GF/B26/ER 07

REPORT OF THE TECHNICAL REVIEW PANEL AND THE SECRETARIAT ON THE TRANSITIONAL FUNDING MECHANISM

JULY 2012

PURPOSE:

This report summarizes the recommendations, context, modalities, and the observations and lessons learned from the TRP's review of proposals submitted under the Transitional Funding Mechanism (TFM). The report proposes one (1) decision point as follows:

- GF/B26/EDP 11 Approval of Transitional Funding Mechanism Proposals

FOR INFORMATION/DECISION

Part 1: Introduction

1.1 The Technical Review Panel (TRP) met from 9-21 June 2012 to review the funding requests submitted under the Transitional Funding Mechanism (TFM) for technical merit and compliance with the TFM requirements and the Eligibility, Counterpart Financing and Prioritization (ECFP) policy. The meeting was chaired by Mr. Shawn Baker, with Dr. George Gotsadze and Dr. Lucie Blok serving as Vice-Chairs.

1.2 This report is structured as follows:

Part 1: Introduction and overview

Part 2: The context of TFM

Part 3: TRP membership and review meeting modalities

Part 4: Lessons learned, observations and recommendations

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

Annex 1: List of proposals reviewed by the TRP and funding recommendations

Annex 2: CCM eligibility requirements and list of applicants

Annex 3: Analysis of TFM outcomes

Annex 4: TRP Review Forms for individual proposals

Annex 5: TRP membership for TFM

1.3 **Annex 1** is provided with this report. **Annexes 2, 3 and 5** are provided separately. **Annex 4** (TRP Review Forms for individual proposals) is provided on a confidential basis in electronic format as supplementary information to Board members.

1.4 After the Board's funding decisions on TFM proposals, 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 In accordance with the Global Fund's documents policy[1], TRP Review Forms will not be published on the website[2].

The TRP meeting

1.5 The TRP meeting was held in Evian-les-Bains, France. It comprised of induction sessions; the review of TFM proposals; the review of a number of renewals requests to gather learnings[3]; a mini-retreat mid-way through the meeting; and a final session to ensure consistency across TFM proposals, to gather lessons learned, and to capture the general and disease-specific recommendations. For more information on the meeting modalities and TRP recommendations, see **Part 3** and **Part 4** of this report.

[1] Decision Point GF/B16/2.
[2] Stakeholders wishing to obtain copies of the TRP Review Forms should contact the applicants directly.
[3] TRP observations from this process were presented to the Strategy, Investment and Impact Committee (SIIC) at its Third Meeting in July 2012.

TRP funding recommendations for TFM proposals

1.6 For TFM the TRP reviewed 61 proposals from 48 applicants for a maximum of two-years of funding with a total funding request of **US$ 606.6 million**[4].

1.7 In order to address the unique characteristics of TFM, the TRP was granted flexibilities by the Strategy, Investment and Impact Committee (SIIC) to adjust the TRP recommendation categories[5]. The adjusted recommendation categories are presented below for endorsement, together with TRP's funding recommendations for TFM applications of this report. It should be noted that proposals falling in Category 4 are those that in a Rounds-based review would not have been recommended for funding, but encouraged for re-submission at the next Round.

Category 1	Recommended for funding, with no issues for clarification.	
Category 2	Recommended with issues as conditions or matters to be cleared by the Secretariat only.	
Category 3	Recommended with issues as conditions or matters to be cleared by the Secretariat and the TRP.	The clarifications process with regards to the issues to be cleared by the TRP would constitute revisions to the original proposal being sent back to the TRP primary and secondary reviewers, before being reviewed by the TRP Chair or Vice-Chair for final TRP sign-off. Timeline: an initial response to be provided within 4 weeks, and an additional 8 weeks after receipt of the initial response to conclude the clarifications process.
Category 4	Revised proposal, for which a second TRP review and approval would be required prior to funding.	Timelines for the submission of a revised proposal, including any clarification which the TRP may require, are applicant-specific. Applicants are expected to submit a revised proposal within the clear parameters set out in the TRP review form of the TRP's first review to allow for the funding of essential services facing disruption. The revised proposal will be reviewed by a sub-set of the TRP.
Category 5	Not recommended for funding.	The funding request did not meet the TFM requirements: the proposal did not include the continuation of essential services and/or there was no disruption of essential prevention, treatment and/or care services within the TFM eligibility period of 1 January 2012 to 31 March 2014.

1.8 The TRP recommends the Board approve a potential total two-year upper ceiling of **US$ 511 million** for TFM proposals. In the Categories 1, 2 and 3 (where there are either no issues to clarify, or issues to be clarified by the Secretariat and/or TRP) the TRP is recommending 45 proposals with a total two-year upper ceiling of **US$ 419.8million.** For 11 proposals, the TRP is requesting that applicants submit a revised proposal for further review by the TRP before making a funding recommendation (Category 4), for a potential

[4] Total demand figures as of 1 July 2012. As some proposals requested funds in Euros, this report, including relevant annexes, uses the 1 July 2012 OANDA interbank exchange rate of 1.26596 to translate Euro funding requests into US dollars.
[5] Decision Point SIIC03/ER1.

total two-year upper ceiling of **US$ 91.2 million**. The TRP funding recommendations to the Board on TFM proposals, by category, are listed in **Annex 1** of this report. **Annex 3** provides detailed analysis of these results.

1.9 Table 1 below summarizes the funding recommendations by disease.[6]

Table 1: Summary of funding recommendations

Disease proposal	Number reviewed	No. recommended for funding (Cat. 1, 2 & 3)	No. recommended for submission of revised proposal (Cat. 4)	2-year demand (in million US$)	2-year upper ceiling recommended (Cat. 1, 2 & 3)		2-year upper ceiling recommended for submission of revised proposal (Cat. 4)	
					Amount (in million US$)	% of demand	Amount (in million US$)	% of demand
HIV	26	16	8	250.6	111.7	18.4%	67.6	11.1%
TB	21	18	3	128.2	103.8	17.1%	23.6	3.9%
Malaria	14	11	0	227.8	204.2	33.7%	0	0.0%
Total	61	45	11	606.6	419.8	69.2%	91.2	15.0%

The General and Targeted Funding Pools

1.10 At its Twenty-Third Meeting in May 2011, the Board adopted[7] a new Eligibility, Counterpart Financing and Prioritization (ECFP) policy[8] for all funding channels starting from 2011. The Board decided that the policy would be applicable to TFM, in addition to additional eligibility and prioritization provisions.

1.11 Under the ECFP policy, there are two distinct funding pools for all three diseases: the General Funding Pool and the Targeted Funding Pool[9]. Both funding pools are open to single and multi-country applicants, however eligibility for the General Funding Pool is restricted according to an applicant's income level and disease burden[10]. Resources allocated to the Targeted Funding Pool cannot exceed 10 percent of the resources available for a given funding window.

1.12 Applicants submitting a proposal to the Targeted Funding Pool were restricted to a US$ 5 million funding request for two years, and had to ensure that 100 percent of their proposal budgets were focused on underserved and most-at-risk populations and/or highest-impact interventions within a defined epidemiological context.

1.13 **In the General Funding Pool:** The TRP is recommending 35 proposals with a total two-year upper ceiling of **US$ 382.7 million**. The TRP is requesting that applicants submit a revised proposal for further review by the TRP before a final funding recommendation can be confirmed (Category 4) for 9 proposals, for a total two-year upper ceiling of

[6] Stand-alone cross-cutting health systems strengthening (HSS) requests were not permitted under TFM. However, applicants could request funding for certain HSS activities through a disease proposal that met the TFM requirements and were necessary to prevent the disruption of essential services.
[7] Decision Point GF/B23/DP23.
[8] Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization of Proposals for Funding from the Global Fund (GF/B23/14 Attachment 1).
[9] Applicants, even if eligible for both funding pools, cannot apply to both funding pools for the same disease at the same time.
[10] For more information, please see the information note on Eligibility, Counterpart Financing and Prioritization (January 2012).

US$ 85.7 million. The combined total of recommended proposals and requested revised proposals is 44, with a total upper ceiling of **US$ 468.5 million**.

1.14 **In the Targeted Funding Pool:** The TRP is recommending 10 proposals with a total two-year upper ceiling of **US$ 37 million**. The TRP is requesting that applicants submit a revised proposal for further review by the TRP before a final funding recommendation can be confirmed (Category 4) for 2 proposals, for a total two-year upper ceiling of **US$ 5.5 million**. The combined total of recommended proposals and requested revised proposals is 12, with a total upper ceiling of **US$ 42.5 million**.

Decision Point GF/B26/EDP 11: Approval of Transitional Funding Mechanism Proposals

1. The Board endorses the Technical Review Panel (TRP) Recommendation Categories for the Transitional Funding Mechanism (TFM) as set forth in the GF/B26/ER 07.

2. The Board approves all TFM proposals recommended for funding by the TRP as Categories 1, 2, and 3 as indicated in Annex 1 of GF/B26/ER 07, subject to all applicable clarifications or conditions outlined in TRP review forms. The aggregate total of the maximum upper ceilings of funding for Category 1, 2 and 3 TFM proposals is US$ 419.8 million.

3. Applicants whose proposals are recommended for funding as “Category 3” shall:

   a. provide an initial detailed written response to the requested TRP clarifications no later than four (4) weeks after the applicant’s receipt of notification in writing by the Secretariat of this Board decision; and

   b. conclude the TRP clarifications process, as indicated by the written approval of the Chair and Vice Chair of the TRP, not later than eight (8) weeks after the Secretariat’s receipt of the applicant’s initial detailed response to the issues raised for clarification and/or adjustment.

4. The Board conditionally approves all TFM proposals which are recommended for funding by the TRP as “Category 4” as indicated in Annex 1 of GF/B26/ER 07 subject to review and approval by the TRP of the revised TFM proposals. The Board notes that applicants whose proposals are recommended for funding as “Category 4” submitted proposals in need of substantial revision despite risks of disruption of essential prevention, treatment and/or care services during the TFM eligibility period of 1 January 2012 and 31 March 2014. The aggregate total of the maximum upper ceilings of funding for Category 4 TFM proposals is US$ 91.2 million.

5. Applicants whose proposals are recommended for funding as “Category 4” shall:

   a. submit a revised proposal, based on the parameters set out in the applicants’ TRP review form; and

   b. complete the revised proposal review process, including any clarification which the TRP may require, within the timeframe stipulated in the TRP review form resulting from such a review.

6. The Secretariat will notify the Board of the outcomes of all Category 4 proposals.

7. The Board declines to approve for funding those proposals recommended by the TRP as "Category 5." These proposals are eligible to appeal this decision subject to the grounds and process for appeals as stipulated in the 'Rules Governing the Global Fund's Appeal Mechanism for Applications not Approved for Funding'.

8. The Board notes that many applicants will face disruption during the second half of 2013 or in 2014, the latter stages of the TFM eligibility period. There may be circumstances where there are advantages to signing a TFM grant closer to the date of disruption, including circumstances created by the Board's decision to accelerate the implementation of the Global Fund Strategy (GF/B26/DP6). As such, the Board decides that TFM grants may be signed beyond the currently required 12-month period after Board approval of a proposal (GF/B8 Timeframes for Grant Agreements, Decision Point 2) and may have start dates that are beyond 15 or 18 months after Board approval, as applicable, in accordance with their respective disruption dates.

9. The Board's approval of proposals is made with the clear understanding that the proposal amounts recommended for funding by the TRP, as set forth in Annex 1 – GF/B26/ER 07, are maximum upper ceilings rather than final approved grant amounts and are subject to reduction upon successful completion of TRP clarifications, TRP reviews of revised proposals, and grant negotiations.

Part 2: The context of TFM

2.1 At its Twenty-Fourth and Twenty-Fifth Meetings, the Board acknowledged the severe, resource-constrained economic environment created the likelihood that there would be inadequate funding to support proposals under Round 11, which had been launched in August 2011.

2.2 As a result, the Board decided that in order to safeguard gains from existing services, it was necessary to replace Round 11 with TFM to ensure that the limited resources would be available to continue essential prevention, treatment and/or care services presently supported by the Global Fund. TFM would be available only for existing grantees that: (i) would face disruption of essential services, currently supported by the Global Fund within the period of 1 January 2012 and 31 March 2014; and (ii) for which no alternative sources of funding could be secured, including through the re-programming of existing grants.

2.3 The Board's intent for TFM was to fund all eligible funding requests to ensure the continuation of essential prevention, treatment and/or care services until new resources become available in early 2014, through a new funding model that would be consistent with the Global Fund Strategy 2012-2016[11].

2.4 The scope of TFM, as stipulated by the Board Decision on TFM[12] (the "TFM requirements"), established the criteria for determining an applicant's TFM eligibility[13]. The Secretariat published an information note on TFM and Frequently Asked Questions to guide applicants in a self-assessment of compliance with the TFM requirements and in the development of their proposal.

2.5 The Board's decision to establish TFM had important implications on the eligibility of applicants, the application process and the allowable scope and duration of a TFM funding request. The TRP's approach to the review of applications and funding recommendations was therefore adjusted accordingly from those of previous rounds.

Scope of applications under TFM and preparatory consultations

2.6 The TRP was tasked with the assessment of compliance with the TFM requirements. Under TFM:

a. Applicants had to have a current Global Fund grant that was facing significant program disruption between 1 January 2012 and 31 March 2014;

b. The funding request was restricted to the minimum amount of funding needed for the continuation of essential prevention, treatment and/or care services;

c. Applicants were limited to a two-year funding request. The start of the TFM request was to be the date from which additional funding would be required; and

d. Applicants had to demonstrate that there were no alternative sources of funding available to fund the activities proposed. Applicants were therefore expected to review existing and new resources that could be accessed[14].

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[11] Available on the Global Fund website: http://www.theglobalfund.org/en/about/strategy/
[12] GF/B25/DP16.
[13] Eligibility, as defined in "The Global Fund eligibility list for 2012 funding channels", was distinguished from compliance with TFM requirements. An applicant identified as eligible on this eligibility list may not have met the additional requirements for funding under TFM. Potential applicants were encouraged to refer to the information note on the Transitional Funding Mechanism to determine whether they complied with the TFM requirements.
[14] Alternative sources of funding could include: Government budgets or other domestic sources; other donors; or funds from other Global Fund same-disease grants, which could be reprogrammed.

2.7 Applicants had to demonstrate that the proposed interventions and/or services within their TFM application represented essential services for the national response to the relevant disease. There was broad consensus between the TRP, Technical Partners and the Secretariat that what was permissible within an application would be specific to a country's epidemiological and funding context. As such, no definitive list of interventions or services was provided to applicants; rather, illustrative examples of what was likely or unlikely to be funded under TFM was provided as an annex to the TFM information note.

2.8 Explicit guidance was given to applicants to ensure that their funding requests supported core interventions at the existing scale that: (i) protected the gains achieved (e.g. interventions whose interruption would mean a significant rebound in transmission); and (ii) saved lives; and (iii) were high impact, evidence-based, targeted to most appropriate populations and represented good value for money in a resource-constrained environment.

2.9 This guidance stipulated that TFM would typically not support interventions that: (i) scaled up services beyond the levels of patients, geographic areas or populations that would be reached at time of disruption; (ii) were not high impact, that have not been evaluated and demonstrated to be effective, were not targeted to appropriate populations, and/or have not demonstrated adequate value for money in a resource-constrained environment; or (iii) introduced new interventions.

2.10 Where applicants did include interventions or services deemed ineligible under TFM, the TRP either requested the removal of these elements or requested further clarifications from the applicant. The TRP did reject outright a small number (five, only 8 percent) of proposals that did not meet TFM requirements.

2.11 As the Board decision on TFM applied the ECFP policy to this funding opportunity, applicants also had to demonstrate that their TFM request complied with both the counterpart financing and focus of proposal requirements (in addition to the TFM requirements). Compliance with these criteria was assessed by the TRP as part of the technical review of proposals (see **Part 4** for more information).

Consultations with Technical Partners and the Secretariat

2.12 In recognition of the Board's approval of the Global Fund Strategy Framework 2012-2016[15] at its Twenty-Third Meeting[16], the TRP engaged with Technical Partners and key Secretariat staff prior to the TRP meeting in order to lay the ground for a more iterative and dialogue-based approach to the review of proposals.

2.13 Given the complexities of TFM and the Board's request to the Secretariat to develop specific guidance to applicants, TRP disease focal points met with the Secretariat and Technical Partners in Geneva, Switzerland, in December 2011, to define the scope and scale for TFM[17] and discuss how best to engage with all stakeholders in preparation for the TRP review.

2.14 As agreed between the parties, TRP disease focal points met again with the Secretariat and Technical Partners in Geneva on 29 February 2012. The objective of this meeting was to: (i) review TFM requirements and its context in order to frame expectations on the scope and scale of services/interventions that could be funded; (ii) discuss concerns related to the scope and scale of services permissible in the context of the Board decision point on TFM for the continuation of essential prevention, treatment and/or care services; and (iii) discuss any

[15] The Global Fund Strategy Framework 2012-1016 is available on the Global Fund website.
[16] Decision Point GF/B23/DP14.
[17] Board Decision GF/B25/DP16, point #4.

recent technical developments. The outcomes of this meeting were captured in additional guidance to applicants to complement existing information and communication on TFM[18].

2.15 The TRP also held meetings with a number of Secretariat staff on 28 February 2012 to articulate the new information needs of the TRP with regards to the review of TFM applications, arising from the Board decision point on TFM. These sessions were extremely useful in preparation for the information required to carry out the TFM and ECFP-related assessments of proposals at the review meeting, particularly the contextual information that was provided by the Secretariat for internal use by the TRP in "Country Team Input Sheets".

Secretariat screening for eligibility and completeness

2.16 A total of 61 proposals were received from 48 applicants by 31 March 2012. The 48 applicants included 43 Country Coordinating Mechanisms (CCMs), three Non-CCM applicants and two Regional Coordinating Mechanisms (RCMs). Application materials were available in English, French, Spanish and Russian.

2.17 The Secretariat screening of TFM proposals for CCM eligibility and completeness took place from April to May 2012[19].

2.18 At its Twenty-Third Meeting in May 2011, the Board approved revised guidelines and requirements for CCMs. TFM was the first funding opportunity in which these updated guidelines were applied.

2.19 The outcome of eligibility screening is documented in **Annex 2** of this report, which details remedial actions and next steps for those applicants with indeterminate compliance issues.

[18] The document was entitled, "Supplementary Guidance on the Transitional Funding Mechanism" and was available in English, French, Spanish and Russian.

[19] A total of 14 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 the assessment of compliance with applicant-specific requirements and the Technical Review Panel.

Part 3: TRP membership and review meeting modalities

Membership for TFM

3.1 Membership of the TRP for TFM consisted of 39 experts, including the Chair and two Vice-Chairs[20]. It is important to note that TRP members include both disease experts on HIV/AIDS, tuberculosis and malaria, as well as broader health systems and development 'cross-cutting' experts in fields such as health financing, ethics, human rights, gender, and supply chain management. There were 15 members serving for the first time on the TRP, four of whom were Alternate Members. All had been recruited through the 2010 TRP replenishment process[21] and identified by the TRP Chair and Vice-Chairs, in consultation with the TRP focal points, for the review of TFM applications[22].

3.2 The TFM meeting was chaired by **Mr. Shawn Baker,** a cross-cutting expert from the United States of America. **Dr. George Gotsadze**, a cross-cutting expert from Georgia, and **Dr. Lucie Blok**, a cross-cutting expert from the Netherlands, served as the two Vice-Chairs.[23]

3.3 At the end of the TFM clarifications process, six 'TRP Permanent Members' will complete their term of service. The TRP and the Secretariat would like to acknowledge the contributions of **Dr. Ambrose Talisuna (malaria expert, Uganda), Dr. Ahmed Awad Abdel-Hameed Adeel (malaria expert, Sudan), Dr. Alison Heywood (cross-cutting expert, Australia), Beatriz Ayala-Öström (cross-cutting expert, Mexico/United Kingdom), Dr. Elsie LeFranc (cross-cutting expert, Jamaica) and Dr. Edith Lyimo (malaria expert, Tanzania)** and to sincerely thank them for their time and commitment to the work of the Global Fund.

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

3.4 The independence of the TRP and its members is fundamentally important to maintain the integrity and reputation of the TRP as an independent body of experts who makes funding recommendations in their personal capacities only, and on the basis of their judgment of technical merit. In this regard, TRP members must comply with the general Global Fund Policy on Ethics and Conflicts of Interest[24] and in addition, as stated in the TRP Terms of Reference[25], the TRP's internal guidelines to avoid any actual, potential or perceived conflicts of interest ("COI") and to ensure independence of the TRP (TRP COI Guidelines)[26]. This has been the TRP's practice since the early Rounds.

As the Secretariat is currently designing a new funding model, the TRP underlines the importance of aligning the current COI policies with the new modalities of such a model.

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[20] Please refer to Annex 5 for details.
[21] Decision Point B21/EDP/18.
[22] At its Twenty-Fifth Board Meeting, the Board delegated authority to the TRP Chair and TRP Vice-Chairs to appoint replacements for vacancies in the Permanent TRP and Alternate members from members of the TRP Support Group (Decision Point GF/B25/DP11).
[23] According to TRP internal practices, the incumbent Vice-Chairs were re-elected for a further one-year term at the review meeting.
[24] Please refer to the Global Fund Policy on Ethics and Conflicts of Interest.
[25] Please refer to the TRP Terms of Reference.
[26] Please see the revised Ethics and Conflict of Interest Guidelines for TRP Members (October 2011).

TRP meeting modalities

3.5 In order to prepare new members for the tasks ahead, four identical induction sessions were organized by the Secretariat prior to the review meeting. These were held remotely, facilitated by either the TRP leadership or TRP disease focal points, with the objective of introducing Global Fund policies, the grant architecture, TRP review modalities and internally agreed practices.

3.6 The first three days of the review meeting were dedicated to: (i) framing the establishment of TFM in the context of the Twenty-Fifth Board meeting in Accra, and in the broader context of the Global Fund Strategy 2012-2016; (ii) providing an overview of the review process specific to TFM applications, presenting the information and tools available to the TRP; (iii) discussion on the possible recommendation categories and next steps after the TFM review. In addition, there were briefings from the Office of the Inspector General and from the Secretariat on the grant renewals process.

3.7 Technical Partners were invited to the meeting for technical briefings, as well as to provide opportunity for Partners to provide their feedback regarding their experiences during TFM proposal development. These meetings built on the earlier meetings between TRP and Partners.

3.8 A mini-retreat was organized mid-way through the TRP meeting, which provided an important opportunity for the Secretariat to consult with the TRP on four key areas related to evolving the funding model: (i) information needs for TRP decision-making; (ii) the two-step process and TRP involvement; and (iii) roles and responsibilities of other actors; and (iv) the evolution of the TRP. This came at an opportune time to inform the work of the Secretariat on the new business model. During the mini-retreat, the TRP also discussed some internal TRP matters, including the term of service of TRP members and the TRP leadership[27].

3.9 The TRP also used the opportunity of the full TRP membership being together to review a sample of countries at different stages of the grant renewals pipeline (pre-assessment, request for continued funding etc.) to determine how best to implement the Board decision GF/B25/DP16 related to the TRP involvement in the grant renewals process.[28]

3.10 On 22 June 2012, the TRP held three post-review debriefing sessions which provided key observations coming out of the review and next steps for Country Teams managing TFM, applicants as well as for Technical Partners.

3.11 On 10 July, at the Third Meeting of the SIIC, the TRP Chair provided an update to the Committee on the TRP's review of TFM proposals, including outcomes, lessons learned and recommendations moving forward.

Proposal review methodology

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

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

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

[27] Given that TFM was not a Round and the Global Fund is moving away from Rounds, the TRP suggests that, in interim (i.e., until the new funding mechanism is established) the TRP term of service is linked to **years** of service instead of Rounds, to ensure smooth functioning of the TRP until the new policy is set.

[28] GF/B25/DP16 stipulates that "The TRP will support the renewals process by providing independent technical expertise to the Secretariat Panel making recommendations on grant renewals".

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

iv. a final plenary, for TRP discussion of the overall review process, consistency between findings and the confirmation of recommendation categories and final recommendations; and to capture lessons learned (from the TFM application review and renewals learning process) and make recommendations for the Global Fund moving forward.

3.13 Where the TRP had difficulty in reaching consensus in plenary sessions, the case was re-examined by the small review groups, in light of the plenary discussions, and if necessary by an additional reviewer. Decisions were eventually made after a full discussion at subsequent plenary sessions.

3.14 While each disease proposal was reviewed as a whole, the TRP did remove a limited set of elements of some proposals[29] that did not fit within the scope of the TFM requirements. This resulted in up-front budget removals for some recommended proposals, which is reflected in the overall upper-ceiling being recommended for funding by the TRP. Further budget amounts may have been queried by the TRP, in addition to other clarifications and adjustments, and may lead to additional reductions/adjustments during the clarification/grant negotiations process.

Technical review of proposals

3.15 The TRP's technical review remained focused on: i) soundness of approach; ii) feasibility; iii) potential for sustainability and impact; and iv) value for money, as per the criteria[30] defined in the TRP Terms of Reference[31].

Compliance with TFM requirements

3.16 In its review of proposals, the TRP took into account the TFM requirements and the context of the resource-constrained environment in which the Board's decision was taken to establish this funding mechanism. The TRP assessed whether: (i) the applicant had demonstrated a risk of disruption of essential prevention, treatment and/or care services currently funded by Global Fund during the TFM eligibility period (1 January 2012 to 31 March 2014); (ii) whether the activities requested were at the same scope and scale as existing grants; and (iii) whether the activities for which funding was sought could be funded by alternate sources of funding, including the re-programming of existing grants for the same disease component.

Compliance with new requirements as set out in the ECFP policy

3.17 The TRP was also required to assess compliance with certain requirements set out in the ECFP policy[32]. The TRP assessment of compliance formed a material part of the TRP review of proposals and of its funding recommendation.

a. **Counterpart financing:** Applicants had to demonstrate that they met the minimum thresholds of counterpart financing for the national disease program; and that contributions would increase overtime to the national disease program and the

[29] Not subject to appeal.
[30] The Terms of Reference of the Technical Review Panel, Attachment 1 "Proposal Review Criteria".
[31] Decision Point GF/B23/DP18 , which approved the most recent Terms of Reference.
[32] Available at:
http://www.theglobalfund.org/documents/board/23/BM23_14PICPSCJEligibilityAttachment1_Policy_en/

overall health sector. The counterpart financing thresholds differ according to an applicant's income category.

b. **Focus of proposals:** Lower-middle and upper-middle income countries had to ensure that either 50 percent or 100 percent of the proposal budget was focused on underserved and most-at-risk populations and/or highest-impact interventions. The level of proposal focus required differs according to the applicant's income category and the choice of funding pool.

c. **NGO rule:** Within the ECFP policy, there is a provision for upper-middle income countries not listed on the OECD's DAC list of ODA recipients[33] to submit HIV/AIDS applications for funding provided certain requirements are met. This provision is referred to as the "NGO Rule". This rule only applied to two of the three non-CCM applications received under TFM.

Documentation and quality assurance mechanisms

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

i. Secretariat documentation on existing grants (e.g. Country Team Input with additional contextual information on existing grants for each TFM component; Grant Performance Reports, Grant Scorecards, Applicant Disease Profiles[34], high-level budget reviews provided by the Secretariat and TRP review forms from previous funding opportunities);

ii. epidemiological data provided by UNAIDS and WHO (including country profiles for malaria 2011, country and financial profiles for tuberculosis 2012, UNAIDS country and epidemiological factsheets 2012 and UNGASS progress reports 2010-11); and

iii. where applicable, other relevant documents from Donors.

3.19 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. As mentioned in **Part 1** of this report, the TRP did agree on new recommendation categories which were more appropriate to the nature of TFM.

3.20 The TRP funding recommendations for each proposal reviewed is provided in an individual TRP Review Form (**Annex 4**). TRP Review Forms provide detailed explanations for the funding recommendation, including strengths and weaknesses, and requested clarifications where appropriate. In the case of Category 4 recommendations (requesting that the applicant submit a revised proposal), strong guidance on the scope of the revised proposal is provided.

3.21 Quality assurance is taken very seriously by the TRP and a number of measures were taken during the review process. These included the rotation of members of each small review group, as well as the TRP Chair and Vice-Chair supporting all review groups (reading

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[33] The Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD) publishes a list of countries eligible for Official Development Assistance (ODA).

[34] Following the implementation of the new Grant Architecture and the Board's requirement for all proposals to be presented in a consolidated manner, Applicant Disease Profiles (ADPs) were introduced for Round 11 and used for TFM. The tool provided information on the country and epidemiological contexts, consolidated programmatic and financial information about the performance and achievements of the portfolio of active Global Fund grants, disbursement and expenditures, and results per program area. It was created to help applicants in the development of a (consolidated) proposal and used by the TRP in their review of the same. All relevant ADPs were updated to include the most recent information prior to the review meeting.

proposals assigned to small review groups and observing/participating in small review group discussions). The final plenary day was also used to ensure consistency of funding recommendations, particularly in relation to the assessment of compliance with TFM and ECFP requirements. The TRP Review Forms were also subject to a number of quality assurance measures, including the sign-off from the relevant disease focal point and the TRP Chair or Vice-Chair who had supported the small review group.

FOR INPUT

Part 4: Lessons learned, observations and recommendations

4.1 This section documents the lessons learned by the TRP during their review of TFM proposals and provides recommendations for applicants, the Global Fund Board, Partners and the Secretariat for consideration in future funding opportunities. The TRP acknowledges that the lessons learned as described below are based on proposals that were developed under very different circumstances than the Rounds-based system, the product of a technical review which was different in scope from previous Rounds and the fact that the Global Fund's business model is to change following TFM. Nevertheless, the TRP believes that there are important messages in the recommendations presented below, which can be taken into account in the context of a new funding opportunity. For ease of reference, all recommendations are presented in bold text.

GENERAL

The scope of TFM

4.2 Overwhelmingly, the proposals received and reviewed adhered to the spirit of TFM, which is a testament to the good faith effort on the part of applicants, Technical Partners and the Secretariat to responsibly manage the resource-constrained situation that led to the implementation of TFM by the Board.

4.3 The TRP notes that TFM funding requests were limited to the continuation of essential services already funded by existing grants, and that these existing grants are based on proposals that were written five years ago or more. This limitation may have had an unintended negative effect on other essential services which happen not to have been previously funded under Global Fund grants, but are nevertheless also very important. This was particularly evident for services for most-at-risk populations and prevention services.

4.4 TFM will help *maintain* gains in those countries that have been successful in addressing critical services and approaching global targets. However, those countries which are lagging behind have not been permitted to *accelerate* efforts through TFM, despite the fact that some countries have the will and capacity to do so.

The TRP recommends that the Global Fund gives special attention to such cases in the new funding opportunity.

The following general observations and recommendations have been grouped into three priority areas: (a) Global Fund influence over human rights and increased domestic investment; (B) Strategic information; and (c) Investment models.

A. Global Fund influence over human rights and increased domestic investment

4.5 Despite a decade of massive investment by the Global Fund, the TFM review demonstrated only feeble advances in improvement of the human rights environment as concerns disease outcomes, and in catalyzing increased investments from domestic resources to address the three diseases. This may well be a structural issue, as legal agreements are with Principal Recipients (PRs), and even when these are Government PRs they are seldom in a position to be held accountable (or demand accountability) for human rights and domestic financing commitments.

The TRP recommends that the Global Fund consider entering into compact agreements with recipient country governments (prioritizing those with highest

levels of disease burden and Global Fund investments) at the highest political levels, to lay out a road map for improvement of the human rights environment and monitoring/accountability for the level of domestic investments in the areas of the three diseases.

Human rights

4.6 The TRP notes that human rights related actions (e.g. ensuring equitable access to quality services, removing human rights-related barriers and creating supportive environments) continue to be insufficiently addressed and articulated in Global Fund proposals. In fact, evidence of progress is often lacking in many proposals. There were many stark examples where, despite its massive investment, the Global Fund seems to have had little or no influence in leveraging impact on human rights.

4.7 The TRP noted that in some cases serious human rights violations that have been documented elsewhere were never discussed in the proposals, despite the fact that these issues may represent major impediments to the implementation of Global Fund-supported programs.

The TRP recommends that, in order to ensure effective program implementation, applicants should be instructed that human rights-related issues be given due importance in the discussion of how the proposal will be implemented, and that failure to do so will jeopardize the application. The TRP recommends that more attention be given to developing monitoring frameworks that allow the tracking of progress and placing of accountability for human rights interventions related to the success of Global Fund-supported programs using defined indicators. The Global Fund should consider entering into agreements with recipient country governments (beyond the Principal Recipient) to define commitments to remove human rights constraints that have negative impacts on disease outcomes.

The Secretariat, in consultation with the TRP, should work to develop criteria and application requirements to ensure human rights issues relevant to the application under consideration are appropriately described and concretely addressed in materials submitted for future funding opportunities and submit these requirements to the Board for review and approval.

The Global Fund should work to identify means to provide essential services to these populations, including, where necessary, more proactive engagement for submission of non-CCM proposals (in line with the Sexual Orientation and Gender Identity strategy).

Counterpart financing

4.8 TFM was the first funding opportunity in which the TRP was requested to assess country compliance with the new counterpart financing requirements set out in the ECFP policy. The fundamental issue associated with compliance with this requirement is the *credibility* of data provided by countries:

i. **Availability and veracity of data**: In the absence of routine expenditure tracking systems in most countries, the health and disease expenditure data provided by countries are missing, imprecise, and/or ad hoc, and inconsistent. There are very limited ways for the TRP to validate the information at the time of proposal review. For example, the TRP noted cases where the same country, referencing same source document provided completely different data in different disease proposals;

ii. **Potential for the 'manipulation of figures' in order to meet the established threshold**: The TRP noted cases in which counterpart financing levels

were at a similar percentage level for all three diseases, therefore appearing questionable; and

iii. **Under or overestimating shared health system costs**: In countries where the disease programs are well integrated into the health system, estimating the non-disease targeted or shared health systems costs, such as human resources and hospital beds, and attributing them to the disease expenditures is likely to be very imprecise or arbitrary.

In light of this, the implementation of the counterpart financing provision in the ECFP policy is very challenging for the TRP. For the current Board policy to be seriously applied (and the TRP strongly feels it should be), the TRP and the Grant Renewals Panel must be assured of strong Secretariat support which presents country profiles describing the budgetary context and commenting on the government contribution (past expenditures and future allocations), as well as the past and expected future financial support from other sources. This is necessary to properly review the data in the financial gap analysis table.

These profiles should contain health sector and disease expenditure figures that can be validated with the Technical Partners' databases, including the WHO National Health Accounts (NHA) database, along with program financing history and the budgetary policy context in the given country. Without this complementary information, review of and commentary on the data provided in the gap analysis table is not feasible.

Human resources and sustainability

4.9 Significant funding was requested for human resources despite the limited scope of TFM. The TRP notes that in many instances applicants continue to depend on Global Fund support for human resources even after five to seven years of Global Fund support.

The TRP recommends that applicants start developing plans for taking on these recurrent costs and have a monitoring framework that allows tracking of progress over the course of a grant period to ensure longer-term sustainability. The TRP recognizes that this situation is different for salaries in non-governmental organizations and that there is particular urgency for such planning in upper-middle income countries.

Heavy reliance on external funding for community interventions

4.10 The TRP is concerned about the sustainability of programs that heavily rely on community interventions for their success (e.g. community DOTS to improve case detection, case holding for tuberculosis). The TRP recognizes the critical nature of these approaches, however these activities are often entirely left for civil society organizations to implement with donor funds and without government contribution. While there are examples where the government has started to assume responsibility through different models (including using domestic resources to fund civil society organizations), many proposals contained activities that continue to be fully funded by external resources, with very little uptake from the national government in absorbing part of the costs and delivering funding to CSOs.

In order to ensure the sustainability of certain programs, the TRP recommends that national governments begin to assume some of the costs of community interventions that are currently funded entirely by external sources, such as community worker salaries and volunteer stipends and/or grants to CSOs. Future proposals are expected to demonstrate shared responsibility for these costs and a clear plan to transition from external funds.

Global Fund engagement in national and donor reviews

4.11 The TRP noted a lack of transparency in documentation (or absence thereof) on what other donors are supporting in the application and the country at large. The very limited information available on which donors are supporting what activities in-country made the TRP's assessment challenging.

In order to ensure more leverage of Global Fund investments as recommended above, it is important, in the context of an evolving model, that the Secretariat Country Team representatives participate in relevant national or donor coordination meetings and reviews. This will allow the Global Fund to obtain important feedback about its grants and developments in the sector, as well as to align Global Fund processes (such as periodic reviews) with national reviews. It will also allow the Global Fund's representatives, through informal exchanges, to more deeply understand the issues and challenges in the sectors in which it is involved.

B. Strategic information

4.12 Strategic information is a key input into the TRP's decision making. When data are weak, patchy or inconsistent, and when implementation progress cannot be measured or when program achievements cannot be clearly established, this makes the task of the TRP all the more difficult to assess technical soundness, value for money and make recommendations on strategic investments.

Lack of evidence of programmatic achievements

4.13 The TRP was concerned over the consistent lack of, or inadequate evidence, presented in TFM applications on past programmatic achievements, despite years of Global Fund support for a particular disease program. The TRP was particularly cautious in recommending activities that had shown no evidence of progress at the outcome level and therefore did not represent good value for money.

The TRP recommends that applicants and the Secretariat ensure that Global Fund-supported programs that have been implemented for several years provide robust evidence of programmatic achievements at the very least at the outcome level. This should be based on efficient monitoring and evaluation (M&E) systems as well as independent evaluations. This evidence should underpin and inform the design of interventions included in new applications. As the TRP has consistently emphasized in previous reports, funding requests should be informed by evidence and built on lessons learned.

Performance frameworks

4.14 In general, the TRP notes that performance frameworks continue to be weak. Overall, the TRP did not feel it had enough information on what activities were being carried out on the ground, or their achievements after five years or more of implementation.

4.15 Performance frameworks were very often not focused on the right populations, and emphasis was frequently placed on national indicators at the expense of those that would allow the TRP to make a robust assessment of whether a Global Fund-supported program was having the desired impact or not. While Global Fund indicators should feed into national indicators where appropriate, national indicators by themselves generally do not provide sufficiently disaggregated data to assess Global Fund-supported program performance, outcomes and impacts. This is a weakness that has been repeatedly identified by the TRP in previous Rounds.

The TRP recommends that performance frameworks and M&E approaches be strengthened to allow for better monitoring of outcome and impact indicators directly relevant to the program activities proposed. For example, performance assessment should be based on the number of condoms used by specific targeted populations, rather than the number of condoms distributed.

Strengthened data quality and use

4.16 The TRP stresses the need for data quality, adequate data collection and analysis systems, and adequate resources for data collection.

The TRP requests that the Secretariat consider a data access policy where information collected from the Global Fund goes into the public domain after a reasonable period of time. This would increase the utility of the data, and would allow more extensive use for decision-making by the Global Fund, other Partners and national programs.

4.17 The TRP also recognizes the need to develop better guidance on some of the data and monitoring and evaluation components, in terms of what applicants include in proposals and what is happening at the country level. This should include the required level of capacity, appropriate protocols, analysis recommendations, and report guidelines. More emphasis should be placed on building evidence on effectiveness of interventions and lessons learned.

4.18 The TRP believes that Global Fund grants need to be driven by strengthened routine data flow and collection, ongoing analyses of these data, and their regular use as a tool for program management and program strengthening, in addition to periodic reviews at longer intervals. **The TRP expects stronger M&E systems, with more frequent assessments of implementation progress, rather than only at three-year intervals that provide little information on a program's activities and/or performance.**

Secretariat country contextual information

4.19 As an input into its review, the TRP received country contextual information (in the form of Country Team Input Sheets) from the Secretariat in order to facilitate its assessment of TFM proposals. This information was received for all proposals and overall the TRP found this documentation extremely useful in its decision-making processes. However the TRP noted that there was inconsistency between them in terms of quality and comprehensiveness.

4.20 Overall, the TRP notes an improvement in the quality of information from the Secretariat on existing grants and would welcome the opportunity to continue to engage on improving the quality of such information.

Knowledge management

4.21 The TRP recognizes the need for the Secretariat to systematically organize strategic information. One of the difficulties faced in reviewing applications is the variability in information on the epidemiological situation, human rights challenges, donor landscape and other relevant factors available in the application packages. Some applicants included extensive annexes containing such information, while others did not. Some described in detail the contribution of and programs supported by other donors related to those in the application, while others sometimes exclude such information entirely. Thus, requests for more clarity on such contributions and programs are common in the clarifications process and further delay the processing of grants. While such information is frequently in reports

obtained by Country Teams, the Secretariat and the Technical Partners as part of their duties, it is not organized and centralized in a way that makes it accessible to the TRP.

The TRP recommends that national and regional strategic and operational plans, partner reports, epidemiological analyses, human rights analyses, behavioral and programmatic studies, and donor information be organized for easy access by the Secretariat, applicants and the TRP. These should be readily available to the TRP during the application review process.

C. Investment models

4.22 While TFM was established as an interim mechanism to sustain the critical gains already achieved, the context of TFM and its review accentuated some of the shortcomings of the current Global Fund architecture, and the processes to access funding. The following lessons learned and observations aim to provide meaningful recommendations to the Secretariat, Partners, Donors and applicants as the Global Fund considers options for a new funding model.

Summary analysis of Global Fund investments

4.23 It is important that the TRP have the overall view of the grant portfolio in its decision-making processes. The TRP finds the Global Fund grant landscape difficult to comprehend from the voluminous existing documentation on separate grants. The TRP recognizes that the move towards a single stream of funding will help address this issue, and encourages countries and the Secretariat to accelerate this process. In the meantime, **the TRP recommends that a summary sheet be developed that presents past grants together with active ones and that the TRP have the overall view of the past and present grant portfolio. In cases where the grant landscape is particularly complex (multiple, concurrent grants in different stages of the grant lifecycle, some of which may have been or will be consolidated), the TRP recommends that the overview also be represented graphically with timelines.**

Multiple entry points to access funding

4.24 A number of applicants that submitted a funding request under TFM had ongoing grants from previous Rounds, the Rolling Continuation Channel, National Strategy Applications and the renewals of these grants. The TRP notes the contradictions and tensions between different funding channels, and notes the challenges that multiple entry points to access funding brings to the assessment of a disease program and the overall monitoring and evaluation of activities. This issue was more pronounced due to the TFM requirement to evaluate the 'disruption' of essential services and the 'need' for additional funding.

The TRP requests that these challenges be considered in the development of the new funding model.

Consolidation of proposals

4.25 A relatively low number of applicants presented consolidated proposals for TFM, despite many having ongoing grants over the period of the TFM funding request. While in the context of TFM, the consolidation of proposals and performance frameworks posed some challenges to the review, the TRP would like to reiterate the importance of having a consolidated overview of an applicant's portfolio for its assessment. **Given the inter-linkages between the three diseases and the common link to health systems**

strengthening, the TRP would like to see this extended to the whole portfolio, and not just to the specific disease.

Other investments

4.26 In order to review the technical merit of a particular program, the TRP needs a clear picture of the investments being made by other donors, as well as domestic resources (see also 4.8.iii above). **It is important that the TRP be able to assess whether there is adequate coverage of a program in the national context.**

Costs of prevention and care

4.27 **The TRP recommends the development of regional guidance (including estimates and costing) of testing, prevention and care activities, such as unit costs for particular types of interventions**. Without such guidance, the evaluation of budgets in a given country context becomes very challenging.

Approach to proposals with late start dates

4.28 The TRP noted that there were many proposals that would only face disruption at the end of 2013 and beginning of 2014. In many cases it was difficult for the TRP to evaluate the scale of disruption and whether or not there were alternative sources of funding. **For all recommended proposals, the TRP is requesting that the Secretariat reassess at the time of grant signing the scale of disruption and availability of alternative resources to fund the activities.**

The role of United Nations agencies

4.29 As mentioned in previous reports, the TRP continues to support local capacity development and continues to be concerned about the role and the number of United Nations (UN) agencies being nominated as Principal and Sub-recipients (PRs and SRs) after almost a decade of Global Fund investments. The TRP reiterates its concern that the continued use of UN agencies as PRs and SRs may create parallel systems, fail to build local capacity and not represent value for money. The TRP continues to recognize the important role played by UN agencies in terms of providing technical assistance to countries in the development and implementation of strategic approaches, as well as proposal development support, and is concerned that playing the role of PR or SR may compromise their critical technical assistance role.

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

HIV/AIDS

The marginalization of most-at-risk populations

4.30 The TRP was particularly concerned over the fact that activities for most-at-risk populations (MARPs) were often reduced in scale or removed altogether under TFM. Furthermore, the TRP notes that there were serious reductions in the number of community-based organizations (CBOs) working in this domain.

4.31 The TRP noted that there were reductions in targets associated with MARPs, which for the most part are poorly monitored and absent from performance frameworks. In some cases, activities mentioned in the proposal were not included in the budget even though listed as a priority.

4.32 It was further noted that requests to sustain treatment services rarely discussed issues of access for most-at-risk populations to essential anti-retroviral therapy (ART) and counseling and testing services, despite the fact that these populations are often over-represented in the population with ART need and frequently have more limited access to ART support that meets their communities' needs.

4.33 The TRP observed that overall there is a lack of knowledge among applicants regarding most-at-risk populations. The TRP acknowledges that size estimates of MARPs change frequently, but this issue was exacerbated by the absence of coverage and in-country effectiveness assessments of the various programs supported by Global Fund or by others donors. This made it impossible for the TRP to assess whether a program in a given country was having the desired outcome(s) and whether or not countries are delivering on what had been promised. Particularly concerning were the very limited number of long-running Global Fund-supported programs where TFM applications did not provide any locally generated evidence of effectiveness and impact in affected populations, despite the explicit request for such evidence in the application form.

The TRP recommends that applicants ensure that MARPs-related interventions are solid and based on evaluated previous experiences and lessons learned. Proposed approaches should be well articulated in proposals and have clear potential for sustainability.

Lack of prevention activities in TFM requests

4.34 Despite the fact that applicants could request funding for the continuation of both essential prevention and treatment services, the TRP observed that there was a stronger emphasis on treatment activities over HIV prevention activities and services in TFM proposals. This may have been due to a more limited interpretation of "essential services" on the part of applicants than was originally intended; however prevention gains are among those that TFM is intended to sustain.

The TRP notes that in order to sustain the critical prevention gains already achieved, it is important that applicants allocate the needed resources to prevention activities. Furthermore, investments are needed to assess the effectiveness of prevention activities that have been implemented for five years or more (e.g. RCCs).

4.35 The TRP takes this opportunity to emphasize the fact that that prevention goes beyond mere commodities. In order to make its assessment as a technical body, the TRP needs detailed descriptions of prevention activities, which include what is being done, how is it being done, who is doing it, what access they have to the targeted populations, where is it being done, what barriers are faced, how those barriers are being addressed, and what has been achieved. The TRP observed and was concerned that applicants, for the most part, did not provide details in proposals, and the lack of detail was particularly pronounced for activities relating to most-at-risk populations. Based on the information reviewed, the TRP noted that overall assessments of progress made to date were generally of very poor quality. The TRP was very concerned about the apparent lack of effectiveness of prevention programs.

The TRP underscores the need for applicants to include more details regarding prevention activities proposed, as well as to provide adequate budgeting for the monitoring and evaluation of the same.

4.36 It was noted that overall prevention indicators did not reflect actual grant performance, which inhibited the TRP from assessing progress made towards targets.

The TRP recommends that prevention indicators for coverage, effectiveness (knowledge and/or behavioral improvements) and impact (epidemiological outcomes) be included in proposals. These need to include indicators for both Global Fund and non-Global Fund coverage areas so that the TRP can assess national progress towards Global Fund and national targets. Regular collection and analysis of outcome data against program exposure data should be included in Global-Fund programs to allow better assessment of their effectiveness.

Prevention of mother-to-child transmission (PMTCT)

4.37 Thirteen of the 26 HIV/AIDS proposals included prevention of mother-to-child transmission activities. **The TRP notes that adoption of new policies needs to be supported by clear policies and plans on how prevention and elimination of mother-to-child transmission (e-MTCT) strategies will be implemented, in particular as it relates to the implementation of new guidelines.**

TB/HIV collaborative activities

4.38 Cutting across both the HIV and tuberculosis-specific observations and recommendations, the TRP acknowledges that many countries have made progress with regards to TB/HIV collaborative activities. However, there was limited inclusion of these activities in TFM proposals. The TRP has consistently flagged the inclusion, or lack thereof, in all relevant TRP Review Forms as the TRP notes this is a requirement for all HIV and tuberculosis proposals.

The TRP recommends that applicants and Technical Partners remain vigilant in ensuring the inclusion of tuberculosis/HIV collaborative activities as appropriate and in line with the Board's decision.

TUBERCULOSIS

4.39 The TRP was encouraged to see, and welcomes the positive trend of governments committing to funding first-line tuberculosis drugs as part of their overall health budgets for tuberculosis.

4.40 Overall, the TRP found that tuberculosis proposals were generally well focused on essential services. However, proposals commonly reflected an overly narrow interpretation of TFM guidance, removing elements such as lab activities/costs and community involvement which would have been deemed essential by the TRP.

Quality of the service delivery of DOTS

4.41 The TRP noted that many TFM proposals were not protecting the quality of core DOTS implementation for drug-sensitive tuberculosis. Improving the quality of programming was not prioritized, even in countries where case notification and treatment success rates remain alarmingly low or in some instances are in decline. The TRP was very concerned that poor service delivery is effectively breeding multi-drug resistant tuberculosis (MDR-TB) in countries. Overall the TRP noted that applicants tended to favor the inclusion of MDR-TB activities at the expense of core DOTS interventions for the more numerous drug-sensitive cases.

4.42 There were limited activities to promote treatment adherence (e.g. community involvement) and case detection among hard-to-reach populations included in proposals.

4.43 The TRP was concerned about the quality of smear microscopy, as there was insufficient focus to ensuring the quality of diagnostic networks overall and specifically for microscopy.

4.44 The TRP noted that while drug stock-outs were addressed in some proposals, there was a lack of activities to strengthen related systems to ensure the effective procurement and delivery of these drugs.

It is imperative that applicants and Technical Partners work together to improve the quality of DOTS implementation and ensure that the gains that have been made in some countries are not jeopardized, while promoting higher quality programs in others.

MDR-TB interventions

4.45 There was substantial focus on MDR-TB interventions in TFM proposals, often at the expense of quality DOTS programs (as noted above), and this even in contexts where the management of drug-sensitive cases is sub-optimal.

4.46 The TRP noted the rapid expansion of programmatic management of drug-resistant tuberculosis (PMDT), without giving adequate attention to quality assurance, and in some instances, despite poor treatment outcomes. This is of particular concern when evidence indicates that poor MDR-TB programs may be breeding extensively drug-resistant tuberculosis (XDR-TB). Furthermore, the TRP noted that WHO 2011 guidance is not being consistently applied by countries.

Applicants should not focus on increasing the detection and enrolment rate of MDR-TB patients without ensuring sufficient attention is given to the quality of their treatment, i.e. treatment success.

The TRP recommends the articulation of globally-endorsed target(s) for MDR-TB treatment outcomes, as a measure against which programs can be assessed.

New diagnostic technologies

4.47 As noted in previous Rounds, the TRP remains concerned by the absence of clear diagnostic algorithms that incorporate the use of new diagnostic technologies for tuberculosis. In light of several new diagnostic technologies, there is the need for increased technical assistance in this area to ensure efficient placement of the technologies and their appropriate and quality assured use.

4.48 There was limited inclusion of Xpert[35] in TFM proposals and only in rare instances did applicants include the use of x-ray, which is an important technology for confirming smear negative tuberculosis, as well as for diagnosing tuberculosis in children.

4.49 The TRP was also concerned at the over-use of expensive tests, e.g. drug sensitivity testing (DST) of all new smear-positive cases in low-MDR contexts.

4.50 The TRP further noted that there was limited external quality assurance (EQA) and proficiency testing included in proposals.

[35] A diagnostic which dramatically reduces the time for detection and replaces culture methods and also delivers additional data on drug sensitivity.

The TRP recommends that Partners provide increased technical assistance to countries to ensure that the new diagnostic technologies proposed are supported by clear diagnostic algorithms, and that that the most appropriate technologies are included in proposals.

Measuring intervention effectiveness

4.51 The TRP noted that food support, as an incentive of adherence to TB treatment, was included in a number of proposals, but with limited evidence of its effectiveness in a given country/program.

4.52 Similarly, advocacy, communication and social mobilization (ACSM) activities were included in proposals with limited evidence of their effectiveness.

The TRP encourages Technical Partners to work on monitoring and evaluation tools to help countries measure the effectiveness of programs of food support and other patient support (e.g. psychological support) that provide incentives for improving adherence. Partners are also encouraged to measure the effectiveness of ACSM activities so that the TRP is able to make evidence-based funding recommendations, ensuring good value for money.

MALARIA

Responding to impact of malaria control

4.53 The TRP recognizes that many countries are making rapid progress in malaria control resulting in changes in the epidemiology of the disease. There is therefore a need for malaria risk mapping and country disease trends to be updated frequently and interventions tailored appropriately. For example, intermittent preventive treatment (IPT) in pregnancy and infants is only recommended for areas of high transmission, and surveillance approaches need to be adapted to changes in epidemiology.

In light of the rapid changes in epidemiology for malaria, Technical Partners are asked to assist countries to update their risk maps for malaria, which should form the basis for future funding requests. Based on these risk maps, Technical Partners should provide clear and regular guidance on which interventions are most appropriate with regards to the country's epidemiological context and operational feasibility.

Prevention and control strategies

4.54 The TRP reviewed proposals that demonstrated marked reduction of malaria transmission to levels at which a switch from malaria control to malaria elimination could be justified. However, in one such case, activities associated with the universal coverage of nets were proposed, which is a control strategy. Countries have general guidance and 'milestones' for transmission from malaria control to malaria elimination. However, these guidelines need to be adjusted for each country and situation. For example, countries adopting universal coverage for vector control intervention should have clear guidance when they should switch from total coverage to management of foci, which is a strategy for malaria elimination.

Partners should give technical guidance to individual countries that achieved significant reduction in malaria transmission to adopt appropriate policies for control, pre-elimination or eradication of malaria, based on an updated epidemiological context and the appropriate assessment of feasibility.

Mass campaigns for LLINs

4.55 The TRP notes that there are countries with mature malaria programs which included mass campaigns and, at the same time, routine distribution of bed nets to mothers and children under five years of age. The quantification models for these campaigns need to be closely examined.

The TRP recommends that Technical Partners revisit the quantification models for mass distribution campaigns of long-lasting insecticide-treated (LLINs) which aim to achieve universal coverage.

Bed net lifespan

4.56 The TRP recognized that the TFM demand for bed net replacement (72 percent of the total funds requested for malaria) was very modest compared to the global need. The TRP also noted that a three-year lifespan of bed nets is used as a basis for the quantification of bed net replacement. There is a need for more contemporary evidence on the lifespan of bed nets in various contexts. The TRP notes that if the effective lifespan of a bed net is shorter, programs will not have optimal impact; inversely, if the effective lifespan is longer, resources are not being used efficiently.

The TRP recommends that an index of effective lifespan for LLINs be developed that combines both the physical durability of the bed net and the persistence of the insecticide.

The TRP recommends that countries should be assisted to conduct operational research to provide contemporary evidence on the appropriate lifespan of LLINs in different contexts.

Quantification models for diagnostics

4.57 The TRP notes that as countries shift to parasite-based diagnosis, there is a need for a redefinition of the quantification models for diagnostics, primarily for rapid diagnostic tests (RDTs).

Partners should provide countries with updated quantification models for diagnostics that take into account their local context e.g. their potential for expansion in deployment of RDTs and expansion of home management of malaria.

4.58 The TRP notes that applicants need to focus more attention on routine measurement of the quality of antimalarial drugs given the threat posed by sub-standard medication.

Countries should be assisted to establish systems for sustained routine surveillance for the quality of antimalarial drugs.

List of eligible TFM proposals reviewed by the TRP, classified by recommended category

No.	Applicant type	Applicant	Income level (from Global Fund's eligibility list of 2012)	WHO Region	Global Fund Regional Team	Disease	Funding Pool	TRP Recommended* 2-Year upper ceiling**
PROPOSALS RECOMMENDED FOR FUNDING BY THE TRP								
				CATEGORY 1				
1	CCM	Bhutan	Lower-LMI	SEARO	SEA	Malaria	General	$ 850,210
Sub-Total: Category 1 Proposals in US$								**$ 850,210**
Total: Category 1 Proposals in US$ Equivalent								**$ 850,210**
				CATEGORY 2				
2	CCM	Burkina Faso	LI	AFRO	CA	Malaria	General	€ 38,264,884
3	CCM	Chad	LI	AFRO	WA	Malaria	General	€ 21,368,712
4	CCM	Togo	LI	AFRO	CA	Tuberculosis	General	€ 1,047,120
Sub-Total: Category 2 Proposals in EURO								**€ 60,680,716**
5	CCM	Ethiopia	LI	AFRO	HI Africa II	Malaria	General	$ 45,191,147
6	CCM	VietNam	Lower-LMI	WPRO	SEA	Malaria	General	$ 7,427,970
7	CCM	Yemen	Lower-LMI	EMRO	MENA	HIV	General	$ 882,058
8	CCM	Zambia	Lower-LMI	AFRO	HI Africa II	Malaria	General	$ 24,362,329
Sub-Total: Category 2 Proposals in US$								**$ 77,863,504**
Total: Category 2 Proposals in US$ Equivalent								**$ 154,682,863**
				CATEGORY 3				
9	CCM	Benin	LI	AFRO	CA	Malaria	General	€ 5,825,702
10	CCM	Benin	LI	AFRO	CA	Tuberculosis	General	€ 1,559,725
11	CCM	Central African Republic	LI	AFRO	MENA	HIV	General	€ 15,088,317
12	CCM	Guinea-Bissau	LI	AFRO	WA	HIV	General	€ 10,216,357
13	RCM	Multi-c Af (West Africa Corridor Program)	Mixed	AFRO	CA	HIV	General	€ 6,937,801
14	CCM	Niger	LI	AFRO	WA	Malaria	General	€ 13,552,264
15	CCM	Romania	UMI	EURO	EECA	Tuberculosis	Targeted	€ 3,632,193
16	Non-CCM	Russian Federation IDU ESVERO (Round 5)	UMI	EURO	EECA	HIV	Targeted	€ 3,752,733
Sub-Total: Category 3 Proposals in EURO								**€ 60,565,092**
17	CCM	Afghanistan	LI	EMRO	SEA	HIV	General	$ 3,744,102
18	CCM	Angola	Upper-LMI	AFRO	SA	HIV	General	$ 15,177,448
19	CCM	Bhutan	Lower-LMI	SEARO	SEA	HIV	General	$ 987,708
20	CCM	Bhutan	Lower-LMI	SEARO	SEA	Tuberculosis	General	$ 751,144
21	CCM	Botswana	UMI	AFRO	SA	Tuberculosis	Targeted	$ 2,755,576
22	CCM	Burundi	LI	AFRO	CA	Tuberculosis	General	$ 2,592,114
23	CCM	Djibouti	Lower-LMI	EMRO	MENA	HIV	General	$ 5,456,219
24	CCM	Egypt	Lower-LMI	EMRO	MENA	HIV	General	$ 4,032,535
25	CCM	Egypt	Lower-LMI	EMRO	MENA	Tuberculosis	Targeted	$ 3,794,327
26	CCM	Guatemala	Upper-LMI	AMRO	LAC	Tuberculosis	General	$ 2,162,547
27	CCM	Indonesia	Upper-LMI	SEARO	HI Asia	Malaria	General	$ 18,185,770
28	CCM	Jamaica	UMI	AMRO	LAC	HIV	Targeted	$ 4,975,268
29	CCM	Lao (People's Democratic Republic)	Lower-LMI	WPRO	SEA	Malaria	General	$ 6,444,995
30	CCM	Malawi	LI	AFRO	CA	Tuberculosis	General	$ 4,677,100
31	CCM	Mozambique	LI	AFRO	HI Africa II	Tuberculosis	General	$ 8,671,151
32	RCM	Multi-c Western Pacific	Mixed	WPRO	SEA	Tuberculosis	General	$ 3,509,605
33	CCM	Philippines	Lower-LMI	WPRO	HI Asia	HIV	Targeted	$ 4,989,198
34	Non-CCM	Russian Federation OHI (Round 3)	UMI	EURO	EECA	HIV	Targeted	$ 4,999,809
35	CCM	Sierra Leone	LI	AFRO	CA	Tuberculosis	General	$ 3,265,946
36	CCM	Swaziland	Upper-LMI	AFRO	SA	HIV	General	$ 13,232,298
37	CCM	Syrian Arab Republic	Upper-LMI	EMRO	MENA	Tuberculosis	Targeted	$ 2,073,885
38	CCM	Tajikistan	LI	EURO	EECA	Tuberculosis	General	$ 17,127,733
39	CCM	Tajikistan	LI	EURO	EECA	HIV	General	$ 6,484,621
40	CCM	Tajikistan	LI	EURO	EECA	Malaria	General	$ 1,727,684
41	CCM	Tanzania (United Republic)	LI	AFRO	HI Africa II	Tuberculosis	General	$ 8,290,952
42	CCM	Timor-Leste	Lower-LMI	SEARO	SEA	Tuberculosis	Targeted	$ 2,850,782
43	CCM	Uzbekistan	Lower-LMI	EURO	EECA	Tuberculosis	General	$ 29,181,882
44	Non-CCM	West Bank and Gaza	Lower-LMI	EMRO	MENA	HIV	Targeted	$ 1,202,391
45	CCM	Zambia	Lower-LMI	AFRO	HI Africa II	Tuberculosis	General	$ 4,204,126
Sub-Total: Category 3 Proposals in US$								**$ 187,548,916**
Total: Category 3 Proposals in US$ Equivalent								**$264,221,899.94**
Total: Proposals Recommended for Funding (Category 1, 2, 3) in US$ Equivalent								**$ 419,754,973**

No.	Applicant type	Applicant	Income level (from Global Fund's eleigibility list of 2012)	WHO Region	Global Fund Regional Team	Disease	Funding Pool	Requested upper ceiling (2 Years)
PROPOSALS RECOMMENDED TO SUBMIT A REVISED PROPOSAL SUBJECT TO A SECOND TRP REVIEW PRIOR TO FUNDING								
				CATEGORY 4				
46	CCM	Azerbaijan	UMI	EURO	EECA	TB	General	€ 7,865,280
47	CCM	Niger	LI	AFRO	WA	HIV	General	€ 8,487,001
Sub-Total: Category 4 Proposals in EURO								**€ 16,352,281**
48	CCM	Ethiopia	LI	AFRO	HI Africa II	HIV	General	$ 8,439,831
49	CCM	Ghana	Lower-LMI	AFRO	HI Africa I	HIV	General	$ 20,233,386
50	CCM	Mauritania	Lower-LMI	AFRO	MENA	HIV	General	$ 4,818,040
51	RCM	Multi-c Western Pacific	Mixed	WPRO	SEA	HIV	General	$ 5,889,580
52	CCM	Sri Lanka	Lower-LMI	SEARO	SEA	TB	General	$ 4,325,931
53	CCM	Sudan South	LI	EMRO	MENA	HIV	General	$ 12,003,699
54	CCM	Sudan South	LI	EMRO	MENA	TB	General	$ 9,345,111
55	CCM	Suriname	UMI	AMRO	LAC	HIV	Targeted	$ 980,476
56	CCM	Tunisia	UMI	EMRO	MENA	HIV	Targeted	$ 4,484,845
Sub-Total: Category 4 Proposals in US$								**$ 70,520,899**
Total: Proposals Conditionally Recommended for Funding (Category 4) in US$ Equivalent								**$ 91,222,233**

No.	Applicant type	Applicant	Income level (from Global Fund's eleigibility list of 2012)	WHO Region	Global Fund Regional Team	Disease	Funding Pool	Requested upper ceiling (2 Years)
PROPOSALS NOT RECOMMENDED FOR FUNDING BY THE TRP								
				CATEGORY 5				
57	CCM	Serbia	UMI	EURO	EECA	HIV	Targeted	€ 3,400,000
Sub-Total: Category 5 Proposals in EURO								**€ 3,400,000**
58	CCM	Nepal	LI	SEARO	Southern and Eastern Asia	Malaria	General	$ 7,251,099
59	CCM	Nicaragua	Lower-LMI	AMRO	LAC	Malaria	Targeted	$ 1,185,594
60	CCM	Tanzania (United Republic)	LI	AFRO	High Impact Africa II	HIV	General	$ 66,469,743
61	CCM	Yemen	Lower-LMI	EMRO	MENA	Malaria	General	$ 14,422,586
Sub-Total: Category 5 Proposals in US$								**$ 89,329,022**
Total: Proposals Not Recommended for Funding in US$ Equivalent								**$ 93,633,286**

* TRP Recommended upper ceilings correspond to the maximum amount being recommended to the Board. In eighteen 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 (Bhutan H, Bhutan T, Botswana T, Burundi T, Djibouti H, Egypt H, Egypt T, Guatemala T, Lao M, MC Western Pacific T, Romania T, Sierra Leone T, Syrian Arab Republic T, Tajikistan M, Tanzania T, Timor Leste T, West Bank & Gaza H, Zambia T).

** Proposals in EURO - the OANDA exchange rate effective at 1 July 2012: 1 EURO = US$ 1.26596

Global Fund Regional Teams
(Please note that not all countries listed below submitted an application under TFM)

HI Africa 2	**Africa 1 - High Impact:** Congo (Democratic Republic), Côte d'Ivoire, Ghana, Nigeria, Sudan, South Africa.
HI Africa 2	**Africa 2 - High Impact:** Ethiopia, Kenya, Mozambique, Tanzania (United Republic), Uganda, Zambia, Zimbabwe, Zanzibar.
HI Asia	**Asia - High Impact:** Bangladesh, India, Indonesia, Myanmar, Pakistan, Philippines.
CA	Central Africa: Benin, Burkina Faso, Burundi, Congo, Equatorial Guinea, Gabon, Liberia, Malawi, Multicountry Africa (W.Africa Corridor Prog), Sierra Leone, Togo.
EECA	**Eastern Europe & Central Asia:** Albania, Armenia, Azerbaijan, Belarus, Bosnia and , Herzegovina, Bulgaria, Georgia, Kazakhstan, Kosovo, Kyrgyzstan, Macedonia (Former Yugoslav Republic), Moldova, Montenegro, Romania, Russian Federation, Serbia, Turkmenistan, Tajikistan, Ukraine, Uzbekistan.
LAC	**Latin America & The Caribbean:** Bolivia (Plurinational State), Belize, Colombia, Chile, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Multicountry Americas (COPRECOS), Multicountry Americas (REDTRASEX), Multicountry Americas (CARICOM / PANCAP), Multicountry Americas , REDCA+), Multicountry Americas (Meso), Multicountry Americas (OECS), Multicountry Americas (Andean), Nicaragua, Paraguay, Panama, Peru, Suriname, Uruguay.
MENA	**Middle East & North Africa:** Central African Republic, Djibouti, Eritrea, Egypt, Iraq, Jordan, Mauritania, Morocco, Multicountry Middle East and N.Africa (MENAHRA), Somalia, Syrian Arab Republic, South Sudan, Tunisia, West Bank and Gaza Strip, Yemen.
SA	**Southern and Eastern Africa:** Angola, Botswana, Comoros, Lesotho, Madagascar, Mauritius, Multicountry Africa (RMCC), Multicountry Africa (SADC), Namibia, Rwanda, Swaziland.
SEA	**South and East Asia:** Afghanistan, Bhutan, Cambodia, Fiji, Iran (Islamic Republic), Korea (Democratic Peoples Republic), Lao (Peoples Democratic Republic), Maldives, Malaysia, Mongolia, Multicountry East Asia And Pacific (APN+), Multicountry South Asia, Multicountry , Western Pacific, Multicountry E. Asia & Pacific (ISEAN-HIVOS), Nepal, Papua New Guinea, Sri Lanka, Solomon Islands, Thailand, Timor-Leste, Viet Nam.
WA	**Western Africa:** Cameroon, Cape Verde, Chad, Gambia, Guinea, Guinea-Bissau, Mali, Niger, Sao Tome and Principe, Senegal.

Applicant Types

CCM	Country Coordinating Mechanism
RCM	Regional Coordinating Mechanism
Non-CCM	Non-Country Coordinating Mechanism

Key for multi-country proposals

1 - RCM	**ALCO Regional Coordinating Mechanism:** Benin, Cote d'Ivoire, Ghana, Nigeria, Togo.
2 - RCM	**Pacific Island Regional Multi Country Coordinating Mechanism:** Cook Islands, Federated States of Micronesia, Niue, Palau, Republic of Kiribati, Republic of the Marshall Islands, Samoa, Solomon Islands (HIV only), Tonga, Tuvalu, Vanuatu.

Key for Non-CCM proposals

1- Non-CCM	Russian Federation IDU ESVERO (Round 5), Non-Profit Partnership to Support Social Prevention Programmes in Public Health
2- Non-CCM	Russian Federation Open Health Institute (Round 3)
3- Non-CCM	West Bank and Gaza, United Nations Theme Group, Occupied Palestinian Territory

CCM Eligibility Requirements and List of Applicants

1.1 This annex details the approach taken by the Secretariat with regards to CCM eligibility screening, and provides the list of applicants who applied for the Transitional Funding Mechanism (TFM) and the individual eligibility outcomes.

Background

1.2 As per the Guidelines and Requirements for Country Coordinating Mechanisms[1] the Secretariat is required to screen all applicants against the six minimum eligibility requirements at the time of submission of new funding applications. In contrast to previous proposal reviews, the Secretariat decided not to convene a Screening Review Panel (SRP) to make CCM eligibility determinations. The Secretariat decided to adopt a more efficient and stream-lined process in which the outcomes of the CCM eligibility screening were notified to Grant Management for endorsement and action by the Regional Teams. This approach recognized the unique nature of TFM (i.e. to continue essential services of existing grants) and the fact that CCM governance will now be firmly entrenched within grant management; the minimum requirements will be monitored on a regular basis and not just at the time of applying for new funding.

Eligibility Screening Process

1.3 During the screening process, many applicants were required to provide clarifications in relation to these minimum requirements:

- Proposal development: open, transparent and documented process to solicit and review proposal submissions **(Requirement 1)**;
- Principal Recipient nomination: transparent and documented process to nominate the Principal Recipient(s) **(Requirement 2)**;
- Oversight: ensure that the CCM has implemented an oversight plan for all financing approved by the Global Fund **(Requirement 3)**;
- Membership: evidence of the membership of people living with HIV and of people affected by TB or malaria **(Requirement 4)**;
- Membership: transparent and documented process to demonstrate that CCM members representing non-government constituencies were selected by their own constituencies **(Requirement 5)**; and
- Conflict of interest: the development, publication and application of a policy to manage conflict of interest that applies to all CCM members **(Requirement 6)**.

1.4 Following the eligibility screening process:

- Twenty-seven (27) out of 45 (forty-five) CCM applicants were considered Fully Compliant (Table 1).

[1] GF/B23/DP17

- Eighteen (18) out of 45 applicants were found to be indeterminate compliant (IC). Of the 18 applicants, ten (10) were found to be IC for 1 requirement, 7 for 2 requirements and 1 applicant was considered IC for 4 requirements (Table 2).
- There were no applicants found to be Non-Compliant.

1.5 While not a minimum eligibility requirement, proposal endorsement is a de-facto requirement. In those instances where proposal were missing endorsements at the time of submission, clarifications were requested.

1.6 Four (4) out of the 45 TFM applicants (Azerbaijan, Benin, Chad and Romania) still had partial endorsements after the completion of the eligibility screening process.

1.7 For TFM there were 3 non-CCM applicants: West Bank and Gaza (being a state with no legitimate government) and 2 from Russian Federation[2] who is eligible through the NGO Rule according to the Eligibility, Counterpart Financing and Prioritization Policy.

1.8 Non-CCM proposals are accepted in exceptional circumstances. To be eligible to submit a non-CCM proposal applicants must demonstrate that they belong of the following categories:

i. Country in conflict, facing a national disaster or in a complex emergency situation;
ii. Country that suppresses, or has not established partnerships, with civil society and non-governmental organizations; and
iii. State without a national government, and not being administered by a recognized interim administration.

1.9 The six minimum requirements are not applicable to non-CCM applicants who must present documentary evidence justifying one or more of the three categories above. All three Non-CCM applicants were deemed to have met the requirements (see Table 3).

Grant Management Actions

1.10 Following the completion of the eligibility screening process, Regional Teams communicated with CCMs who were found to have indeterminate compliance for one or more requirements.

1.11 Remedial actions have been articulated based on the findings of the eligibility screening process.

1.12 For those requirements which are only applicable at the time of submission of new funding applications (Requirements 1 and 2), Regional Teams have communicated the outcome of the eligibility screening process for these requirements and has stressed the need to improve proposal development and PR nomination processes in the future. Where appropriate the Secretariat will ensure that Technical Assistance is provided to these applicants.

1.13 For Requirements 3 to 6 which are assessed both at the time of new funding applications and through the life cycle of the grant. Regional Teams have agreed on remedial actions with the CCM which are elaborated in Table 2.

1.14 Outstanding items will be assessed over the course of the year, as part of the continuous CCM Performance Management exercise, to ensure that the corrective actions have indeed resolved the issues

1.15 The outcome of the eligibility screening process for TFM will serve as the basis for the CCM Performance Assessment exercise which will occur during the second half of 2012 and will be undertaken on a yearly basis for all CCMs. The findings from the eligibility process will be reviewed during the assessment, as well as the implementation and follow-up of any remedial actions.

[2] Round 3 Open Health Society and Round 5 "ESVERO". For the Round 5 "ESVERO" grant there was a special board decision (B25/ER/05) which allowed for the PR to submit a TFM request.

Table 1: List of Fully Compliant Applicants

Number	Applicant Type	Applicant Name	WHO Region	Income Category	Applicant last applied for funding in round	Component	Original currency EUR/USD	Total Funding Request; per disease proposal (original currency)	Total Funding Request, all disease proposals (USD equivalent)
1	CCM	Angola	AFRO	Upper LMIC	H: Round 10 T: Round 9 M: Round 10	HIV	USD	$15,177,448	$15,177,448
2	CCM	Benin	AFRO	LIC	H: Round 10 T: Round 10 M: Round 8	Malaria	EURO	€ 5,825,702	$9,349,655
						Tuberculosis		€ 1,559,725	
3	CCM	Burkina Faso	AFRO	LIC	H: Round 10 T: Round 8 M: Round 8	Malaria	EURO	€ 38,264,884	$48,441,813
4	CCM	Chad	AFRO	LIC	H: Round 10 T: Round 10 M: Round 9	Malaria	EURO	€ 21,368,712	$27,051,935
5	CCM	Ethiopia	AFRO	LIC	H: Round 10 T: Round 10 M: Round 10	Malaria	USD	$45,191,147	$53,630,978
						HIV/AIDS		$8,439,831	
6	CCM	Ghana	AFRO	Lower LMIC	H: Round 10 T: Round 10 M: Round 8	HIV/AIDS	USD	$20,233,386	$20,233,386
7	CCM	Guinea-Bissau (Republic of)	AFRO	LIC	H: Round 10 T: Round 9 M: Round 9	HIV/AIDS	EURO	€ 10,216,357	$12,933,499
8	CCM	Indonesia	SEARO	Upper LMIC	H: Round 9 T: Round 10 M: Round 8	Malaria	USD	$18,185,770	$18,185,770
9	CCM	Lao PDR	WPRO	Lower LMIC	H: RCC Wave 8 T: Round 10 M: RCC Wave 7	Malaria	USD	$7,039,151	$7,039,151
10	CCM	Mozambique	AFRO	LIC	H: Round 10 T: Round 10 M: Round 9	Tuberculosis	USD	$8,671,151	$8,671,151
11	CCM	Nepal	SEARO	LIC	H: Round 10 T: NSA FLW M: RCC Wave 6	Malaria	USD	$7,251,099	$7,251,099
12	CCM	Niger	AFRO	LIC	H: Round 10 T: Round 10 M: Round 10	HIV/AIDS	EURO	€ 8,487,001	$27,900,828
						Malaria		€ 13,552,264	
13	CCM	Serbia	EURO	UMIC	H: Round 8 T: Round 9	HIV/AIDS	EURO	€ 3,400,000	$4,304,264
14	CCM	Sierra Leone	AFRO	LIC	H: Round 9 T: Round 10 M: Round 10	Tuberculosis	USD	$3,286,426	$3,286,426
15	CCM	Sri Lanka	SEARO	Lower LMIC	H: Round 9 T: Round 10 M: Round 8	Tuberculosis	USD	$4,325,931	$4,325,931
16	CCM	Swaziland	AFRO	Upper LMIC	H: Round 10 T: Round 10 M: Round 8	HIV/AIDS	USD	$13,232,298	$13,232,298
17	CCM	Syria	EMRO	Upper LMIC	H: Round 10 T: Round 9	Tuberculosis	USD	$2,179,885	$2,179,885
18	CCM	Tajikistan	EURO	LIC	H: Round 10 T: Round 10 M: Round 8	HIV/AIDS	USD	$6,484,621	$25,429,644
						Malaria		$1,817,290	
						Tuberculosis		$17,127,733	
19	CCM	Timor Leste	SEARO	Lower LMIC	H: Round 10 T: Round 10 M: Round 10	Tuberculosis	USD	$2,900,782	$2,900,782
20	CCM	Togo	AFRO	LIC	H: Round 10 T: Round 9 M: Round 9	Tuberculosis	EURO	$1,047,120	$1,325,612
21	CCM	Tunisia	EMRO	UMIC	H: Round 10 T: Round 8	HIV/AIDS	USD	$4,484,845	$4,484,845
22	CCM	Uzbekistan	EURO	Lower LMIC	H: Round 10 T: Round 8 M: Round 8	Tuberculosis	USD	$29,181,882	$29,181,882
23	CCM	Zambia	AFRO	Lower LMIC	H: Round 10 M: Round 9	Malaria	USD	$24,362,329	$28,622,455
						Tuberculosis		$4,260,126	
24	CCM	Mauritania	AFRO	Lower LMIC	H: Round 9 T: Round 9 M: Round 9	HIV/AIDS	USD	$4,818,040	$4,818,040
25	CCM	Philippines	WPRO	Lower LMIC	H: Round 8	HIV/AIDS	USD	$4,989,198	$4,989,198
26	RCM	Abidjan-Lagos Corridor Organisation	AFRO	Lower LMIC	H: Round 6	HIV/AIDS	EURO	€ 6,937,801	$8,782,979
27	RCM	Western Pacific	WPRO	Upper LMIC	H: Round 7 T: Round 7	HIV/AIDS	USD	$5,889,580	$9,399,185
						Tuberculosis		$3,509,605	

Table 2: List of Indeterminate Compliant Applicants

Number	Applicant Type	Applicant	WHO Region	Income Category	Applicant last applied for funding in round	Component	Original currency EUR/USD	Total Funding Request; per disease proposal (original currency)	Total Funding Request, all disease proposals (USD equivalent)	Proportion of compliance	Indeterminate Compliance	Management Actions
1	CCM	Afghanistan	EMRO	LIC	H: Round 9 T: Round 10 M: Round 8	HIV/AIDS	USD	$3,744,102	$3,744,102	83%	**Requirement 2: PR Selection Process** Conflict of Interest (COI) policy was not fully implemented in PR nomination. One representative of the PR (MoH) attended the meeting and took part in scoring the PR candidates. The applicant clarified that the CCM Chair (NGO) asked the MoH representative to stay in the meeting to answer any questions that the Executive Committee had.	The Secretariat has discussed this issue with the applicant and reiterated the importance of following the COI policy in PR nomination processes.
2	CCM	Azerbaijan	EURO	UMIC	H: Round 10 T: Round 9 M: Round 10	Tuberculosis	EURO	€ 7,865,280	$9,957,130	83%	**Requirement 4: Broad and Inclusive Membership - PLWD** There is one PLWD member on CCM Azerbaijan and they did not endorse the proposal. When prompted for clarification they submitted a letter of complaint from the email address of the member but signed by the alternate, objecting some CCM actions. This issue was brought to the attention of the FPM who indicated that they had not received any complaints while in Azerbijan after the proposal submission deadline and that this person belonged to an organization which was no longer a Sub-Recipient due to performance issues. **Partial Endorsement:** CCM Azerbaijan is missing 1 endorsement.	After clarifications by the Secretariat, it appears that the Member that registered the complaint has been excluded from the CCM for performance reasons (supporting documentation is available) and the applicant is looking for another representative to replace him (from the same constituency).
3	CCM	Botswana	AFRO	UMIC	H: Round 10 T: Round 10	Tuberculosis	USD	$2,805,576	$2,805,576	83%	**Requirement 3: Program Oversight** The generic oversight committee is composed of 5 members from ML/BL, Government, Private Sector, Academia, and NGO sectors. The Guidelines do not provide any information about the engagement of people living with and/or affected by disease and states that all committee members shall be members of the CCM.	The Secretariat is following up to make sure there is proper involvment from the people living with and/or affected by disease in Program Oversight.
4	CCM	Djibouti	EMRO	Lower LMIC	H: Round 9 T: Round 10 M: Round 9	HIV/AIDS	USD	$5,656,219	$5,656,219	83%	**Requirement 2: PR selection** No PR was selected for this proposal. Upon clarification, the CCM explained that they have not selected a PR for the TFM proposal, as they are awaiting the results of the OIG investigation.	Since the screening processes has concluded, the applicant has submitted their PR nomination (and supporting documenation) and have selected UNDP as PR. Djibouti is under the Additional Safeguard Policy and as a result the Global Fund directly appoints a Principal Recipient.

Number	Applicant Type	Applicant	WHO Region	Income Category	Applicant last applied for funding in round	Component	Original currency EUR/USD	Total Funding Request; per disease proposal (original currency)	Total Funding Request, all disease proposals (USD equivalent)	Proportion of compliance	Indeterminate Compliance	Management Actions
5	CCM	Jamaica	AMRO	UMIC	H: RCC Wave 7	HIV/AIDS	USD	$4,975,268	$4,975,268	83%	**Requirement 2: PR selection** Conflict of Interest (COI) policy was not fully implemented in PR nomination. Meeting minutes do not specify that representatives of the PR recused themselves from the meeting at the time of PR selection. In a clarification email, the applicant stated that representatives of the MoH withdrew from the meeting, but no evidence was provided.	The Secretariat has discussed this issue with the applicant and reiterated the importance of following the COI policy in PR nomination processes.
6	CCM	Malawi	AFRO	LIC	H: Round 10 T: Round 9 M: Round 9	Tuberculosis	USD	$4,677,100	$4,677,100	83%	**Requirement 2: PR Selection** CoI policy was not applied in PR selection. Representatives of the PR (MoH) did not recuse themselves from the meeting. The applicant clarified that MoH representatives stayed to provide clarification on technical issues pertaining to TFM.	The Secretariat has discussed this issue with the applicant and reiterated the importance of following the COI policy in PR nomination processes.
7	CCM	Nicaragua	AMRO	Lower LMIC	H: Round 8 T: Round 10 M: Round 9	Malaria	USD	$1,185,594	$1,185,594	83%	**Requirement 3: Program Oversight** No oversight plan was provided even after clarification. They last applied in Round 10 and no plan was provided in Round 10.	Since the screening processes has concluded, the applicant is receiving technical assistance to meet the Oversight requirement. The Secretariat is monitoring the situation.
8	CCM	Romania	EURO	UMIC	T: Round 6	Tuberculosis	EURO	$ 3,693,979	$4,676,430	83%	**Requirement 5: Broad and Inclusive Membership - NGO** There are 6 new non-governmental organizations and no documentation was provided. Romania last applied for funding in Round 6. The applicant has clarified the following: • Members are not nominated by constituencies (i.e. there is no transparent selection of NGOs by their constituencies) • Instead the CCM is always open to interested organizations who must submit formal written request, oral presentation and 2 letters of recommendation from CCM members • Two meeting minutes where new non-gov members were approved were provided **Partial endorsement:** Clarifications were requested from 1 governmental and 5 non-governmental organizations and only 2 out of 5 NGOs provided clarification and endorsed the proposal. Three other NGOs and 1 non-governmental organization did not provide clarification and endorsement.	Romania is a small country and to date NGOs have not come together as a consituency to elect CCM representatives. There is broad representation of NGOs on the CCM. In the coming year, as the NGO landscape develops, the Secretariat will ensure that the Non-Government representatives will be elected through a transparent election process. The Secretariat is monitoring the situation. **Partial endorsement:** After clarifications by the Secretariat, the 2 outstanding NGOs have endorsed the TFM proposal.

Number	Applicant Type	Applicant	WHO Region	Income Category	Applicant last applied for funding in round	Component	Original currency EUR/USD	Total Funding Request; per disease proposal (original currency)	Total Funding Request, all disease proposals (USD equivalent)	Proportion of compliance	Indeterminate Compliance	Management Actions
9	CCM	South Sudan	EMRO	LIC	H: Round 10 T: Round 10 M: Round 10	HIV/AIDS	USD	$12,003,699	$21,348,810	83%	**Requirement 3: Program Oversight** The current oversight plan does not cover the entire TFM period. In addition, the oversight committee does not include non-CCM members. Following clarification, no draft oversight plan for TFM or an explanation of how the CCM will engage other stakeholders in oversight was provided.	After clarifications by the Secretariat, the applicant is requesting technical assistance to help them on improving oversight functions and capacity, including revising the oversight plan. The Secretariat is monitoring the situation.
						Tuberculosis		$9,345,111				
10	CCM	Tanzania (United Republic)	AFRO	LIC	H: Round 10 T: Round 10 M: Round 9	HIV/AIDS	USD	$66,469,743	$74,811,695	83%	**Requirement 2: PR selection** In the proposal form, the CCM explains that all members agreed by voting that due to the fact that TFM is focused on continuation of the existing interventions, and the fact that the existing PR performed well , it was wise to use the same PR that is Ministry of Finance. However, no supporting documentation was provided. Applicant was asked several times to provide the annex documenting the voting process. Applicant finally answered that Annex does not exist: "for TFM grants this aspect was not captured on minutes"	After clarifications by the Secretarait, the applicant is re-collecting PR selection votes (electronically), the exercice will soon be completed and the results announced. The Secretariat is monitoring the situation.
						Tuberculosis		$8,341,952				
11	CCM	Bhutan	SEARO	Lower LMIC	H: Round 10 T: Round 10 M: Round 10	HIV/AIDS	USD	$1,144,402	$2,795,756	67%	**Requirement 3: Program Oversight** The current Oversight Policy (OP) states that the oversight committee should not include representatives of the PR. The applicant clarified that the CCM agreed to include one representative of the PR in the oversight committee so that he could provide information on complex program implementation issues. **Requirement 6: Conflict of Interest** With respect to PR selection, the CoI policy covers only the CCM Chair and Vice-Chair and not the whole CCM.	**Requirement 3 and 6:** The Secretariat has discussed the situation with the CCM and will be reviewing all CCM requirements in an upcoming visit. Special attention will be given to program oversight and conflict of interest.
						Malaria		$850,210				
						Tuberculosis		$801,144				

Number	Applicant Type	Applicant	WHO Region	Income Category	Applicant last applied for funding in round	Component	Original currency EUR/USD	Total Funding Request; per disease proposal (original currency)	Total Funding Request, all disease proposals (USD equivalent)	Proportion of compliance	Indeterminate Compliance	Management Actions
12	CCM	Burundi	AFRO	LIC	H: RCC Wave 8 T: Round 10 M: Round 9	Tuberculosis	USD	$2,672,114	$2,672,114	67%	**Requirement 2: PR selection** In its internal Guidelines, the CCM states that the PR has to leave the room when discussing issues pertaining to the PR. The CCM selected by consensus the PNILT (GOV) as the PR, to continue the Round 7 activities, based on their good management of the grant. When asked how the Conflict of Interest was managed in the PR selection, the CCM answered that the PR (GOV) nomination did not create any conflict of interest because it was a continuation of the program and because the PR belongs to a different entity than the CCM Chair and Vice-Chair. The Chair is from the Ministry of Health, the Vice-Chair is from the private sector. The minutes are signed by the CCM vice-president and president. 6 members from the Ministry of Health also attended the meeting. **Requirement 3: Program Oversight** The oversight committee is composed of technical experts having the necessary capacities and experience in public health, finance and M&E. Upon clarification, the CCM clarified the membership of the oversight committee: 1 International Organization (ONUSIDA), 3 NGOs, 2 FBOs, 3 GOV, 1 from the private sector, 1 PR (HIV). The three NGOs represent people living with/or affected by HIV and Malaria. However, the membership of the Monitoring and Oversight Committee is restricted to CCM members and does not include any non-CCM member. The guidelines do not include any provision of how non-members are engaged in the oversight.	**Requirement 2: PR selection** The Secretariat has discussed this issue with the applicant and reiterated the importance of following the COI policy in PR nomination processes. . **Requirement 3: Program Oversight** The CCM is requesting Technical assistance to help them restructure their oversight structures and processes. The situation is being monitored by the Secretariat. A roadmap for the CCM reform has been defined. Technical Assistance has been recruited to review the Conflict of Interest policy and governance documents. The CCM is looking for further TA to accompany the members selection process and train the new CCM on their role and responsibilities
13	CCM	Central African Republic	AFRO	LIC	H: Round 10 T: Round 9 M: Round 8	HIV/AIDS	EURO	$ 15,088,317	$19,101,206	67%	**Requirement 3: Program Oversight** An oversight committee exists, but it is not active. The applicant clarified that since its formation, the oversight committee has been inactive due to lack of funds. **Requirement 6: Conflict of Interest** CCM practice goes against one clause of the CoI policy. The CoI policy states that the PR cannot be a member of the CCM Executive Bureau, however, the PR is a member of the Executive Bureau and is also the Vice-Chair of the CCM.	**Requirement 3: Program Oversight** The CCM is requesting Technical assistance to help them restructure their oversight structures and processes. The situation is being monitored by the Secretariat. **Requirement 6: Conflict of Interest** Same as above

Number	Applicant Type	Applicant	WHO Region	Income Category	Applicant last applied for funding in round	Component	Original currency EUR/USD	Total Funding Request; per disease proposal (original currency)	Total Funding Request, all disease proposals (USD equivalent)	Proportion of compliance	Indeterminate Compliance	Management Actions
14	CCM	Egypt	EMRO	Lower LMIC	T: Round 10	Tuberculosis	USD	$ 3,969,415	$3,969,415	67%	**Requirement 2 : PR selection** The CCM minutes of the meeting dated 23 February 2012 document the CCM members' agreement to select the Ministry of Health and Population (MoPH) as the PR. No supporting evidence was provided to show that MoHP staff recused themselves during the meeting. Upon clarification, the CCM justified that the TFM request is a continuation of the existing grant where the MoHP is the only principle recipient. The applicant sent criteria used for PR nomination. **Requirement 3: Program Oversight** The applicant provided an Oversight Plan and the ToRs for the oversight committee. The committee was not nominated yet. Without the list of oversight committee members, the applicant is indeterminate compliant in engagement with various stakeholders.	**Requirement 2 :** The Secretariat has discussed this issue with the applicant and reiterated the importance of following the COI policy in PR nomination processes. **Requirement 3:** The CCM is receiving Technical assistance restructure their oversight structures and processes. The situation is being monitored by the Secretariat.
15	CCM	Guatemala	AMRO	Upper LMIC	H: RCC Wave 8 M: RCC Wave 8	Tuberculosis	USD	$2,212,547	$2,212,547	67%	**Requirement 1: Proposal Development Process** No documentation on the solicitation of ideas/engagement of stakeholders and PLWD was provided. Applicant's clarification refers to documents from 2008-2009. **Requirement 2: PR Selection Process** No documentation on the PR selection process for TFM was provided. Applicant is continuing with existing PR selected in 2008 through a transparent process.	**Requirement 1:** The Secretariat has discussed this issue with the applicant and reiterated the importance of ensuring an open and transparent proposal development process for future funding windows. **Requirement 2:** The Secretariat has discussed this issue with the applicant and reiterated the importance of documenting PR nomination processes for each funding opportunity.
16	CCM	Viet Nam	WPRO	Lower LMIC	H: Round 10 T: Round 9	Malaria	USD	$7,427,970	$7,427,970	67%	**Requirement 2: PR selection process** The PR selection process was not documented. **Requirement 6: Conflict of Interest** Conflict of interest policy is weak and namely since the PR selection process was not documented, there is no possibility to know if the CoI was managed properly.	**Requirement 2:** The Secretariat has discussed this issue with the applicant and reiterated the importance of documenting PR nomination processes. **Requirement 6:** The Secretariat has discussed this issue with the applicant and reiterated the importance of ensuring conflict of interest is properly managed.

Number	Applicant Type	Applicant	WHO Region	Income Category	Applicant last applied for funding in round	Component	Original currency EUR/USD	Total Funding Request; per disease proposal (original currency)	Total Funding Request, all disease proposals (USD equivalent)	Proportion of compliance	Indeterminate Compliance	Management Actions
17	CCM	Yemen	EMRO	LIC	H: Round 10 T: Round 9	HIV/AIDS	USD	$882,058	$15,304,644	67%	**Requirement 1: Proposal Development Process** The applicant is considered indeterminate compliant because of the discontent expressed by a number of CCM members due to the limited time provided to review the proposals and the recurring lack of CCM engagement over the years. **Requirement 2: PR selection** The applicant provided the minutes of the meeting during which CCM members approved the proposals and the PR nominees unanimously. Upon clarifying how conflict of interest was managed in the PRs selection, the applicant provided justification by stating that the MoPHP and its two National Control Programs (NAP and NMCP) are the national bodies mandated the official responsibility of combatting HIV/AIDS and Malaria in Yemen. Despite the applicant's justification for the selection of the PRs, there was no evidence provided to suggest that MoPHP representatives recused themselves from the meeting during the selection.	**Requirement 1:** After clarifications by the Secretariat, the applicant has set-up a task force in place to address the issues. The situation is being monitored by the Secretariat. **Requirement 2:** The Secretariat has discussed this issue with the applicant and reiterated the importance of following the COI policy in PR nomination processes. As noted above, the applicant has set up a task force to address CCM issues.
						Malaria		$14,422,586				
18	CCM	Suriname	AMRO	UMIC	H: Round 9 T: Round 9 M: RCC Wave 8	HIV/AIDS	USD	$980,476	$980,476	33%	**Requirement 1: Proposal Development Process** The CCM mentions having met with key populations to include their input into the proposal, however no documented evidence was provided. **Requirement 2: PR selection** List of participants to the meeting where the PR was selected only shows attendance of two participants CCM chair (FBO) and Vice-Chair (Ministry of Education). These two members appear as only participants in the majority of the minutes provided. **Requirement 3: Program Oversight** Upon clarification the CCM explained that there is an oversight team which consists of 4 or 5 CCM members. However, no information on the sectors or roles was provided. **Requirement 5: Broad and Inclusive Membership** One new organization "Youth Adek" which represents the youth sector. They joined the CCM in 2010. The document presented is a letter directed to the Student's board of a public high school inviting them to participate on the CCM. However, no evidence that this organization was selcted by its own sector.	**Requirement 1:** Since the screening process has concluded, the applicant has provided the Secretariat with the attendance list that have endorsed the application. **Requirement 2:** The Secretariat has discussed this issue with the applicant and reiterated the importance of documenting PR nomination processes which is open, inclusive and transparent. **Requirement 3:** The Secretariat has discussed this issue with the applicant and reiterated the need to ensure program oversight is compliant with the current requirements. The applicant has sent a basic Oversight plan and Governance manual. **Requirement 5:** The Secretariat has discussed this issue with the applicant and reiterated the need for non-governmental sectors to be nominated by their own sector through a documented and transparent process. It is important to note that in the context of Suriname - a small country - there are few organizations representing youth sector.

Table 3: List of Non-CCM Applicants

Applicant Type	Applicant	WHO Region	Income Category	Applicant last applied for funding in round	Component	Original currency EUR/USD	Total Funding Request; per disease proposal (original currency)	Total Funding Request, all disease proposals (USD equivalent)
NGO Rule	Open Health Society (OHI) - Russia	EURO	UMI	H: Round 3	HIV	USD	$4,999,809	$4,999,809
NGO Rule	ESVERO - Russia	EURO	UMI	H: Round 5	HIV	EURO	€ 3,752,733	$4,750,810
Non-CCM	West Bank and Gaza	USD	Lower-LMI	T: Round 7	HIV	EURO	$1,237,595	$1,237,595

ANALYSIS OF THE TRP'S FUNDING RECOMMENDATIONS FOR TFM

Part 1: Introduction

1.1 This annex provides additional information on the Technical Review Panel's assessment and recommendation of proposals under TFM. The annex includes the following analyses:

Part 1: Introduction

Part 2: The TRP's assessment of compliance with TFM requirements and new requirements set out in the ECFP policy

Part 3: Success rate of proposals

Part 4: Distribution of recommended funding by disease, WHO region, income level and high impact countries

Part 5: Distribution of recommended funding for HIV, tuberculosis and malaria by disease burden

Part 2: The TRP's assessment of compliance with TFM requirements and new requirements set out in the ECFP policy

2.1 As noted in its report, in addition to the technical merit of proposals, the TRP had to assess compliance with (i) the TFM requirements; and (ii) the ECFP requirements (namely focus of proposal and counterpart financing).

2.2 Table 1 below provides a summary of applicant compliance with these requirements.

Table 1: Assessment of proposals compliance with requirements under TFM

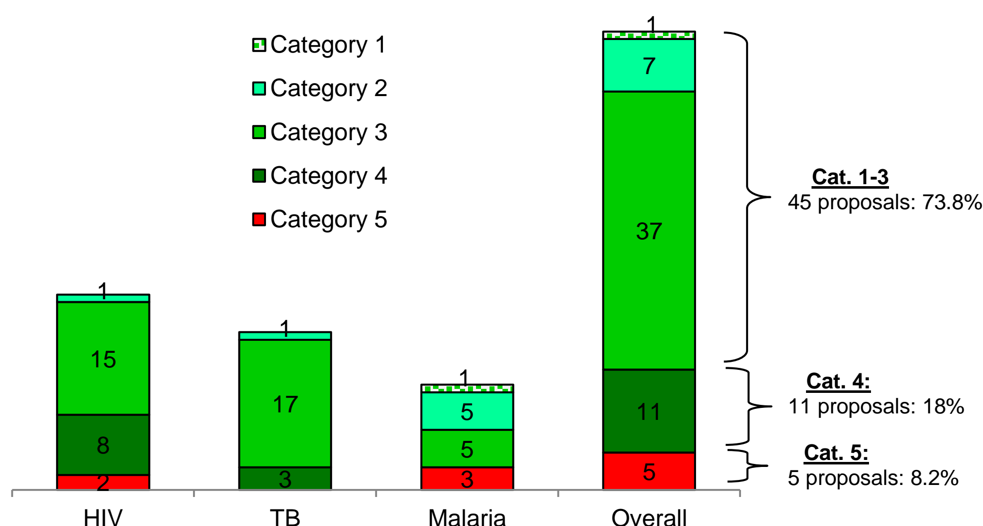
	Focus of proposal requirement	Counterpart financing requirement	TFM-specific requirements	Alternate sources of funding requirement
Not applicable	24	6	0	0
Compliant	32	0	35	37
Conditionally compliant	5	55[1]	21	20
Non-compliant	0	0	5	4

[1] Due to an absence of supporting documentation to validate the counterpart financing figures provided by applicants, the TRP could not fully assess compliance with this requirement. For recommended proposals, the TRP requested that the Secretariat ensures applicant compliance with counterpart financing during grant negotiations.

Part 3: Success rate of proposals

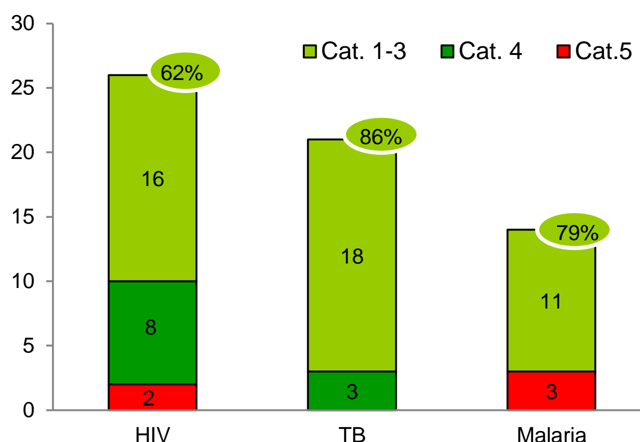
3.1 Of the 61 TFM proposal reviewed, the TRP recommended 45 in Categories 1 to 3. Eleven proposals were rated Category 4 (proposals that must be revised and submitted for a second review by the TRP); and five proposals were given a Category 5 rating (not recommended for funding). Figure 1 shows the breakdown of TRP recommendations in terms of number of proposals.

Figure 1: Breakdown of proposals by recommendation category



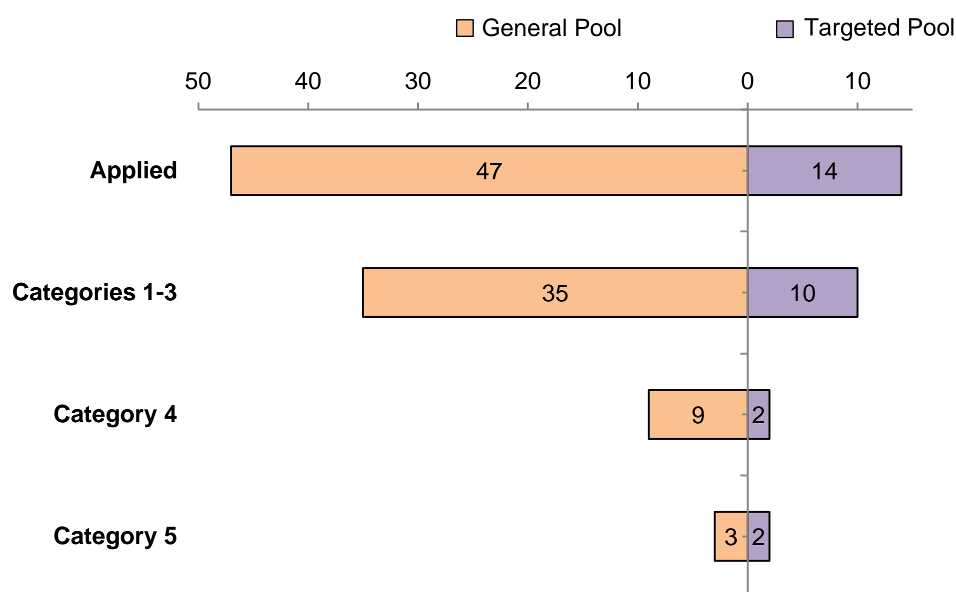
3.2 Figure 2 shows, for each disease, the number of proposals recommended in Categories 1-3 versus Category 4 and Category 5. Tuberculosis applications were most successful, with an 86% recommendation rate in Categories 1-3. Malaria applications were the second most successful with a 79% recommendation rate, followed by HIV proposals with a 62% recommendation rate in Categories 1-3.

Figure 2: Recommended proposals in Categories 1-3 versus Category 4 and Category 5



3.3 General Pool applications constitute 77.8 percent of proposals recommended in Categories 1-3, while Targeted pool proposals make up 22.2 percent. Figure 3 shows the distribution of TFM proposals by funding pool and recommendation category.

Figure 3: Proposals by funding pool and recommendation category



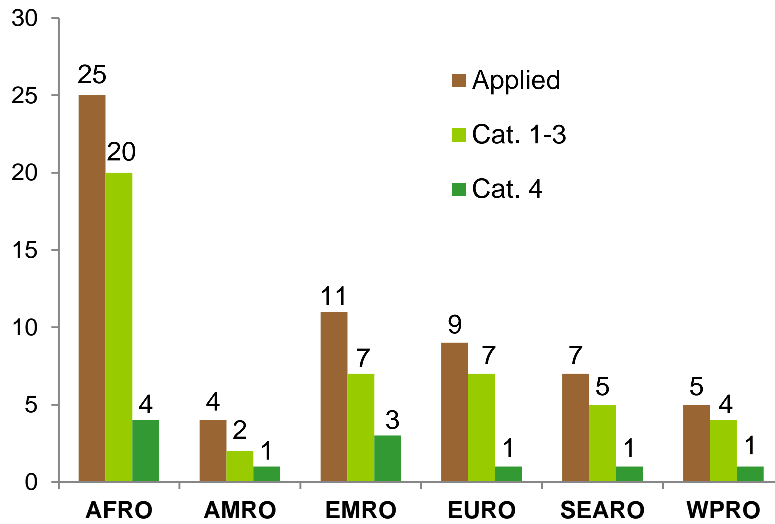
3.4 Forty-four (44) percent of proposals recommended in Categories 1-3 were submitted by lower-middle income (LMI) countries, followed by 40 percent from low income (LI) countries. Table 2 provides a summary of the TRP recommendations by income level.

Table 2: Categories 1-3 and Category 4 recommendations by income level

	Categories 1-3		Category 4	
Income Level	Proposals Recommended	Percentage of proposals recommended	Proposals Recommended	Percentage of proposals recommended
Lower Income (LI)	18	40.0%	4	36.4%
Lower Middle Income (LMI)	20	44.4%	3	27.3%
Upper Middle Income (UMI)	5	11.1%	3	27.3%
Mixed	2	4.4%	1	9.1%
Total	**45**		**11**	

3.5 Proposals from the **WHO AFRO** region make up 41 percent of the total number of proposals reviewed by the TRP under TFM. Figure 4 shows the number of TFM applications from the different WHO regions vis-à-vis the number recommended in Categories 1-3 and Category 4 for each region.

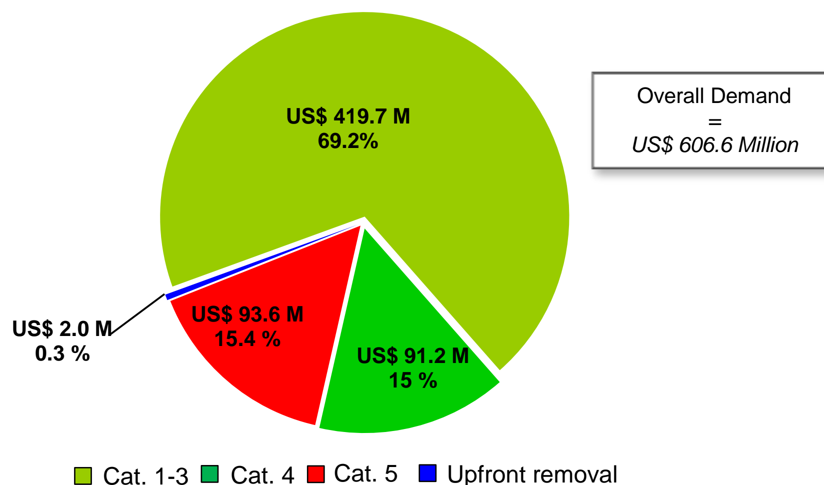
Figure 4: Number of recommended proposals by WHO region



Part 4: Distribution of recommended funding by disease, WHO region, income level and high impact countries

4.1 Of the US$ 606.6 million[2] requested through TFM, the TRP recommended for funding US$ 419.8 million in Categories 1-3; and a potential total upper ceiling of US$ 91.2 million for Category 4 proposals, pending a second TRP review and approval of these revised proposals. The TRP's potential total funding recommendation to the Global Fund Board (Categories 1-3 plus Category 4) was therefore **US$ 511 million**. Figure 5 presents the recommended budget by recommendation category, as well as the total upfront budget deduction made by the TRP.

Figure 5: TRP funding recommendation by category and as a percentage of the total funding request

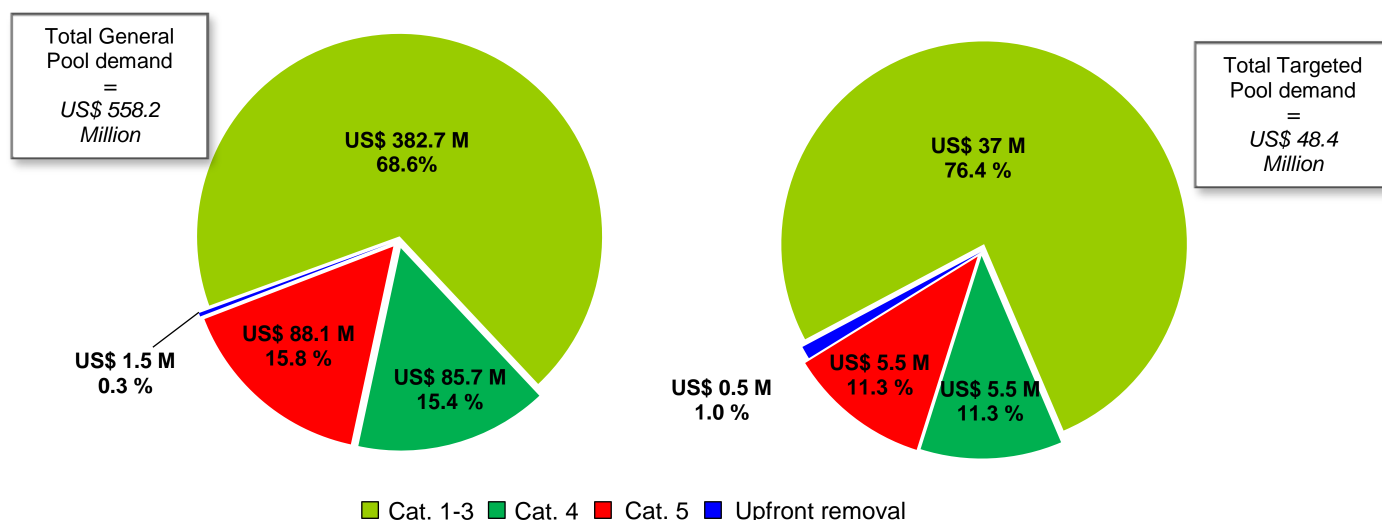


[2] As per the EURO/US$ exchange rate of 01 July 2012 (www.oanda.com).

4.2 Figures 6a and 6b show the breakdown of the recommended budget for the General and Targeted Funding Pools in dollar value, and as a percentage of the total demand in the respective pools. The total amount recommended for upper-middle income applicants who applied to the General Pool amounts to 2 percent of the total recommended amount and therefore is consistent with the ECFP requirement that no more than 10 percent of all recommended funding under the General Pool may go to upper-middle income applicants in a particular funding window.

Figure 6a: Funding recommendation in the General Pool by category and as a proportion of total General Pool demand

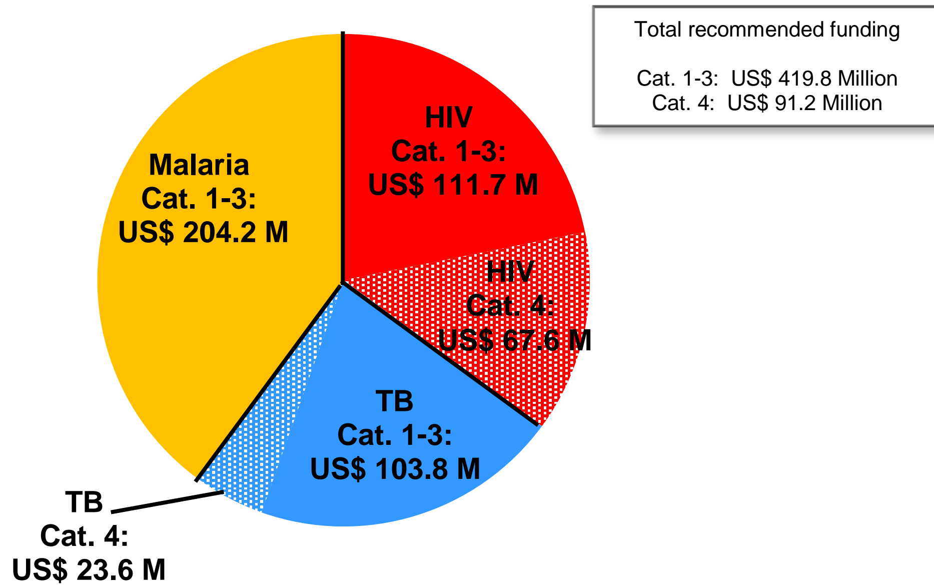
Figure 6b: Funding recommendation in the Targeted Pool by category and as a proportion of total Targeted Pool demand



4.3 The greatest share of the recommended funding for Categories 1-3 proposals goes to malaria proposals (US$ 204.2 million), followed by HIV proposals which take up US$ 111.7 million, and in third place tuberculosis proposals that make up US$ 103.8 million.

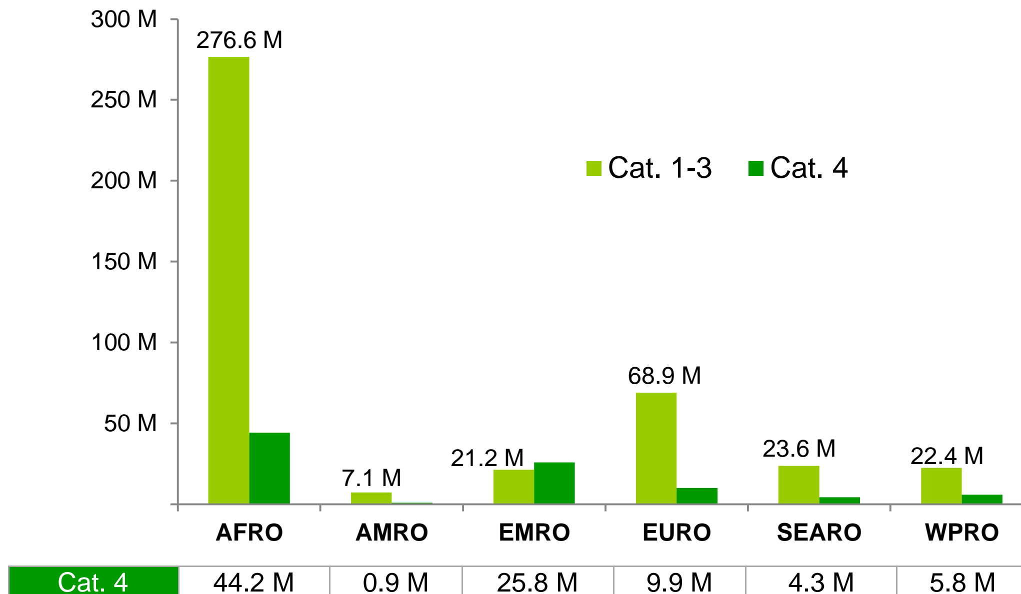
4.4 As Figure 7 illustrates, the total upper ceiling recommended for Category 4 proposals includes US$ 67.5 million for HIV proposals and US$ 23.6 million for tuberculosis. No malaria proposals were recommended as a Category 4 proposal.

Figure 7: TRP funding recommendation by disease



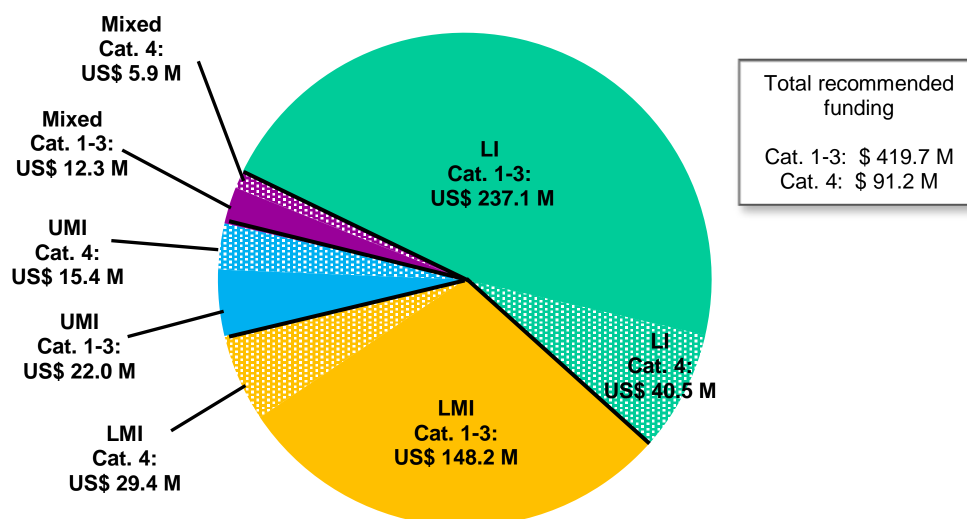
4.5 The WHO AFRO region takes up 65.9 percent of the total funding recommended in Categories 1-3, followed by the EURO and SEARO regions which take up 16.4 and 5.6 percent respectively. Figure 8 presents the distribution of recommended Categories 1-3 and Category 4 budget totals by WHO region.

Figure 8: TRP funding recommendation by WHO region



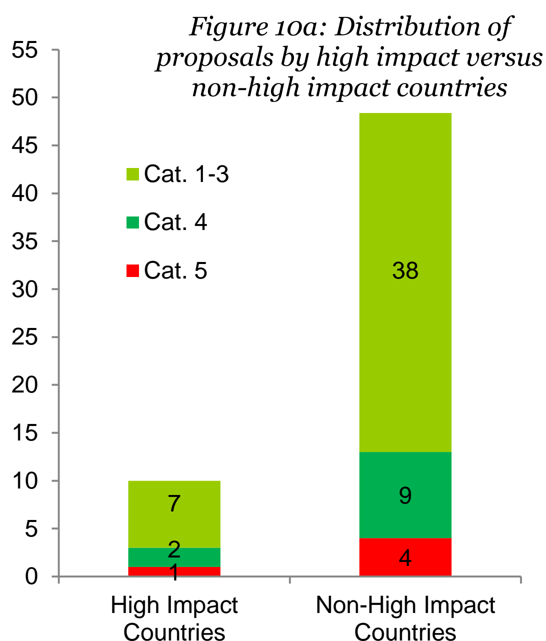
4.6 Figure 9 provides a summary of the TRP's funding recommendation by income level. The largest share of the recommended funding in Categories 1-3 goes to low income countries (US$ 237.1 million) followed by lower middle income countries (US$ 148.2 million).

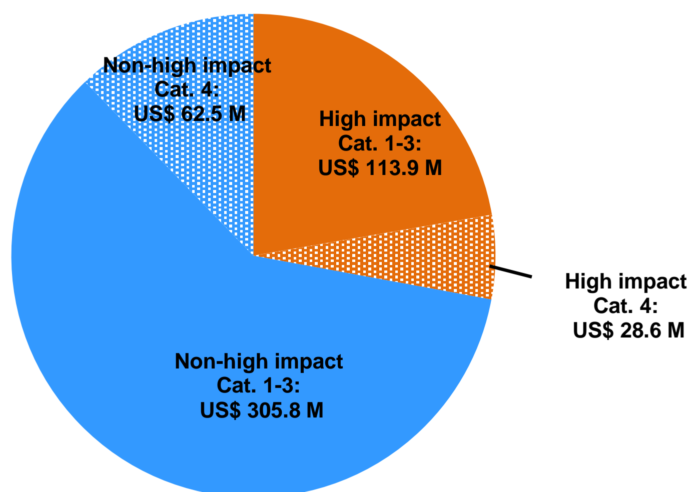
Figure 9: Categories 1-3 and Category 4 funding recommendations by income level



4.7 As part of its reorganization, from March to May 2012, the Global Fund created three departments to focus on 20 high impact countries: countries that account for 70 percent of the worldwide burden of HIV/AIDS, tuberculosis and malaria. Of the 61 proposals reviewed under TFM, 10 were submitted by applicants in the Global Fund list of 'high impact countries' and 51 were submitted by non-high impact countries.

4.8 Figure 10a shows the number of proposals from high impact and non-high impact countries recommended in Categories 1-3 and Category 4; and Figure 10b presents a breakdown of the recommended funding by high impact versus non-high impact countries.

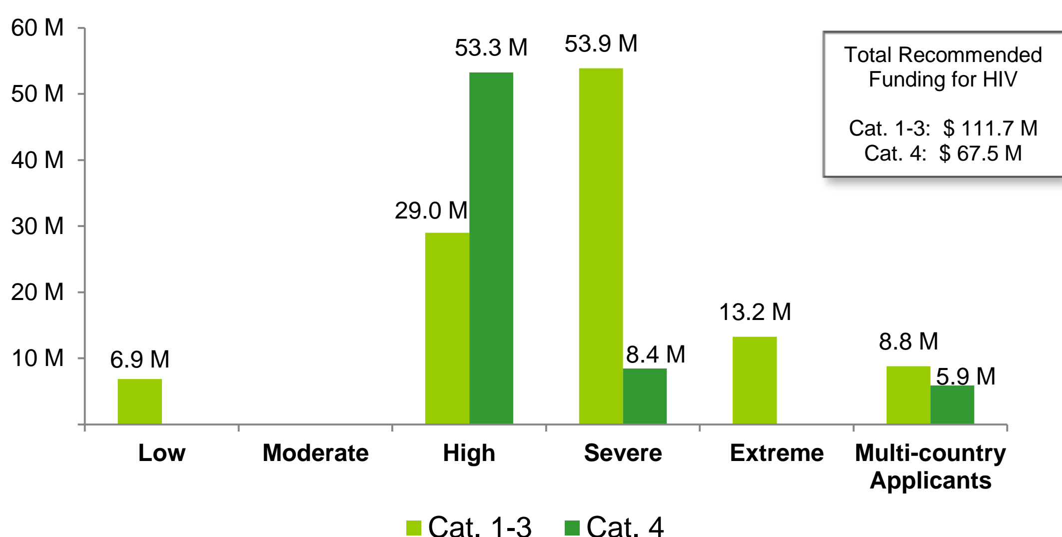




Part 5: Distribution of recommended funding for HIV, tuberculosis and malaria by disease burden

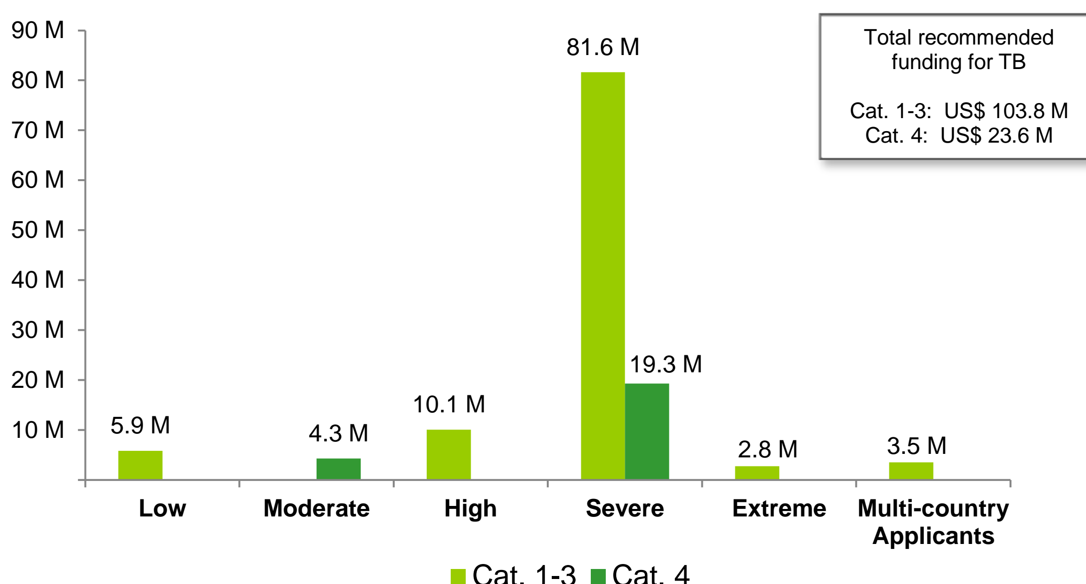
5.1 Of the total US$ 111.7 million recommended for HIV proposals in Categories 1-3, 48.2 percent (US$ 53.9 million) goes to countries with a severe disease burden followed by 25.9 percent (US$ 29.0 million) for countries with a high disease burden. Depending on the outcomes of the second TRP review of HIV proposals recommended in Category 4, the funding recommended for countries with a high HIV disease burden could increase by US$ 53.3 million. Figure 11 shows the distribution of recommended HIV funding by disease burden.

Figure 11: Distribution of recommended funding for HIV by disease burden



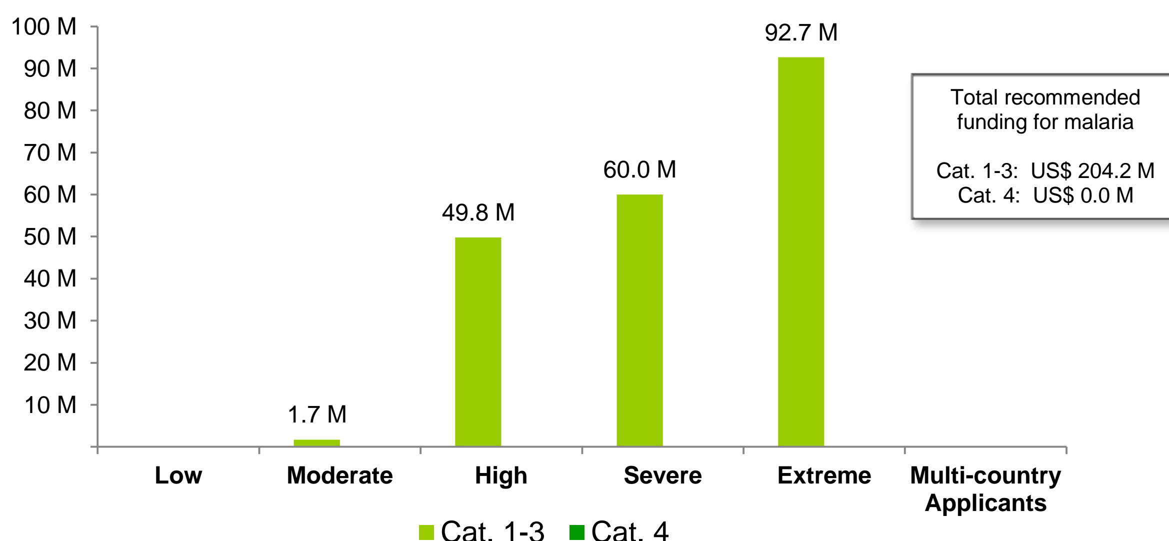
5.2 For tuberculosis proposals, 78.6 percent (US$ 81.6 million) of the total recommended funding in Categories 1-3 goes to countries with a severe disease burden. Depending on the outcomes of the second TRP review of TB proposals recommended in Category 4, the funding recommended for countries with a severe TB disease burden could increase by US$ 19.3 million. Figure 12 shows the distribution of recommended funding for TB by disease burden.

Figure 12: Distribution of recommended funding for TB by disease burden



5.3 In the case of malaria, 45.4 percent (US$ 92.6 million) of the total recommended funding in Categories 1-3 goes to countries with an extreme disease burden, while respectively, 29.4 and 24.4 percent goes to countries with a severe and high disease burden. Figure 13 shows the distribution of recommended funding for malaria by disease burden.

Figure 13: Distribution of recommended funding for malaria by disease burden



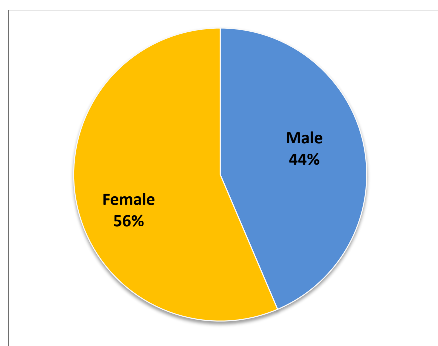
Technical Review Panel - TFM Membership

Category	No.	Surname	First name	Gender	Nationality	Rounds served 7	8	9	10
Chair	1	Baker	Shawn	M	USA				
Vice Chair	2	Gotsadze	George	M	Georgia				
Vice Chair	3	Blok	Lucie	F	Netherlands				
HIV Members	1	Mazaleni	Nomathemba	F	South Africa				
	2	Brown	Tim	M	USA				
	3	Chitwarakorn	Anupong	M	Thailand				
	4	Boltaev	Azizbek	M	Uzbekistan				
	5	Pimenta Oliveira	Cristina	F	Brazil				
	6	Radeny	Samson	M	Kenya				
	7	Dallabetta	Gina	F	USA/Italy				
	8	Etchepare	Michel	M	France				
Malaria Members	1	Talisuna	Ambrose	M	Uganda				
	2	Adeel Adbel-Hameed	Ahmed Awad	M	Sudan				
	3	Lyimo	Edith	F	Tanzania				
	4	Graves	Patricia	F	UK/Australia				
Tuberculosis Members	1	Hanson	Christy	F	USA				
	2	Tadolini	Marina	F	Italy				
	3	Itoda	Ichiro	M	Japan				
	4	Korobitsyn	Alexei	M	Russia				
	5	Bleumink	Marijke	F	Netherlands				
	6	Chiang	Chen-Yuan	M	China				
Cross-cutting Members	1	Oyeledun	Bola	F	Nigeria				
	2	Ayala-Ostrom	Beatriz	F	UK/Mexico				
	3	Heywood	Alison	F	Australia				
	4	Le Franc	Elsie	F	Jamaica				
	5	Rose	Tore	M	Norway				
	6	Leal	Ondina	F	Brazil				
	7	Rabeneck	Sonya	F	Ireland/Canada				
	8	Nagai	Mari	F	Japan				
	9	Surjadjaja	Claudia	F	Indonesia				
	10	Murindwa	Grace	M	Uganda				
	11	Tarantola	Daniel	M	France				
	12	Thapa	Poonam	F	Nepal				
	13	Austen	Anne	F	UK				
	14	Sardie	Marie	F	Australia				
	15	Burns	Katya	F	USA/Canada				
	16	Kireria	Alexander	M	Kenya				
	17	Cardona	Jose	M	Spain				
	18	Frank	Odile	F	France/UK				

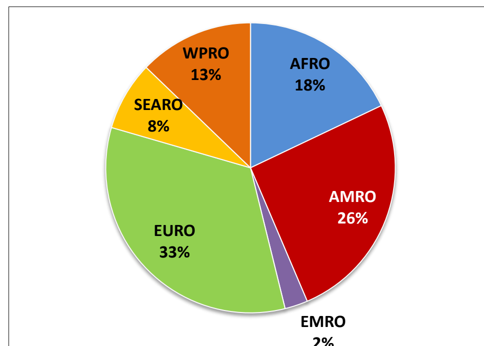
Total Members: 39

Key: Rounds served / Not available / Half a Round**

Gender Breakdown:



Breakdown by nationality*:



* Note that TRP members are primarily chosen on the basis of their area of expertise and in-country experience, which is not necessarily reflected by their nationality

** As part fo the TRP mentoring program