GF/B20/9

For information

REPORT OF THE TECHNICAL REVIEW PANEL AND THE SECRETARIAT ON ROUND 9 PROPOSALS

OUTLINE:

1. This report provides the Board with the Technical Review Panel's (TRP) funding recommendations on Round 9 proposals. This report also summarizes the Secretariat process to determine eligibility, the TRP membership for Round 9 and the proposal review methodology. Finally this report presents the TRP's recommendations and lessons learned from the Round 9 proposal review.

PART 1: INTRODUCTION

1.1 The Technical Review Panel (TRP) met from 24 August to 5 September 2009 to review the technical merit of Round 9 proposals and Affordable Medicines Facility –Malaria (AMFm) Phase 1 applications[1]. The meeting was chaired by Dr Bolanle Oyeledun, with Mr Shawn Baker and Dr George Gotsadze serving as Vice-Chairs.

1.2 This report provides the TRP's funding recommendations for Round 9 proposals and is structured as follows:

Part 1: Introduction

Part 2: TRP Funding Recommendations on Round 9 Proposals **(for information and subsequent Board Decision)**

Part 3: Secretariat Report on Eligibility Determinations **(for information)**

Part 4: TRP Membership and Proposal Review Methodology **(for information)**

Part 5: Recommendations and Lessons Learned from the Round 9 Proposal Review **(for Board input)**

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

Annex 1: List of Eligible Round 9 Proposals Reviewed by the TRP, Classified by Recommendation Category;

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

Annex 3: List of all ineligible applicants in Round 9 and the Secretariat's Screening Review Panel justifications;

Annex 4: Round 9 'TRP Review Forms' for all disease proposals reviewed by the TRP, together with the full text of all proposals;

Annex 5: Detailed Analysis of Round 9 outcomes; and

Annex 6: Round 9 TRP Membership.

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

1.5 The TRP's recommendations on AMFm applications are presented in a separate report (GF/B20/10).

1.6 The TRP's recommendations on National Strategy Applications (NSA) will be presented in a separate report to be issued by 30 October 2009.

1.7 Shortly after the 20th Board Meeting and the Board's funding decisions on Round 9, all eligible proposals, regardless of their recommendation, will be published on the Global Fund's website. In accordance with the Global Fund's documents policy (GF/B16/2), TRP Review Forms will not be published on the website[2].

[1] For information on the outcomes of the Phase 1 AMFm application review, please see GF/B20/10.
[2] Stakeholders wishing to obtain copies of the TRP Review Forms should directly contact the relevant Country Coordinating Mechanism.

PART 2: TRP FUNDING RECOMMENDATIONS ON ROUND 9 PROPOSALS

2.1 The TRP reviewed combined two-year funding requests of **US$ 4.8 billion**, representing 159 disease components which included 34 cross cutting health systems strengthening (HSS) requests[3]. With a total 2-year upper ceiling (Phase 1) being recommended by the TRP of **US$ 2.2 billion**, Round 9 is the second largest Round in terms of Phase 1 recommended funding. The overall success rate of Round 9 proposals, including HSS requests, is 53 percent. The TRP funding recommendations to the Board on Round 9 proposals are listed in Annex 1 of this report. The recommendations are presented by TRP recommendation category[4]. Table 1 below summarizes the funding recommendations by disease components and includes the separate cross-cutting HSS requests (Sections 4B/5B).

Table 1: Summary of funding recommendations, including HSS requests

Disease Proposal	Number recommended for funding	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)	35 of 74	47%	980	44%	2,649	47%
Tuberculosis (including s.4B HSS)	33 of 54	61%	615	28%	1,714	30%
Malaria (including s.4B HSS)	17 of 31	55%	609	28%	1,309	23%
TOTAL	**85 of 159**	**53%**	**2,204**	100%	**5,672**	100%

2.2 The success rate of Round 9 proposals, by disease, excluding cross-cutting HSS requests, is summarized in Table 2 below.

Table 2: Summary of funding recommendations, excluding HSS requests

Component	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	30 of 74	41%	747	41%	2,197	45%
Tuberculosis	32 of 54	59%	495	27%	1,446	29%
Malaria	17 of 31	55%	599	33%	1,290	26%
TOTAL	**79 of 159**	**50%**	**1,841**	**100%**	**4,933**	**100%**

2.3 Of 34 submitted HSS requests, 17 (50 percent) were recommended for funding[5]. Table 3 below summarizes the recommendations related to separate HSS requests[6]. In 11 instances both the disease component and the HSS request are being recommended for funding and in six cases only the HSS request is being recommended.

Table 3: Summary of recommendations related to HSS funding requests (s. 4B/5B)

HSS s4B/5B Funding	HSS Funding Requests	US$ (millions)	Proportion of overall 2 Year funding
Requested	34	672	14%
Recommended	**17**	**363**	**16%**

[3] As with Round 8, applicants could submit a request for 'HSS cross-cutting interventions' (Section 4B/5B of the proposal form) as a separate part (not component) of one disease proposal.
[4] http://www.theglobalfund.org/documents/trp/TRP_TOR_en.pdf
[5] According to the TORs of the TRP, the TRP can recommend for funding either i) the whole disease proposal, including the HSS request; or ii) the disease-specific part, excluding the HSS request; or iii) only the HSS request if the proposed interventions materially contribute to overcome health systems constraints to improve HIV, tuberculosis and/or malaria outcomes
[6] Disease proposals in many cases also included interventions to support health systems strengthening that were not presented as separate sections 4B/5B of the proposal form. This information is not summarized in the table above.

2.4 Table 4 below summarizes, at the time of issue of this report, the recommended funding amounts by recommendation category.

Table 4 – Summary of two-year upper-ceiling funding recommended by the TRP by recommendation category.

Funding Category	Number of Proposals	2 Year Upper Ceiling (US$ millions)	Cumulative 2 Year Upper Ceiling (US$ millions)
1	5	139	139
2	49	1,342	1,481
2B	31	723	2,204
Total Recommended	85	2,204	

2.5 The Board decision on the launch of Round 9 encouraged applicants that had received a 'Category 3' rating in Round 8 to submit a revised version of the same proposal in Round 9. A total of 54[7] re-submissions were received and the overall success rate of re-submissions was 65 percent.

2.6 The TRP is recommending two new countries, Mexico (HIV) and Turkmenistan (tuberculosis), as new single country beneficiaries. It is also recommending four out of 12 multi-country/regional proposals reviewed for funding. For three out of the four recommended proposals, this will be the first time the applicant is being recommended for funding.

2.7 As some proposals requested funds in Euros, this report, including relevant annexes, uses the 1 October 2009 United Nations official exchange rate to translate Euro funding requests into US dollars[8]. The Secretariat will re-issue Annex 1 only at the 20th Board Meeting to reflect the current United Nations official exchange rate that will apply from 1 November 2009 in order to inform funding decisions.

Decision Point Pending

The TRP recommends to the Board that all proposals to which it has assigned Category 1 and 2 (including 2B) ratings be funded.

The TRP recognizes that the Board at its 19th Meeting established a Working Group on Managing the Tension between Demand and Supply in a Resource Constrained Environment ('The Working Group')'[9], to provide a funding recommendation for Round 9. Therefore, no decision point is included in this report. The TRP understands that such decision (including a decision on funding National Strategy Applications) will be included in the Working Group's recommendations to the Board for consideration at its 20th Meeting. The proposed decision will include: (a) the TRP's recommendations that additional time, i.e. two weeks, be allocated for the clarifications process in order to account for the year-end break; and (b) a provision to ensure that, in the cases that an independent budget review has been requested by the TRP as part of the clarifications process, sufficient time will be allocated to allow for the findings of the independent budget review to be completed prior to the beginning of the clarifications process.

[7] This number includes those applicants who re-submitted a 'Category 3' Round 8 disease proposal (including an HSS request, if applicable), or parts of 'Category 1, 2 or 2B proposals' which were not recommended for funding and therefore eligible to resubmit.
[8] http://www.un.org/Depts/treasury/
[9] Decision Point GF/B19/DP26

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

Background

3.1 At its 17th Meeting, the Board decided to launch an extra Call for Proposals in 2008[10]. The Board decided to employ, for the most part, the same proposal form and guidelines for Round 9 as in Round 8. As a result, the guidance that was provided to applicants was similar to that of the previous round.

3.2 The Round 9 Call for Proposals was issued on 1 October 2008, with an initial closing date of 21 January 2009. However at its 18th Board Meeting, the Board decided to extend the submission deadline to 1 June 2009.

3.3 Application materials, fact sheets and links to guidance documents from technical partners continued to be featured on the Global Fund website. As with Round 8, the MyGlobalFund.org website had an online forum dedicated to Round 9 in four languages (English, French, Spanish and Russian). Applicants were encouraged to contact the Proposals Inbox[11] for any question related to Round 9. As with previous Rounds, the Global Fund Secretariat did not provide any technical assistance to countries for proposal preparation.

Proposals received

3.4 A total of 186 proposals from 121 applicants[12] were received by 1 June 2009. Thirty-four disease proposals included a request for support for cross-cutting health systems strengthening interventions (sections 4B/5B of the proposal form), as a distinct part of one of the disease components.

3.5 As with Round 8, the inclusion of section 4B/5B in a Round 9 proposal increased not only the timeframe to screen the proposals for completeness, but also the country response time to clarify issues of eligibility.

3.6 In Round 9, fewer applicants submitted proposals in a language other than English[13]. In contrast to previous Rounds, applicants from Spanish and Russian speaking countries preferred to submit proposals in either English or provided their own English translation. Francophone applicants continued to submit proposals mostly in French. No applications were received in Arabic or Chinese. Applicants are encouraged to submit proposals in the United Nations official language that they most commonly work in, rather than in English.

3.7 The Secretariat continues to experience problems with the quality of the translations it receives and continues to work with its translation companies to improve quality.

Round 9 re-submissions

3.8 To provide guidance to applicants submitting a revised version of a Round 8 proposal in Round 9, the Secretariat released a specific 'frequently asked questions' (FAQ) outlining how these proposals would be screened in Round 9. The FAQ clarified that re-submissions would be screened by the Global Fund in a more streamlined manner. Applicants were required to document the open and transparent process of any revisions and adjustments made to the proposal. In Round 9, the Secretariat received a total of 54 re-submissions from Round 8.

---

[10] Decision Point GF/B17/DP23.
[11] Email: proposals@theglobalfund.org
[12] Note: this number includes the 14 applicants which submitted only parts of the Global Fund proposal form or a Microsoft Word document as their funding request and identified themselves as a Non-CCM, Sub-CCM and in one case a CCM. The applicants were reviewed by the Secretariat and considered to be ineligible.
[13] 21 applicants submitted either the full proposal or a part (i.e. one component) of it in French, 18 in Spanish, and two in Russian.

Screening for eligibility and completeness

3.9 The Round 9 proposal screening process took place from June to August 2009. A total of 20 proposals officers were assigned to different regions based on their experience and language skills, and worked closely with applicants to ensure that all necessary documentation was available for both the Screening Review Panel and the Technical Review Panel.

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

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

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

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

3.11 The Global Fund's Screening Review Panel applied the same principles used for Rounds 6, 7 and 8 to determine eligibility and compliance regarding the minimum requirements for grant eligibility. The CCM team of the Secretariat will, as it did for Rounds 7 and 8[14], release a detailed report of the outcomes of the Screening Review Panel process for Round 9 applicants, including lessons learned and best practices. Table 5 provides a comparison of the outcomes across the last 5 Rounds.

Table 5 – Outcome of Secretariat Screening Review Panel on Eligibility: Rounds 5 to 9

Applicant Type	Total Applicants Round 9	Eligible Applicants Round 9	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	93	88	88	88	80	77	96	93	90	89
Sub-CCM	3	2	3	3	3	2	1	1	1	1
RO	8	8	8	3	5	5	10	9	9	2
RCM	3	3	3	2	1	1	1	1	3	3
Non-CCM	14	0	23	2	21	3	36	4	64	3
Total	**121**	**101 (83%)**	**125**	**98 (84%)**	**110**	**88 (80%)**	**144**	**108 (75%)**	**167**	**98 (59%)**

Addendum: Eligibility Determinations

3.12 The Secretariat reconsidered the eligibility of one applicant. In this instance it was decided that the original decision to deem the applicant ineligible was inappropriate. Consequently, the original decision was reversed to enable the applicant's disease proposals to be reviewed by the TRP. This applicant is therefore treated as eligible in the above table. Due to timing of this determination (and the fact that the Round 9 TRP meeting had concluded three weeks prior), the applicant's proposals were reviewed by the TRP for RCC Wave 7 that met in Vevey, Switzerland from 30 September to 2 October 2009.

[14] http://www.theglobalfund.org/documents/ccm/Screening_Review_Panel_Report_Round_8.pdf

PART 4: TRP MEMBERSHIP AND PROPOSAL REVIEW METHODOLOGY **For Information**

Round 9 TRP Membership

4.1 Membership of the Technical Review Panel for Round 9 consisted of 40 experts which represented an increase of six experts from Round 8. The Round 9 meeting was chaired by **Dr Bolanle Oyeledun,** a cross-cutting expert from Nigeria. Dr Oyeledun was confirmed as the Chair of the TRP in June 2009 after the tenure of the outgoing Chair, Prof. Peter Godfrey-Faussett, ended.

4.2 Prior to the Round 9 TRP meeting, permanent TRP members elected **Mr Shawn Baker,** a cross-cutting expert from the United States of America, as Vice-Chair; during the meeting **Dr George Gotsadze**, also a cross-cutting expert, from Georgia, was elected as the second Vice-Chair. Annex 6 lists the Round 9 membership[15].

4.3 For Round 9 there were 12 members (30 percent) serving for the first time on the TRP. Of these new members, three were recruited through a partial replenishment for cross-cutting experts with a focus on gender and sexual minorities[16].

4.4 Due to the early launch of Round 9, the Board decided to extend, for Round 9 only, the maximum term of permanent TRP members to five Rounds, and the Chair to seven Rounds. The former Chair, Dr Peter Godfrey-Faussett, was not available and this led to the appointment as described above[17].

4.5 In Round 9 the TRP continued to benefit from having experts who also serve on the GAVI Health Systems Strengthening Independent Review Committee as members of the TRP. This cooperation has allowed the TRP to draw on its experience and enhance collaboration with GAVI on health systems matters.

Managing potential conflicts of interest

4.6 The TRP continues to manage conflict of interest and applies strict criteria to avoid any potential conflict of interest arising in order to ensure a high standard of ethical conduct and preserve its independence. This is achieved through the application of the Global Fund's policy[18] on managing potential conflicts of interest, and through the application of internal rules of conduct which include:

i. nationals or residents of a country under review cannot 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;

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 or an important sub-recipient; and

iv. a one year "cooling-off" period, upon completion of service[19], requires former TRP members to restrict themselves from assisting countries in Global Fund proposal

[15] For curriculum vitae of all members please see: http://www.theglobalfund.org/en/trp/members/?lang=en.
[16] Decision Point GF/B19/DP17.
[17] Refer to the Board's decision entitled 'Launch of Round 9', GF/EDP/08/07 (2 June 2008).
[18] Refer to the Global Fund's 'Policy on Ethics and Conflicts of Interest' http://www.theglobalfund.org/documents/policies/PolicyonEthicsandConflictofInterestforGlobalFundInstitutions.pdf.
[19] A term of service is considered to be completed after the clarifications process for the last Round upon which the TRP member served as a proposal reviewer is finalized.

development or from participating on Country Coordinating Mechanisms (CCMs) or other mechanisms[20].

TRP meeting modalities

4.7 Prior to the Round 9 meeting, an extranet site was developed for the TRP. Information regarding Global Fund strategies and policies, review material, technical updates from partners, TRP internally agreed guidance notes and other relevant information was provided and regularly updated and accessible to the TRP.

4.8 The Round 9 TRP meeting[21] was held in Montreux, Switzerland. An induction session for new TRP members was organized to discuss Global Fund policies and architecture, TRP review modalities and tools, as well as internally agreed practices. The session also involved a mock proposal review which included the participation of experienced TRP members.

4.9 The first part of the meeting included updates on key Global Fund policies and strategic initiatives, as well as a review and discussion of disease-specific, health systems strengthening (HSS) and cross-cutting issues. The aim of this briefing day was to ensure that consistent approaches would be applied across all Round 9 proposals. As with Round 8, discussions with technical partners occurred via telephone conference calls. The TRP recognized that this was perhaps not the most effective way to engage with partners and has identified new mechanisms to ensure that partner briefings are more engaging. The TRP would also like to introduce a debriefing process for technical partners at the end of each TRP Rounds-based meeting as a means for communicating information regarding technical matters identified during the proposal review process.

4.10 For the first time, a mini-retreat was organized midway through the TRP Round 9 meeting in order to discuss issues relating to the independence of the TRP, the quality of the TRP's work, as well as the role and scope of the TRP. This approach was deemed very constructive and useful, and is recommended as a regular part of future TRP review meetings.

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

Proposal review methodology

4.12 The key features of the TRP's review of Round 9 proposals included:

i. TRP members working in ten small groups (two disease experts and two cross-cutters typically for each day of proposal review) to review no more than two disease proposals a day (this was made possible due to the increase in TRP membership[22]);

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

iii. On four days partial parallel plenary sessions were held[23]. The sessions were chaired either by the Chair or one of the Vice-Chairs;

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

[20] For more details please refer to Round 7 TRP report: http://www.theglobalfund.org/documents/board/16/GF-BM16-05-TRP_Report_Round7.pdf
[21] Due to timing, the Phase 1 AMFm applications were reviewed during the Round 9 meeting. For more information on the review of AMFm applications please see GF/B20/10
[22] Decision Point GF/B19/DP16
[23] On Day 3 and Days 7, 8 and 9 (Phase 1 AMFm reviews), parallel sessions were held.

v. in the final review plenary, the TRP discussion of the overall review process, consistency between findings and the confirmation of funding recommendations for all the disease proposals reviewed.

4.13 In some cases, the TRP had difficulty in reaching consensus. The small review groups were then asked to consider their recommendations in light of the plenary discussions. When the small group was unable to reach consensus, at least two additional TRP members reviewed the proposal, focusing on the specific issues raised in the initial plenary. The proposal was then re-discussed in a later plenary after the additional reviewers had sufficient time to review the material. As with previous Rounds, this process was found to be very effective for more difficult cases.

4.14 During the review process, TRP members did not take into account the availability of funds. As mandated by the TRP TORs, each disease proposal was reviewed as a whole[24]. The TRP's review focused on: i) soundness of approach; ii) feasibility; iii) potential for sustainability and impact; and the corresponding 22 criteria[25]. As proposals are country-driven, not all disease proposals include interventions that respond to each of the criteria. There is no predefined 'rating methodology' or allocation of quantitative scores for proposal review. Rather, the TRP draws on its collective experience to make a judgment on the technical merit of the proposal. This is a complex process, but one that ensures that there is appropriate consideration of country and/or regional context.

4.15 As mentioned in paragraph 3.12, one applicant was deemed to be eligible by the Secretariat following additional consideration of the documentation, notwithstanding an earlier decision to deem it ineligible. However, as this decision was made after the Round 9 TRP meeting, the Secretariat requested the TRP for RCC Wave 7 to review the two Round 9 disease components including a cross-cutting HSS funding request. The RCC Wave 7 meeting took place from 30 September to 2 October 2009. The funding recommendations for this applicant are included in the overall Round 9 results presented in this report.

4.16 To be consistent with the Board's decision on health systems strengthening, the TRP did not review proposals that included cross-cutting HSS requests as two distinct funding applications.[26] In Round 9, 34[27] applicants submitted an HSS cross-cutting request (section 4B/5B of the proposal form). The TRP could recommend for funding either both parts of the disease proposal (i.e. the disease component and the HSS request), one part, or neither.[28] In addition, the TRP could recommend the modification or elimination of weak elements in an otherwise strong HSS request.

4.17 Applicants who submitted a cross-cutting HSS request with their disease proposal receive one TRP Review Form with comments relating to both proposal parts. When one part is not recommended for funding, but the other part is, the TRP recommends that the country review the TRP Review Form and determine whether or not to submit a revised request for this support in a future funding window in line with the Global Fund's current position on the funding of HSS cross-cutting interventions.

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

[24] This is different to the RCC funding channel where the TRP is entitled to remove out a limited set of elements. From Round 10, the TRP will be able to select out weak elements of an otherwise technically sound proposal as part of the recommendation for funding.
[25] Terms of reference of the Technical Review Panel, Attachment 1 "Proposal Review Criteria", http://www.theglobalfund.org/documents/trp/TRP_TOR_en.pdf. In addition, these criteria are described in the Guidelines for Proposals for every Round.
[26] In Round 9, applicants were encouraged to include requests for health systems strengthening support within disease specific proposals whenever possible. HSS requests could be submitted as a distinct part (section 4B/5B) within one disease proposal, but not as a separate 'component' (GF/B17/DP10, paragraphs 2 and 3).
[27] Compared to 45 in Round 8.
[28] Refer to paragraph 39 of the TRP TORs.

i. Secretariat documentation on existing grants (Grant Performance Reports, Grant Scorecards, Country Strategic Information Sheets[29], and previous TRP review forms for Rounds 4-8);

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

iii. where applicable, country profiles from the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI);

iv. Green Light Committee Country Reports (where applicable); and

v. World Bank Poverty Reduction Strategy Papers (where applicable).

4.19 For the first time, and on a pilot basis, the TRP had access to external financial analysis support services during the Round 9 meeting. Five financial experts and one procurement expert were on hand and reviewed the proposal budgets requesting more than US$ 100 million over five years (41 in total). These reviews were independent of the TRP's own review and their findings were provided for the TRP's consideration. As mentioned in Part 5 of this report, the TRP welcomed this addition to the review process.

4.20 As with Round 8 and RCC Waves 5 and 6, there were certain instances (12) in which the TRP requested an independent budget review as part of the post-TRP review clarifications process. The findings of the independent budget review will inform this process and may result in the TRP reducing the upper-ceilings of certain proposals.

4.21 In four instances for Round 9, the TRP recommended a funding amount, both for Phase 1 and for the entire proposal term, that was less than that requested by the applicant.

4.22 The TRP continued to make an effort to clearly state the reasons behind their funding recommendations in the 'TRP Review Form' which is sent to each applicant. Where the TRP did not recommend a proposal for funding (i.e., 'Category 3' and 'Category 4'), detailed explanations for this choice were provided, separating major weaknesses from minor issues.

Round 10 TRP membership

4.23 The last replenishment of the TRP Support Group took place in early 2006 - a process that typically occurs every two years. Due to various policy and strategic initiatives that were underway in 2008-2009, the recruitment of new experts was, on the advice of the Portfolio Committee, deferred to incorporate potential changes in the structure and/or role of the TRP resulting from potential changes in the architecture. The full replenishment of the TRP Support Group will now take place in late 2009/2010[30].

4.24 The TRP leadership will discuss the overall skills requirements for Round 10 and the Support Group after the Board makes its decisions at the upcoming Twentieth Board meeting. The TRP expressed concern regarding the loss of institutional memory due to the fact that the terms of service of 11 experts (28 percent) expire after Round 9. For example, unless policies are changed, there will be at least 50 percent new malaria experts in Round 10.

[29] In response to its Round 8 recommendation, the Secretariat provided the TRP with Country Strategic Information sheets during its review. These sheets provided information on the full Global Fund portfolio in a country and include programmatic and financial performance summaries by grant; results on top 10 indicators; latest Health Metrics Network (HMN)-WHO assessment information; and for the latest available results for countries monitored by the Paris Declaration on aid effectiveness.

[30] Report of the Portfolio Committee to the Board, GF/B18/5, p.5.

The TRP recommends that the Board consider extending the term limits for TRP members in light of this high turnover and that this be considered by the Portfolio and Implementation Committee during the TRP Replenishment process.

4.25 As noted above, eleven 'TRP Permanent Members' will complete their term of service following the completion of the Round 9 TRP clarifications process. **The TRP and the Secretariat would like to acknowledge the contributions of Dr Martin Alilio (cross-cutting expert, Tanzania), Dr François Boillot (cross-cutting expert, France), Dr Thomas Burkot (malaria expert, USA), Dr Josef Decosas (cross-cutting expert, Germany), Prof. Asma El Sony (tuberculosis expert, Sudan), Dr Blaise Genton (malaria expert, Switzerland), Dr Andrew McKenzie (cross-cutting expert, South Africa), Dr Yvo Nuyens (cross-cutting expert, Belgium), Dr Gladys Antonieta Rojas de Arias (malaria expert, Paraguay), Dr Godfrey Sikipa (HIV expert, Zimbabwe) and Dr Nêmora Tregnago-Barcellos (HIV expert, Brazil) and to sincerely thank them for their time and commitment to the Global Fund.**

For Input

PART 5: RECOMMENDATIONS AND LESSONS LEARNED FROM THE ROUND 9 PROPOSAL REVIEW

INTRODUCTION

5.1 This part documents the lessons learned by the Technical Review Panel (TRP) during their review of Round 9 proposals and provides recommendations for Applicants, the Global Fund Board, Partners and the Secretariat for consideration in future Rounds.

GLOBAL FUND POLICIES AND ARCHITECTURE

5.2 The following lessons learned and recommendations are related to existing Global Fund policies and architecture. The TRP recognizes that some of the recommendations made may be addressed through the architecture review that will be presented to the Global Fund at its 20th Meeting.

Parallel Funding Channels

5.3 Currently there is no policy restricting applicants from submitting a Rounds-based proposal as well as a Rolling Continuation Channel (RCC) proposal at the same time, unless the proposals request funding for the same activities.[31] However, the TRP noted during its review of Round 9 applications that some countries were making applications through both Round 9 and an upcoming RCC**.**

The TRP recommends to the Board, should RCC continue under the new architecture, that a parallel submission of proposals in a Round and a RCC wave should not be allowed.

Clarifications

5.4 In their deliberations regarding funding recommendations in Round 9, the TRP discussed the importance of a clarification process as it allows for additional information and justifications to inform their ultimate approval of the original funding recommendation.

The TRP would like to remind applicants that funding recommendations are conditional upon the satisfactory completion of the clarification process. If the clarifications requested are not provided or suggested adjustments made in the Board sanctioned timeframes established, the TRP recommendation for funding (and the Board's approval based on such recommendation) will be withdrawn.

5.5 The TRP recognizes the pressure to sign grants within 12 months of Board approval and the limitations in the current timeframe of the clarification process scheduled over the end of year holiday period.

The TRP recommends that the clarification process include a provision to suspend the process during the end of year break[32]. In addition, the TRP recommends that, as with RCC Wave 6, additional time be allocated for those proposals which are required to undergo an independent budget review as part of the clarifications process.

5.6 The TRP would appreciate greater support from the Secretariat during the clarifications process.

In order to ensure a consistent approach, the TRP recommends that the clarifications process be managed by the Country Proposals Team within the Secretariat.

[31] Decision Point GF/B14/DP9, paragraph 7

[32] This could be included as a two-week extension to the normal clarification period (i.e. from 8 weeks to 10 weeks for Category 1 proposals and 6 weeks to 8 weeks for the initial response for Category 2 proposals), rather than a suspension of the process.

5.7 **Recognizing the time required to carefully review complex budget issues, the TRP also recommends and requests that access to financial analysis support, like that provided during the Round 9 meeting, be made available (remotely) to the TRP during the clarifications process.**

Eligibility requirements and focus on poor and/or vulnerable populations

5.8 The Global Fund's income eligibility and cost sharing criteria clearly indicate that proposals from 'lower middle' and 'upper-middle' income countries must focus on poor and/or vulnerable populations. During its review of Round 9 proposals, the TRP noted that many proposals from 'middle' income countries did not clearly demonstrate that the proposal was predominantly focused on these populations.

The TRP recommends to the Secretariat that the Round 10 proposal form and guidelines highlight this important eligibility requirement and that applicants be requested to describe in detail how their proposal focuses on these groups.

Multi-country and regional proposals

5.9 In Round 9, the TRP recommended 4 (HIV proposals) out of 12 eligible multi-country disease proposals (11 HIV and 1 malaria) reviewed. The recommended proposals clearly demonstrated the added value of a multi-country and/or regional approach. Although this represents an improvement over previous Rounds, the TRP continues to question the value-added of most multi-country and regional proposals.

5.10 As with previous Rounds, the rationale for the specific countries collectively presenting a proposal is often unclear. In addition, the TRP questions the relevance of including service delivery interventions in regional proposals, as they may contribute to the creation of parallel structures in some cases.

The TRP recommends that applicants clearly describe the expected value-added of a multi-country or regional approach, as well as justify the selection of countries (i.e. epidemiological or strategic reasons).

5.11 The TRP noted that in many cases single-country applicants repeatedly failed to acknowledge their parallel inclusion in a multi-country or regional proposal (when applicable) and it is evident that CCMs are not undertaking a full analysis of these proposals when they endorse them**.**

The TRP recommends to the Secretariat that single-country applicants be required to mention their inclusion in a regional or multi-country proposal and vice versa. In addition the TRP recommends that proposal guidelines and forms be reviewed in order to avoid duplication and fragmentation, as well as ensure consistency, with national and sub-national proposals.

GENERAL RECOMMENDATIONS FOR THE SECRETARIAT AND THE GLOBAL FUND BOARD

Financial analysis of proposals

5.12 As noted in Part 4 of this report, the TRP was provided for the first time with financial analysis support for its review of those proposals whose lifetime budgets exceeded $100 million. In addition this support was made available to the TRP for ad-hoc requests. The TRP found this a welcome addition to its review process.

The TRP recommends to the Board to make the necessary budgetary provisions to ensure that this type of support is made available for future Rounds and for all proposals, regardless of the overall budgetary ceiling. The TRP further recommends that the financial analysis be

undertaken prior to the TRP review meeting and that on-hand support during the meeting also be made available as necessary.

Grant Performance Reports[33]

5.13 The TRP continues to use Global Fund Grant Performance Reports (GPRs) as the main source of programmatic and financial data for existing Global Fund grants. As these reports are developed on a grant by grant basis, it is difficult to have a holistic view of all the Global Fund grants in a particular country for a particular disease.

The TRP recommends that under the new architecture, GPRs be designed to provide a more holistic view of Global Fund grants in a particular country.

5.14 The TRP notes that there is a significant variability in the quality, completeness and relevance of Grant Performance Reports. The TRP also observes that GPRs tend to provide more financial information than programmatic information, noting that the latter is particularly relevant to the TRP for its review.

The TRP recommends that the Secretariat continues to improve quality and content of GPRs and ensure that GPRs provided to the TRP are (1) up to date and exhaustive; (2) include enhanced programmatic and quantitative information, as well as financial information.

Translation

5.15 While the quality of translations provided to the TRP by both the Secretariat and applicants themselves continues to improve, concern remains regarding the overall quality of translations. The sub-optimal quality of translations has not hindered the TRP review process as TRP members' language skills allowed them to review the original proposal when needed.

The TRP recommends that the Secretariat continue to improve quality of translations and if needed allow staff dedicated to this function to review translations prior to the TRP meeting.

5.16 The Global Fund currently only allows for proposal submission in Arabic, Chinese, English, French, Spanish and Russian. The TRP notes that a number of Portuguese speaking countries submit proposals to the Global Fund.

The TRP recommends that these countries be allowed to submit in Portuguese and that the Secretariat provide for the translation of these documents.

Proposal Form and Guidelines

5.17 The TRP recognizes that for Round 9 the Board decided that there would be no changes to the Proposal Form and Guidelines, other than to facilitate clarity of the 'Round 9 re-submission' possibility[34]. The TRP recognizes the importance of the proposal forms and guidelines as key tools to communicate Global Fund policies and TRP recommendations to applicants and notes that Round 10 will provide the opportunity for their revision.

The TRP recommends to the Secretariat to request TRP input and review at key stages of this revision process.

5.18 Some proposals are very long and exceed the requested page limits. In addition, the TRP recognizes that the Secretariat undertakes an extensive screening process in order to ensure that the most complete information is provided to the TRP. However, in spite of this, some proposals are incomplete and lack significant information.

[33] Grant Performance Reports (GPRs) are living documents prepared by Country Programs staff and are intended to be updated on a regular basis with updated programmatic, financial and contextual information.
[34] Decision Point GF/B17/DP23

The TRP strongly recommends that the Board authorizes the Secretariat to more strongly emphasize page limits and/or to adopt an automated proposal form which does not allow additional information beyond established page limits; and to screen out incomplete proposals based on pre-defined criteria.

TECHNICAL QUALITY OF PROPOSALS: GENERAL RECOMMENDATIONS

5.19 This section follows, for the most part, the TRP proposal review criteria as set out in the TRP Terms of Reference and provides general recommendations on the overall technical quality of proposals.

SOUNDNESS OF APPROACH

Coherence and quality of proposals

5.20 Many proposals are penalized/hindered by not providing a clear situational analysis. Many times the TRP had difficulty in finding a link between the proposal narrative, budget and work plan. This is exacerbated when poor quality budgets and performance frameworks are presented.

The TRP recommends that applicants ensure that attention is given to these areas in order to strengthen their proposals.

The Secretariat is requested to reinforce this message in its proposal form and guidelines, fact sheets, and tools for applicants.

The TRP also recommends that the Secretariat clearly communicate to applicants the importance of having proposal narratives that are well aligned and consistent with submitted budgets and work plans.

Evidence-based interventions

5.21 During its review the TRP noted that in many cases proposals included strategies lacking evidence-based interventions (e.g. BCC interventions for the three diseases, concomitant use of indoor residual spraying (IRS) and long-lasting insecticide nets (LLINs) for malaria, etc.).

The TRP recommends to:

- **Applicants to carefully consider the proposed interventions and ensure that they are evidence-based and appropriate to the country and epidemiological context;**
- **Applicants to undertake an evaluation of proposed interventions when the evidence base is insufficient, before including them in a proposal for funding; or to conduct operational research on small-scale pilot interventions included in the proposal before going to scale; and**
- **Partners who assist with proposal development to provide technical assistance in this area.**

Value for money

5.22 Proposals continue to be generally weak in demonstrating cost-effectiveness and value for money of the proposed interventions. This is true not only for the disease-specific proposals but also for HSS cross-cutting interventions.

The TRP recommends that from Round 10, the proposal form and guidelines should explicitly elicit this type of information.

Human rights

5.23 The TRP noted that in many instances proposals which targeted vulnerable groups did not adequately address the legal environment (e.g. criminalization of intravenous drug use (IDU) and homosexuality) in which interventions will be implemented. This is a crucial aspect to ascertain the soundness, feasibility as well as sustainability of the proposed interventions.

The TRP recommends to applicants to ensure that this dimension is adequately addressed in proposals.

Gender

5.24 As with Round 8, applicants were encouraged in Round 9 to consider the different needs of women and men, and boys and girls, sexual minorities[35] and other vulnerable populations when developing their proposals. Overall the TRP found the gender issues were addressed in Round 9. However, similar to the previous Round, many proposals, in particular HIV proposals, mentioned gender and used appropriate terminology, but did not for the most part include a serious situational analysis or attempt to develop strategies to address gender inequality issues. In addition many proposals did not clearly describe the implementation strategies of gender sensitive interventions**.**

The TRP recommends that partners provide guidance and technical assistance to applicants in order to adequately address gender issues in future proposals.

5.25 The TRP noted that some proposals, mostly HIV, targeted key population groups (e.g. men who have sex with men, transgenders, female, male and transgender sex workers) which are addressed in the recently approved Sexual Orientation and Gender Identities (SOGI) strategy. Successful proposals clearly identified the vulnerabilities of these populations and included adequate programmatic responses. The TRP notes that in some cases, although proposals mention sexual minorities as an at-risk population, a larger discussion on sexual orientation and gender identity as it relates to issues of HIV vulnerability was missing.

The TRP recommends applicants to include a sound gender situational analysis, on which gender sensitive approaches will be based, and that this be supported by clear implementation strategies. The TRP requests that the Secretariat improve guidance on this, in line with the Gender Equality and SOGI strategies, and in consultation with partners.

FEASIBILITY

Implementation strategy

5.26 Many proposals lack detailed information on proposed implementation strategy which hinders the TRP in its assessment of the feasibility of the proposal.

The TRP recommends to the Secretariat to revise the proposal form and guidelines from Round 10 to explicitly elicit this type of information, including information related to the implementation of M&E strategies.

Alignment

5.27 The TRP continues to underscore the importance of proposals aligning with national plans and expenditure frameworks. Although the future roll-out of National Strategy Applications will address this, the TRP notes that not all countries will be able to submit an application through this channel.

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

The TRP strongly recommends that Rounds-based applicants ensure that proposals submitted are within the context of existing national plans and frameworks (expenditure and monitoring and evaluation). The TRP recommends that the Secretariat reinforce this message in the revised proposal forms and guidelines.

Complementarity

5.28 The TRP found that many Round 9 proposals did not demonstrate clearly the complementarity and additionality of their request for funding for both disease-specific components as well as HSS funding requests. Applicants frequently failed to demonstrate links with existing Global Fund grants and other donor funding, therefore making it difficult for the TRP to assess the new proposal.

The TRP strongly recommends that a revised proposal form explicitly request applicants to show complementarity of the proposal with existing funding and activities (e.g. new table requiring clear side-by-side analysis).

Implementation history

5.29 Linked to complementarity is the question of "repeat applications" in successive Rounds from the same applicant for the same disease component.

The TRP strongly discourages this practice, as it promotes a "piece meal" or "project type" approach to the three diseases.

5.30 The TRP welcomes the idea put forward in the architecture review of requiring consolidated proposals as of Round 10 as this will require applicants to holistically evaluate their response to a particular disease and request funding in context of the overall national program. As with previous Rounds, the TRP did not usually recommend for funding a proposal to continue, scale-up or alter an existing program that has not yet reported progress beyond a few months or had not yet been signed. However, the TRP recognizes that there may be exceptional circumstances in which a new proposal from applicants with recently approved funding may be justified (e.g. when proposals submitted in subsequent rounds focus strategically on very different areas of interventions).

Should the Global Fund decide not to limit the frequency of funding applications, the TRP strongly recommends applicants to only submit a proposal when it can clearly demonstrate the results of the previous same disease proposal(s).

Performance frameworks

5.31 The TRP found that appropriate performance frameworks, for both existing Global Fund grants and new proposals, continue to be lacking. Performance frameworks for the most part tend to focus on process and output indicators, do not contain appropriate outcome and impact indicators, fail to include indicators to measure the quality of interventions. Mechanism for countries to report back on the implementation of interventions are also lacking. This applies both to disease-specific proposals and HSS requests.

The TRP recommends that more detailed guidance be provided to applicants as part of future proposal guidelines in consultation with partners. The TRP also recommends that the Secretariat support the development of appropriate and more rigorous performance frameworks during grant negotiations.

Previous TRP comments

5.32 The TRP was encouraged to see that in Round 9 many applicants took previous TRP comments seriously into account in the proposal development.

The TRP recommends to the Secretariat and partners to continue to reinforce this message for future funding channels.

POTENTIAL FOR SUSTAINABILITY AND IMPACT

Additionality of Global Fund funding

5.33 The TRP notes with concern that in certain instances a decreasing government financial commitment over the proposal lifetime was evidenced with the Global Fund assuming an increasing share. It also notes that many Round 9 proposals did not demonstrate clearly the additionality of their request for funding for both disease-specific components and cross-cutting HSS funding requests.

The TRP recommends that the Secretariat reinforce the message about additionality of funding in the proposal forms and guidelines and for partners to provide, where possible, the TRP with a summary of relative funding flows (national versus external sources).

Absorptive capacity

5.34 During its review, the TRP voiced numerous concerns related to the absorptive capacity in countries, in particular when a country has many ongoing grants, Global Fund or otherwise. This was particularly apparent when countries were recently funded for Round 8 for the same disease component and were once again requesting funds for Round 9.

The TRP strongly recommends that applicants take into account absorptive capacity when assessing their funding needs.

Impact of Behavior Change Communication (BCC) interventions

5.35 Many proposals continue to lack appropriate quality indicators for the measurement of the impact of BCC interventions.

The TRP recommends to applicants to undertake an evaluation of BCC interventions, before including them in a proposal for funding; or to conduct operational research on small-scale pilot BCC interventions (to be included in a proposal) before going to scale; and to include more indicators for the impact measurement of BCC interventions.

TECHNICAL QUALITY OF PROPOSALS: RECOMMENDATIONS SPECIFIC TO DISEASE COMPONENTS AND HEALTH SYSTEMS STRENGTHENING

HIV/AIDS

5.36 HIV continues to remain the disease component that is least likely to be recommended for funding. In Round 9, 41 percent of HIV proposals were recommended for funding (30 out of 74 proposals), which is slightly higher than Round 8 in which had a success rate of 40 percent (30 out 76 proposals)[36].

5.37 There is a general concern that the quality of prevention strategies in HIV proposals is lacking. Many applicants did not elaborate how prevention strategies would be evaluated and what mechanisms would be used to ensure the quality and appropriateness of these.

[36] The Report of the Technical Review Panel and the Secretariat on Round 8 cites a 49% success rate for HIV/AIDS proposals which includes those cases in which only the cross-cutting HSS request was recommended for funding and the disease component was not. The percentages indicated above and in 5.45 and 5.48 are strictly related to the success rates of disease proposals and exclude cross-cutting HSS requests.

The TRP recommends that applicants pay more attention to this issue and that partners and the Secretariat provide more guidance to countries, especially those countries with a low prevalence of HIV.

5.38 The TRP continues to be concerned that international best practice guidelines regarding infant replacement feeding are not being communicated at the country level.

In this context, the TRP reaffirms its Round 8 recommendation[37] that partners provide in-country HIV program managers with short, clear recommendations when replacement formula may be appropriate. The Secretariat is requested to ensure that clear guidance be provided in future information to applicants (e.g. factsheet).

5.39 The TRP welcomes the recent Board decision which reiterates the importance of TB/HIV collaborative activities[38]. In Round 9, the TRP noted that TB/HIV co-infection and collaborative activities are not systematically addressed in all TB and HIV proposals. Applicants should clearly describe in their proposals TB/HIV collaborative activities, even in the cases where Global Fund resources are not being requested, and should they chose not to, they should provide compelling reasons as to why they are not included.

The TRP recommends that all HIV and tuberculosis proposals should address TB/HIV collaborative activities.

The TRP recommends that the Secretariat clearly communicate the Board decision to applicants as part of Round 10 application materials.

In addition, the TRP recommends that international guidelines be communicated to applicants; as well as the TRP recommendation that both HIV and tuberculosis proposals should address TB/HIV collaborative activities unless compelling reasons exist not to do so – even if no funding is sought from the Global Fund for these activities.

TUBERCULOSIS

5.40 Tuberculosis proposals had the highest success rate with 59 percent (32 proposals), up from 49 percent (28 out of 57 proposals) in Round 8, of proposals being recommended for funding.

5.41 The TRP noted that Round 9 proposals did not always clearly elaborate proposed strategies, or their subsequent monitoring and evaluation, for Advocacy, Communication and Social Mobilization (ACSM); Practical Approach to Lung Health (PAL); and Infection control (IC).

The TRP recommends that partners and the Secretariat provide clear guidance to applicants in these areas.

5.42 The TRP noted that the rationale for, and demonstration of cost-effectiveness of, tuberculosis prevalence surveys in proposals is sometimes weak.

The TRP recommends to partners and the Secretariat to provide clear guidance to applicants.

MALARIA

5.43 Malaria proposals saw a drop in the overall success rate from Round 8 from 68 percent to 55 percent in Round 9 (17). Although the drop is significant, the TRP still felt that malaria proposals were overall strong.

[37] http://www.theglobalfund.org/documents/board/18/GF-B18-10_TRP_ReportToBoard_and_Annexes2-5-6.pdf (page 22)
[38] Decision Point GF/B18/DP12

5.44 The TRP supported the inclusion in several Round 9 proposals of an evaluation of mosquito resistance to insecticide.

The TRP recommends to applicants to build on the results of resistance surveys to design a management plan of insecticide resistance and to consider including measures of mosquito behavior in the presence of insecticides to guide strategy selection and implementation.

5.45 In Round 9, the TRP welcomed that all proposals dealing with case management included a diagnostic component. The TRP noted that some proposals were even ahead of the WHO recommendations.

The TRP recommends to WHO to issue guidelines on the universal use of laboratory-confirmed diagnosis, as this would support a quick scale up at all levels of the health system.

5.46 A general lack of understanding and conceptualization of pre-elimination strategies resulted in some countries proposing a 'cocktail' of interventions that were not always appropriate given their local epidemiological context.

The TRP recommends partners and the Roll Back Malaria Harmonization Working Group develop more guidance on the pre-elimination concept and on appropriate strategies in different contexts.

5.47 An overall misunderstanding of the UN Secretary General call for universal access to malaria control interventions led some countries to request blanket coverage of all malaria control interventions without consideration of epidemiological strata.

The TRP recommends that applicants base any IVM strategy on local evidence of its effectiveness, in particular with regard to the additional benefit of having several interventions with the same target. This also applies to the concurrent universal use of long-lasting insecticide treated nets (LLINs) and indoor residual spraying (IRS) at country level.

5.48 Some Round 9 malaria proposals included larviciding as a vector control strategy without demonstration of its effectiveness in the local context.

The TRP recommends that larviciding should only be included in a proposal if its effectiveness can be demonstrated.

HEALTH SYSTEMS STRENGTHENING (HSS)

5.49 As with Round 8, applicants had the opportunity to submit an additional health systems strengthening (HSS) cross-cutting request, using sections 4B/5B, with a disease component, as long as the proposed interventions would strengthen two or more of the three diseases. The overall success rate of the HSS parts was 50 percent (17 parts), which was down from the Round 8 success rate of 53 percent.

5.50 The TRP found that there is a general lack of understanding among applicants regarding the difference between HSS interventions which should be included in the disease-specific sections versus in a HSS cross-cutting section.

The TRP recommends that the Secretariat improve guidance to applicants on the difference between HSS activities that should be included in a HSS cross-cutting section versus a disease-specific section.

5.51 During its review of Round 9 HSS cross-cutting requests, the TRP noted that many applicants are often requesting a "shopping list" of all theoretical HSS needs, without giving thought to longer-term HSS programmatic planning and expected impact. HSS must be clearly presented as being auxiliary to, and flowing from, a national health strategy. At the same time, HSS requests must

also demonstrate their benefit in addressing the three diseases. In addition the TRP also found that health sector reform leadership and governance issues were often inadequately addressed in proposals.

The TRP strongly recommends that applicants base their HSS request on a gap analysis of their national health sector strategy which is supported by holistic needs assessment of the health system. Applicants must also demonstrate how their HSS request will improve the outcomes in relation to the three diseases.

5.52 The TRP recognizes that the current health systems strengthening section of the proposal form is not satisfactory and could be improved. During Round 9, the TRP further attempted to understand why countries are not presenting stronger HSS applications.

The TRP strongly recommends that the Secretariat revise the current proposal guidelines and forms. Moreover, the TRP strongly recommends that the Secretariat utilizes TRP expertise when developing the next proposal form and ensure that the TRP plays an active role.

LATE ELIGIBILITY DETERMINATION BY THE SECRETARIAT

5.53 The TRP members present at the RCC Wave 7 Review were, on an exceptional basis, tasked with reviewing an additional proposal with two disease components submitted under Round 9 (these proposals were deemed eligible after the completion of the Round 9 review process). The TRP is concerned that while the results of TRP Round 9 are the product of deliberation of all TRP members (40 members) present, the recommendations made as a result of this proposal review are based on inputs from only those TRP members (17 members) participating in RCC Wave 7.

5.54 The TRP in general and the RCC Wave 7 members in particular, express concern that this late eligibility determination may create a precedent. It is important to note that (while the TRP is not mandated to ascertain eligibility) a screening process called into question might reflect adversely on the entire system, including the TRP review.

The TRP strongly reiterates the recommendation on the timing of eligibility determinations that was made in the Round 6 Report[39] be strictly adhered to by the Secretariat to maintain the integrity and credibility of both the TRP and the Global Fund Secretariat as a whole.

[39] Report of the technical review panel and the Secretariat on Round 6 Proposals, GF/B14/10, page 32, 5.7, paragraph 2

List of Eligible Round 9 Proposals Reviewed by the Technical Review Panel, Classified by Recommendation Category

No.	Applicant type	Applicant	Income level (from Annex 1 in Round 9 Guidelines)	WHO Region	Global Fund Regional Team	Disease	TRP Recommended' Phase 1 Upper ceiling (2 Years)	TRP Recommended' Lifetime Upper ceiling (Up to 5 years)
CATEGORY 1 PROPOSALS								
1	CCM	Georgia	Lower-middle	EURO	EECA	HIV	€7,209,605	€12,826,501
Sub-Total: Category 1 Proposals in EURO							**€ 7,209,605**	**€ 12,826,501**
2	CCM	Cambodia	Low	WPRO	EAP	Malaria	$43,717,857	$102,033,561
3	CCM	Eritrea	Low	AFRO	EA	Malaria, incl. CCHSS	$29,855,990	$69,433,635
4	CCM	Myanmar	Low	SEARO	EAP	HIV	$51,716,207	$157,776,471
5	CCM	Serbia	Lower-middle	EURO	EECA	Tuberculosis	$3,441,632	$7,540,351
Sub-Total: Category 1 Proposals in USD							**$128,731,686**	**$336,784,018**
Total: Category 1 Proposals in USD Equivalent							**$139,210,763**	**$355,427,188**
CATEGORY 2 PROPOSALS								
6	CCM	Azerbaijan	Lower-middle	EURO	EECA	HIV	€11,831,706	€26,983,960
7	CCM	Azerbaijan	Lower-middle	EURO	EECA	Tuberculosis	€1,983,042	€5,065,216
8	CCM	Benin	Low	AFRO	WCA	HIV, incl. CCHSS	€48,272,734	€108,636,826
9	CCM	Benin	Low	AFRO	WCA	Tuberculosis	€2,813,599	€4,815,146
10	CCM	Bosnia & Herzegovina	Lower-middle	EURO	EECA	HIV	€14,428,659	€32,453,777
11	CCM	Cameroon	Lower-middle	AFRO	WCA	Malaria	€77,791,996	€113,983,337
12	CCM	Cameroon	Lower-middle	AFRO	WCA	Tuberculosis	€6,823,011	€15,422,473
13	CCM	Chad	Low	AFRO	MENA	Malaria	€20,807,913	€29,993,968
14	CCM	Comoros	Low	AFRO	EA	HIV, incl. CCHSS	€1,833,520	€3,107,636
15	CCM	Cote d'Ivoire	Low	AFRO	WCA	HIV, disease part only	€46,066,302	€125,953,322
16	CCM	Cote d'Ivoire	Low	AFRO	WCA	Tuberculosis	€9,672,256	€33,977,331
17	CCM	Guinea-Bissau	Low	AFRO	WCA	Malaria, incl. CCHSS	€6,145,091	€13,492,563
18	CCM	Senegal	Low	AFRO	WCA	HIV, incl. CCHSS	€29,125,467	€88,751,831
19	CCM	Togo	Low	AFRO	WCA	Malaria, disease part only	€41,116,176	€70,116,448
Sub-Total: Category 2 Proposals in EURO							**€ 318,711,472**	**€ 672,753,834**

No.	Applicant type	Applicant	Income level (from Annex 1 in Round 9 Guidelines)	WHO Region	Global Fund Regional Team	Disease	TRP Recommended' Phase 1 Upper ceiling (2 Years)	TRP Recommended' Lifetime Upper ceiling (Up to 5 years)
20	CCM	Bangladesh	Low	SEARO	SWA	Malaria	$10,280,071	$43,649,545
21	CCM	Belarus	Lower-middle	EURO	EECA	Tuberculosis	$10,127,774	$24,679,591
22	CCM	Bolivia	Lower-middle	AMRO	LAC	HIV	$9,501,866	$26,267,794
23	CCM	Bolivia	Lower-middle	AMRO	LAC	Tuberculosis	$4,379,037	$9,833,163
24	CCM	Burundi	Low	AFRO	EA	Malaria	$21,578,809	$60,448,200
25	CCM	Cambodia	Low	WPRO	EAP	HIV, incl. CCHSS	$63,502,281	$165,087,396
26	CCM	Ecuador	Lower-middle	AMRO	LAC	HIV	$10,813,915	$27,922,499
27	CCM	Ecuador	Lower-middle	AMRO	LAC	Tuberculosis	$6,834,160	$13,736,572
28	CCM	El Salvador	Lower-middle	AMRO	LAC	Tuberculosis	$3,588,887	$7,810,938
29	CCM	Fiji	Lower-middle	WPRO	EAP	HIV, CCHSS only	$1,242,510	$2,075,508
30	CCM	Guatemala	Lower-middle	AMRO	LAC	Malaria	$21,452,001	$42,171,298
31	CCM	Guinea	Low	AFRO	WCA	Tuberculosis	$4,035,589	$10,736,627
32	CCM	Honduras	Lower-middle	AMRO	LAC	HIV	$9,821,491	$21,899,375
33	CCM	India	Low	SEARO	SWA	Tuberculosis	$69,477,410	$199,544,948
34	CCM	Indonesia	Lower-middle	SEARO	EAP	HIV, disease part only	$27,723,275	$87,142,130
35	CCM	Lesotho	Lower-middle	AFRO	SA	HIV	$10,356,112	$30,796,293
36	CCM	Malawi	Low	AFRO	SA	Malaria	$33,170,946	$94,006,593
37	CCM	Mexico	Upper-middle	AMRO	LAC	HIV	$31,008,826	$76,492,174
38	CCM	Mongolia	Low	WPRO	EAP	HIV, CCHSS only	$2,780,049	$4,223,964
39	CCM	Mozambique	Low	AFRO	SA	Malaria	$67,401,102	$157,490,802
40	CCM	Myanmar	Low	SEARO	EAP	Malaria	$37,578,282	$77,384,020
41	CCM	Myanmar	Low	SEARO	EAP	Tuberculosis	$34,024,424	$85,520,947
42	RO	Naz Foundation International	Mixed	MIXED	SWA	HIV	$18,660,775	$47,002,257
43	CCM	Nigeria	Low	AFRO	WCA	HIV	$61,980,496	$341,019,908
44	CCM	Pakistan	Low	EMRO	SWA	Tuberculosis	$40,146,549	$173,045,676
45	RCM	PANCAP-CARICOM	Mixed	AMRO	LAC	HIV	$14,458,896	$34,527,244
46	CCM	Paraguay	Lower-middle	AMRO	LAC	HIV, CCHSS only	$6,463,831	$12,735,212
47	CCM	Paraguay	Lower-middle	AMRO	LAC	Tuberculosis	$2,080,336	$3,974,941
48	CCM	Sierra Leone	Low	AFRO	WCA	HIV, incl. CCHSS	$35,159,372	$86,543,306
49	CCM	South Africa	Upper-middle	AFRO	SA	HIV	$42,577,518	$108,974,360
50	Sub CCM	Sudan South	Low	EMRO	MENA	HIV, CCHSS only	$27,230,100	$52,572,614
51	CCM	Suriname	Lower-middle	AMRO	LAC	Tuberculosis	$3,112,254	$5,765,300
52	CCM	United Republic of Tanzania	Low	AFRO	EA	HIV, CCHSS only	$97,901,945	$176,089,978
53	CCM	The Gambia	Low	AFRO	WCA	Malaria	$10,611,436	$26,346,040
54	CCM	Vietnam	Low	WPRO	EAP	HIV	$27,363,443	$101,950,596
Sub-Total: Category 2 Proposals in USD							**$878,425,768**	**$2,439,467,809**
Total: Category 2 Proposals in USD Equivalent							**$1,341,669,187**	**$3,417,307,684**
Total: Category 1 and 2 Proposals in USD Equivalent							**$1,480,879,950**	**$3,772,734,872**

No.	Applicant type	Applicant	Income level (from Annex 1 in Round 9 Guidelines)	WHO Region	Global Fund Regional Team	Disease	TRP Recommended' Phase 1 Upper ceiling (2 Years)	TRP Recommended' Lifetime Upper ceiling (Up to 5 years)
CATEGORY 2B PROPOSALS								
55	CCM	Bosnia & Herzegovina	Lower-middle	EURO	EECA	Tuberculosis	€7,287,274	€15,007,449
56	CCM	Central African Republic	Low	AFRO	WCA	Tuberculosis	€12,167,295	€29,782,006
57	CCM	Colombia	Lower-middle	AMRO	LAC	HIV	€16,659,253	€42,317,779
58	CCM	Congo (Republic of)	Lower-middle	AFRO	WCA	HIV	€10,773,466	€27,447,268
59	CCM	Djibouti	Lower-middle	EMRO	MENA	Malaria	€2,342,193	€6,591,356
60	CCM	Guinea-Bissau	Low	AFRO	WCA	Tuberculosis	€7,179,501	€14,553,382
61	CCM	Kosovo	Lower-middle	EURO	EECA	Tuberculosis	€2,784,907	€5,821,665
62	CCM	Moldova	Lower-middle	EURO	EECA	Tuberculosis	€5,271,784	€10,099,233
63	CCM	Montenegro	Lower-middle	EURO	EECA	HIV	€2,547,414	€5,164,889
Sub-Total: Category 2B Proposals in EURO							**€ 67,013,087**	**€ 156,785,027**
64	CCM	Angola	Lower-middle	AFRO	SA	Tuberculosis	$11,384,314	$25,766,362
65	CCM	Belize	Upper-middle	AMRO	LAC	HIV, incl. CCHSS	$3,190,410	$6,053,270
66	CCM	China	Lower-middle	WPRO	EAP	Tuberculosis, incl. CCHSS	$76,075,195	$239,655,469
67	RO	COPRECOS	Mixed	AMRO	LAC	HIV	$17,599,678	$58,889,550
68	CCM	Democratic Republic of the Congo	Low	AFRO	EA	Tuberculosis, incl. CCHSS	$110,092,302	$306,794,269
69	CCM	Ethiopia	Low	AFRO	EA	Tuberculosis, CCHSS only	$19,383,242	$38,601,776
70	CCM	Haiti	Low	AMRO	LAC	Tuberculosis	$12,260,870	$27,669,547
71	CCM	India	Low	SEARO	SWA	HIV	$21,000,206	$78,712,640
72	CCM	India	Low	SEARO	SWA	Malaria	$38,105,605	$113,680,179
73	CCM	Iraq	Lower-middle	EMRO	MENA	Tuberculosis	$14,670,783	$28,785,292
74	CCM	Kenya	Low	AFRO	EA	Tuberculosis	$23,682,114	$50,661,608
75	CCM	Kyrgyz Republic	Low	EURO	EECA	Tuberculosis	$7,811,886	$26,273,558
76	CCM	Mozambique	Low	AFRO	SA	HIV, disease part only	$69,377,979	$175,774,009
77	CCM	Nicaragua	Lower-middle	AMRO	LAC	Malaria	$4,299,868	$8,204,092
78	CCM	Nigeria	Low	AFRO	WCA	Tuberculosis	$31,515,160	$113,332,101
79	RO	SADC	Mixed	AFRO	SA	HIV	$24,587,661	$44,982,085
80	CCM	Sri Lanka	Lower-middle	SEARO	SWA	HIV, incl. CCHSS	$19,398,656	$34,901,359
81	CCM	United Republic of Tanzania	Low	AFRO	EA	Malaria	$76,050,523	$173,612,609
82	CCM	The Gambia	Low	AFRO	WCA	Tuberculosis	$8,049,144	$15,626,486
83	CCM	Turkmenistan	Lower-middle	EURO	EECA	Tuberculosis, disease part only	$7,268,169	$19,186,023
84	CCM	Vietnam	Low	WPRO	EAP	Tuberculosis	$19,124,977	$59,392,208
85	CCM	Yemen	Low	EMRO	MENA	Tuberculosis	$11,136,828	$24,769,339
Sub-Total: Category 2B Proposals in USD							**$626,065,570**	**$1,671,323,831**
Total: Category 2B Proposals in USD Equivalent							**$723,468,313**	**$1,899,209,045**
Total: Category 1, 2, and 2B Proposals Recommended for Funding in USD Equivalent							**$2,204,348,262**	**$5,671,943,917**

No.	Applicant type	Applicant	Income classification	WHO Region	Global Fund Regional Team	Disease	Requested Phase 1 Upper ceiling (2 Years)	Requested Lifetime Upper ceiling (Up to 5 years)
PARTS OF CATEGORY 1, 2 OR 2B PROPOSALS NOT RECOMMENDED FOR FUNDING								
Ref. 15	CCM	Cote d'Ivoire	Low	AFRO	WCA	HIV, CCHSS part	€ 43,810,725	€ 97,590,298
Ref. 19	CCM	Togo	Low	AFRO	WCA	Malaria, CCHSS part	€ 2,424,256	€ 5,369,974
Sub-Total: Parts of Category 1, 2 or 2B Proposals not recommended for funding in EURO							**€ 46,234,981**	**€ 102,960,272**
Ref. 69	CCM	Ethiopia	Low	AFRO	EA	Tuberculosis part	$35,441,974	$99,748,261
Ref. 29	CCM	Fiji	Lower-middle	WPRO	EAP	HIV part	$4,567,641	$11,032,725
Ref. 34	CCM	Indonesia	Lower-middle	SEARO	EAP	HIV, CCHSS part	$16,211,864	$34,683,394
Ref. 38	CCM	Mongolia	Low	WPRO	EAP	HIV part	$2,117,412	$5,236,283
Ref. 76	CCM	Mozambique	Low	AFRO	SA	HIV, CCHSS part	$32,700,132	$87,121,662
Ref. 46	CCM	Paraguay	Lower-middle	AMRO	LAC	HIV part	$6,924,331	$16,738,249
Ref. 50	Sub CCM	Sudan South	Low	EMRO	MENA	HIV part	$59,977,815	$143,281,740
Ref. 52	CCM	United Republic of Tanzania	Low	AFRO	EA	HIV part	$141,703,169	$299,064,874
Ref. 83	CCM	Turkmenistan	Lower-middle	EURO	EECA	Tuberculosis, CCHSS part	$181,777	$289,542
Sub-Total: Parts of Category 1, 2 or 2B Proposals not recommended for funding in USD							**$299,826,115**	**$697,196,730**
Total: Parts of Category 1, 2 or 2B Proposals not recommended for funding in USD Equivalent							**$367,028,122**	**$846,848,288**
CATEGORY 3 PROPOSALS								
86	RO	AfriCASO	Mixed	AFRO	WCA	HIV	€ 5,894,744	€ 13,672,440
87	CCM	Brazil	Lower-middle	AMRO	LAC	Tuberculosis	€ 26,499,742	€ 57,157,477
88	CCM	Brazil	Lower-middle	AMRO	LAC	HIV	€ 13,097,142	€ 30,940,720
89	CCM	Burkina Faso	Low	AFRO	WCA	HIV, incl. CCHSS	€ 49,925,705	€ 160,561,226
90	CCM	Cameroon	Lower-middle	AFRO	WCA	HIV	€ 41,336,332	€ 121,255,912
91	CCM	Chad	Low	AFRO	MENA	HIV, incl. CCHSS	€ 36,087,457	€ 57,040,882
92	CCM	Chad	Low	AFRO	MENA	Tuberculosis	€ 4,409,888	€ 8,658,158
93	CCM	Colombia	Lower-middle	AMRO	LAC	Tuberculosis	€ 6,981,414	€ 13,155,213
94	CCM	Djibouti	Lower-middle	EMRO	MENA	HIV	€ 4,609,238	€ 15,739,214
95	CCM	Djibouti	Lower-middle	EMRO	MENA	Tuberculosis	€ 1,847,708	€ 5,069,930
96	CCM	Georgia	Lower-middle	EURO	EECA	Tuberculosis	€ 6,334,105	€ 15,198,017
97	CCM	Macedonia, FYR	Lower-middle	EURO	EECA	Tuberculosis	€ 2,406,848	€ 4,846,058
98	CCM	Malaysia	Upper-middle	WPRO	EAP	HIV	€ 16,914,686	€ 55,470,594
99	CCM	Mali	Low	AFRO	MENA	Malaria	€ 78,261,962	€ 174,578,758
100	CCM	Moldova	Lower-middle	EURO	EECA	HIV	€ 6,632,255	€ 6,632,255
101	CCM	Montenegro	Lower-middle	EURO	EECA	Tuberculosis	€ 1,079,081	€ 1,825,708
102	CCM	Niger	Low	AFRO	MENA	HIV	€ 12,273,273	€ 35,668,229
103	CCM	Niger	Low	AFRO	MENA	Malaria	€ 14,774,509	€ 60,296,247
104	CCM	Niger	Low	AFRO	MENA	Tuberculosis, incl. CCHSS	€ 28,683,728	€ 51,445,595
105	CCM	Peru	Lower-middle	AMRO	LAC	Malaria	€ 12,287,854	€ 23,978,876
106	CCM	Senegal	Low	AFRO	WCA	Malaria	€ 13,463,444	€ 43,391,628
107	CCM	Senegal	Low	AFRO	WCA	Tuberculosis	€ 5,439,361	€ 15,223,424
108	CCM	Togo	Low	AFRO	WCA	HIV	€ 19,855,192	€ 54,839,797
Sub-Total: Category 3 Proposals in EURO							**€ 409,095,668**	**€ 1,026,646,358**

No.	Applicant type	Applicant	Income classification	WHO Region	Global Fund Regional Team	Disease	Requested Phase 1 Upper ceiling (2 Years)	Requested Lifetime Upper ceiling (Up to 5 years)
109	CCM	Afghanistan	Low	EMRO	SWA	HIV, incl. CCHSS	$17,157,661	$48,857,724
110	CCM	Albania	Lower-middle	EURO	EECA	HIV	$8,097,017	$13,275,254
111	CCM	Albania	Lower-middle	EURO	EECA	Tuberculosis	$2,482,523	$5,226,962
112	CCM	Angola	Lower-middle	AFRO	SA	HIV	$37,442,140	$138,112,093
113	CCM	Bhutan	Low	SEARO	SWA	HIV	$1,277,902	$3,429,344
114	CCM	Botswana	Upper-middle	AFRO	SA	HIV	$22,137,763	$75,677,032
115	RCM	CCLab	Mixed	AMRO	LAC	HIV	$11,123,412	$18,721,697
116	CCM	Dominican Republic	Lower-middle	AMRO	LAC	HIV	$16,796,759	$49,481,694
117	CCM	Democratic Republic of the Congo	Low	AFRO	EA	HIV	$42,987,274	$94,181,440
118	CCM	Democratic Republic of the Congo	Low	AFRO	EA	Malaria	$117,708,841	$280,495,135
119	CCM	Ethiopia	Low	AFRO	EA	HIV	$38,910,498	$87,776,761
120	CCM	Ghana	Low	AFRO	WCA	Tuberculosis, incl. CCHSS	$35,221,971	$78,630,160
121	CCM	Guinea	Low	AFRO	WCA	Malaria	$41,713,830	$136,406,368
122	CCM	Guinea	Low	AFRO	WCA	HIV, incl. CCHSS	$47,536,996	$133,700,829
123	CCM	Honduras	Lower-middle	AMRO	LAC	Tuberculosis	$4,644,621	$7,973,129
124	CCM	Kenya	Low	AFRO	EA	Malaria	$173,151,886	$270,264,819
125	CCM	Liberia	Low	AFRO	WCA	Tuberculosis	$24,337,864	$54,637,458
126	CCM	Malawi	Low	AFRO	SA	Tuberculosis, incl. CCHSS	$16,586,861	$34,091,794
127	RO	MENAHRA	Mixed	EMRO	MENA	HIV	$15,196,689	$32,966,023
128	CCM	Nepal	Low	SEARO	SWA	HIV	$10,250,156	$33,295,636
129	CCM	Pakistan	Low	EMRO	SWA	HIV, incl. CCHSS	$34,771,776	$101,928,849
130	CCM	Pakistan	Low	EMRO	SWA	Malaria	$22,058,072	$38,444,514
131	CCM	Panama	Upper-middle	AMRO	LAC	HIV, incl. CCHSS	$8,681,679	$19,791,821
132	CCM	Papua New Guinea	Low	WPRO	EAP	HIV, incl. CCHSS	$37,755,778	$108,875,287
133	RO	RedTraSex	Mixed	AMRO	LAC	HIV	$7,580,751	$18,140,937
134	CCM	São Tomé and Príncipe	Low	AFRO	WCA	HIV	$3,388,782	$5,893,968
135	CCM	Sierra Leone	Low	AFRO	WCA	Malaria	$46,897,411	$121,926,865
136	CCM	Solomon Islands	Low	WPRO	EAP	HIV	$6,896,921	$17,219,358
137	CCM	Sudan South	Low	EMRO	MENA	Malaria	$47,848,374	$130,852,071
138	CCM	Suriname	Lower-middle	AMRO	LAC	HIV	$13,973,874	$30,918,273
139	CCM	United Republic of Tanzania	Low	AFRO	EA	Tuberculosis	$44,045,185	$99,426,802
140	CCM	Thailand	Lower-middle	SEARO	EAP	HIV	$22,903,685	$68,935,356
141	CCM	Thailand	Lower-middle	SEARO	EAP	Malaria	$32,327,332	$75,648,892
142	CCM	Uganda	Low	AFRO	EA	HIV	$200,824,716	$411,140,514
143	CCM	Uganda	Low	AFRO	EA	Malaria, incl. CCHSS	$135,054,987	$376,353,583
144	CCM	Uganda	Low	AFRO	EA	Tuberculosis	$20,327,175	$32,684,978
145	CCM	Ukraine	Lower-middle	EURO	EECA	Tuberculosis	$34,584,205	$103,459,618
146	CCM	Uruguay	Upper-middle	AMRO	LAC	HIV	$7,679,330	$24,664,893
147	CCM	Yemen	Low	EMRO	MENA	HIV	$10,943,780	$25,246,321
148	CCM	Zambia	Low	AFRO	SA	HIV	$26,111,595	$142,597,930
149	CCM	Zambia	Low	AFRO	SA	Malaria	$21,843,651	$54,966,386
Sub-Total: Category 3 Proposals in USD							**$1,471,261,723**	**$3,606,318,568**
Total: Category 3 Proposals in USD Equivalent							**$2,065,877,520**	**$5,098,537,112**

No.	Applicant type	Applicant	Income classification	WHO Region	Global Fund Regional Team	Disease	Requested Phase 1 Upper ceiling (2 Years)	Requested Lifetime Upper ceiling (Up to 5 years)
CATEGORY 4 PROPOSALS								
150	RCM	Andean Regional Coordinating Mechanism	Lower-middle	AMRO	LAC	HIV	€19,820,520	€40,189,363
151	CCM	Democratic People's Republic of Korea	Low	SEARO	EAP	HIV	€3,621,666	€10,260,105
152	CCM	Russian Federation	Upper-middle	EURO	EECA	Tuberculosis	€39,148,932	€139,266,200
153	Sub CCM	Russian Federation	Upper-middle	EURO	EECA	Tuberculosis	€25,586,216	€46,500,983
154	CCM	Togo	Low	AFRO	WCA	Tuberculosis	€1,904,955	€1,904,955
Sub-Total: Category 4 Proposals in EURO							**€ 90,082,289**	**€ 238,121,606**
155	CCM	Syria	Lower-middle	EMRO	MENA	HIV, incl. CCHSS	$12,748,562	$25,664,260
156	CCM	Syria	Lower-middle	EMRO	MENA	Tuberculosis	$4,632,686	$9,343,366
157	RO	Mano River Union	Low	AFRO	WCA	HIV	$21,688,571	$36,300,171
158	RO	REDCARD	Mixed	AMRO	LAC	HIV	$8,667,612	$31,042,376
159	RO	SADC	Mixed	AFRO	SA	Malaria	$8,183,343	$12,571,057
Sub-Total: Category 4 Proposals in USD							**$55,920,774**	**$114,921,230**
Total: Category 4 Proposals in USD Equivalent							**$186,854,334**	**$461,028,215**
Total: Proposals Not Recommended for Funding in USD Equivalent **							**$2,619,759,975**	**$6,406,413,615**

*** TRP Recommended upper ceilings correspond to the maximum amount being recommended to the Board. In four instances, the TRP Recommended upper ceilings are less than the funding amount requested by the applicant because the TRP is recommending the removal of certain elements from the proposal (Kenya TB, Senegal HIV, Serbia TB and Vietnam HIV). In one instance the funding ceiling has been adjusted to take into account already existing funds in the case of a consolidated proposal (China TB).**

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

*** Proposals in EURO - the UN official exchange rate effective at 1 October 2009 - 1 USD = 0.688 EURO

Key for multi-country proposals

1 -	RO	Naz Foundation Int. - Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan, Sri Lanka
2 -	RCM	PANCAP-CARICOM - Haiti, Dominican Republic, Guyana, Jamaica, Suriname, Belize, Dominica, Grenada, St. Lucia, St Vincent and the Grenadines, Dominica, Antigua and Barbuda, Bahamas, Barbados, Montserrat, St. Kitts and Nevis, Trinidad and Tobago
3 -	RO	COPRECOS LAC - Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, Panama, Paraguay, Peru, Uruguay, Venezuela
4 -	RO	SADC (for HIV/AIDS proposal) - Angola, Botswana, Congo (Democratic Republic), Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland , United Republic of Tanzania, Zambia, Zimbabwe
5 -	RO	SADC (for Malaria proposal) - Angola, Botswana , Namibia, Zambia, Zimbabwe
6 -	RO	AfriCASO - Benin, Cameroon, Central African Republic, Gabon, Gambia, Liberia
7 -	RCM	CCLAB - Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica, Panama
8 -	RO	MENAHRA - Afghanistan, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, West Bank and Gaza, Pakistan, Syrian Arab Republic, Tunisia
9 -	RO	RedTraSex - Argentina, Bolivia, Brazil, Chile, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay
10-	RCM	Andean Regional Coordinating Mechanism - Chile, Peru, Colombia, Bolivia, Ecuador, Venezuela
11-	RO	Mano River Union (MRU) - Côte d'Ivoire, Guinea, Liberia, Sierra Leone
12-	RO	REDCARD - Costa Rica, Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, Panama

Global Fund Regional Teams

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

Annex 5

GF/B20/9

ANALYSIS OF THE TRP`S ROUND 9 FUNDING RECOMMENDATIONS

PART 1: INTRODUCTION

1.1 This annex of the report provides additional analysis of the overall recommendations of the Technical Review Panel in Round 9. This includes:

- an overview of Round 9 outcomes (part 2);
- a comparison of Round 9 with prior Rounds (part 3);
- an analysis by WHO regional classification (part 4);
- an analysis of budgeted expenditure for Phase 1 by cost category (part 5); and
- additional data on health systems strengthening cross-cutting requests (part 6).

1.2 **Table 1** provides a summary of the number of proposals and parts (disease parts and HSS requests) reviewed and recommended by the TRP. In Round 9, the TRP reviewed 159 disease proposals. Of these, 34 proposals included a cross-cutting HSS request. On the whole, the TRP therefore reviewed 193 parts (159 disease parts and 34 distinct HSS requests).

1.3 In Round 9, as in Round 8, requests for health systems strengthening support could be made by integration within a disease part of the proposal or, in the case of cross-cutting health systems strengthening, by either integrating within a disease part or by submitting a distinct health systems strengthening part that is attached to a disease proposal ('HSS request' in section 4B/5B).

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

1.5 The TRP recommended for funding 85 proposals made up of 96 parts. Among the 85 proposals, 68 proposals are recommended for a disease part only, 11 for both a disease part and a HSS request, and 6 for the cross-cutting HSS request only.

1.6 Most of the analyses presented in this annex refer to proposals including the disease part and the HSS request (when applicable). In other cases, it is specified that the analyses focus on either the disease part or on the HSS request.

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

	Number reviewed	Number recommended for funding	Success rate
Proposals	159	85	53%
Parts (disease parts and HSS requests)	193	96	50%
Disease parts	159	79	50%
Distinct HSS cross-cutting requests or 'HSS requests' (s. 4B/5B)	34	17	50%

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

1.8 The comparative analysis across the Rounds does not include final outcomes (i.e. successful outcome of an appeal), but rather TRP recommendations to the Board following the review meeting.[2]

1.9 The information below on Round 9 should be analyzed bearing in mind that some countries were invited to apply through the National Strategy Applications First Learning Wave (NSA) and Rolling Continuation Channel (RCC) funding channels in parallel with Round 9. The comparison across Rounds is purely based on Rounds 1 to 9 and does not feature recommended funding through several waves of the Rolling Continuation Channel.

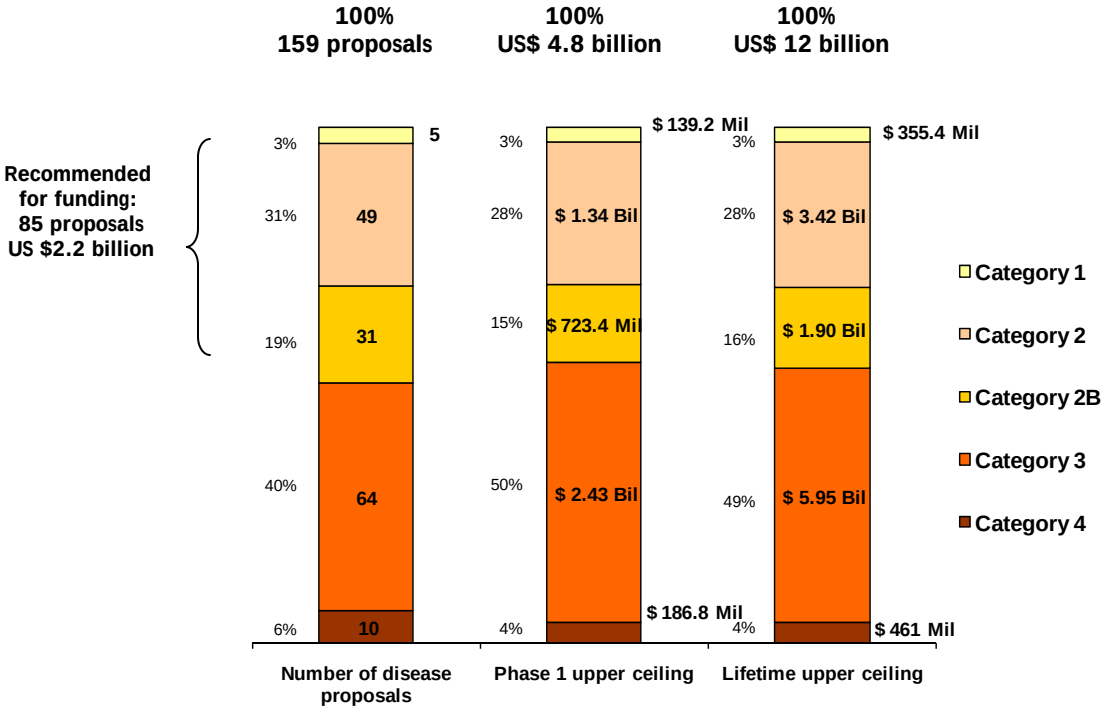
[1] This report uses the 1 October 2009 United Nations official exchange rate for the conversion of Euro funding requests in United States dollars. http://www.un.org/Depts/treasury/

[2] If applications were reclassified following a successful appeal (i.e. 16 successful appeals) or if for any reason a grant was not signed (i.e. 6 instances), this will not be reflected in the analysis.

PART 2: OVERVIEW OF ROUND 9 OUTCOMES

2.1 Round 9 is the second largest Round both in terms of the number of proposals and the amount of funding being recommended by the TRP. In total, 85 proposals are recommended for funding by the TRP with a Phase 1 upper ceiling budget of US$ 2.2 billion (in Round 8 this amount was US $ 3.1 billion prior to efficiency reductions). **Figure 1** below shows the distribution of proposals by TRP recommendation category[3] and provides the breakdown by recommendation category of the two-year and five-year upper funding ceilings.

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

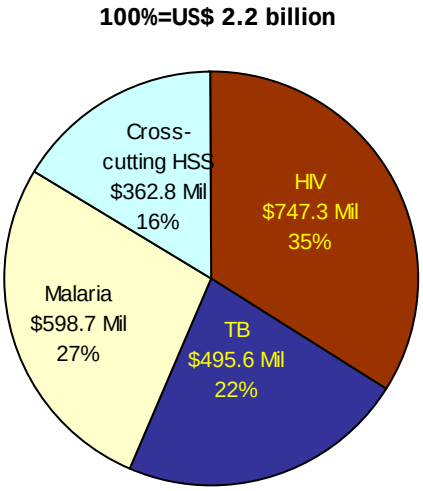


Analysis by disease component

2.2 **Figure 2** illustrates the distribution of recommended demand of US $2.2 billion across the three diseases and cross cutting health systems strengthening requests. The most notable feature, relative to Round 8, is the significantly lower recommended funding for malaria (US $ 0.6 billion in Round 9 versus US $ 1.5 billion in Round 8). This is a consequence of lower demand and lower success rate in Round 9, and may be linked to the high funding success achieved by malaria proposals in Round 8 especially by some of the countries with significant demand.

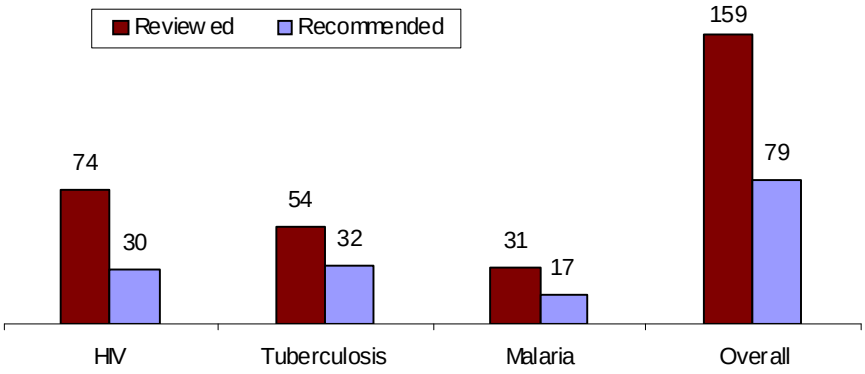
[3] Category 1 - Recommended for funding with no or only minor clarifications
Category 2 - Recommended for funding provided that adjustments and clarifications are met within a limited timeframe. This also includes the subset of recommended 'Category 2' proposals which have been classified as 'Category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

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



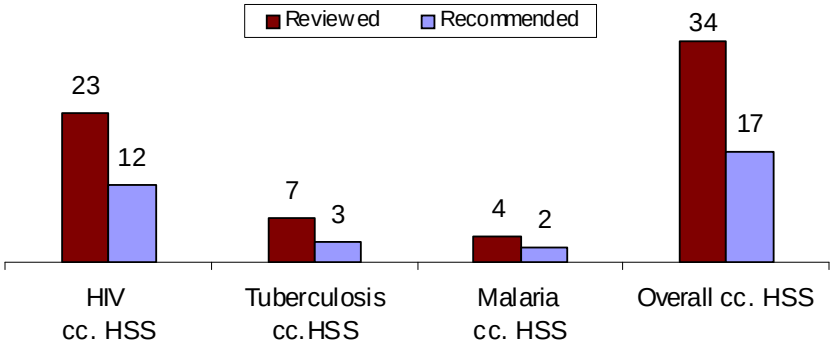
2.3 **Figure 3** illustrates the number and proportion of disease parts recommended for funding in Round 9 (excluding HSS requests) per disease and overall. **Figure 4** provides a similar analysis for the distinct HSS requests, indicating the disease proposal they are attached to. In each case the Round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

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



Round 9 Success rate	**41%**	**59%**	**55%**	**50%**
Round 8 Success rate	**40%**	**49%**	**68%**	**49%**

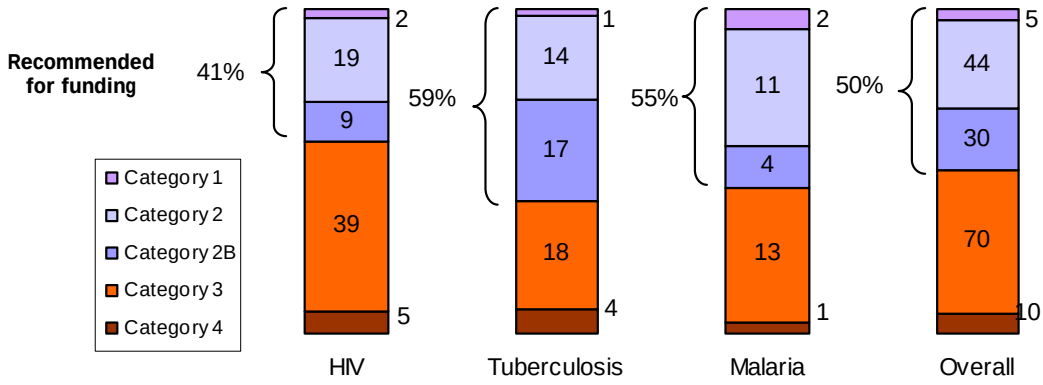
Figure 4 – Number of HSS cross-cutting requests recommended for funding (attributed to the host disease proposal)



Round 9 Success rate	**52%**	**43%**	**50%**	**50%**
Round 8 success rate	**56%**	**50%**	**50%**	**53%**

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

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

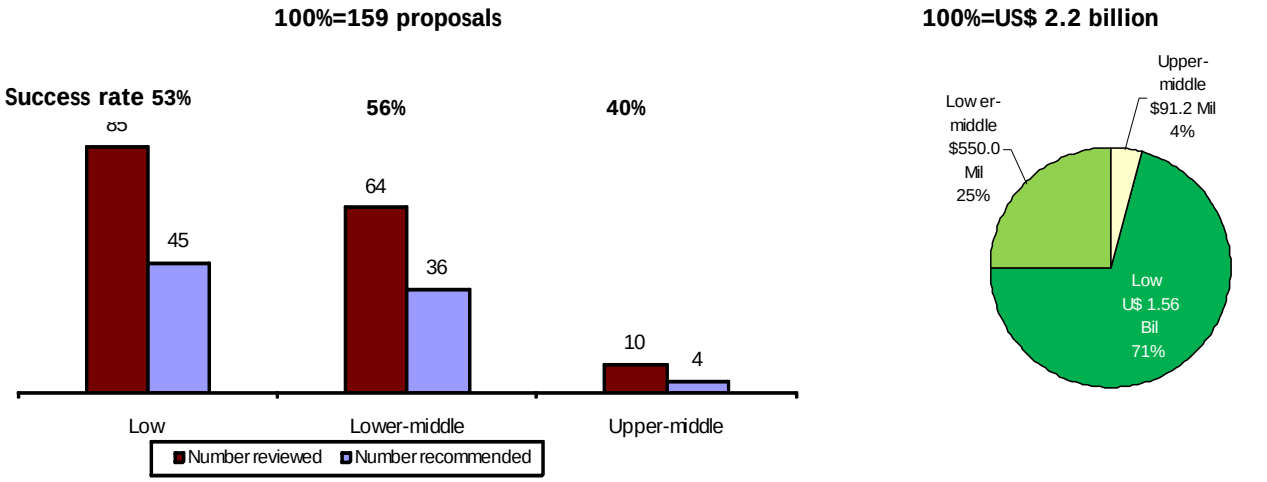


Analysis by income level classification[4]

2.5 **Figure 6** shows the number and proportion of proposals recommended for funding according to the applicant's income level, and the corresponding two-year upper ceiling recommended for funding. Of the total two-year upper ceiling budget recommended for funding by the TRP 71 percent is for low income countries.

[4] The income level classification used by the Global Fund can be found in annex 1 to the Round 9 guidelines. For Round 9, it is based on the World Bank's income level classification at 1 March 2008. Countries moving up from the 'low-income' to the 'lower-middle income' category or from the 'lower-middle income' to the 'upper-middle income' category benefit from a "one year grace period" according to which they are classified by the Global Fund based on their earlier World Bank income level classification. For regional proposals the income level was attributed based on the income level for the majority of the countries targeted in that proposal.

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



2.6 Round 9 sees a shift in funding from Low income to Lower- and Upper-middle income countries. By comparison, in Round 8, 79 percent of recommended funding was for low income countries, 20 percent for lower-middle income countries and less than 1 percent for upper-middle income countries.

2.7 Recommended funding for countries classified as upper-middle income, despite the increase from Round 8, accounts for a minor part of recommended funding (4 percent) and is within the limits set by the Board (10 percent of funding).[5]

Round 9 re-submissions

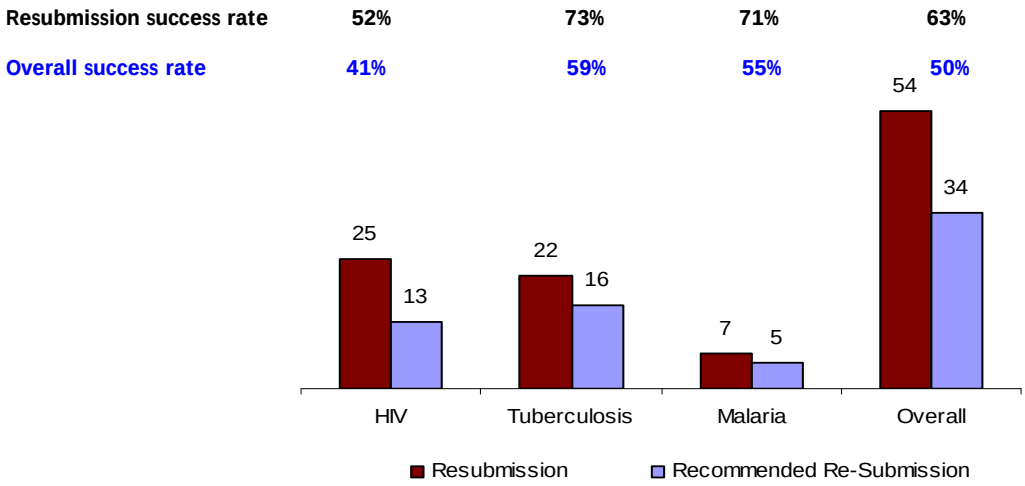
2.8 In Round 9, the Board encouraged applicants to re-submit a revised version of Round 8 proposals that were not recommended for funding and classified as 'Category 3' by using the same proposal form.

2.9 In total 54 proposals were re-submitted in Round 9 (76 percent of the 71 possible re-submissions).

2.10 **Figure 7** shows that the success rate of re-submissions is higher than the average success rates achieved across all disease parts[6].

[5] Global Fund funding for programs that will be implemented in upper-middle income countries will be limited to 10 percent according to Board decision GF/B16/DP18 .
[6] This does not include distinct cross-cutting HSS requests.

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



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

2.11 If their Round 9 proposal is approved by the Board as recommended by the TRP, Mexico and Turkmenistan would receive funding from the Global Fund for the first time (for HIV/AIDS and tuberculosis respectively). In addition, two other applicants will receive funding for a specific disease for the first time: they are Fiji for HIV/AIDS and Suriname for tuberculosis. Three regional applicants would also receive funding from the Global Fund for the first time[7].

Applicants who have not been recommended for funding in several consecutive Rounds

2.12 Some applicants have repeatedly applied for the same disease and have not been recommended for funding over at least three consecutive Rounds (three Rounds, n=6; four Rounds, n=2, five Rounds, n=2, and seven Rounds, n=1). The majority of these cases concern HIV and tuberculosis proposals; one case concerns malaria. A small number of these countries have a high disease burden, and the repeated presentation of technically weak proposals is therefore of concern.

2.13 It is also of concern to note that several countries failed to be recommended for funding for either all three diseases (n=2) or two diseases (n=14).

[7] COPRECOS, Naz Foundation International, and SADC

PART 3: COMPARISON OF ROUND 9 WITH PRIOR ROUNDS

3.1 **Figure 8** shows the proportion of proposals recommended for funding by the TRP across Rounds 1 to 9. This shows that the success rate achieved in Round 9 is comparable to that in Round 8. **Figure 9** shows the proportion of 5 year upper ceiling budgets for proposals recommended by the TRP across Rounds 1 to 9. Note however that initial commitments are only made for the first two years of recommended proposals.

Figure 8 – Proportion of proposals recommended for funding by the TRP across Rounds 1 to 9

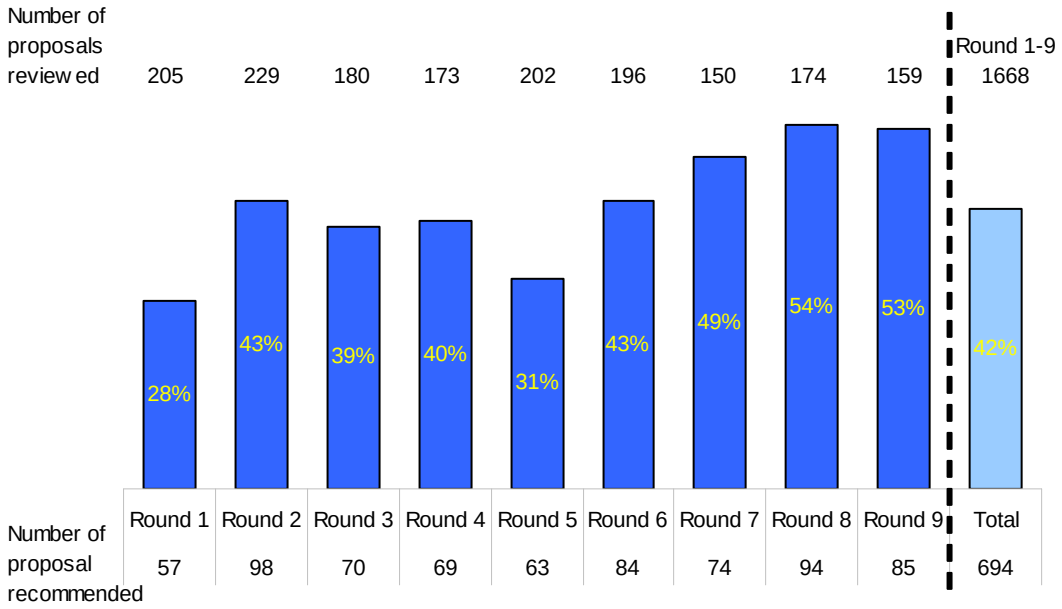
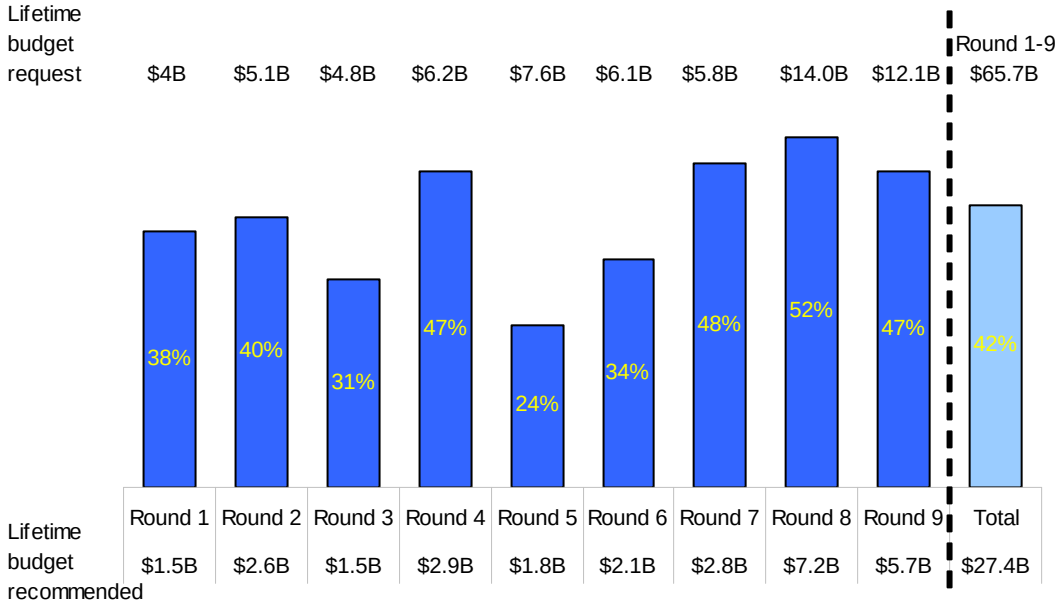
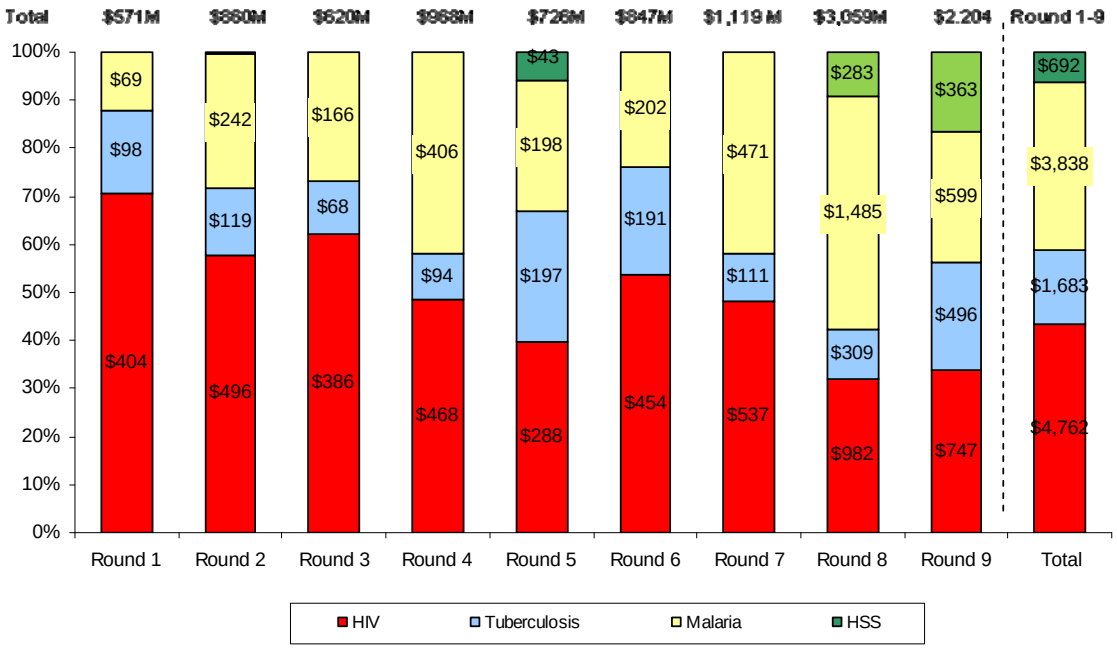


Figure 9 – Proportion of 5 year upper ceiling budgets for proposals recommended by the TRP across Rounds 1 to 9



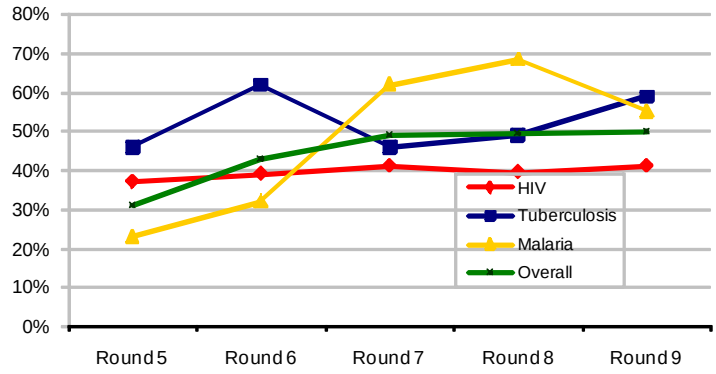
3.2 **Figure 10** illustrates the proportion of total Phase 1 upper ceiling budgets recommended by the TRP across Rounds 1 to 9 linked to HIV, tuberculosis and malaria disease parts and HSS requests[8].

Figure 10 – Distribution of Phase 1 upper ceiling budgets by disease and HSS across Rounds 1 to 9 (in million US$)



3.3 The success rates for each disease in recent Rounds are shown in **figure 11**. This graph shows that the success rates for HIV disease parts remain steady and consistently lower than the success rates achieved by tuberculosis and malaria. There is an upward trend in success rates for tuberculosis disease parts since Round 7. The success rate for malaria disease parts in Round 9 has decreased from the very successful outcomes achieved in Round 8.

Figure 11– Success rates by disease from Rounds 5 to 9

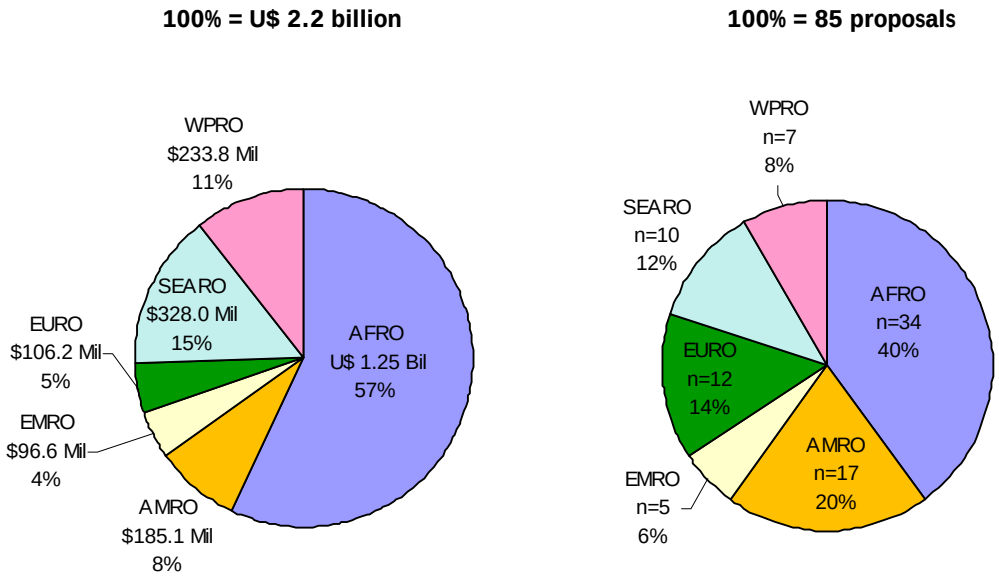


[8] There was a separate HSS funding window in Round 5 only. In Rounds 8 and 9, applicants could apply for distinct cross-cutting HSS interventions (s.4B) as part of the disease proposal. In both Rounds, the TRP could recommend for funding either the whole proposal or only the disease part or the distinct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

PART 4: ANALYSIS BY WHO REGION

4.1 **Figure 12** shows the proportion of proposals recommended for funding and of the overall Phase 1 upper ceiling budgets by **WHO region**.

Figure 12 – Proportion of recommended proposals and Phase 1 upper ceiling budget by WHO region



4.2 As in prior Rounds, the largest proportion of recommended proposals (40 percent) and related funding (57 percent) is directed to the **WHO AFRO region**. However, these proportions have decreased compared to recent Rounds (46 percent and 72 percent respectively in Round 8 and 43 percent and 66 percent in Round 7).

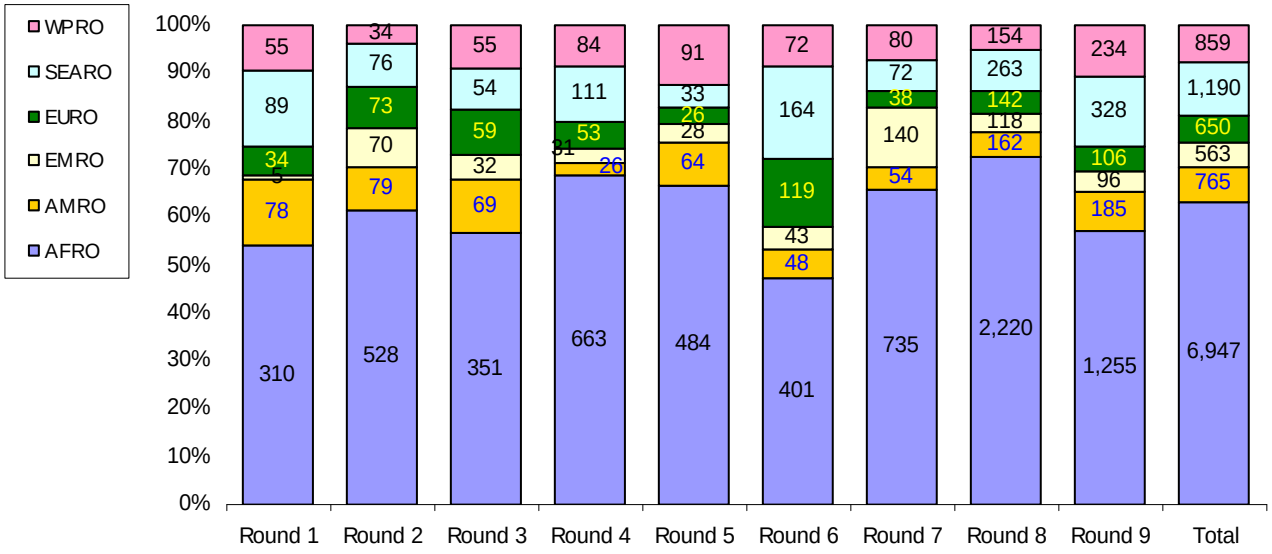
4.3 Success rates vary between WHO regions and across rounds as shown in **table 2.** The success rates of proposals coming from the AMRO, SEARO and WPRO regions improved in Round 9. The success rate for the WPRO region is relatively constant across recent Rounds. Proposals from the AFRO, EMRO and EURO regions were less successful in Round 9 than in previous Round(s).

Table 2 – Success rate of disease proposals by WHO regions

Round	AFRO	AMRO	EMRO	EURO	SEARO	WPRO
Round 5	30%	38%	15%	43%	16%	59%
Round 6	38%	24%	28%	65%	52%	77%
Round 7	51%	45%	59%	36%	35%	59%
Round 8	60%	34%	57%	67%	53%	59%
Round 9	50%	57%	33%	57%	67%	70%

4.4 **Figure 13** illustrates the breakdown by region of the total Phase 1 upper ceiling budget for TRP-recommended proposals across Rounds. Although AFRO benefits from the largest proportion of the recommended funding, this proportion is less than in Rounds 7 and 8. The regions of WPRO, SEARO and AMRO all show an increased proportionate share of recommended funding in Round 9.

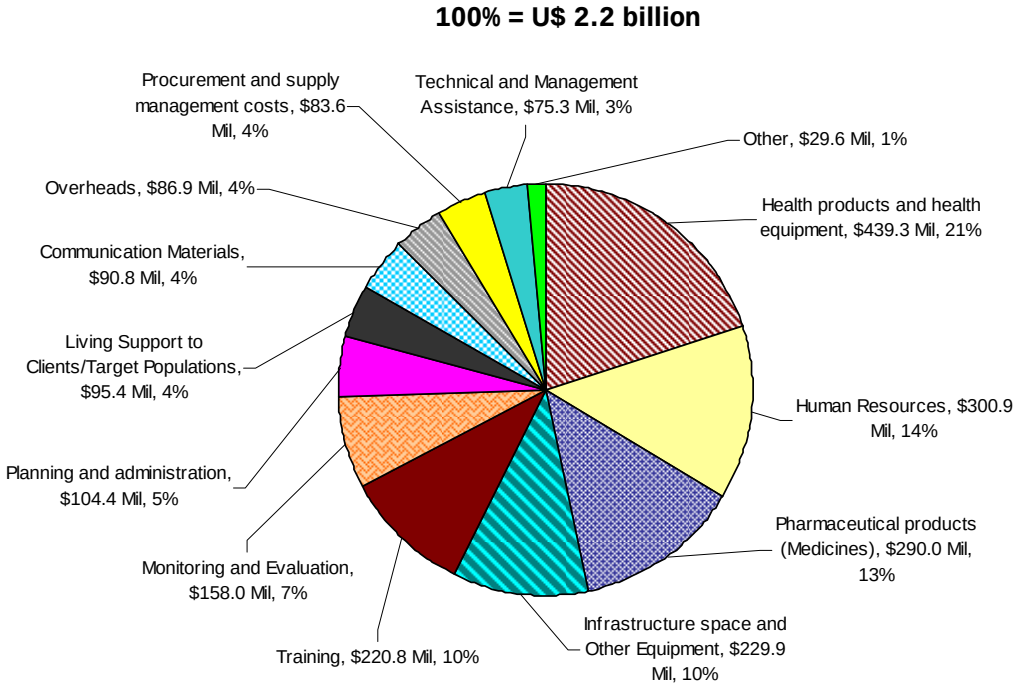
Figure 13 - Distribution of the Phase 1 upper ceiling budget for proposals recommended by the TRP by WHO region (million US$)



PART 5: BUDGETED EXPENDITURE FOR PHASE 1

5.1 **Figure 14** shows the planned expenditure by cost category over the initial two years of funding for the 85 proposals recommended for funding.

Figure 14 – Distribution by cost category of the Phase 1 upper ceiling budget for recommended proposals including cross-cutting HSS requests (US$)



5.2 In Round 9 compared to Round 8, there was a substantial decrease in the funding requested for 'health products and health equipment': in Round 9, this cost category represented 21 percent of the total Phase 1 upper ceiling budget (US$ 439 million) compared to 36 percent in Round 8 (US$ 1.1 billion).

5.3 The distribution of budgets across cost categories by disease is summarized in **table 3**. This table includes data on disease parts only (excluding cross-cutting HSS requests). This allows a comparison across diseases on items such as the proportion of the total budget allocated to the procurement of health products.

Table 3 – Distribution of Phase 1 upper ceiling budgets by cost category and disease (cross-cutting HSS requests excluded)

Cost Category	HIV		Tuberculosis		Malaria		Total Upper ceiling Phase 1 (Disease only)
	Phase 1 upper ceiling (US$ equiv)	% of Total Phase 1 Upper ceiling	Phase 1 upper ceiling (US$ equiv)	% of Total Phase 1 Upper ceiling	Phase 1 upper ceiling (US$ equiv)	% of Total Phase 1 Upper ceiling	
Communication Materials	$33.1 Mil	4%	$13.7 Mil	3%	$35.7 Mil	6%	$82.5 Mil
Health products and health equipment	$84.9 Mil	11%	$48.9 Mil	10%	$278.7 Mil	47%	$412.5 Mil
Human Resources	$104.3 Mil	14%	$54.1 Mil	11%	$39.6 Mil	7%	$198.0 Mil
Infrastructure space and Other Equipment	$50.3 Mil	7%	$62.9 Mil	13%	$20.9 Mil	4%	$134.2 Mil
Living Support to Clients/Target Populations	$67.2 Mil	9%	$20.5 Mil	4%	$2.2 Mil	0%	$89.9 Mil
M&E	$59.7 Mil	8%	$47.6 Mil	9%	$36.0 Mil	6%	$143.2 Mil
Other	$15.8 Mil	2%	$8.1 Mil	2%	$2.0 Mil	0%	$25.9 Mil
Overheads	$34.4 Mil	5%	$23.0 Mil	5%	$13.3 Mil	2%	$70.8 Mil
Pharmaceutical products (Medicines)	$114.4 Mil	15%	$112.6 Mil	22%	$56.4 Mil	9%	$283.4 Mil
Planning and administration	$48.2 Mil	6%	$19.4 Mil	4%	$26.9 Mil	5%	$94.5 Mil
Procurement and supply management costs	$14.3 Mil	2%	$18.8 Mil	4%	$33.3 Mil	6%	$66.4 Mil
Technical and Management Assistance	$37.7 Mil	5%	$17.0 Mil	3%	$5.2 Mil	1%	$59.9 Mil
Training	$83.3 Mil	11%	$49.1 Mil	10%	$48.6 Mil	8%	$181.0 Mil
Total	**$745.2 Mil**	**100%**	**$502.6 Mil**	**100%**	**$596.5 Mil**	**100%**	**U$ 1.84 Bil**

PART 6: HEALTH SYSTEMS STRENGTHENING

6.1 In Round 9 as in Round 8, applicants had the possibility to apply for health systems strengthening support either within a specific disease component or as a distinct cross-cutting section within a disease component (section 4B/5B).

6.2 Applicants were encouraged to integrate their responses to health system weaknesses and gaps within the relevant disease component(s) wherever possible. All responses to health systems weaknesses that are specific to only one disease had to be included in the implementation strategy for that disease only. Furthermore, inclusion in a disease part was encouraged for cross-cutting responses. However, in cases when cross-cutting responses could not be easily included within disease program strategies, applicants could request funding for the necessary HSS cross-cutting interventions through a distinct and complementary section (section 4B/5B). The following analysis

refers to HSS cross-cutting requests only, which represent only a part of all requests for HSS support presented by applicants. The breakdown of planned expenditure in Table 3 provides some indication of funding that has been requested, other than through the HSS cross-cutting requests, which contributes to the strengthening of health systems.

6.3 **Table 4** summarises requested and recommended funding for HSS cross cutting parts with the Round 8 comparison.

Table 4 – Requested and recommended Phase 1 upper ceilings in Rounds 8 and 9

Round	Requested Phase 1 upper ceiling (million US$)	Recommended Phase 1 upper ceiling (million US$)	Percentage of Phase 1 upper ceiling recommended for funding	Success rate of HSS requests
Round 8	603	283	47%	53%
Round 9	672	363	54%	50%

6.4 The distribution of HSS cross-cutting requests by disease component and WHO region for Round 9 is shown in **table 5**. In Round 9, 31 percent of HIV components include an HSS cross-cutting request, when only 13 percent of TB and malaria components respectively do so. In addition, there are more HIV components than TB or malaria components in Round 9. This accounts for the fact that 68 percent of applicants attached their HSS cross-cutting request to the HIV component in Round 9. In round 8, 56 percent of applicants did so.

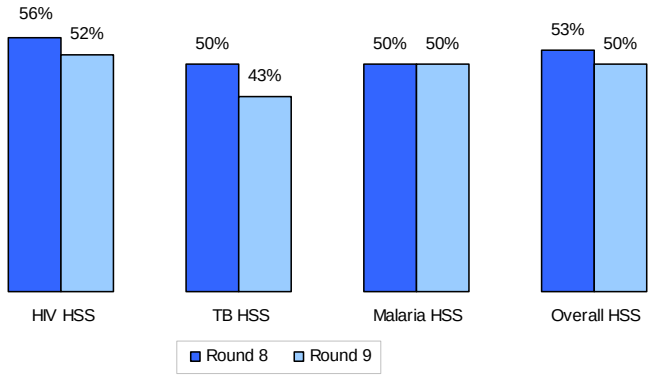
6.5 In both Rounds, more than 50 percent of HSS requests emanated from the WHO AFRO region (56 and 53 percent respectively in Round 9 and Round 8) (**table 5**).

Table 5. HSS cross-cutting requests by disease components and WHO region

WHO Region	HSS attached to HIV	HSS attached to TB	HSS attached to Malaria	TOTAL	Percentage HSS from each region
AFRO	10	5	4	19	56%
AMRO	3	0	0	3	9%
EMRO	4	0	0	4	12%
EURO	0	1	0	1	3%
SEARO	2	0	0	2	6%
WPRO	4	1	0	5	15%
Total	23	7	4	34	100%
Total number of disease components	74	54	31	159	
% disease component including an HSS request	31%	13%	13%	21%	
Recommended funding amounts by host disease (US$)	232.0 m	119.5 m	10.8 m	362.3 m	

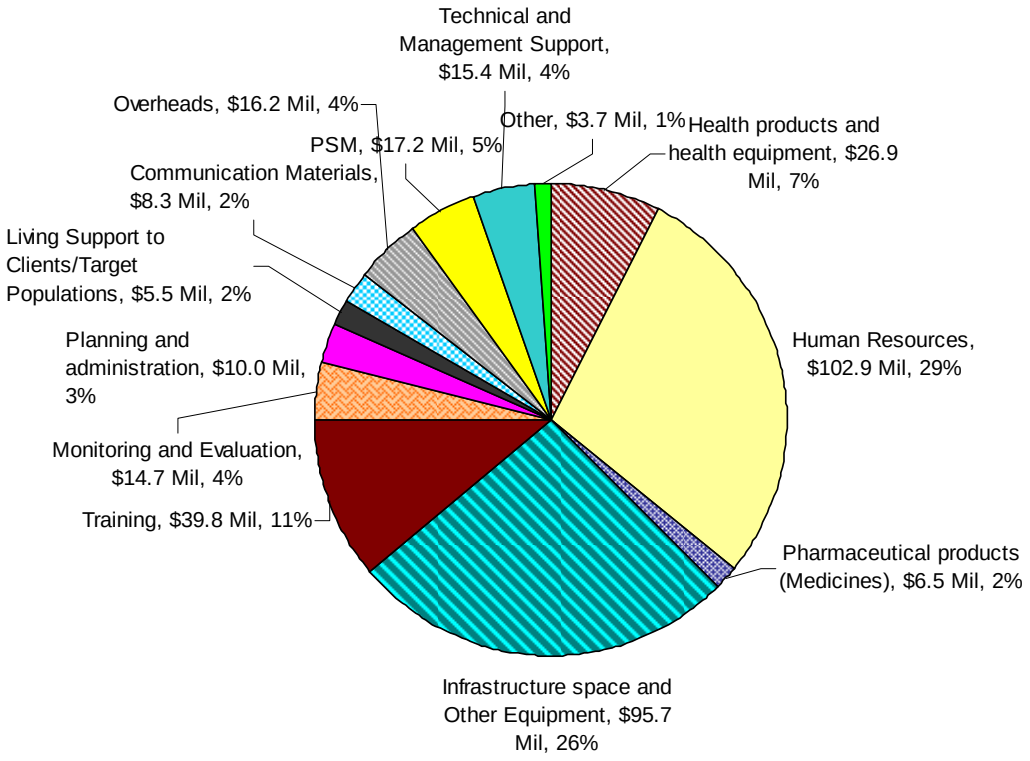
6.6 Success rates of HSS cross-cutting requests attached to different disease components are very similar in Rounds 8 and 9 as shown in **Figure 15**.

Figure 15 – Success rate of HSS cross-cutting requests recommended for funding (S.4B/5B) attributed to the host disease component in Round 8 and Round 9



7.9 **Figure 16** presents a breakdown by cost category of the Phase 1 upper ceiling budgets for HSS cross-cutting requests recommended for funding. More than half of the funding is requested for the 'Human resources' and 'Infrastructure, space and other equipment' cost categories which account for 29 and 26 percent of the phase 1 upper ceiling respectively.

Figure 16 – Distribution by cost category of the Phase 1 upper ceiling budget for recommended cross-cutting HSS interventions (s.4B/5B) (US$)

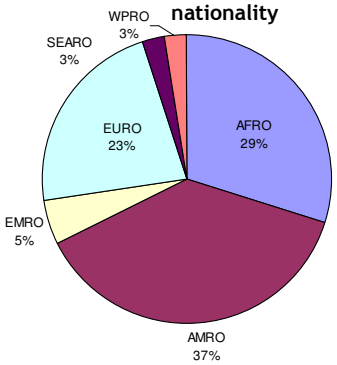


Technical Review Panel (TRP) Round 9 Membership

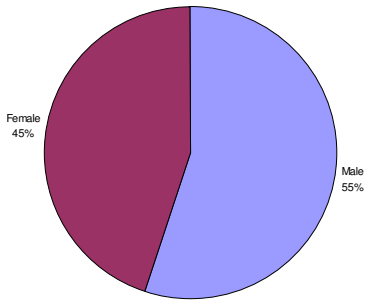
Category	No.	Surname	First name	Gender	Nationality	Rounds served 1	2	3	4	5	6	7	8
HIV/AIDS (8) Members	1	Sikipa	Godfrey	M	Zimbabwe								
	2	Tregnago Barcellos	Nemora	F	Brazil								
	3	Kornfield	Ruth	F	USA								
	4	Lauria	Lilian de Mello	F	Brazil								
	5	Brown	Tim	M	USA								
	6	Topouzis	Daphne	F	USA/Greece								
	7	Mazaleni	Nomathemba	F	South Africa								
	8	Nyenwa	Jabulani	M	Zimbabwe								
Malaria (6) Members	1	Genton	Blaise	M	Switzerland								
	2	Rojas De Arias	Gladys Antonieta	F	Paraguay								
	3	Burkot	Thomas	M	USA								
	4	Talisuna	Ambrose	M	Uganda								
	5	Adeel Adbel-Hameed	Ahmed Awad	M	Sudan								
	6	Lyimo	Edith	F	Tanzania								
Tuberculosis (6) Members	1	El Sony	Asma	F	Sudan								
	2	Hanson	Christy	F	USA								
	3	Bah-Sow	Oumou Younoussa	F	Guinea								
	4	Hamid, Salim	Abdul	M	Bangladesh								
	5	Kimerling	Michael	M	USA								
	6	Ticona	Eduardo	M	Peru								
Cross Cutting (20) Members	1	Decosas	Josef	M	Germany								
	2	Alilio	Martin S.	M	Tanzania								
	3	Nuyens	Yvo	M	Belgium								
	4	McKenzie	Andrew	M	South Africa								
	5	Boillot	Francois	M	France								
	6	Barron	Peter	M	South Africa								
	7	Okedi	William	M	Kenya								
	8	**Baker**	**Shawn Kaye (Vice Chair)**	M	USA								
	9	Ayala-Öström	Beatriz	F	Mexico/UK								
	10	Murindwa	Grace	M	Uganda								
	11	Heywood	Alison	F	Australia								
	12	Le Franc	Elsie	F	Jamaica								
	13	**Oyeledun**	**Bola (Chair)**	F	Nigeria								
	14	Rose	Tore	M	Norway								
	15	**Gotsadze**	**George (Vice Chair)**	M	Georgia								
	16	Bianco	Mabel	F	Argentina								
	17	Leal	Ondina	F	Brazil								
	18	Rabeneck	Sonya	F	Ireland/Canada								
	19	Herbert-Jones	Sarah	F	UK								
	20	Dusseljee	Jos	M	Netherlands								

Key:
Rounds served
Rounds not served

Regional balance by country of nationality



Gender balance



This document is part of an internal deliberative process of the Fund and as such cannot be made public. Please refer to the Global Fund's documents policy for further guidance.