussions with technical partners (held through telephone conference links) could focus on the residual questions of TRP members.

11. The Secretariat's ongoing high quality support, now at venues external to Geneva, provides the TRP with a high degree of comfort that TRP meetings can be held in other cities with equal (if not stronger, and more uninterrupted) support. The Round 8 venue, located outside a city, and with significant opportunity to work in outside areas, was certainly appreciated given the intensity and concentrated workload of Rounds-based TRP review meetings.

One funding recommendation for each proposal – including those with HSS requests[11]

12. In Round 8 proposals, 'whenever possible' applicants were required to include requests for health systems strengthening support within disease specific proposals. HSS requests were possible to be submitted as a distinct part within one disease proposal, but not as a separate 'component'.[12]

13. To be consistent with the Board's decision, the TRP determined it was not requested by the Board to review proposals that included HSS requests as two distinct funding applications – one, a disease 'component', and the other a 'HSS component'.

14. Accordingly, when reviewing the 45 proposals that were submitted with a distinct HSS request as part of the overall disease proposal, the TRP approached the review as if considering a RCC proposal. For those proposals, the TRP is mandated by the Board to select out the weaker 'elements' of a proposal, and recommend the balance of the proposal for funding.[13] In this way, the TRP could give full effect to the Board's instructions that are set out in paragraph 5 of part 2 above. It is recognized that this approach may cause complexity to those applicants where only one 'part' of the overall disease proposal was recommended for funding. This is commented upon further in the TRP's recommendations, at paragraph 53 of part 5 of this report.

[11] *All of paragraphs 12 to 14 were included as part of Revision 1 to this report*.
[12] GF/B17/DP10, paragraphs 2 and 3.
[13] Refer to paragraph 39 of the TRP TORs (reference at footnote 3 above).

PART 5: LESSONS LEARNED AND TRP RECOMMENDATIONS **Board Input**

Recommendations on disease proposal issues

1. Round 8 represents, by a considerable degree, the largest recommendation for funding made to date by the TRP. This is the result of both larger proposals being submitted and a higher quality of proposals, leading to a higher rate of approval.

2. Funding recommended for all three diseases was substantially larger than in previous Rounds. The two-year upper ceiling budgets recommended for both malaria and tuberculosis proposals more than tripled, while those for HIV have doubled relative to Round 7.

3. These increases are not explained by the inclusion of the cross-cutting HSS requests within the proposals, as the overall requested, and then recommended budgets for the HSS requests totals, respectively, less than 10 percent.

4. The trend commencing from Round 5 of an improvement in the overall rate of proposals recommended for funding by the TRP, therefore continued in Round 8 (54 percent).

5. **For HIV**, there has been a steady rise in the approval rate over the past four Rounds. Nonetheless, with a within disease overall success of 49 percent in Round 8, HIV remains the disease component that is least likely to be recommended for funding by the TRP. Positively, Round 8 saw the continuation and scale up of a number of large programs aiming to move towards universal access in several high burden countries. It also saw innovative approaches to prevention, such as a significant expansion of male circumcision in one proposal, with a serious effort to learn about effectiveness and acceptability within a larger context than a clinical trial. However, the TRP was disappointed that in too many proposals there was insufficient thought given to the current epidemiological situation, with inappropriate, unfocused activities proposed for concentrated epidemics.

6. **For Tuberculosis**, the proportion of proposals recommended was higher than Round 7, but not as high as in Round 6. The TRP is concerned that an over-reliance on the planning tools developed by partners may lead to incoherent proposals. Specifically, the TRP noted examples where a sound analysis of the situation and the challenges facing tuberculosis control was linked to a set of objectives and activities that did not address the identified gaps. In these situations, it was felt that the lists of objectives and activities presented may have been selected from planning tools without sufficient reflection on the priority and sequencing of different tuberculosis control interventions.

7. **The TRP recommends that the Secretariat work with the StopTB Partnership on the budget and planning tools** that are offered to applicants. The TRP recommends to the partnership that the tool be presented to applicants with more flexibility (i.e., less 'bundling'). This revision may encourage applicants to select out priority interventions most relevant to the specific epidemiological context in the country concerned, and the country's national priorities.

8. In both HIV and tuberculosis disease specific proposals, the TRP found that there were many missed opportunities for integration. The Global Fund's position, endorsed fully by the TRP, is that it is not adequate to present either tuberculosis or HIV proposals without specifically reflecting on the potential for HIV/TB collaboration. The clear rationale for this is discussed in many technical guidelines, recommendations, and policies. Similarly, there is an increasing body of technical guidance on the benefits of providing access to prevention services for, especially women and adolescents through reproductive health care.

9. **The TRP recommends the StopTB Partnership, UNAIDS and WHO's HIV and StopTB teams, to emphasize during the provision of technical assistance, the important need for HIV/TB co-infection, reproductive health care, and other potential opportunities for integration and synergy to be discussed in proposals**, and addressed as relevant.

10. **Malaria proposals** were particularly strong in Round 8, with more than two thirds being recommended for funding. Somewhat in contrast to the more formulaic tuberculosis proposals, the TRP felt that a concerted effort had been made in malaria proposals to identify the priority interventions needed in differing epidemiological and entomological settings. The large budgets associated with some of these proposals are driven by commodities. Over half the total cumulative upper ceiling budget for the 28 malaria proposals recommended for funding will be used for health products and equipment, with a predominant focus being the purchase of long-lasting insecticide treated bednets.

11. Based upon the Roll Back Malaria pre-TRP meeting presentation materials, the TRP believes that the partnership's provision of targeted proposal development support is instrumental to the presentation of increasingly stronger proposals. This does, however, make it more difficult to determine the extent to which the proposals reflect ownership by the country and local stakeholders. The issue is that once a grant is negotiated, the implementation of the program may reveal specific contextual constraints and operational challenges that have not always been anticipated during the proposal preparation process.

12. Accordingly, while the TRP strongly encourages countries to seek appropriate technical assistance when it is needed, the **TRP recommends that sufficient emphasis is placed on building local capacity relevant to submitting strong, fundable proposals**. Such capacity consists of not only public health experts and consultants, but also individuals well-trained in proposal development frameworks, planning and budgeting.

Impact of existing Global Fund grants

13. The larger proposals seen in Round 8 reflect an increased confidence from applicants to apply for substantial grants that form an integral part of the national strategy for the relevant disease. The TRP is highly supportive of this trend.

14. In this context, analysis in Annex 5 demonstrates that most applicants presenting proposals in Round 8 have at least one continuing Global Fund grant for the same disease. When submitting new proposals for funding, almost all applicants identify the full scope and range of the existing grant(s), highlighting linkages and dependencies. As mandated by the Board in the TRP's Terms of Reference, this is important information relevant to the TRP's assessment of the complementarity and additionality of the new funding request compared to ongoing implementation.

15. However, some applicants are presenting a proposal in a Round very soon after the same disease was approved by the Board for funding in a preceding Round. In these cases, it is a complex task to assess and recommend the new proposal as being genuinely complementary to the existing grant or grants. This is particularly true when the Principal Recipient for the new proposal is the same as that for all existing Global Fund support. In several instances in Round 8, a large Round 7 same disease proposal had not yet been translated into a signed grant by the time the TRP met to consider the Round 8 request.

16. In this context, the TRP's Terms of Reference require a focus on only recommending proposals that have the potential for sustainability and impact. To fulfill this mandate, the TRP needs a level of comfort that the existing same disease grants are having, or have the potential to have, an impact on the disease before recommending that further funding is granted for the same program. Thus, the TRP is unlikely to recommend for funding a proposal to continue, expand, or modify an existing program that has not yet reported progress beyond a few months.

17. In addition, the TRP continues to request and have access to the Global Fund's Grant Score cards and Grant Performance Reports[14] as its main source of grant performance data. Although useful at the individual grant level, these documents are difficult to use to obtain a holistic view of a country's overall achievement of national targets. In particular, interrelated issues (such as the reasons for a change of Principal Recipient, or dependencies that one grant may have on another) are not always well addressed.

18. **The TRP recommends that:**

i. **The Secretariat amend the Grant Performance Report profile,** to include interdependency data, including an overview of other same disease grant start and end dates in a tabular format with most recent grant performance ratings; and

ii. **In any application for incremental funding** (including under new policy initiative pilots) **applicants clearly describe what they believe has been achieved, both in quantity and in quality with prior grants, in order to facilitate the TRP's assessment of the added value of subsequent proposals**.

19. As the Global Fund moves towards supporting applicants in their integration of Global Fund contributions into national strategies, the TRP does not consider it appropriate to submit multiple proposals that provide a piecemeal coverage of the gaps and priorities, even if the subsequent proposal does not directly overlap the earlier grant.

20. The TRP recommends a more considered approach which should fit more closely into national planning cycles and clearly articulated priorities for the next few years. **The TRP recommends that countries consider preparing proposals less regularly, and when submissions are made, draw on the national strategy to describe (and request funding for) gaps in the national strategy to ensure a comprehensive response to the diseases**. Submissions for new funds should also clearly document performance history against indicators that are relevant to the scope of the new proposal, whether the same Principal Recipient is nominated or otherwise.

Performance framework

21. The TRP still finds the performance framework of many existing grants unsatisfactory and hard to use as a tool in its review of new proposals. The multitude of indicators is not prioritized sufficiently to be able to provide a useful summary of progress in a grant. Time periods, targets and results are not always easily understood, or are incomplete on Grant Performance Reports despite efforts to improve the situation. Similarly, data reported in the Grant Scorecard (for the Phase 2 review), or the Qualification Score card (for the RCC review process) does not always present the TRP with a convincing argument that the grant in question is demonstrating an impact from the previous funding.

[14] **Grant Scorecards** have a fixed date (the time of the Board's decision on funding the grant during Phase 2), and **Grant Performance Reports** are living documents (prepared by the Country Programs' fund portfolio personnel and intended to be updated and remain current during the lifetime of a grant, whether in Phase 1 or Phase 2).

22. Since this is another key criterion against which new proposals are assessed[15], **the TRP recommends the Board to consider requesting the Secretariat to develop additional independent means of verifying progress at key stages of the Global Fund grant management lifecycle**. For example, the TRP would be interested to see independent, in-country assessments of the progress of previous grants prior to submitting a new proposal for scale-up or continuation of funding. Similarly the Phase 2 review or the recurrent reviews proposed within the new single stream of funding model currently under discussion[16] would benefit from an independent in-country assessment. Such an assessment might involve the Local Fund Agent after completion of the re-competition process to public health and program implementation expertise. It might involve local institutions not directly involved in the program, or missions from outside the country, either from within the region or from without; or a combination of all of the above.

Scale up and continuation issues

23. As at Round 8, there are an increased number of situations where the proposal being presented is, in effect, either seeking to 'continue', for example, a Round 2, 3 or 4 grant, or 'scale up' a more recent same disease proposal.

24. Applicants coming with 'continuation' proposals appear to be those that either do not qualify for the Rolling Continuation Channel (RCC) proposals channel, or come for ongoing funding in advance of the RCC qualification decision. Implementation of program activities is of course based on earlier TRP recommended and Board approved proposals.

25. The TRP understands that a clear intent of the RCC proposal channel was to permit grantees to change their strategies to ensure an ongoing effective response to the drivers of the relevant disease in their country context. This is through the 'scope change' feature of the RCC channel. In the same way, requests for funding under the Rounds-based channel should, if they are the de-facto request for 'continued funding' of earlier grants that do not qualify for the RCC, clearly address any changed epidemiological data. **Where the data is outstanding or otherwise unavailable, the TRP recommends that applicants delay their funding request until there is an evidence base for the funding request that is being made**.

26. The TRP also refers to those proposals that seek to 'scale up' the program activities of existing Global Fund grants. That is, expand the number of people receiving services, expand the range of services they receive, and/or expand the geographic scope of service delivery. The TRP is concerned that a number of applicants are bringing these proposals for funding for clearly interlinking interventions without a clear strategy to 'consolidate' the funding and work plans of relevant grants. The TRP believes that a grant by grant approach for the same Principal Recipient can adversely impact performance based implementation, including the ability to learn from implementation experience and strengthen programs to achieve improved outputs and outcomes.

27. **The TRP recommends that applicants should, wherever possible, request a formal consolidation of the activities in the new proposal with the existing same disease grants**. This would better support applicants in their management of Global Fund resources as a single stream of funding. This is anticipated to provide increased efficiencies in program management and improved

[15] The TRP's Terms of Reference require, as part of the assessment of 'Feasibility', the TRP to consider whether the applicant has been able to: *'Demonstrate successful implementation of programs previously funded by international donors (including the Global Fund), and, where relevant, efficient disbursement and use of funds. (For this purpose, the TRP will make use of Grant Score Cards, Grant Performance Reports and other documents related to previous grant(s) in respect of Global Fund supported programs)'.*

[16] Refer to the Policy and Strategy Committee's paper presented at the Eighteenth Board Meeting for a description of this possible initiative (GF/B18/4).

visibility of the overall contribution that this funding makes towards achievement of national prevention, treatment, and care and support outcome and impact targets.

Research capacity strengthening in proposals

28. The TRP considers the relatively weakly articulated operations/implementation research components within relevant proposals to be a major missed opportunity. Round 8 proposals saw no improvement on Round 7 levels. Within the extraordinary scale-up of cost effective responses to the three diseases, there are many areas where the most effective and efficient methods to overcome bottlenecks are not yet known. Some proposals included operations research activities. However, these often appeared as unnecessary additions, or more often, afterthoughts rather than integrated components of a program that should lead to more effective implementation and generate evidence that can be used for ongoing expansion.

29. Operations/implementation research that is anticipated by the TRP to be needed to assist countries to strengthen their response to the three diseases goes beyond the monitoring and evaluation of interventions supported by Global Fund financing. It also should seek systematic solutions to existing bottlenecks, and contribute to a country's understanding of the effectiveness of different interventions, including how differing interventions contribute to the attainment of planned outcomes and impact.

30. As in previous reports, the TRP encourages applicants to include realistic proposals that aim to strengthen local institutional capacity to carry out operations, health system and public health research that is closely tied in to the overall objectives of their programs.

Completion of the Proposal Form, and Work Plan and Budget materials

31. Although Round 8 again presented applicants with a significantly revised proposal form, it was improved in terms its flow and reduced complexity from Round 7. The TRP recognizes that for Round 9, the Board has determined that there will be no changes to the Proposal Form or Guidelines for Proposals, other than to facilitate clarity of the 'Round 9 re-submission' possibility. The TRP is largely supportive of the current application materials. In particular, the TRP is supportive of the Secretariat's initiative to provide an optional budget template for use by applicants. **The TRP recommends that, to the extent possible, further revisions to application materials be kept to a minimum to reduce complexity for applicants.**

32. As indicated in paragraph 6 of part 4 above (what distinguishes a Category 2B proposal from a Category 3 proposal), many applicants continue to present proposals with a significant number of weaknesses that appear avoidable. **For Round 9, the TRP recommends the Secretariat communicate to potential applicants**, perhaps through an additional 'Fact Sheet' or some other appropriate means:

i. **The essential need for coherency and logic between the objectives, program areas (SDAs), the budget, a separate detailed work plan, and the 'performance framework'**. The TRP has identified to the Secretariat 'strong examples' that may provide materials for case studies to help in this communication; and

ii. **The desirability of a clearly separate budget and work plan** to ensure that non-costed activities, and important pre-implementation events (e.g., planning for key procurement events) are detailed and linked to the timing of the intended outputs, outcomes and impact.

Improving weaker proposals

33. The TRP remains particularly concerned about the thirteen countries which have not been recommended for funding for same disease applications submitted over consecutive Rounds[17]. **The TRP recommends that the Global Fund's partners develop country specific strategies to provide technical assistance to these countries, with particular efforts to ensure that future submissions respond to the TRP's detailed Round 8 feedback**. The TRP also recommends the Secretariat to share 'examples of stronger proposals' with these countries, as identified to the Secretariat team supporting the TRP during the Round 8 TRP meeting. This is to assist applicants to see the overall approach of the proposal, and the coherence between goals, objectives, program areas (SDAs), and indicators within budgets, work plans and the proposal form text itself.

34. There is a small group of countries that are in particularly difficult circumstances, which creates an increased challenge to the grant application process. Some countries are exiting conflict situations, and others face an emergency humanitarian situation that is destabilizing the health care delivery system, including the capacity to prepare an application that would contribute to a strengthening of their national HIV, tuberculosis, and malaria programs. The TRP also reflects on the capacity of these countries to implement grants on a timely basis according to the performance based funding framework that underpins the Global Fund model. **The TRP recommends that the Board consider its role in funding countries in emergency situations, including whether funding emergency humanitarian responses falls under the Global Fund mandate, and if so, whether alternative funding application processes should apply**.

Assessing value for money in larger proposals

35. In Round 8, ten proposals were submitted with two year upper ceiling funding requests of more than US$ 100 million. Referring to the five year upper ceiling, there are 27 disease proposals with funding requests greater than US$ 100 million. As proposal review increases in complexity, the TRP is appropriately focused on a review of the overall appropriateness of a proposal. Time limitations arising from the Board determined proposal review modalities (a TRP meeting involving 35 TRP members, and held over a two week period to review more than 170 proposals) do not permit the TRP to continue to support pre-grant negotiations with a detailed review of the reasonableness of the detailed budget. **The TRP recommends that the services of an independent financial expert be retained during the screening process to undertake a budget review, as an input for the TRP meeting, of all disease proposals which exceed US$ 100 million over the proposal life time**.

36. In certain situations the TRP also finds it problematic to assess the appropriateness of the indirect costs included in detailed proposal budgets. One aspect of this assessment is the need for a detailed analysis of the budget, to see which elements have been included as direct cost items (e.g. accounting and administrative staff positions) that can (or are) also considered as indirect costs. The TRP anticipates that challenges in this regard would be addressed by the recommendation made above.

37. Less guidance is available to the TRP from the Board of the Global Fund on which type of organizations should be allowed to charge indirect costs. In particular, the TRP would find it helpful for the Global Fund to clarify whether the budgets of government Principal Recipients can be including support for indirect costs, and also whether there are desirable maximum upper ceilings for the operations of relatively affluent international profit or non-profit organizations.

[17] Some countries have applied as many as five times over the various Rounds and not been recommended for funding. Others have still not been recommended after three or four consecutive submissions.

Infant feeding in the context of public health care delivery of PMTCT services

38. Round 8 saw a number of HIV funding requests proposing relatively broad access to free breast milk replacement formula to mothers living with HIV. In relevant cases, it was proposed that distribution take place through public health care centers, typically in urban settings. During the Round 8 meeting, the TRP had access to a series of evidence based studies and partner guidance. On balance, that material identifies such strategies as inappropriate in many country contexts. Thus, Round 8 saw a number of situations where the replacement food component was required to be removed as part of the TRP recommending the balance of the proposal to the Board for funding. In no situation was the proportion of the funding for this activity so material as to warrant the whole HIV proposal being rejected.

39. The **TRP recommends to partners to provide in-country HIV program managers with short, clear recommendations on the situations when replacement formula may be appropriate.** It is recommended that this guidance include information on how to develop a strategy for the appropriate selection of HIV positive mothers as beneficiaries of replacement formula and in which social settings.

Multi-country proposals

40. In Round 8, the TRP has not recommended to the Board for funding any of the five eligible multi-country proposals reviewed. The TRP finds 'Regional Organization' proposals more problematic than 'Regional Coordinating Mechanism' proposals. One particular issue that again appeared in Round 8 is the inclusion of countries that appear to be grouped together because they meet the eligibility requirements of the Global Fund, rather than because of a common epidemiological situation or regionally-based needs. This apparent selection of particular countries as a sub-set of an otherwise natural grouping of regional or sub-regional states weakens the overall rationale of the proposal being submitted.

41. **The TRP recommends that the Board consider revising its requirements for eligibility for multi-country proposals,** to determine whether the existing framework for Regional Organization eligibility provides a negative incentive to develop more appropriate cross-border and regional proposals.

Sub-national country proposals

42. In Round 8, the TRP has not recommended to the Board for funding the three sub-national proposals reviewed. The TRP recognizes that, in appropriate situations, the submission of proposals on a sub-national basis can be helpful in a country's overall management of its response to HIV, tuberculosis and/or malaria. The Global Fund Guidelines for Proposals identify situations when this may be so. In two of the three sub-national proposals submitted in Round 8, no solid justification for why the proposal was not included in the CCM's overall national proposal was provided. In addition, the Global Fund's required 'CCM endorsement' appeared to have been given without any analysis of the merits of the proposal that the sub-national applicant was proposing, or the potential for fragmentation of the response.

43. **The TRP recommends that the Secretariat develop additional guidance for future Rounds on the processes and criteria that sub-national applicants and the relevant CCMs should follow, and clearly demonstrate at the time of proposal screening**.

Proposals submitted within pooled funding mechanisms

44. The TRP welcomes the emphasis that the Global Fund places on harmonization. It is anticipated that important changes will be introduced in how countries bring their national strategies to the Global Fund from the current access to funding architecture review. Of particular importance in the Global Fund's decision on what form its new architecture will take, is a statement of *how disbursement into common funding mechanisms* is possible to be requested from the Global Fund.

Gender focus within proposals

45. In the Round 8 Guidelines for Proposals, the Secretariat made a number of meaningful additions to encourage applicants to develop their proposals having regard to the different needs of women and men, and boys and girls, and sexual minorities[18]. Additional visibility was provided through the new 'Fact Sheet' series referred to earlier in this report.

46. The TRP was pleased to see, in limited situations, robust gender analysis informing programming in both generalized (e.g., the clear disaggregation of at risk populations by age and sex to inform tuberculosis programming) and concentrated epidemic settings (e.g., including the clients of commercial sex workers and non-client sexual partners as target populations).

47. However, as in Round 7, the TRP was disappointed to see that the majority of proposals submitted to the Global Fund for support (and HIV proposals especially) failed to include any real discussion on whether particular groups are under-represented in accessing and/or receiving prevention, treatment, and/or care and support services relevant to the particular country context. What is more positive is that a much larger range of HIV intervention categories was proposed in Round 8 than in Round 7.

48. In the context of the Board's decision to maintain the Round 8 proposal form and guidelines unchanged for Round 9, **the TRP recommends that the Secretariat prepare a number of case studies on stronger gender focused proposals presented in Round 8, and distributes these case studies to partners providing technical assistance to applicants preparing Round 9 proposals**.

Health systems strengthening

49. Overall, the TRP welcomes the inclusion of the dedicated 'HSS requests' section to address broader health sector needs relevant to country efforts to achieve HIV, tuberculosis and/or malaria and broader health system outcomes. *Detailed analysis on the number, type, and scope of interventions proposed by applicants in the 45 HSS requests is set out in part 3 of Annex 5 to this report.*

50. Based on the Round 8 proposal review experience:

i. from a process perspective:

a. the space available in the application form to describe the needs and challenges to the health sector and to present a rational and coherent response is inadequate; and

[18] 'Sexual minorities' in this context includes a reference to persons identifying themselves as gay, bi-sexual, transsexual, or lesbian.

b. HSS requests require as much time for review by the TRP as the disease specific part of the same proposal. This resulted in the TRP reviewing, in effect, '219' (and not 174) requests for funding in Round 8. This brought considerable time pressures to the TRP in the context of very few 'tools' (e.g., self or external assessment reports) being available to assist the TRP to consider the overall appropriateness of the request*; and*

ii. more importantly:

a. *although invited to do so, few countries indentified their HSS needs by reference to a recent in-country review of constraints and gaps in the health system that act as bottlenecks to the achieve outcomes;*

b. *the WHO 'building blocks' framework referred to the Guidelines for Proposals was very recently introduced by WHO, and in turn the Global Fund as a possible framework for elaborating HSS needs; and*

c. *few countries proposed interventions that were focused on achieving improved equity and efficiency in the health system through integrated responses.*

51. *Taking these factors together, the opportunity for countries to develop cross-cutting interventions that are necessary to respond to complex health systems constraints may not be well supported by a Proposal Form that has a focus on input-centered 'building blocks' as the overarching framework.* Increasing the length and complexity of the proposal form does not strike the TRP as an appropriate solution. It would risk widening the gap that is appearing between the quality of proposals, and program implementation over time. *Nor is it suggested to dispense entirely with the WHO 'building block' framework as a point of reference. Conversely, the analysis in part 3 of Annex 5 also identifies that, as an analysis framework at the international level the 'building blocks' framework offers an opportunity for commonality between funding partners.* **Rather, the TRP recommends that the Board reflect on how the increasing complexity of programs, their feasibility, their systemic constraints, and their performance can be captured in the Global Fund grant application and review process, and introduce appropriate revisions as appropriate to other new policy initiatives**. *In particular, the TRP recommends that the Global Fund consider pursuing a dialogue with WHO and other organizations working on health systems strengthening (e.g., the World Bank, other multi-lateral or bilateral agencies and/or universities) on developing more operationally focused frameworks, to assist countries in planning cross-cutting responses to disease specific program constraints. It is recommended that such a framework have a clear focus on countries prioritizing responses that are more outcome and impact focused, and less on input and output focused. It is believed that a framework that looks to the outcomes/impact of Global Fund support will deliver stronger performance towards attainment of those measures, and improve equity and efficiency.*

52. A good proportion of proposals submitted in Round 8 (and in prior Rounds) sought significant salary support for per-person amounts and/or by cadre of health professionals, that were not based on salary structures within national human resource development strategies or other fiscal planning frameworks. The potential for distortion in country, and between funding sources, is significant. As part of the above recommended review, or through an earlier process, **the TRP recommends that the Board consider the provision of guidance to countries and the TRP on the salary support framework that the Global Fund is comfortable to support moving forward**. It is recommended that this framework focus heavily on efforts to incentivize health worker retention in innovative ways, and beyond the top up of salaries at levels that could be perceived as excessive in particular country settings.

53. Where a HSS request was not recommended for funding, but the 'disease specific part' was, the **TRP recommends that the country review the TRP Review Form** (comments on the HSS request are included in the 'host disease' form) **and determine whether (and if so, when), to submit a revised request for this support in a later Round in line with the Global Fund's then current position on funding of HSS cross-cutting interventions to improve outcomes for and beyond the three diseases.**

TRP matters

54. Drawing on the material set out in part 6 of this report below, **the TRP recommends that**:

i. **The Board endorses the TRP's decision to select a second Vice Chair** to facilitate the sharing of TRP leadership responsibilities more broadly, and alter the TRP Terms or Reference accordingly;

ii. **The Secretariat proposes, for consideration by the TRP by end December 2008, alternative approaches to the review of, approximately, 190 separate proposals twice yearly**. Strategies may include longer TRP meetings; the holding of concurrent plenary sessions more regularly, TRP meetings where some part of the membership stays for a longer period, or a combination of these and other factors. The TRP recognizes that this may have budgetary implications for the Secretariat and the TRP, although notes that change is necessary; and

iii. **The Secretariat reviews and adjusts, commencing from 2009, the honorarium structure for the TRP**, to take into account the significant additional scope of work introduced since Round 4 and exchange rate losses over the same four years that the honorarium has remained unchanged (also acknowledging potentially unanticipated budgetary implications).

PART 6: TRP MEMBERSHIP FOR ROUNDS 8 AND 9 **Information**

2. Annex 6 provides specific information on those persons serving as TRP members in Round 8 (with resumes for all members available on the Global Fund's external website).

3. Of note:

i. 34 percent (n=12) of persons served as a Global Fund TRP member for the first time;

ii. Three of these people have previously (and continue) to serve as members of the GAVI Health Systems Strengthening *Independent Review Committee* (GAVI HSS *IRC*). The Global Fund is specifically drawing on this expertise to enhance collaboration with GAVI on healthy systems issues. The TRP welcomes this initiative and recommends to the Board that cross-membership of the Global Fund TRP with counterparts from GAVI continues;

iii. In May 2008, the Board decided to extend, for Round 9 only at this time, the maximum term of TRP members to five Rounds, and the Chair or Vice Chair to seven Rounds[19]. Without this decision, six TRP members who have already confirmed their availability for Round 9 could not have served, as they would have completed their term as 'TRP Permanent Members' (as defined in the TRP's TORs);

iv. There will be a minimum of eight (and possibly up to 12), vacancies to be filled for the Round 9 proposal review process. Further discussion on this is set out in paragraph 5 below; and

v. Due to the increasing role of the TRP in proposal review meetings; attending Board and committee meetings; and, participation in discussions and ad-hoc working groups and/or committee meetings on new policy initiatives, the TRP has determined it is appropriate to elect a second Vice Chair, Bola Oyeledun (cross-cutting expert, with a focus on health systems). This is discussed further in paragraph 9 below.

Managing potential conflicts of interest

4. The TRP maintains an appropriate standard of objectivity, without resulting in country-context ignorance, through its application of the Global Fund's policy[20] on managing potential conflicts of interest. Principles that are applied internally by the TRP include that:

i. Nationals or residents of a country under review do not review or participate in group or plenary discussions for that country's proposals;

ii. Reviewers who otherwise have a major personal or professional connection with a country similarly do not participate; and

iii. A reviewer cannot participate in the review of, or plenary discussion for, a country's disease proposal if their organization is nominated as a Principal Recipient (PR) or an important Sub-Recipient.

[19] Refer to the Board's decision entitled 'Launch of Round 9', *GF/EDP/08/07 (2 June 2008)*
[20] Refer to the document entitled 'Policy on Ethics and Conflicts of Interest' (GF/B5/2)

5. This policy avoids any potential for TRP members to be approached in regard to their potential recommendations on funding, or for there to be any perception that they would bring their personal views into the review process.

Round 9 TRP membership

6. Consistent with prior Rounds, the TRP leadership (Chair and Vice Chairs) will discuss the overall skills requirements for Round 9 after the Board makes its decisions at the upcoming Eighteenth meeting.

7. In the interim, the TRP understands that at its 10th meeting after the conclusion of the Round 8 TRP meeting, the Portfolio Committee requested the Secretariat to issue a limited additional call for TRP members to fill up to five cross-cutting vacancies for Round 9. The TRP will make its recommendations on continuing membership and skills gaps to the Portfolio Committee in the context of this interim replenishment of TRP members.

Increasing complexity of TRP Review

8. It remains, for all TRP members, a privilege to serve the Global Fund in its goal to contribute significant additional resources to support in-country efforts to respond effectively to the threat and presence of the three diseases. To support this shared goal, the TRP's role has expanded considerably over recent years. With policy discussions including the Global Fund's role in the International Health Partnership, its funding of national strategies through a streamlined process, and the potential for a pilot of the Affordable Medicines Facility – Malaria, the TRP's engagement with the Secretariat is anticipated to expand even further.

9. Over time, the TRP has considered (and re-considered) the optimal number of TRP members required in each of the small groups to ensure a robust, in-depth discussion before presenting to the TRP plenary. Experience shows that this is two disease experts and two cross-cutters. The TRP, in the way it is presently constituted and remunerated, is contributing as much time as possible towards the ongoing review of RCC proposals, HSS requests as part of Rounds-based proposals, and other ad-hoc reviews of Phase 2 and reprogramming applications. This is without the introduction of multiple annual funding windows now anticipated.

10. As encouraged by the Board in its decision to launch Round 9 with a re-submit option, the TRP has made increased effort to state clearly the reasons for its funding recommendations in the 'TRP Review Form' that is sent to each applicant. Where the TRP recommended the proposal as 'Category 3' (not recommended for funding), detailed examples of challenges in the Round 8 proposal are provided as often as appropriate.

11. **Importantly, the TRP notes that it will review any Round 8 'Category 3' disease proposal that is re-submitted in Round 9 as a whole, and not only those parts of the disease proposal that were strengthened**. This is because the TRP believes it appropriate to undertake a review of the disease proposal's overall strategy and logic, and not on a by-objective basis.

Annex 2
Revision 2
GF/B18/10

List of Round 8 eligible Per-Disease Proposals reviewed by the Technical Review Panel (Classified by the 'Category' in which they are recommended to the Board)

No.	Source	Country	WB Income classification	WHO Region	Global Fund cluster	Disease	Phase 1 Upper ceiling (2 Years)	Lifetime Upper ceiling (Up to 5 years)
CATEGORY 1 PROPOSALS								
1	CCM	Afghanistan	Low	EMRO	SWA	Tuberculosis	€ 7,394,272	€ 22,669,094
2	CCM	Armenia	Lower-middle	EURO	EECA	Tuberculosis	€ 2,006,371	€ 6,205,708
3	CCM	Belarus	Lower-middle	EURO	EECA	HIV, incl. CCHSS	€ 11,120,812	€ 25,389,385
4	CCM	Gabon	Upper-middle	AFRO	WCA	HIV	€ 6,879,029	€ 17,006,207
5	CCM	Mauritius	Upper-middle	AFRO	EA	HIV	€ 4,052,662	€ 7,890,632
6	CCM	Moldova	Lower-middle	EURO	EECA	Tuberculosis	€ 5,281,042	€ 13,322,904
7	Non-CCM	West Bank and Gaza	Lower-middle	EMRO	MENA	Tuberculosis	€ 972,386	€ 2,152,074
8	CCM	Peru	Lower-middle	AMRO	LAC	Tuberculosis	€ 11,484,622	€ 22,229,143
Sub-Total: Category 1 Proposals in EURO							**€ 49,191,196**	**€ 116,865,147**
9	CCM	Ethiopia	Low	AFRO	EA	Malaria, incl. CCHSS	$148,412,502	$291,064,713
10	CCM	Indonesia	Lower-middle	SEARO	EAP	HIV	$45,384,545	$130,653,560
11	CCM	Indonesia	Lower-middle	SEARO	EAP	Tuberculosis	$28,106,251	$93,001,059
12	CCM	Mauritania	Low	AFRO	MENA	HIV, CCHSS only	$2,772,376	$3,942,505
13	CCM	Sao Tome and Principe	Low	AFRO	WCA	Tuberculosis	$1,132,914	$2,608,818
14	CCM	Swaziland	Lower-middle	AFRO	SA	Malaria	$5,637,713	$13,880,938
15	CCM	Thailand	Lower-middle	SEARO	EAP	Tuberculosis	$12,420,804	$30,547,583
16	CCM	Zambia	Low	AFRO	SA	HIV, incl. CCHSS	$144,079,863	$307,273,164
Sub-Total: Category 1 Proposals in USD							**$387,946,968**	**$872,972,340**
Total: Category 1 Proposals in USD Equivalent							**$451,583,703**	**$1,024,156,230**

* Proposals are grouped by the category in which they are recommended for funding by the TRP and by the original currency in which they have applied for fund (first – applications in EURO, second – applications in USD). Category 2B proposals are also ranked by composite index in line with the policy on prioritization in resource constrained environments (GF/B8/2).

* For the disease proposals which included the cross-cutting Health Systems Strengthening (CCHSS) interventions as a distinct part of that proposal (s.4B), in the disease column it is indicated whether the recommended category applies to the both parts, disease specific and CCHSS or only one part of the proposal in line with the Board Decision (GF/B16/DP10)

No.	Source	Country	WB Income classification	WHO Region	Global Fund cluster	Disease	Phase 1 Upper ceiling (2 Years)	Lifetime Upper ceiling (Up to 5 years)			
CATEGORY 2 PROPOSALS											
Proposals with Composite Index 8									**Poverty**	**Disease burden**	**Composite Index**
17	CCM	Burkina Faso	Low	AFRO	WCA	Malaria	€ 53,120,303	€ 63,203,438	4	4	8
18	CCM	Central African Republic	Low	AFRO	WCA	Malaria	€ 10,871,833	€ 30,971,995	4	4	8
19	CCM	Chad	Low	AFRO	MENA	HIV	€ 29,702,927	€ 63,244,477	4	4	8
20	CCM	Côte d'Ivoire	Low	AFRO	WCA	Malaria	€ 139,365,869	€ 180,298,316	4	4	8
21	CCM	Mali	Low	AFRO	MENA	HIV, disease part only	€ 40,526,846	€ 126,634,447	4	4	8
22	CCM	Tajikistan	Low	EURO	EECA	HIV	€ 13,264,761	€ 34,578,129	4	4	8
23	CCM	Togo	Low	AFRO	WCA	HIV	€ 31,775,839	€ 81,340,190	4	4	8
Proposals with Composite Index 8 in EURO							**€ 318,628,378**	**€ 580,270,992**			
24	CCM	Bangladesh	Low	SEARO	SWA	TB, incl. CCHSS	$5,627,763	$77,430,875	4	4	8
25	CCM	Democratic Republic of Congo	Low	AFRO	EA	HIV	$79,225,696	$262,911,091	4	4	8
26	CCM	Democratic Republic of Congo	Low	AFRO	EA	Malaria	$153,997,553	$393,102,357	4	4	8
27	CCM	Eritrea	Low	AFRO	EA	HIV, disease part only	$17,071,740	$45,135,676	4	4	8
28	CCM	Ghana	Low	AFRO	WCA	HIV	$51,498,200	$99,858,800	4	4	8
29	CCM	Ghana	Low	AFRO	WCA	Malaria, disease part only	$39,639,118	$158,030,372	4	4	8
30	CCM	Lao People's Democratic Republic	Low	WPRO	EAP	HIV, incl. CCHSS	$9,114,326	$24,569,609	4	4	8
31	CCM	Liberia	Low	AFRO	WCA	HIV, incl. CCHSS	$20,199,587	$78,235,151	4	4	8
32	CCM	Mozambique	Low	AFRO	SA	HIV, CCHSS only	$13,177,452	$34,874,346	4	4	8
33	CCM	Nigeria	Low	AFRO	WCA	HIV, CCHSS only	$75,055,363	$178,030,052	4	4	8
34	CCM	Pakistan	Low	EMRO	SWA	Tuberculosis	$9,810,559	$26,682,133	4	4	8
35	CCM	United Republic of Tanzania	Low	AFRO	EA	HIV, disease part only	$145,848,085	$598,106,619	4	4	8
36	CCM	Vietnam	Low	WPRO	EAP	HIV	$14,577,204	$48,693,061	4	4	8
37	CCM	Zimbabwe	Low	AFRO	SA	HIV	$86,821,730	$296,752,070	4	4	8
Proposals with Composite Index 8 in USD							**$721,664,376**	**$2,322,412,212**			
Sub-Total: Proposals with Composite Index 8 in USD Equivalent							**$1,133,861,501**	**$3,073,086,199**			
Sub-Total Category 1 and 2 Proposals with Composite Index 8 in USD Equivalent							**$1,585,445,204**	**$4,097,242,429**			

Proposals with Composite Index 6									**Poverty**	**Disease burden**	**Composite Index**
38	CCM	Armenia	Lower-middle	EURO	EECA	HIV, CCHSS only	€ 1,466,930	€ 2,062,995	2	4	6
39	CCM	China	Lower-middle	WPRO	EAP	HIV	€ 15,747,191	€ 44,128,188	2	4	6
40	CCM	Paraguay	Lower-middle	AMRO	LAC	HIV, disease part only	€ 4,765,763	€ 13,314,074	2	4	6
Proposals with Composite Index 6 in EURO							**€ 21,979,884**	**€ 59,505,257**			
41	CCM	Guyana	Lower-middle	AMRO	LAC	HIV, CCHSS only	$4,637,491	$10,094,303	2	4	6
42	CCM	Lesotho	Lower-middle	AFRO	SA	HIV, incl. CCHSS	$39,773,696	$103,429,628	2	4	6
43	CCM	Swaziland	Lower-middle	AFRO	SA	HIV, CCHSS only	$8,180,726	$15,136,442	2	4	6
44	CCM	Swaziland	Lower-middle	AFRO	SA	Tuberculosis	$4,785,540	$11,839,346	2	4	6
45	CCM	Thailand	Lower-middle	SEARO	EAP	HIV	$38,254,259	$106,123,200	2	4	6
Proposals with Composite Index 6 in USD							**$95,631,712**	**$246,622,919**			
Sub-Total: Proposals with Composite Index 6 in USD Equivalent							**$124,066,232**	**$323,602,552.89**			
Sub-Total Category 1and 2 Proposals with Composite Indexes 8 and 6 in USD Equivalent							**$1,709,511,436**	**$4,420,844,982**			

No.	Source	Country	WB Income classification	WHO Region	Global Fund cluster	Disease	Phase 1 Upper ceiling (2 Years)	Lifetime Upper ceiling (Up to 5 years)	Poverty	Disease burden	Composite Index
Proposals with Composite Index 5											
46	CCM	Comoros	Low	AFRO	EA	Malaria, disease part only	€ 5,280,932	€ 11,788,954	4	1	5
47	CCM	Democratic People's Republic of Korea	Low	SEARO	EAP	Malaria	€ 9,542,511	€ 18,348,551	4	1	5
48	CCM	Gambia	Low	AFRO	WCA	HIV, incl. CCHSS	€ 15,250,763	€ 36,582,801	4	1	5
49	CCM	Guinea-Bissau	Low	AFRO	WCA	Tuberculosis, CCHSS only	€ 595,684	€ 1,286,514	4	1	5
50	CCM	Tajikistan	Low	EURO	EECA	Malaria	€ 5,224,796	€ 9,615,246	4	1	5
51	CCM	Tajikistan	Low	EURO	EECA	Tuberculosis, incl. CCHSS	€ 9,840,404	€ 17,534,572	4	1	5
52	CCM	Zanzibar	Low	AFRO	EA	Malaria, incl. CCHSS	€ 5,648,340	€ 12,355,905	4	1	5
Proposals with Composite Index 5 in EURO							**€ 51,383,430**	**€ 107,512,543**			
53	CCM	Kyrgyz Republic	Low	EURO	EECA	Malaria	$4,530,888	$8,788,180	4	1	5
54	CCM	Madagascar	Low	AFRO	EA	HIV	$11,768,300	$36,037,600	4	1	5
55	CCM	Papua New Guinea	Low	WPRO	EAP	Malaria	$70,139,822	$152,252,244	4	1	5
56	CCM	Rwanda	Low	AFRO	EA	Malaria, disease part only	$58,567,001	$138,469,243	4	1	5
57	Non-CCM	Somalia	Low	EMRO	MENA	HIV, incl. CCHSS	$25,669,049	$60,261,684	4	1	5
58	CCM	United Republic of Tanzania	Low	AFRO	EA	Malaria	$111,586,404	$113,335,025	4	1	5
59	CCM	Zimbabwe	Low	AFRO	SA	Malaria, incl. CCHSS	$70,994,472	$141,316,927	4	1	5
Proposals with Composite Index 5 in USD							**$353,255,936**	**$650,460,903**			
Sub-Total: Proposals with Composite Index 5 in USD Equivalent							**$419,728,679**	**$789,545,693**			
Sub-Total Category 1and 2 Proposals with Composite Indexes 8, 6 and 5 in USD Equivalent							**$2,129,240,115**	**$5,210,390,675**			

Proposals with Composite Index 3									**Poverty**	**Disease burden**	**Composite Index**
60	CCM	Brazil	Lower-middle	AMRO	LAC	Malaria	€ 20,659,117	€ 42,023,909	2	1	3
61	CCM	Colombia	Lower-middle	AMRO	LAC	Malaria	€ 16,997,092	€ 32,262,166	2	1	3
62	CCM	Serbia	Lower-middle	EURO	EECA	HIV	€ 3,766,988	€ 12,406,231	2	1	3
Proposals with Composite Index 3 in EURO							**€ 41,423,197**	**€ 86,692,306**			
63	CCM	Cape Verde	Lower-middle	AFRO	WCA	HIV	$5,321,184	$12,578,727	2	1	3
64	CCM	Dominican Republic	Lower-middle	AMRO	LAC	Malaria	$4,492,517	$8,703,257	2	1	3
65	CCM	Ecuador	Lower-middle	AMRO	LAC	Malaria	$8,374,965	$15,108,812	2	1	3
66	CCM	Indonesia	Lower-middle	SEARO	EAP	Malaria	$73,453,889	$120,092,536	2	1	3
67	CCM	Nicaragua	Lower-middle	AMRO	LAC	HIV	$31,385,337	$65,390,510	2	1	3
Proposals with Composite Index 3 in USD							**$123,027,892**	**$221,873,842**			
Sub-Total: Proposals with Composite Index 3 in USD Equivalent							**$176,615,469**	**$334,024,303**			
Total Category 2 Proposals in USD Equivalent							**$1,854,271,881**	**$4,520,258,748**			

Sub-Total: Category 1 and 2 Proposals Recommended for Funding in USD Equivalent	**$2,305,855,584**	**$5,544,414,978**

No.	Source	Country	WB Income classification	WHO Region	Global Fund cluster	Disease	Phase 1 Upper ceiling (2 Years)	Lifetime Upper ceiling (Up to 5 years)	Prioritization Criteria		
CATEGORY 2B PROPOSALS											
Proposals with Composite Index 8									Poverty	Disease burden	Composite Index
68	CCM	Burkina Faso	Low	AFRO	WCA	Tuberculosis, incl. CCHSS	€ 12,045,997	€ 27,167,685	4	4	8
69	CCM	Chad	Low	AFRO	MENA	Tuberculosis	€ 3,427,453	€ 5,385,007	4	4	8
Proposals with Composite Index 8 in EURO							**€ 15,473,450**	**€ 32,552,692**			
70	CCM	Burundi	Low	AFRO	EA	HIV	$41,315,145	$159,105,087	4	4	8
71	CCM	Nigeria	Low	AFRO	WCA	Malaria	$334,351,033	$599,810,494	4	4	8
72	CCM	Sudan, Northern Sector	Low	EMRO	MENA	Tuberculosis, incl CCHSS	$17,979,663	$58,048,795	4	4	8
73	CCM	Zimbabwe	Low	AFRO	SA	Tuberculosis	$29,538,652	$58,298,297	4	4	8
Proposals with Composite Index 8 in USD							**$423,184,493**	**$875,262,673**			
Sub-Total:Proposals with Composite Index 8 in USD Equivalent							**$443,201,893**	**$917,374,823**			
Sub-Total Category 1, 2 and 2B with Composite Index 8 Proposals in USD Equivalent							**$2,749,057,477**	**$6,461,789,801**			
Proposals with Composite Index 6									Poverty	Disease burden	Composite Index
74	CCM	China	Lower-middle	WPRO	EAP	Tuberculosis	€ 24,012,517	€ 87,664,363	2	4	6
75	CCM	Congo (Republic of)	Lower-middle	AFRO	WCA	Malaria	€ 25,465,537	€ 54,135,175	2	4	6
76	CCM	Congo (Republic of)	Lower-middle	AFRO	WCA	Tuberculosis	€ 2,303,089	€ 5,005,041	2	4	6
77	CCM	Moldova	Lower-middle	EURO	EECA	HIV	€ 8,606,392	€ 16,723,816	2	4	6
Proposals with Composite Index 6 in EURO							**€ 60,387,535**	**€ 163,528,395**			
78	CCM	Iran	Lower-middle	EMRO	SWA	HIV	$10,328,021	$32,354,404	2	4	6
79	CCM	Lesotho	Lower-middle	AFRO	SA	Tuberculosis	$10,967,381	$28,083,618	2	4	6
Proposals with Composite Index 6 in USD							**$21,295,402**	**$60,438,022**			
Sub-Total:Proposals with Composite Index 6 in USD Equivalent							**$99,416,405**	**$271,988,339**			
Sub-Total Category 1, 2 and 2B with Composite Indexes 8 and 6 Proposals in USD Equivalent							**$2,848,473,881**	**$6,733,778,140**			
Proposals with Composite Index 5									Poverty	Disease burden	Composite Index
80	CCM	Afghanistan	Low	EMRO	SWA	Malaria, incl CCHSS	€ 30,075,545	€ 55,397,259	4	1	5
81	CCM	Democratic People's Republic of Korea	Low	SEARO	EAP	Tuberculosis	€ 17,686,423	€ 47,102,407	4	1	5
Proposals with Composite Index 5 in EURO							**€ 47,761,968**	**€ 102,499,666**			
82	CCM	Haiti	Low	AMRO	LAC	Malaria	$33,402,457	$50,046,179	4	1	5
83	CCM	Madagascar	Low	AFRO	EA	Tuberculosis	$8,987,239	$22,797,620	4	1	5
84	CCM	Solomon Islands	Low	WPRO	EAP	HIV CCHSS only	$845,725	$1,686,884	4	1	5
85	CCM	Solomon Islands	Low	WPRO	EAP	Tuberculosis	$3,608,714	$7,334,716	4	1	5
86	CCM	Uzbekistan	Low	EURO	EECA	Malaria	$2,789,923	$6,144,821	4	1	5
87	CCM	Uzbekistan	Low	EURO	EECA	Tuberculosis	$13,881,631	$56,124,183	4	1	5
Proposals with Composite Index 5 in USD							**$63,515,689**	**$144,134,403**			
Sub-Total:Proposals with Composite Index 5 in USD Equivalent							**$125,303,487**	**$276,734,230**			
Sub-Total Category 1, 2 and 2B with Composite Indexes 8, 6 and 5 Proposals in USD Equivalent							**$2,973,777,368**	**$7,010,512,370**			

No.	Source	Country	WB Income classification	WHO Region	Global Fund cluster	Disease	Phase 1 Upper ceiling (2 Years)	Lifetime Upper ceiling (Up to 5 years)			
Proposals with Composite Index 3									Poverty	Disease burden	Composite Index
88	CCM	Bulgaria	Lower-middle	EURO	EECA	Tuberculosis	€ 3,661,435	€ 10,527,766	2	1	3
Proposals with Composite Index 3 in EURO							**€ 3,661,435**	**€ 10,527,766**			
89	CCM	Bolivia	Lower-middle	AMRO	LAC	Malaria	$6,744,407	$15,578,630	2	1	3
90	CCM	Fiji	Lower-middle	WPRO	EAP	Tuberculosis, incl CCHSS	$4,789,119	$9,929,474	2	1	3
91	CCM	Guyana	Lower-middle	AMRO	LAC	Tuberculosis	$3,087,615	$7,125,899	2	1	3
92	CCM	Kazakhstan	Lower-middle	EURO	EECA	Tuberculosis	$37,557,518	$69,880,919	2	1	3
93	CCM	Sri Lanka	Lower-middle	SEARO	SWA	Malaria	$24,040,444	$40,915,151	2	1	3
94	CCM	Tunisia	Lower-middle	EMRO	MENA	Tuberculosis	$4,400,014	$7,560,548	2	1	3
Proposals with Composite Index 3 in USD							**$80,619,117**	**$150,990,621**			
Sub-Total: Proposals with Composite Index 3 in USD Equivalent							**$85,355,773**	**$164,609,982**			
Total Category 2B Proposals in USD Equivalent							**$753,277,557**	**$1,630,707,374**			

Grand Total: Proposals Recommended for Funding in USD Equivalent	**$3,059,133,141**	**$7,175,122,352**

Prioritization among the proposals recommended by the TRP in category 2B is done in accordance with the Board approved policy on Prioritization in Resource Constrained Environments (GF/B8/2). In line with this policy the composite index (poverty and disease burden) is calculated on the following basis:

Criteria	Indicator	Value	Score
Disease burden	Eligibility criteria for proposals from Upper-Middle Income countries (applied to all proposals)	"Very high"	4
		Not "very high"	1
Poverty	World Bank classification	Low Income	4
		Lower-Middle Income	2
		Upper-Middle Income	0

According with Guidelines for Round 8 Proposals a high national disease burden is defined for each disease on the following basis:

* HIV/AIDS: HIV prevalence in 15-49 years = to or > 1% and HIV prevalence is equal or more than 5 % in at least one identified vulnerable population (Source: 2008 Report on Global AIDS epidemic)
* TB: WHO list of 22 high burden countries (Source: Global Tuberculosis control: surveillance, planning, financing, WHO Report 2008) and WHO list of the 41 countries that account for 97% of estimated burden of new tuberculosis cases attributable to HIV/AIDS
* More than 1 death per 1000 people per year due to malaria - estimates (Source: World Malaria Report 2008)

Round 8 Income level classification is based on World Bank income classification, taking into account 'one year grace period' as decided at the 16th Board meeting

No.	Source	Country	WB Income classification	WHO Region	Global Fund cluster	Disease	Phase 1 Upper ceiling (2 Years)	Lifetime Upper ceiling (Up to 5 years)
PARTS OF CATEGORY 1, 2 OR 2B PROPOSALS NOT RECOMMENDED FOR FUNDING *(Refer to Part 4 of the covering report to this Annex, at paragraphs 12 - 14)*								
Ref.17	CCM	Armenia	Lower-middle	EURO	EECA	HIV part	€ 2,394,212	€ 6,257,962
Ref.24	CCM	Comoros	Low	AFRO	WCA	Malaria, CCHSS part	€ 1,061,171	€ 2,834,024
Ref.28	CCM	Guinea Bissau	Low	AFRO	WCA	Tuberculosis part	€ 7,818,909	€ 21,213,426
Ref.29	CCM	Mali	Low	AFRO	MENA	HIV, CCHSS part	€ 21,852,585	€ 49,979,708
Ref.30	CCM	Paraguay	Lower-middle	AMRO	LAC	HIV, CCHSS part	€ 1,514,597	€ 3,267,216
Sub-Total: Parts of Category 1, 2 or 2B Proposals not recommended for funding in EURO							**€ 34,641,474**	**€ 83,552,336**
Ref.43	CCM	Eritrea	Low	AFRO	EA	HIV, CCHSS part	$6,087,808	$14,939,526
Ref.45	CCM	Ghana	Low	AFRO	WCA	Malaria, CCHSS part	$4,462,500	$13,420,570
Ref.46	CCM	Guyana	Lower-middle	AMRO	LAC	HIV part	$6,005,402	$18,370,517
Ref.12	CCM	Mauritania	Low	AFRO	MENA	HIV part	$9,367,617	$22,266,256
Ref.53	CCM	Mozambique	Low	AFRO	SA	HIV part	$39,073,131	$170,770,762
Ref.55	CCM	Nigeria	Low	AFRO	WCA	HIV part	$293,867,577	$831,612,641
Ref.58	CCM	Rwanda	Low	AFRO	EA	Malaria, CCHSS part	$33,702,875	$48,541,601
Ref.87	CCM	Solomon Islands	Low	WPRO	EAP	HIV part	$4,570,062	$10,472,323
Ref.60	CCM	Swaziland	Lower-middle	AFRO	SA	HIV part	$49,055,285	$90,214,010
Ref.63	CCM	United Republic of Tanzania	Low	AFRO	EA	HIV, CCHSS part	$65,422,207	$96,794,019
Sub-Total: Parts of Category 1, 2 or 2B Proposals not recommended for funding in USD							**$511,614,464**	**$1,317,402,225**
Total: Parts of Category 1, 2 or 2B Proposals not recommended for funding in USD Equivalent							**$556,428,790**	**$1,425,490,629**

PROPOSALS NOT RECOMMENDED FOR FUNDING IN ROUND 8:

No.	Source	Country	WB Income classification	WHO Region	Global Fund cluster	Disease	Phase 1 Upper ceiling (2 Years)	Lifetime Upper ceiling (Up to 5 years)
CATEGORY 3 PROPOSALS								
95	CCM	Belarus	Lower-middle	EURO	EECA	Tuberculosis	€ 14,254,281	€ 31,226,265
96	CCM	Benin	Low	AFRO	WCA	Malaria	€ 26,909,499	€ 26,909,499
97	CCM	Benin	Low	AFRO	WCA	Tuberculosis	€ 3,556,947	€ 6,658,804
98	CCM	Bosnia Herzegovia	Lower-middle	EURO	EECA	HIV	€ 12,336,077	€ 29,441,571
99	CCM	Bosnia Herzegovia	Lower-middle	EURO	EECA	Tuberculosis	€ 5,722,028	€ 9,796,973
100	CCM	Brazil	Lower-middle	AMRO	LAC	HIV	€ 9,372,000	€ 30,000,000
101	CCM	Brazil	Lower-middle	AMRO	LAC	Tuberculosis	€ 40,191,174	€ 80,560,970
102	CCM	Burkina Faso	Low	AFRO	WCA	HIV	€ 24,844,539	€ 48,473,676
103	CCM	Cameroon	Lower-middle	AFRO	WCA	HIV	€ 28,961,003	€ 66,797,527
104	CCM	Cameroon	Lower-middle	AFRO	WCA	Tuberculosis	€ 7,015,400	€ 13,782,656
105	CCM	Central African Republic	Low	AFRO	WCA	Tuberculosis	€ 9,742,228	€ 22,482,120
106	CCM	China	Lower-middle	WPRO	EAP	Malaria	€ 29,681,060	€ 61,332,628
107	CCM	Colombia	Lower-middle	AMRO	LAC	HIV	€ 12,254,560	€ 32,867,073
108	CCM	Colombia	Lower-middle	AMRO	LAC	Tuberculosis	€ 11,968,726	€ 22,919,271
109	CCM	Côte d'Ivoire	Low	AFRO	WCA	HIV, incl. CCHSS	€ 55,758,904	€ 142,745,182
110	CCM	Côte d'Ivoire	Low	AFRO	WCA	Tuberculosis	€ 7,152,767	€ 17,886,903
111	CCM	Democratic People's Republic of Korea	Low	SEARO	EAP	HIV	€ 15,119,159	€ 28,699,056
112	CCM	Djibouti	Lower-middle	EMRO	MENA	Malaria	€ 4,335,600	€ 10,391,353
113	CCM	Gabon	Upper-middle	AFRO	WCA	Malaria	€ 5,030,319	€ 13,851,883
114	CCM	Guatemala	Lower-middle	AMRO	LAC	Malaria	€ 21,586,329	€ 41,174,990
115	CCM	India	Low	SEARO	SWA	HIV	€ 21,263,481	€ 75,212,496
116	CCM	India	Low	SEARO	SWA	Malaria	€ 39,883,180	€ 100,310,326
117	CCM	India	Low	SEARO	SWA	Tuberculosis	€ 32,420,155	€ 79,915,954
118	CCM	Paraguay	Lower-middle	AMRO	LAC	Malaria	€ 4,403,483	€ 8,558,518
119	CCM	Paraguay	Lower-middle	AMRO	LAC	Tuberculosis	€ 8,277,793	€ 18,576,825
120	CCM	Peru	Lower-middle	AMRO	LAC	HIV, incl. CCHSS	€ 30,545,347	€ 50,546,403
121	CCM	Philippines	Lower-middle	WPRO	EAP	HIV, incl. CCHSS	€ 25,581,667	€ 42,391,843
122	CCM	Russian Federation	Upper-middle	EURO	EECA	Tuberculosis	€ 65,687,022	€ 139,199,580
123	CCM	Senegal	Low	AFRO	WCA	HIV, incl. CCHSS	€ 54,507,488	€ 136,440,454
124	CCM	Senegal	Low	AFRO	WCA	Tuberculosis	€ 6,930,243	€ 17,791,333
Sub-Total: Category 3 Proposals in EURO							**€ 635,292,459**	**€ 1,406,942,132**

No.	Source	Country	WB Income classification	WHO Region	Global Fund cluster	Disease	Phase 1 Upper ceiling (2 Years)	Lifetime Upper ceiling (Up to 5 years)
CATEGORY 3 PROPOSALS								
125	CCM	Bangladesh	Low	SEARO	SWA	HIV	$14,964,866	$48,892,309
126	CCM	Bangladesh	Low	SEARO	SWA	Malaria	$22,729,707	$68,436,372
127	CCM	Bolivia	Lower-middle	AMRO	LAC	HIV	$7,763,930	$23,802,395
128	CCM	Cambodia	Low	WPRO	EAP	HIV	$38,283,888	$134,514,948
129	CCM	Cambodia	Low	WPRO	EAP	Tuberculosis, incl. CCHSS	$11,449,113	$34,686,505
130	CCM	Democratic Republic of Congo	Low	AFRO	EA	Tuberculosis, incl. CCHSS	$71,422,674	$199,682,709
131	RO	COPRECOS LAC	Mixed	AMRO	LAC	HIV	$23,122,297	$68,666,796
132	CCM	Ecuador	Lower-middle	AMRO	LAC	HIV	$14,389,246	$35,615,171
133	CCM	Ecuador	Lower-middle	AMRO	LAC	Tuberculosis	$14,066,522	$32,819,024
134	CCM	Guyana	Lower-middle	AMRO	LAC	Malaria	$2,993,178	$5,573,355
135	CCM	Haiti	Low	AMRO	LAC	Tuberculosis, incl. CCHSS	$31,167,222	$59,742,348
136	CCM	Honduras	Lower-middle	AMRO	LAC	HIV	$5,334,334	$13,389,159
137	CCM	Honduras	Lower-middle	AMRO	LAC	Tuberculosis, incl. CCHSS	$8,031,166	$16,170,525
138	CCM	Kazakhstan	Lower-middle	EURO	EECA	HIV	$13,880,664	$35,851,200
139	CCM	Kenya	Low	AFRO	EA	Malaria	$89,634,705	$200,581,638
140	CCM	Kenya	Low	AFRO	EA	Tuberculosis, incl. CCHSS	$41,216,118	$137,406,953
141	CCM	Kyrgyz Republic	Low	EURO	EECA	Tuberculosis	$7,507,988	$24,622,765
142	CCM	Mozambique	Low	AFRO	SA	Malaria	$78,152,630	$210,466,897
143	CCM	Namibia	Lower-middle	AFRO	SA	HIV	$64,688,284	$160,505,034
144	CCM	Nepal	Low	SEARO	SWA	HIV, incl CCHSS	$35,249,649	$90,220,063
145	CCM	Nigeria	Low	AFRO	WCA	Tuberculosis	$42,169,586	$181,584,855
146	CCM	Pakistan	Low	EMRO	SWA	HIV	$18,636,708	$66,219,051
147	CCM	Panama	Upper-middle	AMRO	LAC	HIV	$4,949,840	$13,592,440
148	CCM	Rwanda	Low	AFRO	EA	HIV	$15,591,988	$38,979,970
149	RCM	SADC	Mixed	AFRO	SA	Malaria, incl.CCHSS	$36,018,686	$86,985,372
150	CCM	Sao Tome and Principe	Low	AFRO	WCA	HIV	$568,464	$1,529,157
151	CCM	South Africa	Upper-middle	AFRO	SA	HIV	$91,680,358	$259,056,796
152	Sub-CCM	Sudan, Southern Sector	Low	EMRO	MENA	HIV, incl CCHSS	$28,482,979	$124,015,542
153	CCM	Turkmenistan	Lower-middle	EURO	EECA	Tuberculosis	$10,649,147	$20,279,651
154	CCM	Ukraine	Lower-middle	EURO	EECA	Tuberculosis	$36,251,905	$94,715,697
155	CCM	Uruguay	Upper-middle	AMRO	LAC	HIV	$8,951,242	$21,393,157
156	CCM	Uzbekistan	Low	EURO	EECA	HIV	$26,428,887	$79,669,868
157	CCM	Yemen	Low	EMRO	MENA	HIV	$6,495,225	$25,735,775
Sub-Total: Category 3 Proposals in USD							**$922,923,196**	**$2,615,403,497**
Total: Category 3 Proposals in USD Equivalent							**$1,744,776,312**	**$4,435,509,748**

No.	Source	Country	WB Income classification	WHO Region	Global Fund cluster	Disease	Phase 1 Upper ceiling (2 Years)	Lifetime Upper ceiling (Up to 5 years)
CATEGORY 4 PROPOSALS								
158	RO	CARE	Low	SEARO	SWA	HIV	€ 14,145,331	€ 40,817,080
159	CCM	Comoros	Low	AFRO	EA	HIV	€ 1,235,586	€ 2,229,001
160	CCM	Djibouti	Lower-middle	EMRO	MENA	Tuberculosis	€ 3,912,029	€ 8,688,954
161	CCM	Guatemala	Lower-middle	AMRO	LAC	HIV, incl. CCHSS	€ 37,104,756	€ 115,595,987
162	Sub-CCM	Russian Federation	Upper-middle	EURO	EECA	Tuberculosis, incl. CCHSS	€ 18,808,972	€ 33,180,557
163	CCM	Zanzibar	Low	AFRO	EA	HIV	€ 4,127,078	€ 7,274,018
Sub-Total: Category 4 Proposals in EURO							**€ 79,333,752**	**€ 207,785,597**
164	CCM	Algeria	Lower-middle	AFRO	MENA	HIV	$15,252,168	$32,720,961
165	CCM	Angola	Lower-middle	AFRO	SA	HIV	$75,142,046	$235,955,998
166	CCM	Angola	Lower-middle	AFRO	SA	Tuberculosis	$11,756,766	$25,098,444
167	CCM	Bolivia	Lower-middle	AMRO	LAC	Tuberculosis	$9,191,385	$16,777,841
168	RCM	CCLAB	Mixed	AMRO	LAC	HIV	$20,292,270	$46,811,258
169	RO	GLIA	Low	AFRO	EA	HIV	$10,824,037	$27,044,765
170	CCM	Kazakhstan	Lower-middle	EURO	EECA	Malaria	$897,612	$1,376,877
171	CCM	Kenya	Low	AFRO	EA	HIV	$105,743,946	$129,929,146
172	Sub-CCM	Kyrgyz Republic	Low	EURO	EECA	HIV	$3,560,042	$6,770,643
173	CCM	South Africa	Upper-middle	AFRO	SA	Tuberculosis	$68,229,369	$194,670,986
174	CCM	Yemen	Low	EMRO	MENA	Tuberculosis	$6,767,022	$19,880,527
Sub-Total: Category 4 Proposals in USD							**$327,656,663**	**$737,037,446**
Total: Category 4 Proposals in USD Equivalent							**$430,287,649**	**$1,005,841,582**

Grand Total: Proposals Not Recommended for Funding in USD Equivalent *	**$2,731,492,751**	**$6,866,841,958**

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

Key for multi-country proposals

1 - RO COPRECOS - Colombia, ElSalvador, Nicaragua, Panama, Paraguay, Dom.Rep., Uruguay, Argentina, Belize, Brazil, Ecuador, Guatemala, Haiti, Honduras, Peru, Chile, Costa Rica, Venezuela
2 - RCM CCLAB - Guatemala, ElSalvador, Honduras, Nicaragua, Dom.Rep., Panama, Costa Rica, Belize
3 - RCM SADC (TZM) - Angola, Botswana, Namibia, Zambia, Zimbabwe
4- RO CARE - India Nepal, Bangladesh
5 - RO GLIA - Burundi, DRC, Kenya, Rwanda, Tanzania, Uganda

The Global Fund Clusters

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

** Proposals in EURO - the UN official exchange rate effective at 1 November 2008 - 1 USD = 0,773 EURO

This revision has been issued to apply the UN official exchange rate effective at 1 November 2008 for EURO denominated proposals.
Also, the prioritization category has changed for Iran HIV and Moldova HIV proposals (2B), because of the HIV prevalence rate in at least one vulnerable population

Annex 5
Revision 1

GF/B18/10

Detailed analysis of the TRP's funding recommendations for Round 8 proposals

Part 1: Introduction

1. Part 2 of the covering report to this Annex 5 provides a summary of the overall recommendations of the TRP for the 174 disease proposals reviewed in Round 8. Those recommendations identify which of the proposals were recommended as technically sound ('Category 1' and 'Category 2', including 'Category 2B' proposals as a sub-set of all 'Category 2' proposals).

2. In addition, the covering report summarizes the TRP's funding recommendation to the Global Fund Board on the maximum two year upper ceiling for the 174 proposals. The Global Fund Board will consider these recommendations in November 2008 at its Eighteenth meeting.

3. Recognizing an interest in more detailed analysis of the TRP's funding recommendations, this Annex provides information on:

i. the 174 disease proposals received (part 2); and

ii. As a sub-set of these proposals, the *45 HSS requests for funding (Part 3)*.

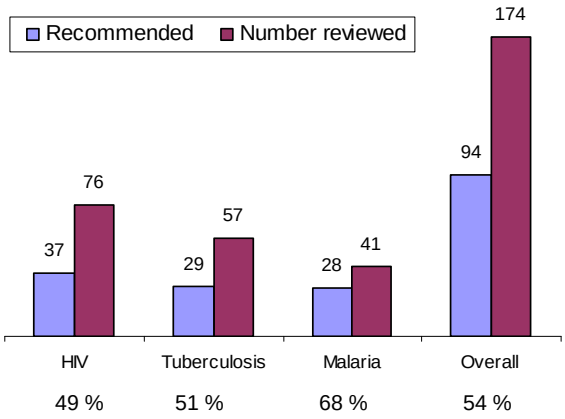
4. Different from the covering report, this Annex also provides information and analysis on the five year upper funding ceiling budget requests, compared to earlier Rounds. Once a grant is signed, access to funding for years three to five (Phase 2) is subject to performance and the availability of funds at the time of the Phase 2 evaluation.

5. Lessons learned and recommendations to the Global Fund Board that were drawn from this analysis are set out in part 5 of the covering report.

Part 2: Summary of Round 8 disease proposals received and TRP recommendations

1. **Round 8** has resulted in the largest recommendations for funding made to date by the TRP. **Figure 1 below** illustrates the relative proportion of proposals recommended for funding in Round 8 on a by disease basis, and then overall.

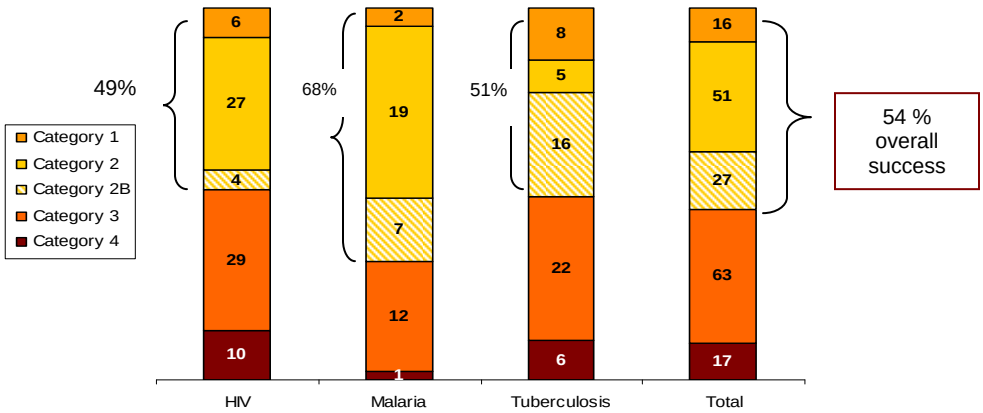
Figure 1 – Number of disease proposals recommended for funding by disease, compared to all eligible proposals reviewed



2. Following the Board's consideration of the TRP's recommendations on funding of Round 8 proposals at the Eighteenth Board meeting, the Global Fund will publish detailed analysis on other facets of proposals received. This will include analysis on gender matters, community systems strengthening, and grant consolidation possibilities.

3. The relative proportion of proposals recommended within the four possible categories for proposals is identified in **figure 2 below**. In addition to Round 8 resulting in the highest recommendation rate for applicants, this Round also has the most proposals recommended in 'Category 1' (n=16, compared to five disease proposals in Round 7). The primary reason for this increase is the Board's decision[21] to increase the time during which 'Category 1' proposals must complete clarifications. The increase from one month to two months provides the TRP with comfort that the residual issues for otherwise technically sound proposals can be appropriately answered by applicants within the time limited period.

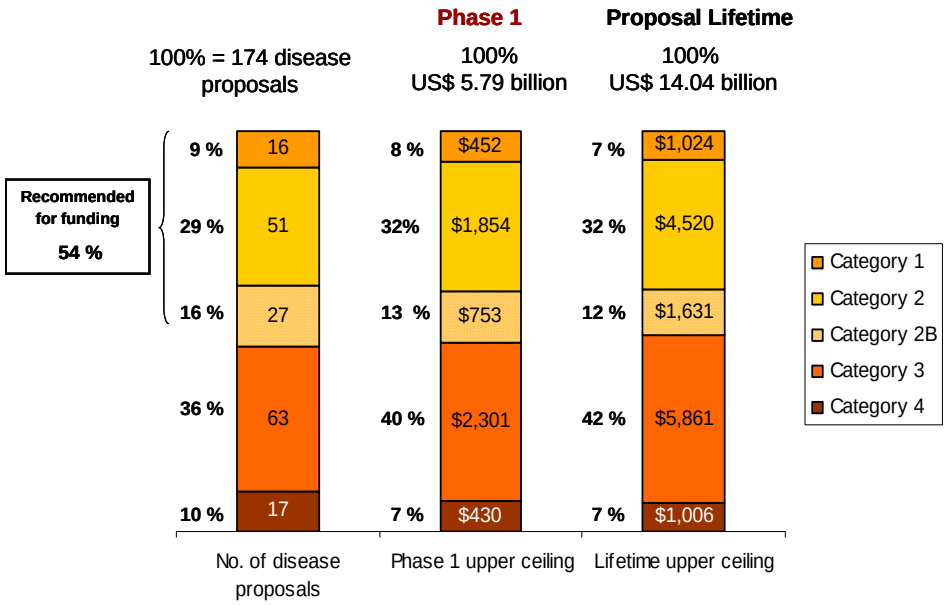
Figure 2 – Proportion of disease proposals recommended by disease, and by 'Category'



[21] Refer to the decision entitled "Approval of Round 7" (GF/B16/DP4)

4. **Figure 3 below** reveals the overall two year (and cumulative five year) upper funding ceiling requests within the four categories in which proposals could be recommended for funding by the TRP, drawing on the 'overall' column from figure 2 above.

Figure 3 – Summary of Two and Five Year Upper Ceiling Budget Requests by Recommended Category



5. The comparative success rates within the diseases for recent Rounds are set out in **table 1 below**. This table shows a significant upward trend in the overall success rates within the three diseases. The improvement in the success rate for malaria proposals is the most significant from Round 5. The historical success rate over all prior Rounds, and the US$ equivalent value for each disease by Round is shown in the sub-paragraphs headed 'Comparison of Round 8 with previous Rounds' below.

Table 1 – Comparison of success rate within the diseases across Rounds 5 to 8

	HIV	Tuberculosis	Malaria	Overall
Round 5	37%	46%	23%	31%
Round 6	39%	62%	32%	43%
Round 7	41%	46%	62%	49%
Round 8	**49%**	**51%**	**68%**	**54%**

6. In figures 1 and 2, and table 1, and throughout this part 2 (*unless stated otherwise*), the HSS requests for cross-cutting health systems support are integrated into the host disease proposal. This is because of the clear statement from the Board that health systems strengthening is not a separate 'component' for funding (as compared to Round 5). Thus, for example, a 'tuberculosis' proposal will be identified as recommended for funding in any of the following scenarios:

i. Both the 'disease part' and the HSS request were assessed as technically sound; or

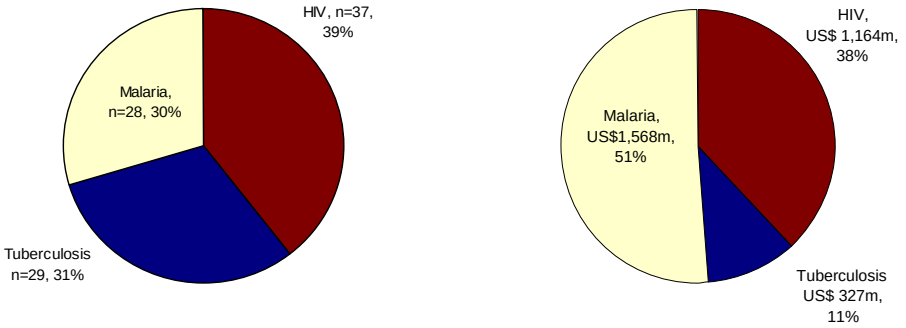
ii. Only the 'disease part' was assessed as technically sound; or

iii. Only the HSS request was assessed as technically sound.

Comparison of financial and disease proposal outcomes – Two Year Upper Ceiling Funding

7. **Figure 4 below** displays, for the two year upper ceiling maximum funding recommended by the TRP for approval, the overall number of disease proposals recommended by disease in Round 8, compared to the relative proportion of the recommended monetary amount (US$ value) also on a per-disease basis.

Figure 4 – Comparison of recommended disease proposals and proportion of two year upper ceiling recommended for funding



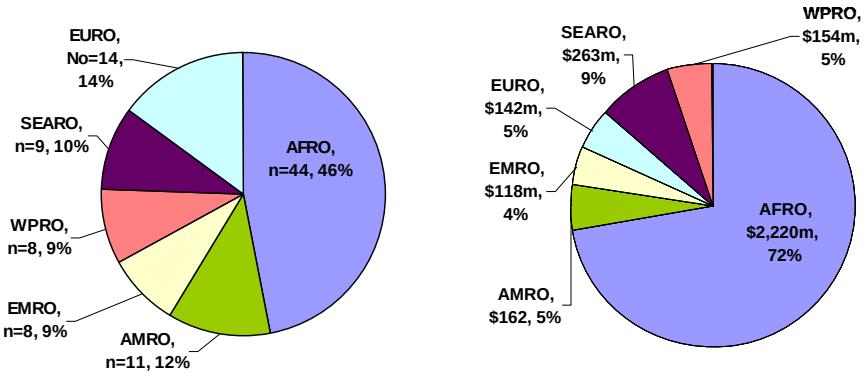
100% = 94 disease proposals **100% = *US$ 3.059 billion***

8. As seen in prior Rounds, the relative discrepancy between the number of tuberculosis proposals recommended for funding (n=29), compared to the proportion of the recommended overall two year upper ceiling funding (US$ *327* million), is directly attributable to the lower cost of medicines and other health products.

9. By contrast, Round 8 malaria proposals that are recommended for funding plan to purchase and distribute more than 120 million insecticide treated bed nets, and more than 80 million courses of ACTs. These interventions carry with them significant cost and account for the discrepancy showing in figure 2 above.

10. **Figure 5 below** demonstrates the relative proportion of the disease proposals recommended for funding by **WHO regional classification**, compared to the two year upper ceiling funding recommended for the 94 disease proposals.

Figure 5 – Recommended disease proposals by region, and two year upper ceiling funding recommended



100% = 94 disease proposals **100% = US$ *3.059* billion**

11. As with prior Rounds, the largest proportion of recommended proposals and budget relate to countries within the **WHO AFRO region**. Of all disease proposals recommended for funding, 46 percent were submitted from AFRO applicants (43 percent in Round 7). In financial terms, AFRO based applicants account for *72* percent of recommended two year upper ceiling budget (US$ *2,220* million, compared to 66 percent, and US$ 733 million in Round 7). A significant proportion of this demonstrable increase in the size of funding for the AFRO continent comes from the success of AFRO malaria proposals (with AFRO malaria proposals having a success rate of 78 percent, or 14 of the 18 malaria proposals submitted from the continent).

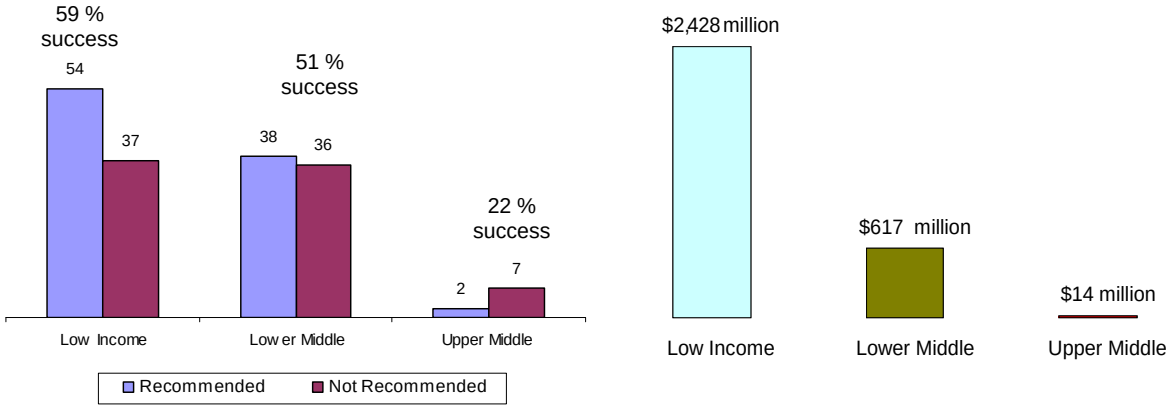
12. The WHO regions of AFRO, EMRO, and SEARO all saw considerable improvements in the success rates of disease proposals, as shown in the summary data provided in **table 2 below**. Additional data on the historical trends is provided under the heading 'Comparison of Round 8 with previous Rounds' below.

Table 2 – Summary of success rate of disease proposals by WHO regional office

	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	60%	34%	57%	67%	53%	54%

13. **Figure 6 below** shows a comparison of the relative number of disease proposals recommended for funding according to the applicant's **World Bank income level** classification, and the corresponding two year upper funding ceiling recommended for approval. Subject to Board approval, the TRP's Round 8 funding recommendations will result in the majority of Round 8 additional funding (79 percent of the two year upper funding ceiling) being disbursed to countries classified by the World Bank as 'low income'[22].

Figure 6 – Disease proposals recommended for funding, by World Bank Income Level classification and Phase 1 Upper Ceiling Funding



100% = 94 disease proposals **100% = US$ *3.059* billion**

[22] The data relied on is the World Bank's list of income level classifications at 1 July 2007, upon which the Global Fund made its 2008 determinations for eligibility based on income level.

14. As **table 3 below** indicates, Round 8 saw a demonstrable increase in the funding being contributed to countries classified by the World Bank as 'low income' and 'lower middle income' compared to earlier Rounds.

Table 3 - Comparison over Rounds 5 to 8 of applicant income level for TRP recommended proposals

Proposals Recommended for funding	Low Income		Lower Middle Income		Upper Middle Income	
	Disease proposal	2 Year Upper Ceiling	Disease proposal	2 Year Upper Ceiling	Disease proposal	2 Year Upper Ceiling
Round 5	41	$ 557 m	21	$ 163.5 m	1	$ 5.5 m
Round 6	48	$ 513.4 m	36	$ 277.9 m	1	$ 55.7 m
Round 7	49	$ 908 m	24	$ 209 m	0	$0
Round 8	54	$ 2,428 m	38	$ 617 m	2	$ 14 m

Applicants who have not yet been recommended for funding

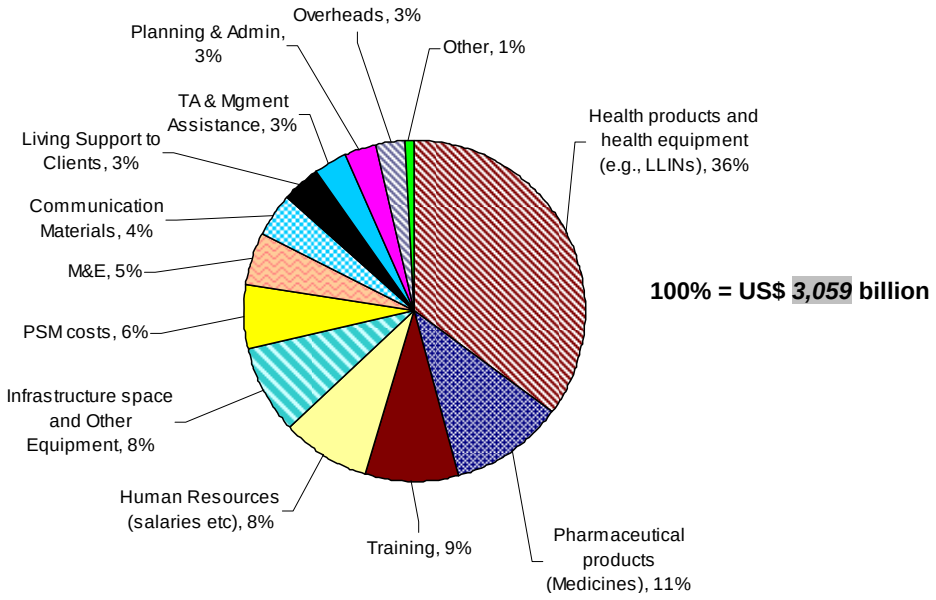
15. In Round 8, there were a very small number of applicants who applied for funding for the first time (or were re-submitting their initial Round 7 application) and were not recommended for funding (n=2).[23]

16. Data analyzed by the Secretariat shows that 14 applicants have applied for the same disease and not been recommended for funding in multiple successive Rounds (three Rounds, n=6; four Rounds, n=4, and five successive Rounds, n=4). The majority of these countries are organized regionally in the AFRO and AMRO WHO regions. A small number of these have a particularly high disease burden, and the repeated presentation of technically weak proposals is therefore of concern.

Planned Expenditure for Phase 1 by Expenditure Item

17. **Figure 7 below** sets out the planned expenditure by cost category over the initial two years of funding for the 94 disease proposals recommended for funding.

Figure 7 – Two year Upper Ceiling Budget for recommended disease proposals by cost category in US$



[23] Solomon Islands and Turkmenistan.

18. How applicants apportioned their costs between the disease proposals is summarized in **table 4 below**. Different from all other graphs and tables in this part 2, table 4 includes information for only the disease specific part of proposals. This is to enable a comparison on items such as the planned procurement of health products within the disease part, relative the total value of the disease specific proposals for that disease.

Table 4 – Applicant apportionment of two year upper ceiling budget requests by disease (s.4B HSS requests excluded)

Cost Category from Round 8 Proposals	HIV Upper Ceiling Phase 1 (USD equiv)	% of Total Phase 1 Upper Ceiling	Tuberculosis Upper Ceiling Phase 1	% of Total Phase 1 Upper Ceiling	Malaria Upper Ceiling Phase 1	% of Total Phase 1 Upper Ceiling	Total Upper Ceiling Phase 1 (Disease only)
Communication Materials	52,870,178	5.4%	14,962,679	4.8%	50,570,621	3.4%	118,403,478
Health products and health equipment	162,433,586	16.5%	56,806,048	18.4%	836,926,177	56.4%	1,056,165,811
Human Resources	82,263,848	8.4%	24,915,607	8.1%	81,097,529	5.5%	188,276,985
Infrastructure space and Other Equipment	73,223,745	7.5%	39,823,737	12.9%	66,597,589	4.5%	179,645,071
Living Support to Clients/Target Populations	82,943,664	8.4%	23,057,847	7.5%	542,339	0.04%	106,543,850
Monitoring and Evaluation	52,596,892	5.4%	26,881,132	8.7%	55,819,076	3.8%	135,297,099
Other	7,174,586	0.7%	975,731	0.3%	14,770,522	1.0%	22,920,839
Overheads	37,809,687	3.9%	9,853,629	3.2%	35,774,410	2.4%	83,437,726
Pharmaceutical products (Medicines)	195,537,816	19.9%	45,693,251	14.8%	91,595,935	6.2%	332,827,001
Planning and administration	39,351,782	4.0%	13,857,402	4.5%	36,311,024	2.4%	89,520,207
Procurement and supply management costs	30,658,003	3.1%	12,412,512	4.0%	129,189,985	8.7%	172,260,500
Technical and Management Assistance	43,223,964	4.4%	12,238,558	4.0%	19,415,538	1.3%	74,878,060
Training	121,857,919	12.4%	27,396,305	8.9%	66,540,589	4.5%	215,794,814
Total	**$981,945,670**	**100%**	**$308,874,437**	**100%**	**$1,485,151,334**	**100%**	**$2,775,971,441**

19. The most substantial change compared to Round 7 is the significant increase in the funding requested for 'health products and health equipment' (Round 7 amounted to US$ 272 million, or 25% of the overall two year upper ceiling funding approved, US$ 1,119 million). As introduced in the covering report to this Annex 5, the significant contributing factor to the increase in this cost category is the planned early procurement and distribution of insecticide treated nets in, particularly, Sub-Sahara Africa.

20. Drawing on figure 7 and table 4 above, other comparisons with Round 7 include:

i. An important increase in the funding requested for 'human resources' (including salary support), which in Round 7 was US$ 115 million, and 10 percent of the overall two year upper ceiling budget request;

ii. More than doubling of the funding requested for 'pharmaceutical products' (medicines), which in Round 7 was US$ 149 million for two years; and

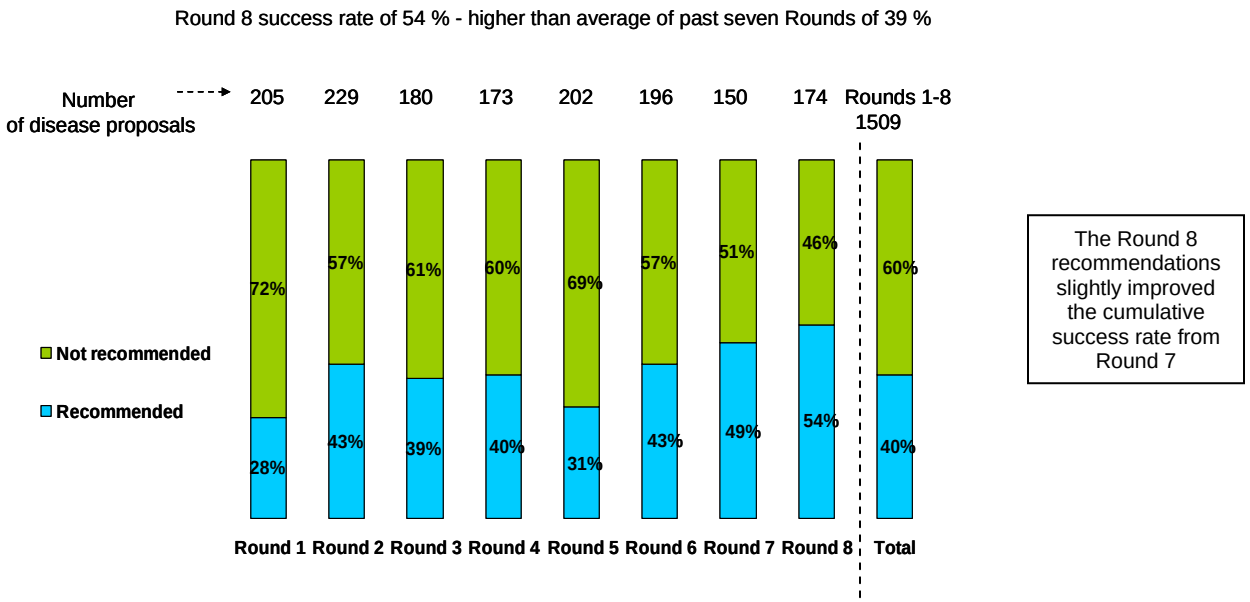
iii. Whilst retaining the same overall relative proportion of the two year upper ceiling funding request (respectively, 3 percent and 5 percent), important monetary increases in the funding requested for:

- technical and management assistance during grant implementation (US$ 35 million in Round 7); and
- monitoring and evaluation (US$ 59 million in Round 7).

Comparison of Round 8 with previous Rounds

21. **Figure 8 below** shows that the proposals submitted in Round 8 had a higher success rate than in Round 7, and all prior Rounds.

Figure 8 – Comparison of Percentage of Proposals Recommended for Funding by the TRP across Rounds 1 to 8



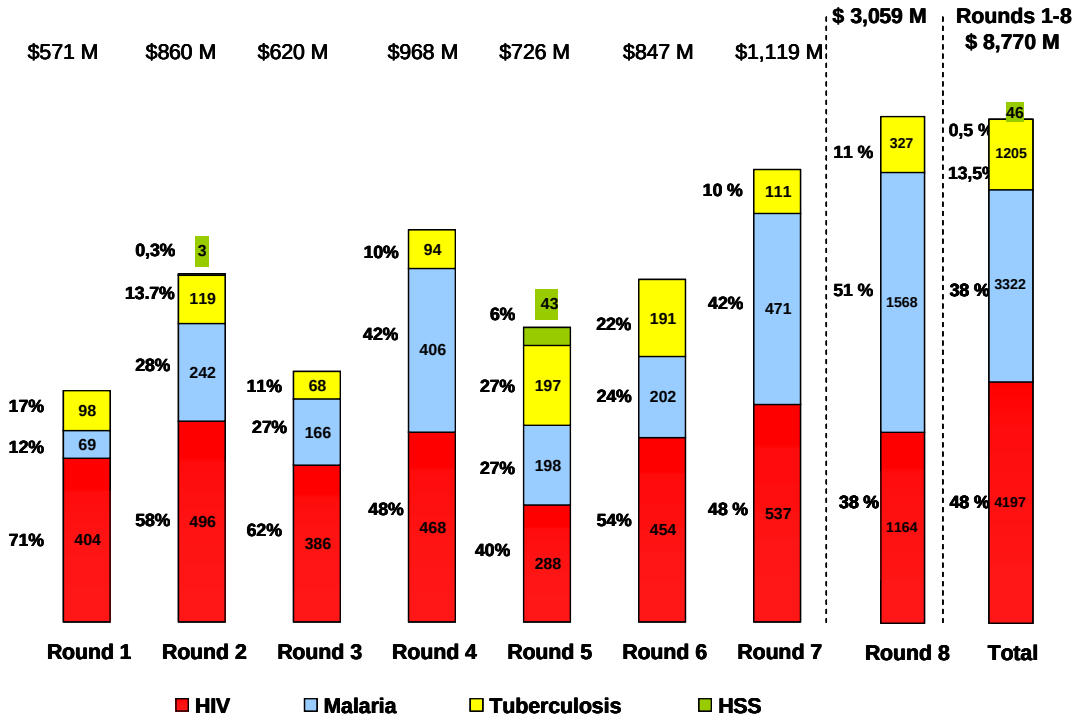
22. The TRP has applied a consistent standard and approach to evaluation of proposals across all Rounds, and the higher success rate in this Round does not reflect any decline in rigor. Rather, there was a noticeable improvement in the overall quality and technical merit of those proposals recommended for funding.

Upper ceiling funding comparisons across prior Rounds

23. The TRP's Round 8 recommendations to the Board for the initial two years of proposals (Phase 1) comprise the largest upper ceiling funding recommendation of the TRP to date. Significantly, the amount represents 55 percent of the value of all of the Phase 1 funding historically recommended (including Round 8) to the Global Fund Board for approval.

24. **Figure 9 below** illustrates this factor, together with the proportion of the Phase 1 upper ceiling budget by each disease proposal and/or other component recommended by the TRP across Rounds 1 to 8.

Figure 9 – Comparison of 2 Year Upper Ceiling Budget Amount for Proposals Recommended by the TRP across Rounds 1 to 8



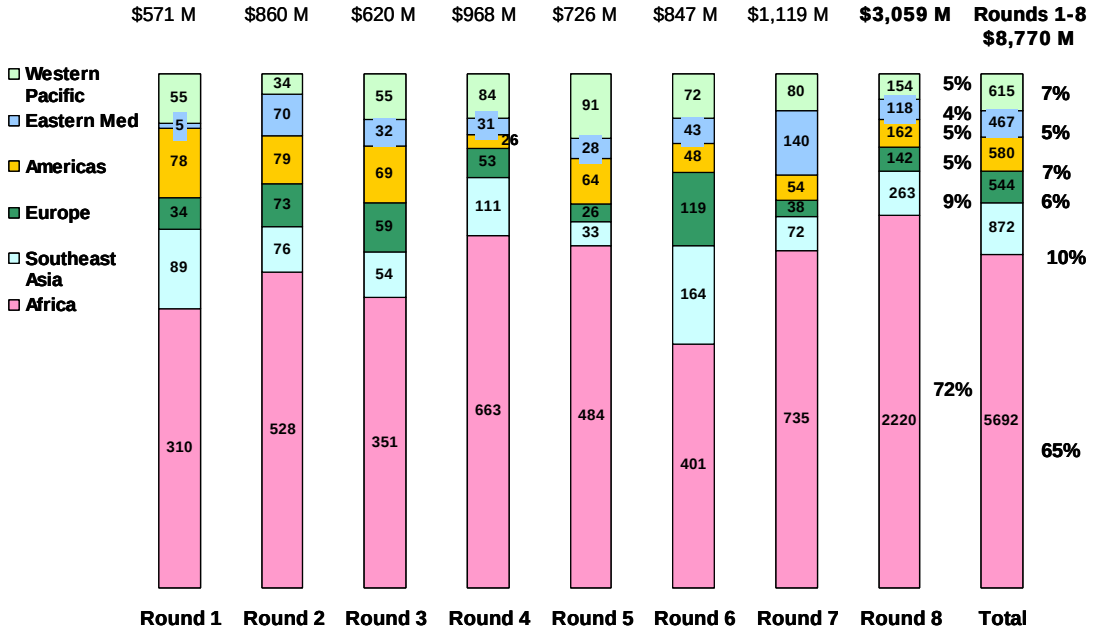
25. Round 8 is the first time that the combined two year upper funding ceiling recommended by the TRP for HIV proposals **does not** account for the largest share of the overall US$ *3,059* billion total funding recommendation.

26. In Round 8, the two year funding ceiling recommended for malaria proposals surpassed the overall HIV total by *approximately US$ 400* million. In addition, the Round 8 two year upper ceiling is only US$ *146* million (or 8 percent) less than the combined total of all malaria proposals recommended over Rounds 1 to 7.

27. Despite this significant increase in the funding recommendations malaria proposals, across all Rounds, HIV proposals collectively continue to account for almost 50 percent of the overall two year upper ceiling funding recommended by the TRP in proposal review meetings.

28. **Figure 10 below** shows the geographical distribution (based on WHO's six regional clusters) of the recommended upper ceiling for Phase 1 funding requests for Round 8, and compared across Rounds 1 to 8.

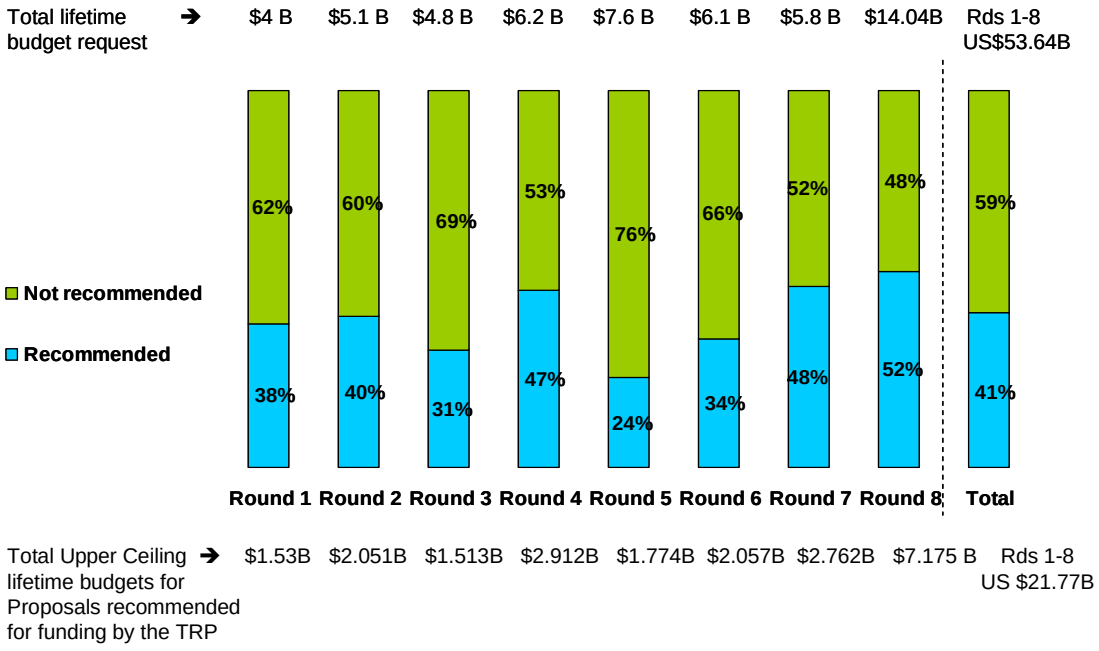
Figure 10 – Comparison of 2 Year Upper Ceiling Budget Requests for proposals Recommended by the TRP by WHO geographical region[24]



65% of cumulative budgets target Africa

29. **Figure 11 below** shows how the total upper ceiling proposal lifetime budget for recommended proposals in Round 8 (approximately US$ *7,175* billion) compares with prior Rounds.

Figure 11 – Comparison of 5 Year Upper Ceiling Budget Amounts for Proposals Recommended by the TRP across Rounds 1 to 8



[24] Each of the upper ceiling 2 year budget amounts represent those proposals recommended for funding by the TRP at the conclusion of each TRP meeting, but not also the proposals subsequently approved through successful appeals (numbering 16 in total across Rounds 2 to 7). This is to enable a like comparison with the pending recommendations of the TRP for Round 8, which remain subject to Board consideration at the time this report was issued to the Board for consideration of the funding recommendations (*November* 2008).

30. Although Round 8 saw a small number of disease proposals submitted with budgets in excess of US$ 500 million for the program lifetime (n=3), the majority of proposals submitted in Round 8 requested significantly larger funding levels than in recent Rounds. It is this that accounts for the increase in both the two year upper ceiling recommended funding and the overall proposal lifetime amounts requested.

Part 3: Analysis of HSS requests submitted within Round 8 proposals[25]

1. With the aim to stimulate and facilitate more appropriate and successful application efforts for health systems strengthening, the Global Fund introduced in Round 8, the possibility for applicants to apply for HSS requests. This was done by drawing predominantly on the WHO experience of 'the building blocks for strong health systems'[26]. Applicants were invited to complete a special section in the Round 8 Proposal Form (section 4B.1) for up to five HSS *cross-cutting interventions* (i.e., HSS requests, as earlier defined). Instructions required applicants to include only interventions that improved outcomes for at least two of the diseases falling within the Global Fund's core mandate, but beyond also. For each HSS request, applicants were requested to provide a title, the diseases that benefit from the interventions, and the main WHO building block which best characterized the interventions.

Overview of HSS requests

2. The total number of applicants that included a cross-cutting 'HSS request' in a Round 8 disease proposal is 45. **Table 5 below** reveals that more than half of these applicants attached this request to the HIV disease specific proposal.

Table 5 - HSS cross-cutting interventions as linked to diseases by WHO region

WHO region	HSS attached To HIV	HSS attached To Tuberculosis	HSS attached to Malaria	TOTAL	Percent of total
AFRO	13	4	7	24	53%
AMRO	4	2	-	6	13%
EMRO	2	1	1	4	9%
EURO	2	2	-	4	9%
SEARO	1	1	-	2	4%
WPRO	3	2	-	5	11%
TOTAL	**25** (55%)	**12** (27%)	**8** (18%)	**45**	**100%**

3. As summarized in part 2 of the TRP's covering report to this Annex 5, HSS requests do not represent the full extent of HSS interventions included in Round 8 proposals to support improved service delivery and disease outcomes. This is because, different from HSS requests, applicants were not expressly requested to attribute all HSS interventions included in a disease specific proposal to any particular framework (whether the WHO building blocks, or other specific HSS 'indicators'). Thus, some applicants will have included 'training' under a program area focused on improving ARV coverage, whilst it would have been differently identified under a HSS request.

[25] *All of part 3 of this Annex 5 was issued with Revision 1 to this report.*
[26] http://www.who.int/healthsystems/strategy/everybodys_business.pdf

Success Rate of HSS requests

4. In Round 8, the overall 'success rate' (i.e., proposals recommended for funding by the TRP to the Board of the Global Fund[27]) for HSS requests was 56 percent.

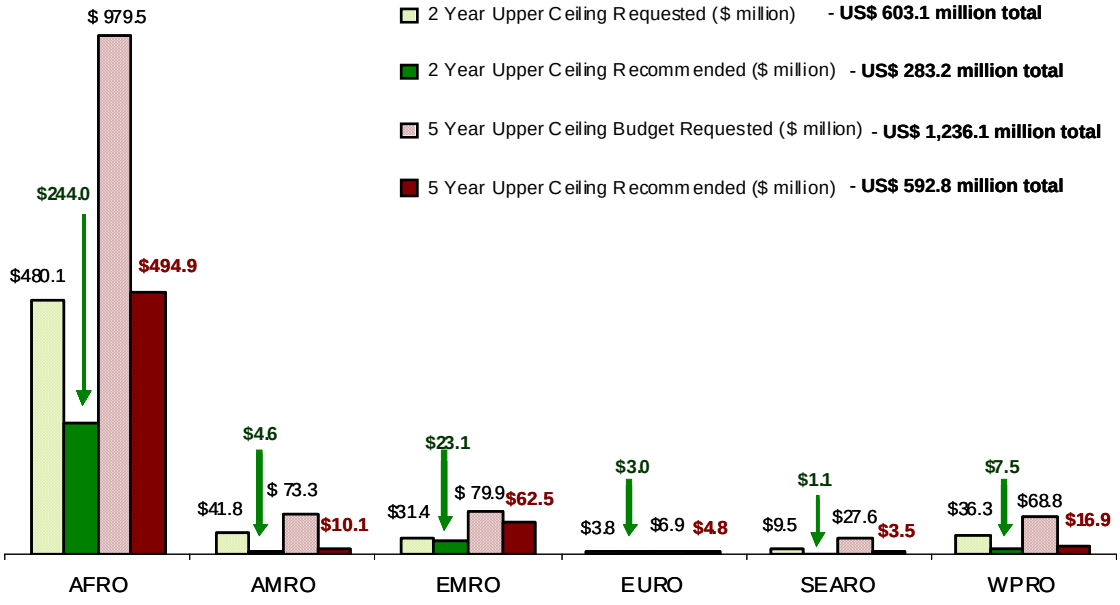
5. Of the 45 HSS requests submitted:

i. In 17 instances (38 percent) both the disease specific part and the HSS request were recommended together;
ii. In seven instances (16 percent) only the disease specific part was recommended;
iii. In eight instances (18 percent), the TRP recommended only the HSS request, and not also the disease specific part of the proposal; and
iv. In 13 instances (29 percent), neither the disease part nor the HSS request was recommended for funding.

6. The overall HSS request 'success rate' is largely equal to the number of all 'disease proposals' recommended for funding (54 percent). However, the outcomes for HSS requests are slightly more favorable if the rate of recommendation is compared to the proportion of disease specific only proposals recommended of 49 percent (n=86)[28].

7. **Figure 12 below** shows the **two year and five year** upper ceiling funding requested, and then recommended for funding for HSS requests by WHO region. Not unexpectedly, the majority of funding **requested** (79 percent of both the two year and five year upper funding ceilings for HSS requests) and **recommended** (86 percent of the two year, and 83 percent of the five year ceilings) is intended to contribute to strengthened health systems within the African continent. Using a basic division formula, the average two year upper funding ceilings for HSS requests recommended for funding is US$ *11.3* million. This compares to the overall average for US$ *40.2* million for all disease specific parts of Round 8 proposals recommended for funding (n=69).

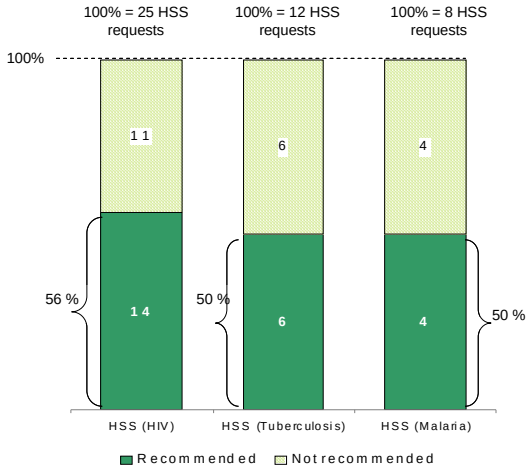
Figure 12: Two and Five year upper ceiling requests and recommendations



[27] The Board of the Global Fund is the sole authorized governance mechanism able to commit new funds.
[28] This outcome arises by subtracting the eight HSS requests that were recommended without the disease specific part of the proposal also. This outcome brings the same 'success rate' for Round 8 disease specific proposals as in Round 7.

8. **Figure 13 below** represents a breakdown of recommended and not recommended HSS requests based upon the disease to which the HSS request was attached.

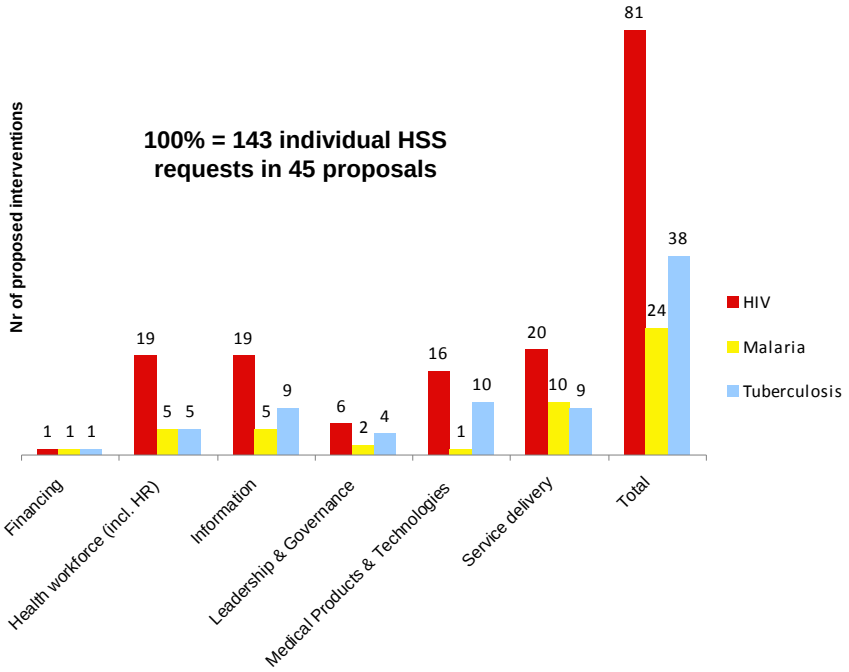
Figure 13: The success of HSS requests per disease under which the request was submitted



Impact of the disease specific 'host' proposal and World Bank income level classifications

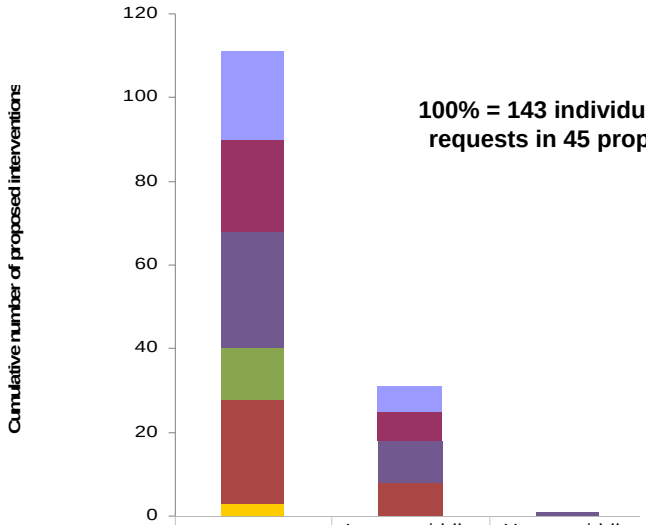
9. As demonstrated by **figure 14 below**, the disease specific proposal that was chosen by countries as the place to include the HSS request (host disease) seemed to have little influence on the use of the building blocks. The noticeable exception is for 'Medical products and technologies', where very few interventions were hosted by a malaria proposal.

Figure 14 Distribution of proposed HSS interventions according to the disease specific proposal hosting the HSS request



10. **Figure 15 below** provides an analysis of the use of the building blocks according to the World Bank's classification of each applicant's income level. In Round 8, low-income and lower-middle income countries tended to make a similar use of the building blocks for the proposed interventions. However, only low-income countries proposed interventions under the 'Financing', and 'Leadership and governance' blocks. The relatively low number of HSS interventions proposed in Round 8 by lower and upper-middle income countries infers that it is low income countries only that require such support. However, this inference would require confirmation through further observation if, for example, this approach is also seen in Round 9 HSS requests.

Figure 15 – Use of the building blocks for health system strengthening according to the level of income of applicant countries



	Low-income	Lower-middle income	Upper-middle income
Medical Products & Technologies	21	6	0
Health workforce (incl. HR)	22	7	0
Service delivery	28	10	1
Leadership & Governance	12	0	0
Information	25	8	0
Financing	3	0	0

Identifying the 'building blocks' for efficient and equitable health systems

11. Round 8 was the first use by the Global Fund of the WHO 'building block' framework, and was intended to promote a common understanding of what a health system is and what constitutes health systems strengthening. The importance of harmonizing the definition of health systems elements was stressed at the July 2007 WHO consultation on the Global Fund's approach to HSS[29] and in separate discussions with WHO.

[29] For more detail refer to the report entitled 'The Global Fund Strategic Approach to Health Systems Strengthening: Report from WHO to the Global Fund Secretariat, September 2007, at: http://www.who.int/healthsystems/GF_strategic_approach_%20HS.pdf

12. **Table 6 below** provides an overview of the building blocks[30], and a more comprehensive list of the types of interventions that fall within each of the building blocks is set out in **Attachment 1** to this Annex 5.

Table 6 - The WHO building blocks

WHO Building block	Possible interventions (non-exhaustive list)
Service delivery	Packages; delivery models; infrastructure; management; safety & quality; demand for care
Health workforce	National workforce policies and investment plans; advocacy; norms, standards and data
Information	Facility and population based information & surveillance systems; global standards, tools
Medical products, vaccines & technologies	Norms, standards, policies; reliable procurement; equitable access; quality
Financing	National health financing policies; tools and data on health expenditures; costing
Leadership and governance	Health sector policies; harmonization and alignment; oversight and regulation

13. The building blocks generally correspond with the main health systems bottlenecks identified during Global Fund grant implementation and could logically include all 15 of the 'HSS strategic actions' that were introduced into the Round 7 Guidelines for Proposals after detailed consultation between the Global Fund and the TRP in late 2006. As a positive, adopting the building block approach avoided inconsistencies between the articulation of HSS needs in Round 8 proposals, and WHO recommendations and technical support to be provided to countries in Round 8 for HSS requests. Nevertheless, as set out below, WHO acknowledges in its framework document 'Everybody's Business' that an integrated approach to HSS, focusing on the interdependence of the individual blocks is needed:

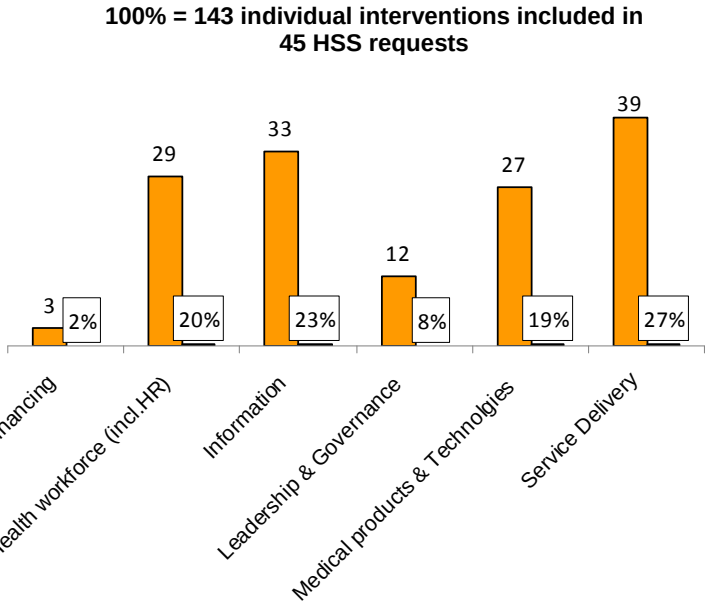
> "*While the building blocks provide a useful way of clarifying essential functions, the challenges facing countries rarely manifest themselves in this way. Rather, they require a more integrated response that recognizes the inter-dependence of each part of the health system*".

Use of the WHO building blocks in HSS requests in Round 8

14. A quantitative analysis of the use of the building blocks by applicant countries, demonstrated through **figure 16 below**, reveals that interventions, as framed by the applicants themselves, are most often proposed in the 'Service delivery', 'Information', 'Health workforce', and 'Medical products and technologies' building blocks.

[30] For more detail, refer to: http://www.who.int/healthsystems/round9_2.pdf

Figure 16 - Number of HSS interventions proposed by applicant countries under each WHO building block



15. The limited number of applications in the field of 'Financing' may suggest that Global Fund resources are currently only sought to support the supply of services through classic institutional approaches. Further investigation would be necessary to determine whether such a preference results from:

i. a bias introduced by the proposal based system (countries feeling more confident to propose classic solutions);

ii. a reluctance to engage in innovative approaches such as subsidizing the demand or introducing third party financing systems; and/or

iii. a reticence to use Global Fund support for such approaches.

16. There is a similarly relatively low inclusion of interventions falling within 'Leadership and governance'.

17. However, the TRP sees both 'Financing' and 'Leadership and governance' as particularly important for performance within the health sector, as they encompass two key functions: equity and efficiency. Further investigation is clearly required to identify the possible multiple causes for this lack of use, and to formulate strategies to address those reasons.

18. **Figure 17 below** sets out, for all HSS requests recommended for funding, early analysis of the breakdown of the budget cost category in which applicants characterized those costs, first by the two year upper ceiling, and then by the five year upper ceiling.

Figure 17 – Distribution of budget cost categories for HSS requests recommended for funding

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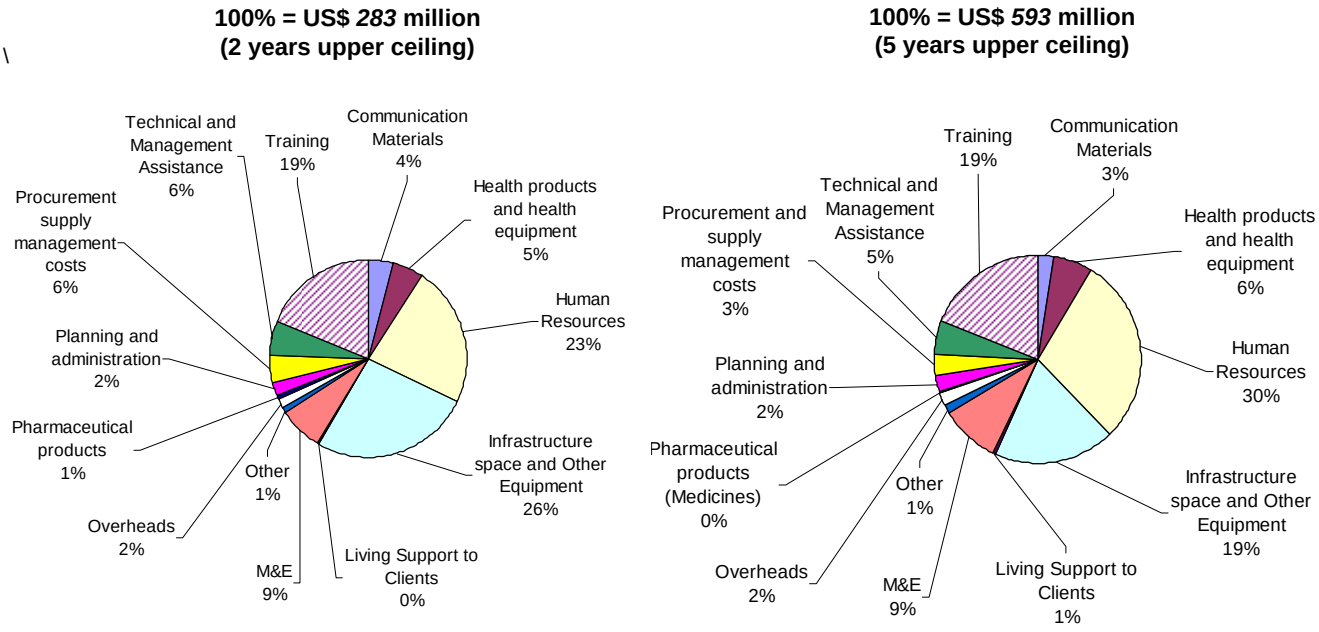


19. **Table 7 below** provides the underlying upper ceiling financial data for figure 17 above.

Table 7 – Upper ceiling funding by cost category for HSS requests recommended for funding

Component / Cost category	Total Phase 1(USD equiv)	Percentage of Phase 1	Five Year Total (USD equiv)	Percentage of full life cycle
Communication Materials	11,838,006	4.2%	15,030,250	2.5%
Health products and health	13,917,159	4.9%	36,584,065	6.2%
Human Resources	65,723,252	23.2%	171,732,960	29.0%
Infrastructure space and Other	73,560,125	26.0%	112,614,162	19.0%
Living Support to Clients	1,003,606	0.4%	3,930,065	0.7%
Monitoring and Evaluation	20,513,274	7.2%	54,022,076	9.1%
Other	2,224,456	0.8%	7,491,309	1.3%
Overheads	4,502,761	1.6%	11,113,378	1.9%
Pharmaceutical products	2,136,657	0.8%	2,184,657	0.4%
Planning and administration	5,597,555	2.0%	14,607,185	2.5%
Procurement and supply	12,634,741	4.5%	20,081,659	3.4%
Technical and Management	15,635,072	5.5%	31,845,710	5.4%
Training	53,875,083	19.0%	111,499,566	18.8%
Totel	283,161,747	100%	592,737,043	100%

Classification of HSS requests

20. To understand better whether the WHO building blocks were adequately used by applicants in Round 8 proposals, a blind classification of the proposed interventions was undertaken independently by a TRP member and by the Global Fund, as compared to the classification by the countries in the Round 8 Proposal Form text. The outcomes of that comparison are set out in table 8 below.

Table 8 - HSS cross-cutting interventions – Comparison between country, TRP, and Global Fund classification

	Financing	Health workforce (incl.HR)	Information	Leadership & Governance	Medical products and technologies	Service Delivery	Disease specific	Blended
Country classification	3	29	33	12	27	39		
TRP classification	4	28	33	8	19	37	4	10
Secretariat classification	4	28	33	9	19	36	4	10

- 'Disease Specific' refers to interventions that were included in a HSS request but were determined to benefit only the host disease.
- 'Blended' refers to complex interventions for which there was no one clear WHO Building Block that best characterized them.

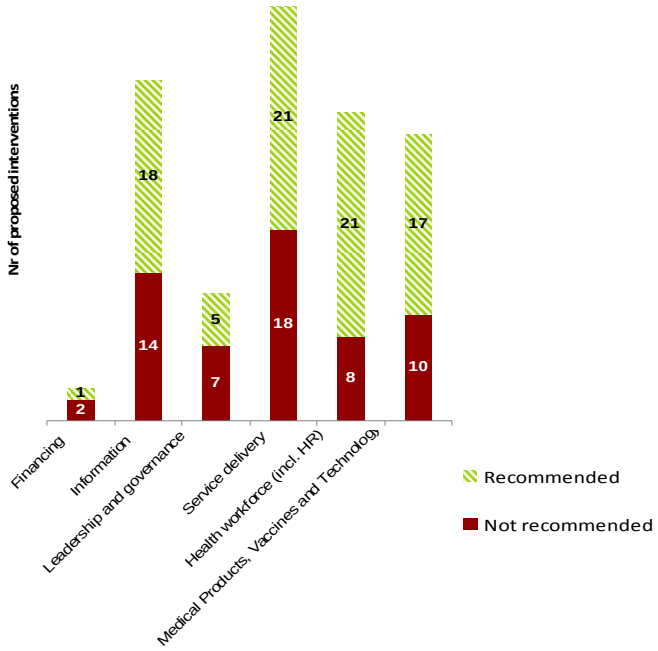
21. While the TRP and the Global Fund classifications largely matched, they corresponded to the classification proposed by countries only for the 'Information', 'Financing', 'Health workforce', and 'Service delivery' building blocks. As table 8 demonstrates, important differences were observed under the 'Leadership and governance', and 'Medical products and technologies' blocks. Such differences of classification may be related to the profile of the analyst, differences in planning culture, or, more simply, that applicants understand the notions presented by WHO and the Global Fund in its proposal form and guidelines in a manner different from what either intended.

22. This difficulty to relate clearly an intervention to a particular building block is not specific to proposals. Different appreciations of the building blocks can also be found in the Round 8 Guidelines for Proposals. For example, the scope provided in the Guidelines for Proposals for 'Medical products and technologies' interventions includes strengthening policies, standards and guidelines, which may also be in the scope of 'Leadership and governance'. In addition, the scope for 'Financing' includes strengthening financial tracking systems, which may be considered part of 'Information' systems.

23. An additional problem also seen in Round 8 disease specific requests relates to the 'Performance Framework' (which includes indicators to facilitate performance based funding) for the interventions included within HSS requests. The indicators included by applicants often remained limited to either input focused aspects, or output quantitative aspects (e.g., the number of district drug stores rehabilitated, the number of computers for data management installed). Less often the indicators focused on qualitative aspects (e.g., the number of expired drugs, the accuracy of health facilities' reports, or an increase in equitable access to services). More guidance to countries to plan cross cutting interventions under a performance based funding framework may be required to ensure that the additional investments in HSS being requested from the Global Fund translate into (or, at a minimum, contribute towards) improved equity and efficiency in the health system, to address constraints to the achievement of disease program outcomes. Additionally, applicants may benefit from more appropriate indicators dealing with equity and efficiency being developed and integrated within the 'Performance Framework' guidance.

24. As demonstrated by **figure 18 below**, a majority of interventions under each building block was recommended for funding, except for 'Financing' and 'Leadership and governance'.

Figure 18: Outcome of TRP review according to the building block identified by the applicant for the intervention



Reviewing specific country examples of funding requests under the WHO building blocks

25. Moving to country specific HSS requests in Round 8, it is possible to review a sample of what may be considered stronger examples of elaboration of HSS needs. Taking (to the extent possible), geographic and 'host disease' diversity into account, the HSS requests selected as the 'stronger examples' are identified in **table 9 below**. Detailed summaries of the particular building block selected for this review are set out in **Attachment 2** to this Annex 5. As noted in paragraph 15 above, the pool of examples from which to select stronger illustrations was considerably more limited for the 'Leadership and governance' and 'Financing' components of the WHO framework, than requests characterized under 'Service delivery', 'Information' and 'Health workforce'. In all cases, the countries identified other HSS needs under one or more of the other 'building blocks'. However, it is the selected example that was most clearly elaborated.

Table 9 – Overview of WHO Building Block case studies (refer to Attachment 2)

Country	Disease	Building Block	Summary of planned intervention
Nigeria	HIV	Leadership and Governance	Strengthen capacity of core processes of community based networks to ensure the provision of an increased range and quality of services in scaled up HIV, tuberculosis, and malaria interventions. Activities include: improving oversight and regulation of service provided by government and non-government providers; instituting regular performance reviews; and, supporting policy and systems research.

Country	Disease	Building Block	Summary of planned intervention
Sudan – Northern Sector	Tuberculosis	Financing	Strengthening the health financing function of the health system assuring equity and access to health services, by: supporting the development of sub-national and national health accounts to enhance the equitable allocation of resources; investing in actuarial and cost-effective studies to expand health insurance to increase equitable access to health care; and, the development of community based health insurance schemes.
Belarus	HIV	Health Workforce	Strengthen the national strategy on human resources for the health system, including, identifying options for task shifting from doctors to nurses and non-clinical staff, and improving the policy framework and managerial system for non-monetary and monetary incentives to attract, motivate, and retain health care providers.
Swaziland	HIV	Information	Improve the timely reporting and analysis of integrated health indicators from all levels, with a focus on developing a national gender-disaggregated indicator set, and developing capacity for monitoring and evaluation in the community-based and private sectors, to contribute to completeness in national health sector information.
Lao PDR	HIV	Medical Products	Develop a more cohesive and cost effective supply and regulatory system for procurement and supply management across the three diseases, replacing the vertical systems currently in place. It focuses on achieving efficiencies in the registration processes, and improving the quality, safety, and efficacy of pharmaceutical products, and access to them.
Zimbabwe	Malaria	Service Delivery	Strengthen community health systems for the effective delivery of HIV, tuberculosis, and malaria interventions. Activities include: strengthening public sector demand for services; involving civil society and the private sector in public health service delivery; and, activities related to the equity and access needs of vulnerable and deprived children.

26. Common to all six of the illustrations above, the planned interventions:

i. Promote longer term approaches to capacity building, including a focus on organizational development and improved information management to inform improved decision making on the efficient use of resources; and

ii. Include a clear strategy for ownership at the country level and, more often than not, a focus on improving access to service delivery at the local and community level through the engagement of both public and non-public service providers.

27. Drawing on a detailed review of all other Round 8 HSS requests recommended for funding, the following (early) trends and gaps arise in regard to HSS requests elaborated within the context of the six WHO building blocks:

Governance

- Within recommended governance interventions, aspects covered are extremely diverse. They range from strengthening civil society via establishing regulatory authorities to budget formulation.
- Three out of four recommended interventions have training as a major strategy to address governance issues.

Financing

- That only one recommended intervention is included in this category[31] illustrates the marginal position of health financing together with governance in the total funding (and applications) basket.

Health Workforce

- A few countries (Belarus, Mauritania, Zambia, Armenia, Guyana, and Lesotho) develop their proposed interventions within the context of and as support for a national human resources strategy.
- Although proposed interventions have a bias towards training, they cover the different components of the health workforce issue: the supply of health workers (training, training facilities, retention), the demand for health workers (needs assessment, planning, and incentives) and utilization of health workers (task shifting).
- Training of various categories of health workers, upgrading of training facilities and systems of monetary and non-monetary incentives are most often proposed as interventions under this category.
- All activities mentioned in the introduction of the building block in the proposal forms' text are in one way or the other represented in the proposed interventions.

Information

- A clear majority of applicants propose interventions to establish (Armenia and Tajikistan) or to strengthen (Ethiopia, Mauritania, Zambia, Gambia, Guyana, Lesotho, Mozambique, and Swaziland) the National Health Management Information system.
- Strategies to strengthen the National Health Information include, in most cases, capacity strengthening activities (including training and personnel), logistics, and management systems (including electronic systems).
- A significant number of applicants (Swaziland, Zambia, Bangladesh, Guyana, Lesotho, and Nigeria) address the issue of the health information system also at sub-national level of regions, districts, and communities.
- Only a few countries (Gambia, Zambia, and Lesotho) propose operational research and surveys as approaches to strengthen health information systems.
- Activities, which are mentioned in the introduction of the building block but do not show up directly under the proposed interventions include: strengthening the collection and quality of mortality statistics; investing in the systematic use of evidence to guide decisions; and, expanding reporting-for-profit health service providers.

[31] Four other HSS requests which included a 'Financing' as one of the 'building blocks' of support requested from the Global Fund were not recommended due to weaknesses in the HSS requests as a whole.

Medical Products

- Less than half of all approved applications include interventions under this building block, which is remarkably low considering the important place of systems to ensure the transparent and cost effective purchase and safe distribution and support of medical products in the mandate and actions of the Global Fund.
- All applications with this focus are proposing interventions and/or activities which are directly or indirectly related to the strengthening of a national supply management system, with procurement systems high on the list.
- Quality assessment, control, and/or assurance of essential medicines, strengthening of guidelines, regulations and/or laws and capacity development and training are most often proposed as interventions.
- Most activities mentioned in the introduction of the building block are included by applicants in their HSS requests, except the one dealing with strengthening mechanisms to enforce the rational use of medicines, commodities, and equipment.

Service Delivery

- Proposals represent a very broad, variable, and heterogeneous range of interventions. For example, strengthening community health workers, development of treatment protocols, refurbishing facilities, maintenance of equipment, improving laboratory services, and procurement and logistic systems.
- A few countries (Zimbabwe, Zambia, Nigeria, and Somalia) focus their interventions on strengthening of basic health services through investing in community health workers, and rolling out minimum health care package and primary health care.
- Infrastructure improvement, procurement of vehicles and equipment and capacity building are among the most popular categories of intervention. Otherwise, no particular domain is recurrently chosen by applicants.

Early lessons learned

28. While taking into account the limitation of the small sample presented by Round 8, some potentially useful lessons learned may be drawn from this initial analysis. These include:

i. there was relatively limited space provided for applicants to provide details regarding their HSS request and implementation arrangements (in section 4B) compared with the disease specific arrangements (explained in sections 4.5.1 and 4.9). This may have encouraged some countries to limit the scope of their description of each of the interventions that comprised their overall HSS request, or led to some level of duplication between them. For example, Cote d'Ivoire proposed three interventions under the 'Medical products and technologies' building block: capacity building of district pharmacies; pharmacovigilance; and drugs quality assurance. Other applicants seem to have taken advantage of this opportunity to propose interventions with a wide scope encompassing several building blocks. For example, The Gambia proposed under 'Leadership and governance', an intervention aimed at strengthening quality assurance of health services, which involved strengthening ethics and practice standards, legislation, but also pharmacovigilance, improving use of drugs and monitoring patient satisfaction;

ii. countries also did not approach certain functions in a similar way. While Mali and Burkina Faso placed supervision under the umbrella of 'Information systems', Nigeria, Bangladesh and Fiji saw it more supportive and proposed it as an activity related to the Health workforce. The Solomon Islands proposed the development of the country laboratory services network under 'Medical products and technologies' rather than 'Service delivery';

iii. the WHO building blocks were introduced very recently by both WHO and the Global Fund as a framework for identifying HSS needs. It is therefore too early to assess if the proposed framework will facilitate the elaboration of national plans and strategies and the formulation of HSS needs by countries accordingly. It may also have increased the number of more mechanical or formulaic presentations of HSS needs in Round 8 proposals; and

iv. although invited to do so in the Round 8 Guidelines for Proposals[32], few countries identified their HSS needs by reference to a recent in-country review of constraints and gaps in the health system that would act as bottlenecks in the achievement of disease outcomes.

29. Drawing on these early experiences, the opportunity for countries to develop cross-cutting interventions that are necessary to respond to complex health system constraints may not be well supported by a focus on 'building blocks' as the overarching framework. This is not to suggest that at the international level this framework is not of use. Indeed, for analysis on the inputs that are being contributed to health systems, there is collective benefit in the use of a common framework that allocates those inputs between various categories. However, at the country level, and especially for the formulation of funding requests to the Global Fund as a financing mechanism of outcomes and impact, the formulaic 'building blocks' approach may dissuade rather than incentivize stronger responses to what are undoubtedly complex, integrated bottlenecks to the delivery by countries of improved equity, efficiency and quality in their health systems. This provides some level of confirmation of WHO's own observations that interdependent interventions are required for effective responses to health sector constraints, with challenges rarely manifesting themselves in categories or 'blocks'.

30. What may also prove problematic for countries in their elaboration of effective responses to health systems constraints that are fundable through the Global Fund's framework is the relatively strong emphasis on improved outcomes for, largely, only HIV, tuberculosis, and malaria. This risk arises from the current formulation of the Global Fund's application materials which, adopting fully the Board's decision on HSS in November 2006, do not provide strong encouragement to applicants to propose interventions impacting on health outcomes beyond the three diseases[33].

31. Thus, one sees examples such as Burkina Faso's elaboration of a 'Health workforce' intervention that targets training and supervision specifically to 'the three diseases'. While the provision of HIV and tuberculosis services may involve common skills and justify combined training, these are quite different from most skills required for malaria control. In addition, capacity building strategies that are developed to improve service delivery within HIV and tuberculosis programs are also clearly likely to benefit other conditions involving recurrent contacts between patients and the health system[34]. This

[32] Refer to s.4B.1 (and, in particular, the instructions under Part E on page 43) of the Round 8 Guidelines for Proposals

[33] From Proposal Form, section 4B: The interventions required to respond to these gaps and constraints are 'cross-cutting' and benefit more than one of the three diseases (and perhaps also benefit other health outcomes)".

[34] Harries AD, Jahn A, Zachariah R et al. Adapting the DOTS Framework for Tuberculosis Control to the Management of Non-Communicable Diseases in Sub-Saharan Africa. PLoS Medicine, June 2008, Volume 5, Issue 6, p 124

same overly restrictive focus on the three diseases was also observed within the titles and elaboration of interventions for the 'stronger examples' that are reviewed above.

32. This does not mean that many of the health systems interventions that were proposed and recommended for funding in Round 8 did not have scope for impact to extend beyond the three diseases, as most did. However, the perception by applicants that they must restrict (even in words if not in scope) the proposed interventions to the three diseases, may lead to a significant number of missed opportunities to develop strong health sector systems, and therefore unintentionally threaten the health system that the Global Fund is seeking to support.

HSS cross-cutting interventions – best practices in Round 8

33. The analysis in earlier paragraphs provides examples where applicants were able to frame their HSS needs effectively within a specific HSS building block. However, the question is whether the WHO framework is sufficiently operational in its focus to enable applicants to elaborate effective responses to health systems constraints in a manner that brings funding for those interventions from the Global Fund.

34. The following paragraphs consider this question in the context of four examples that present a more interconnected approach to the elaboration of HSS needs. The four countries are:

- Ethiopia (Malaria)
- Guyana (HIV)
- Tajikistan (Tuberculosis)
- Zambia (HIV)

35. All four HSS requests were recommended for funding, and the TRP identified, in the 'TRP Review Form' for the disease and HSS request together, clear strengths in these proposals. Importantly, each proposal clearly articulated a need for, and the outcomes/impact that would arise from, additional support for health systems strengthening through an explicit consideration of their specific country context and determinants of the national health system. Each proposal also presented the proposed 'solution' to these constraints as integrated interventions that recognize, in WHO's conceptualization, the interdependence of all parts of the health system, and for these reasons, these countries are being recommended as 'best practice' examples of sound proposals. The selected best practices cover the three diseases, represent various (but not all) geographical regions and include examples of applications where both disease and cross-cutting HSS interventions were approved for funding as well as proposals where only the cross-cutting HSS intervention was recommended for funding.

36. Of these, only Ethiopia is discussed as a case study detail below. The other case studies may be found in **Attachment 3** to this Annex 5.

37. How other countries approached their needs analysis and whether appropriate frameworks are available for people to assist countries to articulate more clearly needs and impact is also discussed in this report.

Using the 'best practice' case study below

38. In contrast to interventions responding directly to gaps within HIV, tuberculosis and/or malaria disease specific programs (for which standard models of best practices have been developed, and have been promoted and implemented by multiple actors in a variety of settings), the situation for

health systems is quite different. At least for the time being, similar standard models or best practices are lacking. There are many reasons why there are no such best practices in health systems strengthening that can be easily generalized and applied in and by a number of countries. One major reason lies in the fact that the macro health system, including its building blocks of governance, information, financing, infrastructure, services and medical products, is shaped by a wide range of political, cultural, social and economic determinants, which are unique to each country. As a consequence, what works for the health system, and thus produces improved outcomes in respect of HIV, tuberculosis and/or malaria, in 'country X', does not necessarily work in 'country Z'. In addition, what looks like an (evidence-based) best practice in 'country A' is not necessarily the best approach in 'country B'.

39. In this report, the suggested 'best practices' in health systems strengthening cross-cutting interventions, as proposed by applicants in Round 8, does not seek to identify a series of standard approaches, models, or practices that can be expected to work independent of their context and specific determinants, and which, as a consequence should be promoted for a more generalized application. Rather, this report highlights proposals that made '**the best case**' for health systems strengthening by taking explicitly into consideration the specificity of context and determinants of the national health system and are likely to be the result of a rigorous in-country proposal development process.

40. Leaving aside the question of whether the health systems strengthening proposals are integrated within the relevant disease specific proposals, or are introduced as a distinct but complementary section in one of them, the question arises as to what criteria can be drawn on to infer that a country has presented a strong or 'best case'. Some answers and guidance can be found in the following information notes and policy documents from the Global Fund and its partners.

41. In a 'Technical Note' prepared for Round 8 road-shows and other workshops on, amongst other matters, health systems strengthening, WHO identified the following seven points to be made when requesting funds for HSS interventions:

1. *The proposed activities clearly respond to constraints to improved HIV and AIDS, tuberculosis or malaria prevention and control identified in other parts of the proposal.*
2. *The proposed activities are required in order to improve HIV and AIDS, tuberculosis, or malaria service delivery, but lie beyond the mandate of an individual program, or could disrupt other priority services if implemented by one program alone.*
3. *The proposed activities fit within overall national health policies, plans and strategies, and fill gaps in available resources.*
4. *The proposed activities have been defined in consultation with key stakeholders.*
5. *Proposed activities are clearly defined, of a realistic scale and credibly costed.*
6. *Returns from investments are possible within a reasonable timeframe.*
7. *A small set of credible health system indicators have been selected, for tracking progress*.[35]

42. The Global Fund itself, in the Round 8 Guidelines for Proposals,[36] formulated some direct and indirect indications and orientations as to how applicants could come up with a technically sound case or 'best practice' for health systems strengthening:

[35] World Health Organization paper entitle 'The Global Fund and Health System Strengthening: how to make the case, in a Proposal for Round 8?', Working Draft, 2008.

[36] Global Fund, Round 8 Guidelines for Proposals, sections dealing with 'Program Description' and Annex 3 'What the Global Fund will support', and the Fact Sheet entitled 'The Global Fund's approach to health systems strengthening, 2008'.

- the information provided by applicants in the cross-cutting HSS section must clearly articulate how the interventions will address identified health systems constraints to improved HIV, tuberculosis and/or malaria outcomes;
- responses to health system weaknesses and gaps should not be developed in isolation from existing national strategies;
- requests for support should be drawn from existing country-specific assessments of weaknesses and gaps in the health system;
- applicants should consider needs of the broad range of non-government organizations, the private sector and communities in any assessment of overall weaknesses and gaps in strategies; and
- applicants are encouraged to include stakeholders who are involved in the planning, budgeting and resource allocation processes for the national disease programs and health system reform.

43. In addition, the terms of reference of the TRP[37] include some valuable criteria which could help to identify 'best practices' in the applications submitted for funding during Round 8. The TRP has indeed to look for proposals that demonstrate the following characteristics:

- *soundness of approach*, which includes criteria like use of interventions that are consistent with international best practices, evidence-based, represent good value for money, involve a broad range of stakeholders, etc.
- *feasibility*, which refers to criteria like providing evidence of the technical and programmatic feasibility of implementation, building on, complementing, and coordinating with existing programs in support of national policies, using innovative approaches to scaling up programs, etc.
- *potential for sustainability and impact,* including criteria like demonstrating that Global Fund financing will be additional to existing efforts rather than replacing them, addressing the capacity to absorb increased resources, reflecting high-level sustained political involvement and commitment.

44. The best practices in this report were selected taking into consideration the above remarks and criteria, and guided by the assessment of the proposals by the TRP.

The case of Ethiopia (Malaria including a HSS request)

The main text of the proposal of Ethiopia has been selected as 'HSS best practice' because it addresses two major national concerns – devolution of operational responsibilities to decentralized levels and the health workforce crisis. In addition, it articulates the proposed interventions within the context of approved national strategies and policies.

- WEAKNESSES IN THE HEALTH SYSTEM THAT AFFECT MALARIA OUTCOMES

The proposal identified the following weaknesses of and/or gaps in the health system that affect malaria outcomes:

1. Human resources issues. The FMOH continues to face a severe HR shortage, inadequate distribution, and lack of necessary staff skill-mix. It is widely accepted by the government and its

[37] Refer to Attachment 1 to the TRP TORs at: http://www.theglobalfund.org/en/files/about/technical/TRP_TOR.pdf

partners that, given the shortage of key HR, the health care system is already strained and may not be well positioned to respond to the rapid scale-up of HIV, tuberculosis, and malaria services.

2. Health Information Systems and Monitoring and Evaluation. Reliable information on population health status as well as the adequacy and performance of health services are not readily available, and where information is available, it is seldom used for decision making. These weaknesses limit the effectiveness of patient level care and public health services.
3. Service delivery infrastructure. Although the FMOH Logistics Master Plan is well underway, shortages in the transport sector impedes its realization. Filling this gap will go a long way in strengthening and further decentralizing existing services, and help to link with community-based services in the catchment areas.

- PROPOSED INTERVENTIONS

As part of its Malaria proposal, Ethiopia proposed the following four HSS cross-cutting interventions:

1. Building community health systems HR strengthening through improved training capacity and supervisor support. Ethiopian HIV, tuberculosis and malaria strategies, and activity plans all stress the critical importance of community-based staff to scale up and sustain program activities. The FMOHs 'task shifting' policy is aimed at moving increasing responsibility of program activities to community level, with HEWs having primary responsibility for implementation of these programs. Activities will include improving HEW training capacity (pre-service training, integrated refresher training, and support during apprentice training) and improving HEW supervision support (strengthening training and procurement of motor cycles).

2. Strengthening health information systems. A key constraint in the three disease programs is the lack of reliable, timely information on program progress to support M&E and evidence-based management. This intervention will support the scale-up of the new HMIS and strengthen DSS. Activities will include accelerated raining for HIO, logistics and supplies, integrated quality management and strengthening DSS.

3. Increase training institution capacity to support improved quality and output. Ethiopia is in the process of developing a comprehensive HRH Strategic Plan. A key strategy is to “flood” the labor market to ensure an adequate workforce supply for the scaling up of the three disease programs. To address the accelerated training there is a need to provide training institutions with the adequate theoretical and practical infrastructure. Activities include the procurement of laboratory/medical training equipment, teaching aids for maintaining the training of HEWs and in-service-training on management.

4. Support comprehensive logistical support to ensure timely supervision of health service delivery and timely provision essential HIV, tuberculosis, and malaria commodities from central level to health posts. There is evidence that health worker district level supervision is weak largely due to transport challenges. The proposal requests funds to cover the transport gap linking central, regional and district levels, particularly for integrated supervision activities, and timely delivery of commodities. Activities include procurement of pickup trucks for supervision activities at district level, procurement of trucks to ensure delivery of commodities from central store to primary and secondary warehouses and procurement of motorcycles for HEW supervisors.

- ENGAGEMENT OF HSS KEY STAKEHOLDERS in proposal development

The proposal development involved key stakeholders including those within the FMOH, i.e. the Planning and Programming Department, Human Resources Development Department, Disease Prevention and Control, Health Education and Extension, but also international organizations, donors and NGOs were involved. *All the available resources for cross-cutting HSS interventions were reviewed, including the GAVI/HSS project which is the main source of funding for cross-cutting HSS interventions.*

- FUNDING REQUEST (FIVE YEARS)

Training	US$ 19,097,899
Pharmaceutical products	US$ 2,100,000
Procurement and supply management	US$ 7,724,671
Infrastructure/equipment	US$ 9,405,000
Communication materials	US$ 11,924,000
Monitoring and evaluation	US$ 733,200
TOTAL	**US$ 50,984,770**

- STRENGTHS IDENTIFIED BY THE TRP

  - Well described and focused HSS interventions
  - Benefit all three diseases and beyond
  - Budget and workplan clear
  - Additionality to other donors demonstrated
  - Integrated with national plan and system

- SPECIFIC ISSUES TO BE CLARIFIED OR ADJUSTED

1. Clarification requested in budget regarding refresher training of HEW
2. Clarification requested unit cost for laboratory equipment

- OTHER OBSERVATIONS

1. The TRP recommended for *funding the disease and cross-cutting health systems strengthening interventions* under category 1.

2. The proposal has a strong focus on and will make a significant contribution to *strengthening the community health system*, which is one of the priority concerns of the Global Fund.

3. The proposal is seeking an *explicit partnership* with the GAVI/HSS project, which is already making significant contributions to the strengthening of health systems in Ethiopia.

4. The strong focus on training is explained and justified by contextualizing proposed training activities within the frame of *a national human resource plan.*

Annex 6
GF/B18/10

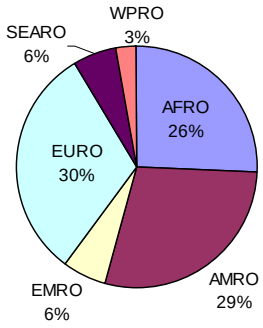
Round 8 TRP Membership

Category	No.	Surname	First name	Gender	Nationality	Rounds served 1	2	3	4	5	6	7
HIV/AIDS (7+ the Chair) Members	1	**Godfrey-Faussett**	**Peter (Chair)**	M	UK							
	2	Sikipa	Godfrey	M	Zimbabwe							
	3	Tregnago Barcellos	Nemora	F	Brazil							
	4	**Gupta**	**Indrani (Vice Chair)**	F	India							
	5	Bobrik	Alexey	M	Russia							
	6	Kornfield	Ruth	F	USA							
	7	Lauria	Lilian de Mello	F	Brazil							
	8	Del Castillo	Fernando	M	Spain							
Malaria (5) Members	1	Genton	Blaise	M	Switzerland							
	2	Rojas De Arias	Gladys Antonieta	F	Paraguay							
	3	Burkot	Thomas	M	USA							
	4	Adeel	Ahmed Awad Adbel-Hameed	M	Sudan							
	5	Lyimo	Edith	F	Tanzania							
Tuberculosis (5) Members	1	El Sony	Asma	F	Sudan							
	2	Metzger	Peter	M	Germany							
	3	Bah-Sow	Oumou Younoussa	F	Guinea							
	4	Hamid Salim	Abdul	M	Bangladesh							
	5	Kimerling	Michael	M	USA							
Cross Cutting (17) Members	1	Elo	Kaarle Olavi	M	Finland							
	2	Decosas	Josef	M	Germany							
	3	Alilio	Martin S.	M	Tanzania							
	4	Nuyens	Yvo	M	Belgium							
	5	McKenzie	Andrew	M	South Africa							
	6	Boillot	Francois	M	France							
	7	Brandrup-Lukanow	Assia	F	Germany							
	8	Barron	Peter	M	South Africa							
	9	Okedi	William	M	Kenya							
	10	Baker	Shawn Kaye	M	USA							
	11	Ghandhi	Delna	F	UK							
	12	Ayala-Öström	Beatriz	F	Mexico/UK							
	13	Murindwa	Grace	M	Uganda							
	14	Heywood	Alison	F	Australia							
	15	Le Franc	Elsie	F	Jamaica							
	16	Oyeledun	Bolanle	F	Nigeria							
	17	Huff-Rouselle	Maggie	F	Canada							

Key:

Rounds served
Rounds not served

Regional balance by country of nationality



Gender balance