



Investing in our future

# The Global Fund

To Fight AIDS, Tuberculosis and Malaria

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**GF/B9/14**

## **LESSONS LEARNED FROM THE TRP, ROUNDS 1-4<sup>1</sup>**

Outline: This report has been drafted by Michel Kazatchkine, Alex Coutinho, Paula Fujiwara, Wilfred Griekspoor, Fabio Luelmo and Kasia Malinowska Semprunch that have left the TRP, with a contribution from Jonathan Broomberg. It deals with lessons learned from reviewing the applications, lessons learned from the review process that has been evolving from the time when the original TOR of the TRP were written to Round 4. It also provides insight on some of the key issues that the TRP has been facing, such as the role of cross cutting experts, the community perspectives in the TRP and the insufficient attention that has prevailed on the issue of access to treatment of IV Drug Users, particularly in proposals originating from Eastern Europe.

The report serves as one of the background papers for the Board consultation on Saturday 20 November 2004.

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<sup>1</sup> draft 14 October 2004

The TRP has now reviewed four Rounds of proposals. When presenting the panel's recommendations for funding to the Board after each round of review, the TRP also brought forward each time a number of "lessons learned" and recommendations.

The present report has been drafted by Michel Kazatchkine, Alex Coutinho, Paula Fujiwara, Wilfred Griekspoor, Fabio Luelmo and Kasia Malinowska Semprunch that have left the TRP, with a contribution from Jonathan Broomberg. It deals with lessons learned from reviewing the applications, lessons learned from the review process that has been evolving from the time when the original TOR of the TRP were written to Round 4. It also provides insight on some of the key issues that the TRP has been facing, such as the role of cross cutting experts, the community perspectives in the TRP and the insufficient attention that has prevailed on the issue of access to treatment of IV Drug Users, particularly in proposals originating from Eastern Europe.

The report provides a number of recommendations that will be discussed by the PMPC prior to submission to the Board.

## 1. LESSONS LEARNED FROM REVIEWING THE APPLICATIONS

When reviewing applications to the GFATM, the TRP has primarily focused on four issues : (1) relevance, (2), soundness (3) feasibility, and (4) budget/additionality of requested funds, in the submitted proposals. We feel that these criteria are appropriate ; yet we found it difficult to find the appropriate information in the proposals and accompanying material in their current form.

**1. 1. Relevance** : The applications usually contain a reasonable description of the context in which funds are requested from the GFATM, but a much **weaker analysis of the short and mid-term addressable needs that arise from the context**. Often missing is the description of the current health system. In most cases, the description of the healthcare system only focuses on the public sector, whereas we know the importance of the private sector (for e.g. Pakistan, India, Nigeria and Latin America). And in some instances of non\_governmental organizations (NGOs), in the delivery care. Applications lack a description of the health insurance systems and information on any out of pocket amounts that patients have to pay to access to services.

There are often insufficient data presented on **resistance** to tuberculosis (TB) (which is mandatory if the Country Coordinating Mechanism (CCM) applies for treatment of multidrug-resistant tuberculosis (MDRTB) through the Green Light Committee (GLC) of the Stop TB partnership and in malaria at a time when therapeutic recommendations are changing based on resistance data.

As emphasized in the report of the June 2004 meeting to the Board, applications lack a description of the articulation of the requested GFATM funds with the **other programs that are under way in the three diseases**, and which of the addressable needs are covered by these other programs. No information was available, in most cases, on funds received from the World Bank, or other major donors especially the funds to be received from the World Bank or other major donor especially the funds to be received from the President's AIDS Initiative, the in-country objectives of ongoing programs of these entities' programs and potential overlaps and duplications with the GFATM application.

There is also insufficient information on ongoing GFATM grants. Cross-cutting experts of the TRP strongly emphasize the importance of having better information on the performance of previous GFATM grants and on the performance of other donor programs to provide us with more insight about the level of realism of the national plans. This would help in the difficult **challenge facing the TRP**- of establishing the balance between a risk-taking “light touch” approach (only acceptable if down stream control mechanisms are in place) and an approach that would only consider “ready-to-go programs”.

**1.2. Soundness** : We found the soundness of the proposed approach with regard to public health and in a medical perspective relatively easy to assess in the case of TB where good practices are standard. **Soundness is more difficult to assess when approaches are new/changing** (e.g. the voucher system for access to malaria prevention) and in applications to scale up access to care for HIV/AIDS where there is no evidence and only little experience of best standards of care. Since best practices may be evolving, the TRP may thus appear to have seemingly different approaches from one Round to another (e.g. the opt-in vs opt-out strategies for HIV testing for accelerating access to treatment). Also to consider is the fact that, although a field may be changing rapidly, it will take a significant time before a policy is changed at the country level and before resources for tests and training and all requirements for the policy to be implemented are indeed in place (e.g. 1-3 years will be needed to introduce new combinations for treatment of malaria).

### **1.3. Feasibility**

The TRP's assessment is limited in that it is only based on what is written on paper rather than on a field assessment. The GFATM's local Fund's Agent's (LFA) mission is currently focused on grant agreements, drug procurement and management capacity of the Principal Recipient (PR), rather than on checks and balances on medical and programmatic practice. The TRP also receives only very limited information from the World Health Organization (WHO) and , UNAIDS in this regard.

The situation analysis on human resources often appears very poor in applications that we have been reviewing although the lack of human resources clearly appears as the most important (e.g. for applications dealing with scaling up of antiretrovirals (ARVs). Relevant information is missing on for e.g. a country's current number and capacity for training of laboratory technicians, nurses and doctors trained, and plans to develop new models for increasing human resources. The analysis of the health systems in place is sometimes insufficient for a reliable assessment of feasibility. In general, the TRP has taken an “optimistic” or “confident” attitude more than remaining on the cautious side.

The TRP has already emphasized that it is lacking sufficiently detailed work plans and calendars of operations (a consistent complaint from cross cutting reviewers). The TRP has also been struggling in each of the previous Rounds with the issue of unspecified major sub-recipients and implementers.

In this context where the TRP, in its final recommendations, is often “taking the risk” that implementation will be slower than predicted on paper and thus that accepted grants will need re-programming during implementation, we wish again draw the attention of the Board on how critical the assessment at the time will be between phases I and II of

approved programs. Since over 50 % of the issues are cross-cutting issues at this juncture, it will be critical not to miss relevant information and to set up the appropriate mechanisms for re-programming and for decision making at that step. There are mechanisms in place for re-programming in other organizations. The tuberculosis Global Drug Facility (GDF), for example, provides grant for TB drugs to countries in need for three years. Progress and obstacles in implementation are assessed after the first year and if necessary the second year, including a desk audit by an external contractor and a field visit by a combination of staff and consultants. Specific recommendations in this regard are presented below (see “recommendations”).

#### **1.4. Budgets and additionality of requested funds.**

The section on budget of the proposal often provides the TRP little or no insight on how the proposed budget links with the proposed activities, expected results, and designated recipients (sub-budgets assigned). We also found it often difficult to understand how amounts were derived because of insufficient information provided on unit costs.

**Technical assistance has not been considered in many of the applications in Rounds 1-4 and therefore had not been assigned any specific budget.**

Budgets have increased between Round 1 and 4. This is due to more ambitious programs of scaling up access to treatment for HIV/AIDS and changing paradigms for the treatment of malaria in areas exhibiting high prevalence of resistance to conventional regimens.

TRP has sometimes extravagant overheads and administrative costs the public and NGO sector.

Of note is the fact that the TRP has sometimes faced what appeared to be extravagant overheads and administrative costs both in the public and NGO sectors.

The issue of **additionality of requested funds** and the difficulties faced by the TRP in assessing additionality discussed in the June 2004 report (see pp. 21/30 and 22/30 of the TRP report).

**1.5. Transparency** : to improve full transparency of the CCM-driven process, the list of proposals that CCMs had decided not to endorse, should be made public as recommended by the Partnership Forum in Bangkok, just as the TRP process is transparent to all.

#### **1.6. Recommendations :**

**a) Proposal form. We recommend that the proposal form is modified to accommodate the above-mentioned issues. We request that relevant documentation is accessible to reviewers in future Rounds, including reports from portfolio managers on ongoing GFATM grants and reports from other major programs. We request from the technical partners on the ground (WHO, UNAIDS, Stop TB partnership and Roll Back Malaria (RBM))much improved country facts sheets : including information on ongoing programs in the country. We acknowledge the plea made at the Board for simplification/ harmonization between donors. The point is not to make the application process more complicated and tedious, but rather to increase the chances of being able to assess the feasibility of approved programs by improving the situation analysis, and having better matching work-plans**

and budgets. GFATM funds are not “entitlement” money but indeed financial resources that should best be given to programs ready to absorb and implement.

**b) Re-programming process.** Our group agrees with the policy put forward by the Board whereby the TRP or, rather, an ad-hoc sub-committee of the TRP would re-review a non-performing program for which the secretariat would suggest that it be discontinued (failing grants not recommended for phase II). For grants that perform and disburse well, we see no need for any other mechanism than those already in place and those currently being discussed by the Board.

**For grants for which a re-programming proposal has come from the CCM** after the secretariat has signaled the need for one, we agree with the current trend in thought at the Secretariat and the board that the TRP is not be the appropriate body for review because of timing/process issues, and because it has insufficient insight to deal with the critical issues at this particular decision point that are highly country-specific. **We suggest that the re-programming proposal be reviewed by a small ad-hoc committee for each proposal : a small group of two to four people called by the Secretariat that could include ex TRP member(s) (particularly since they will often have been involved in the original assessment of the grant) and experts relevant to the main issues that could originate from the pool of the “TRP support group”, from partner organizations, or external consultants. The committee would conduct an evaluation process, at best involving a site visit, and further work with the country through a quality insurance (QA) process somehow similar to that of the current TRP clarification/adjustment process) to come up with a final re-programming recommendation for approval by the Board. within a set time frame.**

## **2. LESSONS LEARNED ON THE TRP REVIEW PROCESS**

**2.1. TRP review process.** So far as the GFATM remains a bottom-to-top, CCM-driven process aiming at all stakeholders in the country, the current procedures for application and review appear to us as the best possible at this time. **The TRP review process** including a two weeks presence of the experts in Geneva and a set of specific internal procedures for the TRP, has been improved in the last two years to a point where **TRP experts now consider it as adequate**. Thus, having experienced four Rounds, we definitely consider the process set up in Round 4 of distributing grants among small groups organized around two disease experts and cross-cutters, is preferable to the previous system of having small groups consisting of experts from all diseases. Rotation of members between groups every three days should be kept to ensure consistency of review. We also feel that the plenary sessions are essential for consensus building, calibration and for maintaining consistency and balance in the TRP’s judgment, as well as the re-calibration session on the last day of the TRP session.

As noted above, the review by the TRP would be greatly assisted if it had access to additional information pertaining to applicant countries. The TRP would thus appreciate the Board to **consider a longer period after receipt of proposals and prior to TRP review**, in order for the secretariat to be able to screen proposals fully, collate missing information, and also gather the additional information outlined above in section 1.

**2.2. Board meetings.** While the TRP considers it essential that it remains fully independent, we also feel that its experience and insights into issues such as re-programming, eligibility, is **underutilized during Board meetings** when the contribution of TRP representatives (Chair and Vice Chair) is limited to the presentation of the results of the TRP review.

**2.3. Composition of TRP.** It appears essential from our experience that the TRP comprises **four TB experts**. There is increasing pressure on TB from HIV/AIDS and a clear advantage in keeping an internal balance of four TB experts and four malaria experts for conducting the review process.

We see no reason why experts from **multilateral agencies** are not considered for TRP membership whereas members of bilateral organizations (e.g. USAID) are allowed to be part of the TRP.

**2.4. Nomination/ renewal.** The current process for nomination, renewal, and selection of TRP members appears to us adequate, as well as the scheme for rotation of TRP members approved by the Board after Round 3. There is an urgent need for replenishment of the "TRP support group" with TB experts. The Fund should aim at targeting strong candidates from the developing world to apply for the selection process.

**2.5. Chair and Vice Chair.** We recommend that the Board approves the following process for the election of Chair and Vice-Chair: Chair and Vice Chair are to be elected by the TRP. The election should take place on the last day of a TRP session. The Chair is to serve for two successive Rounds ; the Vice Chair is to serve as Vice-Chair for one or two successive Rounds prior to becoming the Chair for two Rounds. The person selected to be Chair can serve up to five Rounds total. We encourage that Chairs rotate between South and North in the future.

#### **2.6. Recommendations.**

**We recommend that the TRP be comprised of four TB experts and that experts from multilateral agencies can apply/ be nominated in the future for membership in the TRP.**

**We recommended that the Chair and Vice Chair are elected according to the procedure depicted in 2.5.**

**We also recommend that a more active role is given to the Chair and/or Vice Chair of the TRP during the Board meetings.**

### **3. LESSONS LEARNED FROM THE CLARIFICATION / ADJUSTMENT PROCESS**

**3.1. The process.** The most recent iteration of the Question and Answer (Q and A) clarification/adjustment process (see TRP report of June 2004) is the result of consecutive improvements in the process and, we believe, should be followed in forthcoming Rounds.

**3.2. Conditionalities.** The Q and A clarification process should limit to a minimum the number of conditionalities that the TRP poses on the grant agreement. In practice in previous Rounds, the conditionality has arisen as a way to stay within the time constraints of the Q and A process and within the context of the accessible information

to experts. There seems to be pressure on portfolio managers to sign agreements as soon as possible that may result in insufficient attention to these pending TRP conditions.

**3.3. Recommendation. We suggest that the Cluster managers keep a careful record of conditionalities and, report to the Head of Operations and to the TRP Chair/Vice Chair, on the follow up by the Secretariat of conditionalities during the Grant agreement process.**

#### **4. EXPERTS LEAVING THE TRP**

**4.1. Conflicts of interest.** We re-iterate our request to the Board to endorse a policy to restrict TRP members from serving as consultants to assist countries in drafting of proposals submitted to the GFATM for two Rounds of proposals from the date they leave the TRP. We indeed believe that there is a conflict of interest for TRP members having signed that they would not divulge the content of the TRP deliberations, to work in assisting countries in their proposals. We further consider that this would potentially put TRP members in a difficult situation to select which country to assist in the event of multiple requests.

**4.2. Assistance in the re-programming process.** The Fund should take advantage from the acquired expertise of former TRP members. One suggestion (see above section 1.6.) is that they are actively involved in the evaluation of CCM proposals for grant re-programming for phase II.

There have been other suggestions for specific roles for experts leaving the TRP, including a role as “Global Fund Ambassadors “ or technical consultancy assignments.

**4.3. Recommendation. We recommend that the Board endorses our suggested policy on conflicts of interest for members leaving the TRP (see above 4.1.).**

#### **5. LESSONS LEARNED FROM THE TRP. A “CROSS-CUTTING EXPERT’S PERSPECTIVE.**

The experience of the first four rounds has confirmed the important role of ‘cross cutting experts’ in complementing the evaluation performed by the disease experts. The key issues which cross cutters have focused on include the cost effectiveness, feasibility and probability of success or failure of proposals (including such factors as absorptive capacity, human resource and other constraints). The current balance between cross cutters and disease experts is appropriate, leading to both a reasonable workload for cross cutters, as well as effective interaction between cross cutters and disease experts.

As noted above, the cross cutters have had to rely almost exclusively on the limited information contained in the proposals themselves, with only haphazard and random access to additional information (when TRP members happen to have some knowledge of an applicant country). This places a substantial burden on the information in the proposals. As also noted above, many proposals provide very limited background

information on health systems, the human resources situation and other key systemic issues. Many proposals also fail to provide sufficiently detailed budgets, with clear linkages between budgets and detailed workplans. The changes proposed by the TRP to the Guidelines and Proposal Form are designed to address these problems, and if implemented and responded to properly, will significantly enhance the evaluation performed by the cross cutters.

The cross cutting evaluation will also improve significantly once reviewers have access to adequate information on existing GFATM grants, as well as other bilateral and multilateral programs within applicant countries. It is therefore critical that this background information is submitted together with proposal forms.

One key issue faced by cross cutters in recent rounds is the tension between ambitious proposals, which demonstrate the country's commitment, and are consistent with global targets, and the likely feasibility of the proposals. As proposals become more ambitious, the concerns of the cross cutters in relation to feasibility and absorptive capacity obviously increase. At the margin, proposals which appear more realistic and feasible, typically the smaller, less ambitious proposals, are more likely to obtain approval than very large and ambitious proposals. Obviously, the TRP recognizes that the relationship between feasibility and scope and scale is more complex than this, but there is a risk that applicants will try to 'game' the process by opting for smaller proposals over time. It will therefore be important for the TRP and the Board to review this dynamic over subsequent rounds, and to provide appropriate guidance to applicants on finding the optimal balance between scope and scale of proposals, and the likelihood of success in the review process.

## **6. LESSONS LEARNED FROM THE TRP. A COMMUNITY PERSPECTIVE.**

Having served on TRP and watched the process of disbursement at country level it is clear that at least for the first 3 rounds there was insufficient consultation with civil society at the time proposals were written as well as insufficient knowledge by governments and CCMs as to which civil society players are doing what. Even where civil society is represented on a CCM there is often insufficient consultation with the many players who fit into civil society. As a result many round 1 and 2 proposals were retrofitted to accommodate civil society participation. It would therefore be useful for applications to have a section that describes the extent of civil society involvement in the different areas in the country, the process undertaken to consult with civil society when the proposal was written and in the case here there is insufficient presence of civil society - the process to build that capacity. For those countries that have reviewed grants an outline can be provided detailing how civil society has been involved to date. It has also been useful for the PR for civil society to be a separate entity to speed up disbursements. With regard to civil society applying directly to the GF, the grounds to do so are clearly stated. It is the role of the civil society reps on the board to determine if these are fair. What is important is that the secretariat publishes a list of those applications received with a comment on the reasons why each one has been handled in a particular way i.e. screened out, sent to TRP, TRP outcome etc as this will allow transparency. Finally let us acknowledge that community or civil society is a huge and sometime ill defined entity and therefore it is impossible to fund each entity. We should

therefore ensure the process and its out come are fair and transparent at both country and GF level.

## **7. LESSONS LEARNED FROM THE TRP. THE ISSUE OF TREATMENT OF HIV-INFECTED IDUs.**

The HIV epidemic among drug users is not a new phenomenon – we have been aware of pockets of injecting drug users (IDUs) affected by the disease for number of years. However, the profile of the epidemic has been recently changing, and what we are seeing now is no longer just pockets of IDUs affected by the disease, but rather, in an increasing number of countries, it is IDUs which are at the very heart of the epidemic. Indeed, it is becoming increasingly clear that the third decade of the HIV epidemic will be defined by injecting drug use and our response to it. And, by extension, it is countries like Russia, Ukraine, Iran, China, Vietnam, India, and Pakistan, all of which have large populations and large numbers of IDUs, which will be the defining countries of this decade.

We have seen how dynamic the spread of HIV through sexual transmission has been in parts of Africa. But what is perhaps not yet fully understood is that the spread of HIV through injecting drug use is much more explosive. For this reason, countries confronted with the potential of the epidemic need to take steps to control it, and need to take them **fast**. Yet the positive side is that despite this explosive potential, the epidemic among IDUs is actually the easiest to contain, with simple, cheap and effective interventions. For this reason it is an area where donors such as the Global Fund can achieve success most easily. Injecting drug users respond well to the interventions provided (clean needles, methadone), which are cheap, and do not require heavy investments in the area of human resources to be implemented.

With regard to the work of the Technical Review Panel (TRP), the following lessons learned from earlier rounds will be of use:

**7.1 Applications often contain an inaccurate analysis of the nature of the epidemic**, failing to recognize its origins in the IDU population. This means that the proposed interventions target the wrong population, and thus are unlikely to have any effect on the epidemic, rendering the application pointless. It is crucial that applications contain a correct definition of the problem as a basis on which action can be taken. If not, they should be rejected.

**7.2 Applications correctly identify the populations at most risk, but the proposed interventions are not those which will reach these populations.** An example of this would be determining that IDUs are the population at most risk, and instead of proposing the introduction of needle exchanges, proposing the distribution of condoms in schools. It is important that the proposed interventions tackle the problem as defined in the application. If not, it should be rejected.

**7.3 Applications contain a correct analysis of the epidemic, the interventions are related to drug use, but the interventions are not related to HIV prevention.** An example of this would be proposing the establishment of drug rehabilitation centers. This

type of intervention again will not have any material impact on the HIV epidemic, and applications of this sort should be rejected. A similar situation would arise where, in countries where needle exchange and methadone are illegal, outreach programs are proposed. While these undoubtedly have some merit, it is an illusion to imagine that they will have any significant impact on the epidemic without the introduction of these specific interventions. In the long term, therefore, there needs to be a commitment to introducing them, and the TRP should keep this in mind.

**7.4 Applications which do not contain HIV treatment component.** An assumption is often made that IDUs will not be able to adhere to treatment, and therefore that whilst prevention efforts have some value, treatment will be a waste of time and money. Experience shows, however, that this is simply not the case. The Global Fund has a responsibility to fund cutting edge programs that exclude no-one from access to treatment. Similarly it is the responsibility of people on ground to do everything possible to include IDUs in treatment. An important point to note is that issues of drug use and drug policies are very often viewed in moral rather than in public health terms, and participants in County Coordination Mechanisms will be no exception to this rule. The Global Fund should avoid the temptation to pick the “low hanging fruit”, leaving the harder ones for later - in dealing with the epidemic among IDUs that is simply not an option. For this reason it should insist on the inclusion of a treatment component in all applications, and that this should be equitably implemented.

## **8 TERMS OF REFERENCE (TOR) OF TRP**

The TOR of TRP has been approved at the January 2002 meeting of the Board. The structure of the TRP was reviewed by the Board after Round 2, the number of TRP members and, as a consequence, the number of TRP members were increased from 17 to 25 to acknowledge the need for a larger number of malaria (from 3 to 4) and TB experts as well as cross cutting experts (from 5-11) to better help in evaluating contextual issues.

**It is recommended that the TOR are modified to acknowledge the current TRP position of 25 members including 6 HIV/AIDS experts, 4 malaria experts, 4 TB experts and 11 cross cutting experts.** It is recommended that paragraph 2 on “terms of office of TRP members” is modified to replace “a yearly” terms by Rounds (i.e. replacement by 1/3 should occur after two rounds).

Paragraph 3.1 should be modified to include chair or vice chair to be part of the group that selects the TRSG. It is further recommended that the Board also solicits nominations for the TRP from TRP members, a process that has been highly effective for nominations in Round 4.

Paragraph 5.3 : delete “generally three months annually”

Paragraph 5.4 : delete “the reviewers will receive the proposals at least 4 weeks prior to the TRP meeting”

paragraph 5.6 delete “also directly

paragraph 5.7 should be deleted

paragraph 6.1 to be modified according to the definition of category 1 to 4 that has been accepted by the Board after Round 2 to 4.

The text of paragraph 6.2 and 6.3 needs to be amended accordingly.

Annexe 3 should be deleted from a revised form of the TOR

## **9. LESSONS LEARNED FROM THE TRP ROUNDS 1-4. PENDING ISSUES RAISED BY THE TRP IN PREVIOUS ROUNDS.**

There are a number of pending issues raised by the TRP in previous Rounds that require the attention or policy decisions by the Board. These include :

**9.1.** The need for a clearer policy of the Board on the scope of activities to be funded by the GFATM and, specifically, on the scope of activities to be funded within the framework of “**integrated proposals**”.

**9.2.** The consideration of the complexities of reviewing **Regional proposals** of which few, in Rounds 1-4, have been assessed as demonstrating true additional value. A number of these applications came from superimposed transnational/regional organizations of which the original missions were not at the core of fighting the diseases or even not public health oriented.

**9.3. Private sector.** Two different sets of issues may be categorized under this section. (1) Private companies delivering care in the workplace and in community programs which contribute in this manner to the global scaling-up effort of HIV prevention and treatment. This type of applications may involve individual national or multinational companies, World Economic Forum and/or the Global Business Council (GBC). (2) Privately-owned healthcare services and intermediates such as insurance or health maintenance organizations involved in national scale up efforts; In both areas, we have been surprised to see so little of their respective contributions/ involvement in Rounds 1-4, given the importance of these players in many countries.

**9.4.** The need for a policy on whether countries with **approved prior grants** but not yet signed should apply for a subsequent grant, or should wait until the grant is signed, if not operational, prior to applying for a new grant.

**9.5.** The issue of **risk management of large grant requests**. One approach of reducing such risks would be to develop a policy on re-applications by countries that already have been granted GFATM funds and to have the proposal form improved to provide evidence demonstrating past performance. Another approach would be to discourage countries from making excessively large requests by placing a commitment charge on un-disbursed funds, for which the CCM and/or the PR/sub-PR would be liable.

The TRP is now increasingly confronted with scale up applications (HIV/AIDS and malaria) that involve large amounts of money (a single investment representing a large proportion of the total portfolio) that raise concerns about feasibility and absorptive capacity. We wonder whether the TRP should not consider specific internal procedures for assessing such applications in its review.

#### **9.6. HIV:TB**

There is now strong structural/organizational HIV in the STOP TB Partnership. It is less clear the other way round, i.e. whether enough attention is given to TB in the HIV/AIDS Department of WHO, at UNAIDS and in national AIDS programs. We believe that the management of HIV and TB co-infection should be standard practice and therefore there is no further need for a special category of applications to the GFATM.

**9.7. Technical assistance (TA).** Our experience of Rounds 1-4 has been that budgets for TA are insufficient. In addition, TA has been used too often as a generic term and restricted to the step of assistance in writing proposals. TA, in fact, involves multiple skills and means multiple types of activities all of which in the end will be required in order to successfully implement the programs. These include training, procurement, management, supervision, medical accreditation, storage and distribution and Monitoring and Evaluation (M and E).. Insufficient attention has been given so far to these multiple needs and ways for countries to obtain assistance in all these areas.

**9.8. Appeal process.** The Board guidelines on appeals allow applicants to appeal if they have been unsuccessful in two consecutive rounds, and believe that the TRP has made 'significant and obvious' errors in its review. Based on the experience of three sittings of the Appeal Panel, we believe that these guidelines are appropriate. They filter out what would otherwise become a potential 'flood' of appeals, and they provide an easily measurable standard against which to assess the judgements of the TRP. As demonstrated below, the majority of appeals considered thus far have not convinced the Appeal Panel that the TRP has made 'significant and obvious errors'.

The Appeal Panel has convened three times since the establishment of GFATM. The table below demonstrates, for each sitting, the number of applicants eligible to appeal, the number of appeals received, and the number and percentage of appeals upheld by the Appeal Panel.

	Components eligible to appeal	Valid appeals submitted	Appeals Upheld (% of total)
Round 2	31	2	1 (50%)
Round 3	41	6	3 (50%)
Round 4	36	13	3 (23%)

The current composition of the Appeal Panel includes three outside experts nominated by WHO, the World Bank and UNAIDS, and two members of the TRP (the vice chair and another member). This approach has worked very well, ensuring sufficient understanding of the TRP process, while at the same time allowing a completely

independent review of the decisions of the TRP. It is critical that the outside experts appointed to the Appeal Panel are sufficiently skilled and experienced, and are able to dedicate sufficient time to the process. The experience in this regard has been mixed, although this improved substantially in the most recent sitting of the Appeal Panel. It will be critical, going forward, that the three agencies understand the importance of their nominations, and that they nominate candidates of outstanding caliber. The most recent sitting of the Panel was co-chaired by the TRP vice-chair and one of the outside experts. This approach worked effectively. **We would however recommend that future sittings of the Appeal Panel be chaired by one of the outside experts, provided that there is at least one expert who has served on the Appeal Panel at least once before. Where this is not the case, it will be best to have the TRP vice chair as a co-chair, in order to ensure an effective process.**

When the number of appeals considered by the panel is small, as occurred after rounds 2 and 3, it may be feasible to convene the Appeal Panel by teleconference. However, the experience of the last Appeal Panel, which convened in Geneva, suggests that this leads to a more effective and thorough process, and **we would recommend that the Appeal Panel always be convened in a formal meeting rather than by teleconference.** As the number of appeals grows, the logistics of the appeal process become more critical. Appeal Panel members have to review a substantial number of documents, including the original proposals and appeal documents, as well as TRP reports. It is essential that a full set of documents is made accessible to the Appeal Panel members in a timely fashion. This did not occur in the previous sitting, mainly due to the very short time lines and pressure under which Secretariat staff were working. **We would recommend that there should be a longer time between the cut-off date for receipt of appeals, and the date on which the Appeal Panel must convene.** This would allow the Secretariat more time to gather and distribute the appropriate documents, and more time to the Appeal Panel members to prepare for the session. **We would also recommend that formal guidelines are provided to the relevant Secretariat staff on which documents must be made available to Appeal Panel members.**