Briefing document for Global Fund Pre-Board Session on Technical Assistance

Briefing Document

May 4, 2009

Context for this briefing document

- McKinsey and Company conducted this analysis for the Bill and Melinda Gates Foundation to provide a fact base and landscape of the users, providers, and funders of technical assistance (TA) to identify what is working and not working as it relates to Global Fund grants for HIV/AIDS, tuberculosis and malaria

- The team conducted over 80 interviews and consultations with staff from the Global Fund, implementing countries, Principal Recipients, multilateral agencies, coordinators, funders and providers of TA. An extensive literature was also conducted. A list of interviewees and literature reviewed can be found at the end of this briefing document

- This effort was intended to be a landscape exercise with respect to TA provision for Global Fund grants using available data.

- In the course of the analyses and interviews, however, several areas emerged as possible improvement opportunities which are also included for discussion. This effort did not do a detailed analysis of the likely impact, direct and indirect costs, or implementation requirements for these opportunities but we hope that they can serve as a useful starting point for next steps in this important area of work

Executive summary (1/2)

- An analysis of funding in calendar year 2008 demonstrates that a significant amount of money was budgeted for TA provision directly related to the Global Fund—at least approximately USD $66M including money budgeted in proposals as well as programs designed to help Global Fund recipients with proposals and implementation for example GTZ Backup, GMS etc.
- In addition, multilaterals and bilateral agencies provide significant resources for TA more generally for the three diseases. The WHO and UNAIDS alone budget over USD $200M-$300M for TA. There are also significant contributions from bilateral agencies such as the U.S. through in country missions and DFID, other Foundations as well as implementing countries which were not able to be quantified
- TA provision for the Global Fund can occur at three stages of the grant process: pre-award, pre-implementation (grant signature), and during the implementation phase. Across the three phases, various actors can shape the demand for this TA, including the PR, FPM, CCM, and partner organizations
- Pre-award stage
  - Almost all countries use TA extensively for proposal preparation, but there is variation in proposal approval rates between diseases. Some countries have repeated difficulty with approval
  - Distinct models have emerged to coordinate TA across the three diseases, with varying levels of strategic targeting and approval success
  - Key challenges include: poor communication between the Global Fund and TA providers; lack of consistency and poor use of best practice approaches with existing coordination models; lack of alignment around what good strategies look like, disconnect between good proposals and implementation in the future
- Pre-implementation stage
  - This phase generally lasts 9 to 10 months –it is a key performance indicator for the Global Fund but has not met the set target of 8 months
  - HWG has been targeting reducing signature time to 4 months for malaria grants from Round 8
  - While it appears that TA in this arena can accelerate the timeline and lay the groundwork for disbursement for some grants, few providers focus on this area. This appears to be an opportunity area, although the time compression from TA alone will be limited by remaining Global Fund or country related barriers

Executive summary (2/2)

- Implementation stage
  - TA for implementation can be planned or emergency, more technical in nature or for program management, short-term or long-term. An additional area is support on governance issues especially related to CCM functioning although there is debate as to whether this should be referred to as TA
  - TA budgeted in proposals by PRs is usually for short term planned, technical TA but does not always get spent and is often seen as an area that can be reallocated during grant negotiation. Actual TA expenditure from PRs is likely lower than the average budgeted 3% and is difficult to measure
  - PRs that perform well tend to perform well across rounds. PRs that struggle with implementation tend to struggle across rounds – they do not have a good sense of TA needs and do not budget for TA
  - There is a lack of consensus on effective approaches to providing long term implementation support
  - Key challenges in this stage include:
    - Use of TA when hiring or outsourcing would be more appropriate
    - Lack of an overall TA coordination strategy– identifying countries in need, agreeing on goals for TA provision, and matching needs to providers
    - Confusion around ownership with demand from PRs often coming too late
    - Under-focus in planning for and provision on management assistance
    - Gaps in provider skill sets and general lack of accountability mechanisms
    - Lack of clarity about funding sources and ability to re-budget grant money for TA

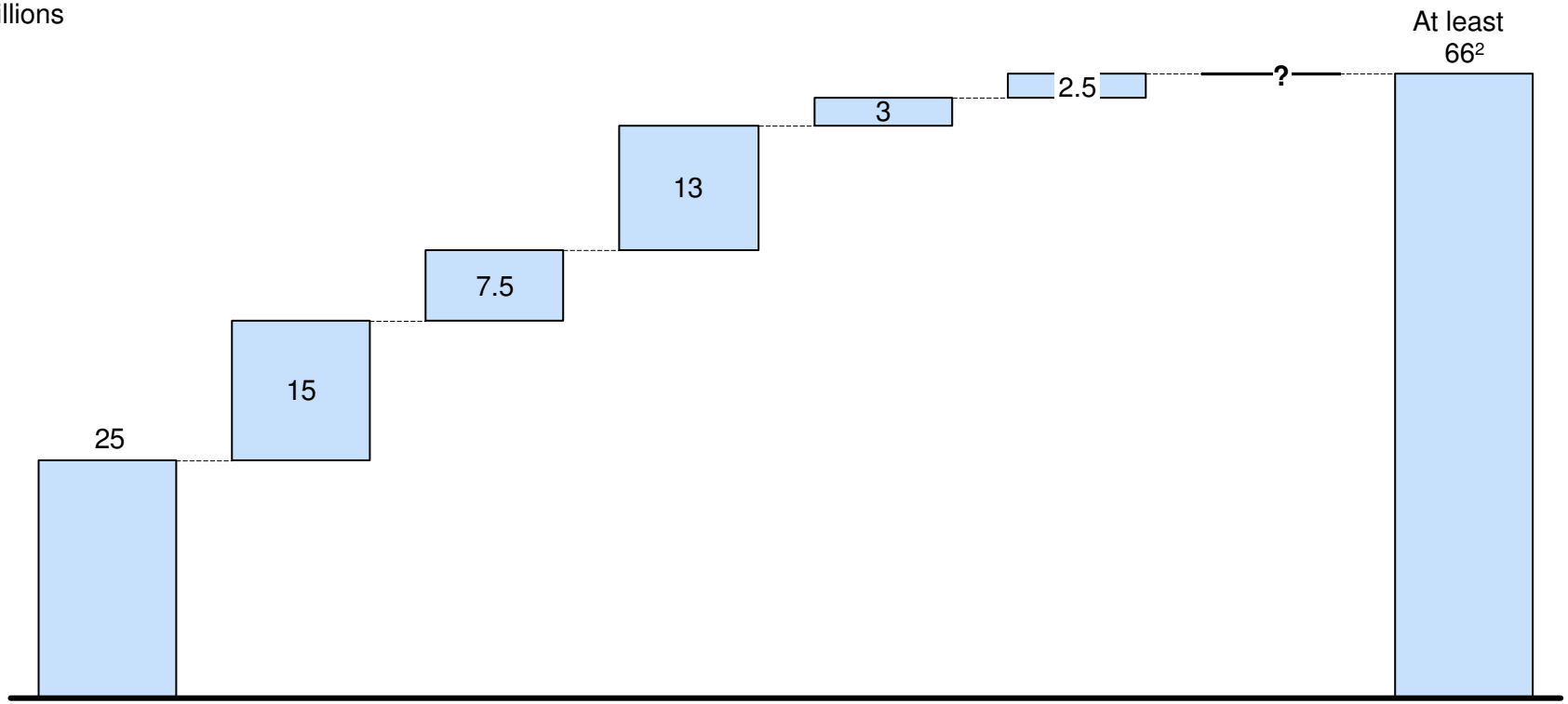
- A summary of the key challenges across the phases include
  - TA is used broadly and often inappropriately instead of hiring, out sourcing, or true capacity building.
  - Confusion and misperceptions with respect to Global Fund policies on TA funding
  - Emergence of ad hoc and supply driven TA
  - Supply gaps among current providers and concerns about quality of the TA that is provided.
  - PRs, CCMs and funders not adequately addressing distinction between management and technical issues when choosing which TA to access
  - No “one stop shop” to connect the various mechanisms for accessing TA
  - Repeat requests for similar TA indicate lack of real capacity building

- Several improvement opportunities emerged as part of the interview and consultation process and focused on increasing the demand driven nature of TA, supply of TA and issues with regards to the market for TA

CY 2008[1] budgets for TA directly related to the Global Fund

Confirmed Global Fund-specific TA funding - CY 2008 TA budget

$ Millions



1 Approximate CY 2008 budgets – some budgets are off cycle from CY by several months.

2 Total will be higher when "other" categories are factored in

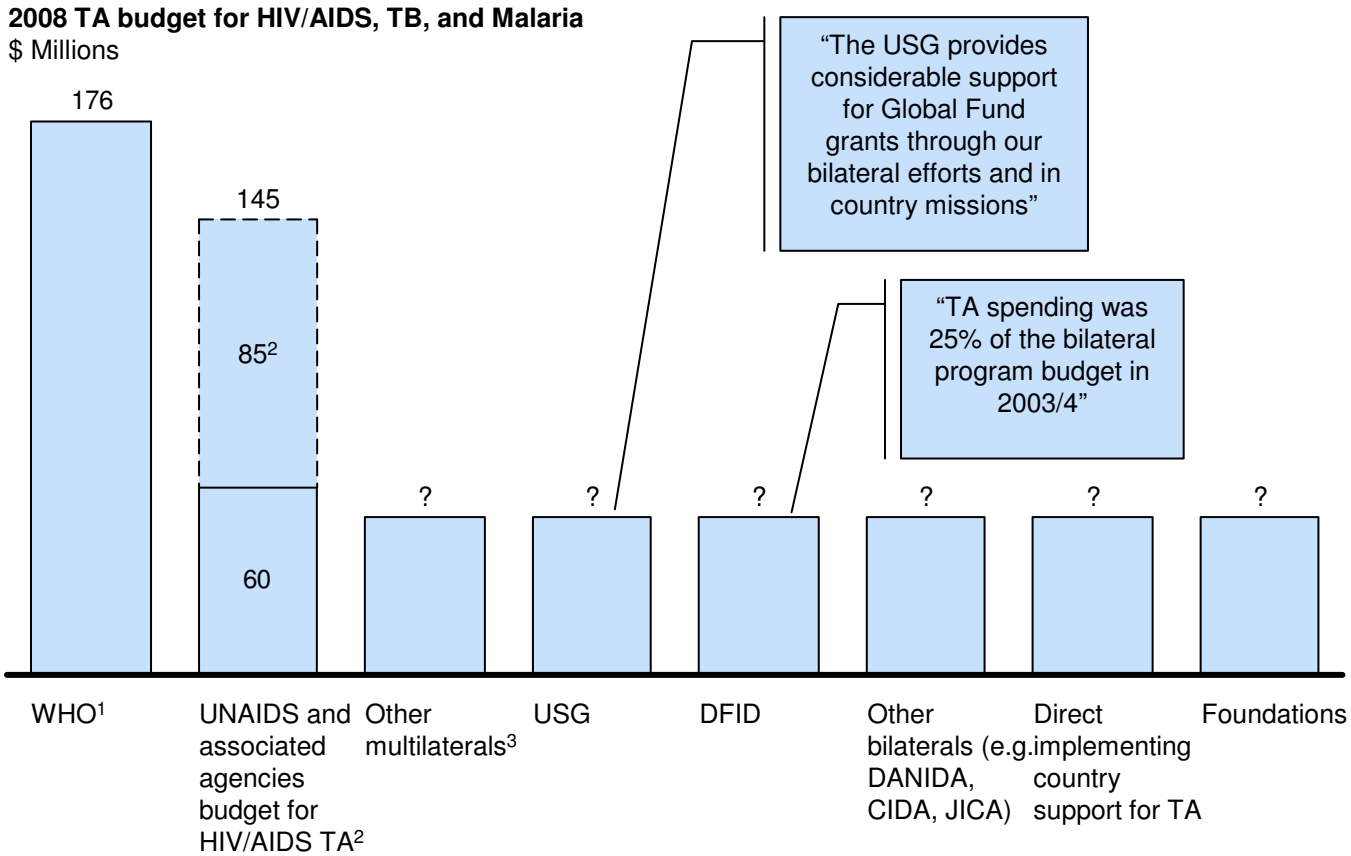
3 Includes $1.5m to UNAIDS, $3m to UNAIDS TSFs, and $3m to RBM. Stop TB did not receive USG money in USG FY 2006 / CY 2008. This $8m, in addition to the $15m allocated to GMS, is part of the 5% withhold from USG allocation to Global Fund foreign operations budget that is to be used in the spirit of providing TA for Global Fund-related projects / issues

4 Includes $2m from UNICEF, $0.7m from Gates Foundation, $0.3 from USG (PMI). Does not include $3m USG funding to RBM

5 Includes $2.5m in direct TB team activity funding, including field visits and workshops

SOURCE: Agency budgets; interviews

Other organizations also provide substantial support for TA



- There is substantial funding for TA for HIV/AIDS, TB, and Malaria generally
- This funding is for TA for country program support – it has been difficult to assess how much is in support of Global Fund grants
- Given the % of funding that is thought to be contributed by the Global Fund to the diseases (25% HIV, 67% TB, 75% Malaria), it is likely that much of this is used to directly and indirectly support Global Fund funded programs
- This funding is likely to include staff salaries and committed programs

1 Reflects three different budget items from the 2008-2009 WHO budget divided by 2, 1) Policy and TA towards prevention, treatment and care interventions for HIV/AIDS, TB and malaria 2) Global guidance and TA to promote equitable access to essential medicines, diagnostic tools and health technologies for the prevention and treatment of HIV/AIDS, TB and malaria and 3) Ensuring political commitment and mobilization of resources through advocacy on HIV/AIDS, tuberculosis and malaria; country support to develop or strengthen and implement mechanisms for resource mobilization and utilization; and engagement of communities and affected persons

2 Reflects all line items within 2008/2009 UNAIDS unified budget by outcome referring to "technical assistance" or "technical support;" does not include any budget from the WHO to avoid double-counting, assumes funding evenly spread over 2008/2009 and divides 2008/2009 total by 2 to reach numbers; $60m reflects Core budget, while $85m reflects supplemental budget

3 Includes World Bank, UNFPA, WFP, ILO, UNICEF; funding from other UN agencies for HIV likely captured in UNAIDS, so this funding is for TA in TB and Malaria

SOURCE: WHO Programme budget 2008-2009, 2008-2009 Unified UNAIDS budget and workplan,

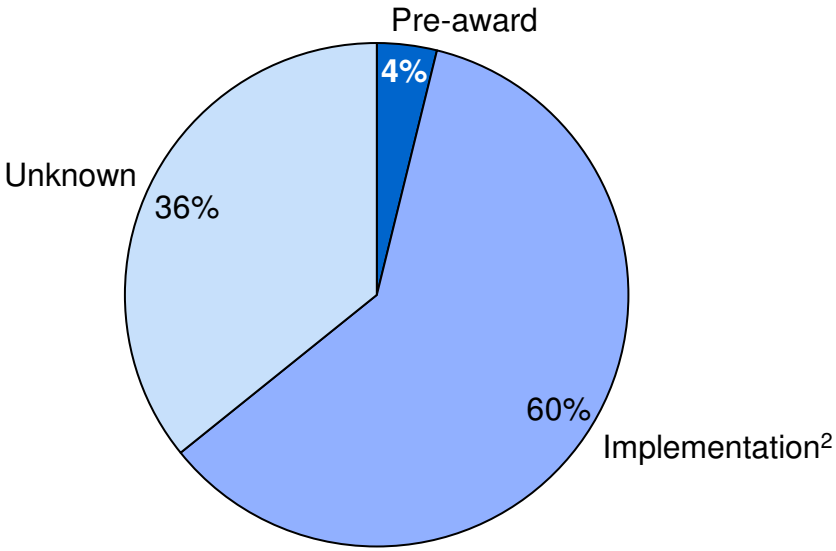
TA can occur at three major stages of the Global Fund grant process

	Pre-award	Pre-implementation (Grant signature)	Implementation
Time frame	Round 8: 5 months between grant announcement and application deadline	Round 7: Averaged 9 months for malaria and TB, 10 months for HIV	Throughout life of the grant (2 years in Phase I, 3 years in Phase II)
Key TA activities	1. National strategy development and needs assessment 2. Direct proposal support 3. Mock TRPs 4. Global Fund clarifications workshops/Q&A's	1. TRP clarifications 2. Legal agreements 3. M&E/PSM plans 4. Capability strengthening of PR 5. Initial implementation activities	1. Program management 2. Targeted expertise – ACSM[1] and BCC[2] – PSM – Implementation support, training – M&E, operations research – Health information systems 3. Additional Global Fund process support

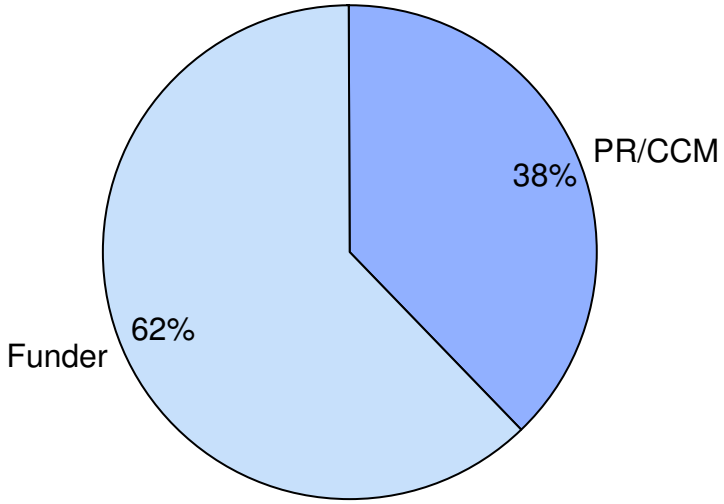
1 Advocacy, communication, and social mobilization
2 Behavior change communication

Much of the funding directly related to Global Fund[1] focuses on implementation and is largely funder-managed

Breakdown of confirmed Global Fund specific TA budget, 100%= $66 million



Breakdown of confirmed Global Fund specific TA budget, 100%= $66 million



- High implementation percentage likely reflects some skewing in that $66 million consists of programs specifically designed for implementation or bottleneck removal
- Large unknown percentage cannot be fully categorized.
- Large percentage of budget managed by funders likely reflects efforts to work around cultural and political barriers for country spending directly for high cost TA

1 Of confirmed/known Global Fund funding which is estimated to be at least $66 million in CY 2008
2 May include some signature activities

SOURCE: Agency budgets; interviews

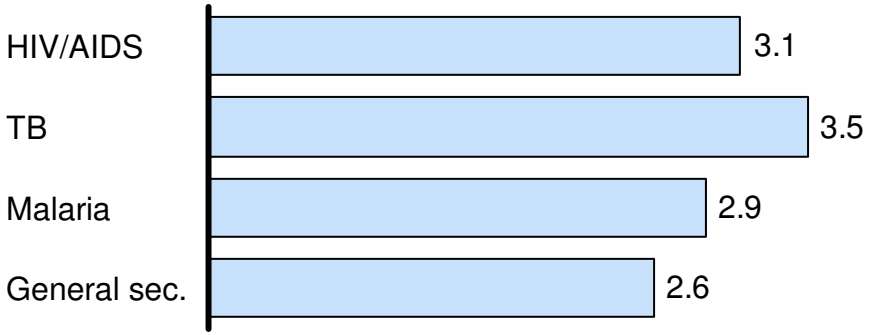
Various actors can shape demand for TA at a country level

	Description	TA-specific role
PR	▪ In charge of implementing the grant ▪ Directly responsible for success of grants (e.g. reaching grant metrics) ▪ Manages SRs and SSRs	▪ Likely the first actor to be aware of implementation problems or TA needs ▪ Can directly request TA
CCM	▪ Oversees proposal process and provides grant oversight ▪ Includes Multi-sectoral representation	▪ Can directly request TA (e.g. to UNAIDS TSF) or coordinate with PR to request TA
FPM	▪ Oversees grant portfolio for specific countries ▪ Acts as link between country and Global Fund	▪ Aware of reported implementation lags and difficulty reaching performance metrics ▪ Can shape PR / CCM request for TA ▪ Can link PR / CCM with TA provider
In-country partners	▪ May sit on CCM or country-based disease councils (e.g. NAC) ▪ Provide funding for programs ▪ Provide long-term assistance as part of "normative role"	▪ May provide or coordinate TA ▪ May flag grant implementation problems

Round 7 applications[1] reviewed used TA, with most applicants using multiple providers

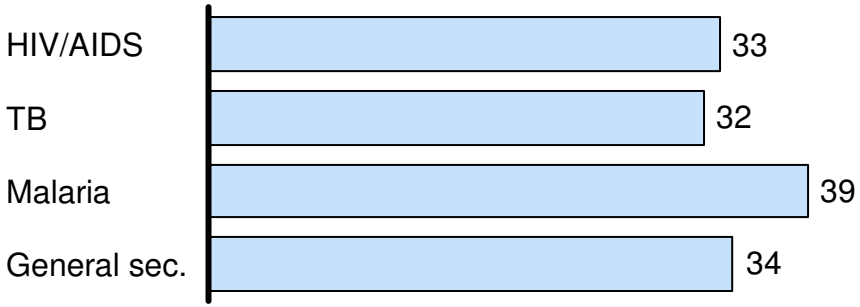
Most diseases used multiple providers

Average number of technical assistance providers per proposal section[2]



Most providers were used for 30 days

Average duration of technical assistance by a provider, per proposal section,[2] Days[3]



Major findings

- There were 74 proposals submitted in Round 7 from Sub-Saharan Africa and South Asia, and 93% of them used TA. 55% of these proposals were **approved – no proposals were approved that did not use TA**
- TA support is variable
  - **Average of 3 providers for each proposal section**, but ranges from 1 to 14
  - **Average length of support from a provider is 1-2 months**, but as short as 3 days or as long as four months

1 Round 7 Global Fund application included a section on TA used for the proposal (unique to Round 7) that was the basis for this analysis. However, data inconsistencies limit the ability to draw very specific quantifications from the results. Proposal sections included general (sections 1-3B), HIV, TB, and malaria. Each application included a general section and a disease-specific section. Analysis reflects only applications from Sub-Saharan Africa and South Asia

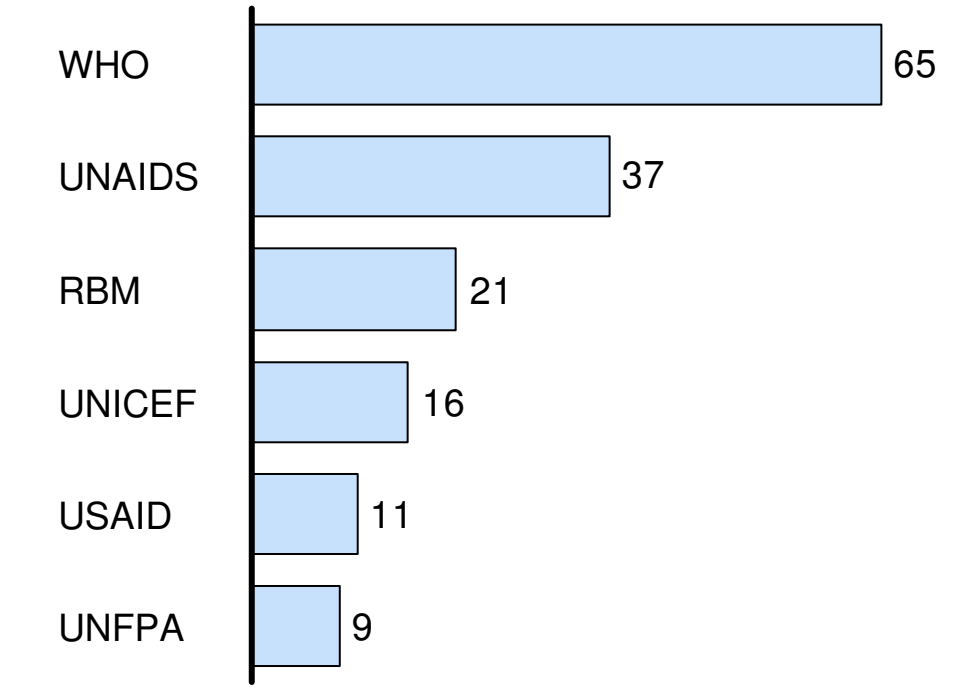
2 Averages exclude those applications not using TA, Analysis reflects only applications from Sub-Saharan Africa and South Asia

3 Calculated using 6 working days per week, as most countries reported weeks or months of work but countries did not specify 7 or 5 working days per week

SOURCE: Global Fund Round 7 applications; McKinsey analysis

A few multilateral agencies were the predominant providers of pre-award TA for Round 7

A few providers were more common, with many other providers supporting fewer sections[1]



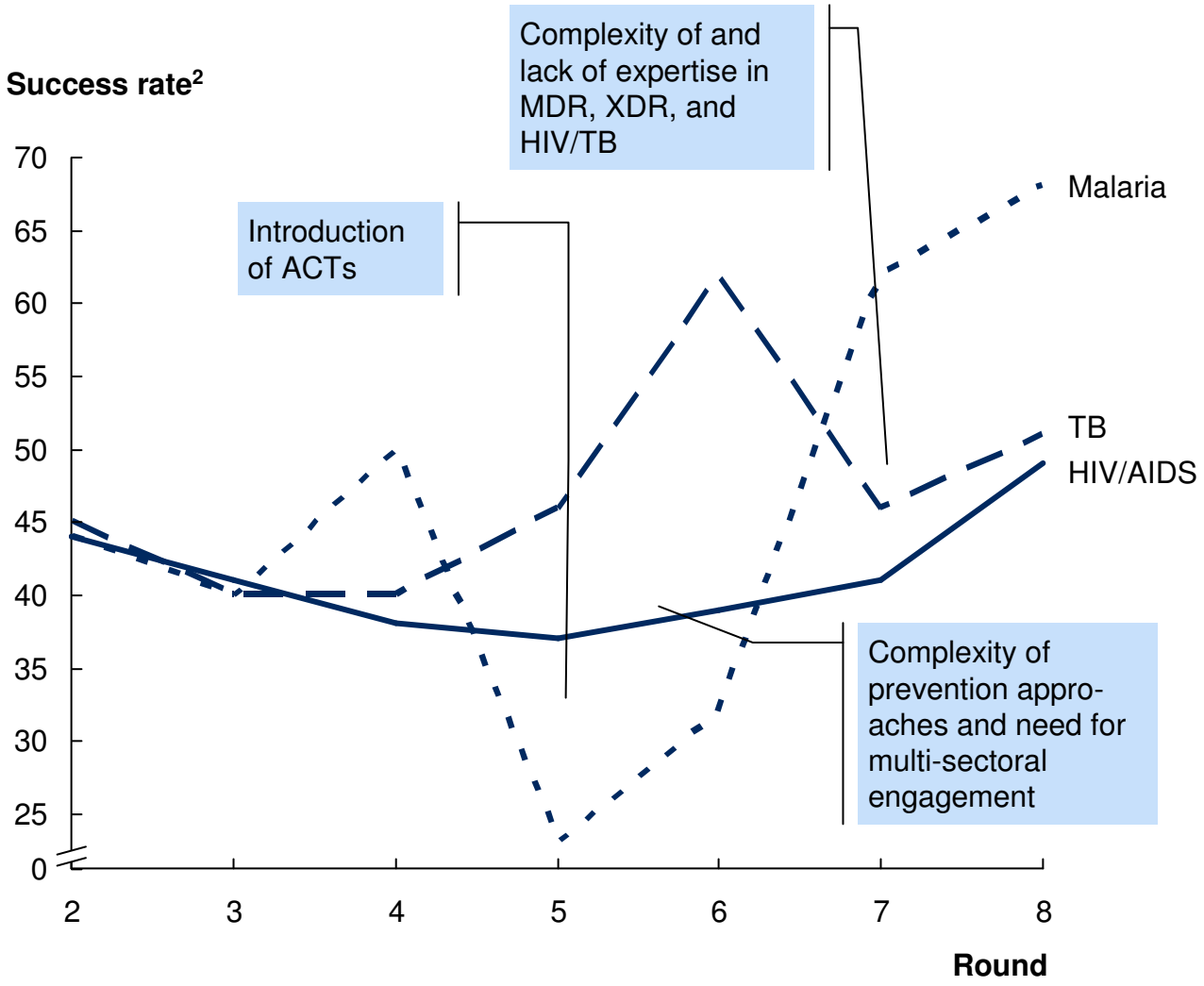
Major findings

- A few multilateral agencies are the predominant providers of proposal technical support in Sub-Saharan Africa and South Asia, with WHO as largest provider
- Provider varied by disease: UNAIDS is top provider in HIV, while WHO is top provider in TB and malaria

1 Averages exclude proposals not using TA,, analysis reflects Round 7 proposals from Sub-Saharan Africa and South Asia only

SOURCE: Global Fund Round 7 applications; McKinsey analysis

Proposal success rate varies by round and disease area[1]



A few initiatives have emerged with a focus on success rates

- Malaria: HWG's model drove success in Round 7 and 8
- TB: TB Team support drove rise in Round 6 approval rate
- HIV/AIDS: 70% Success Coalition members coordinate demand-driven pre-award assistance requests

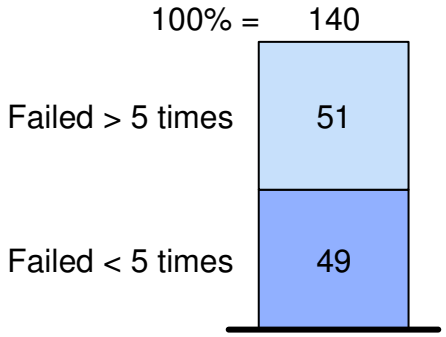
1 Includes 4B HSS for rounds 5-8; the HSS requests for cross-cutting health systems support are integrated into the host disease proposal.
2 Proposals approved as percentage of proposals submitted.

SOURCE: Global Fund TRP Report Round 8 (www.theglobalfund.org/documents/board/18/GF-B18-10_TRP_ReportTo Board_ and_ Annexes2-5-6.pdf); Global Fund TRP Report Round 4 (www.theglobalfund.org/ documents/ board/ 08/ Round_4_TRP_ Report.pdf)

Despite pre-award TA provision, some countries continue to struggle with grant application process

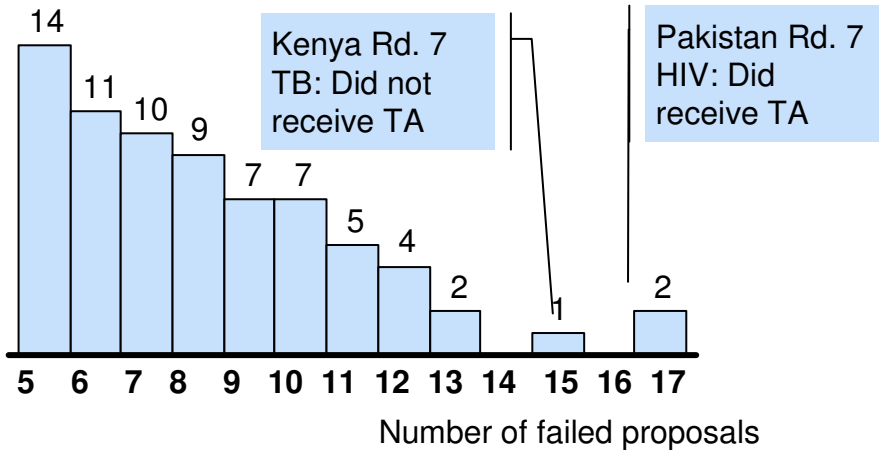
Countries have had substantial problems with proposals …

Percentage of countries failing of all countries applying



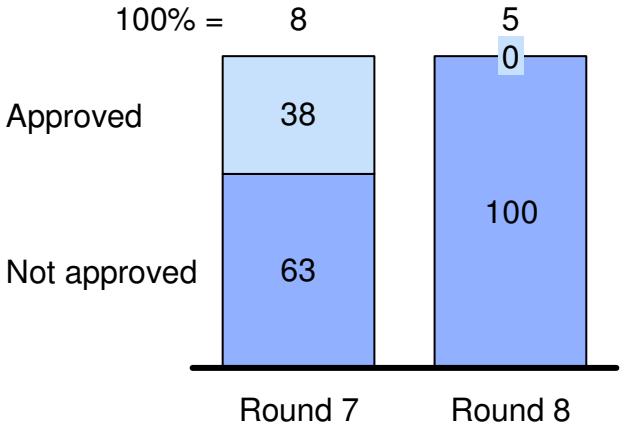
… With some countries faring especially badly, whether they did or did not receive TA

Number of countries with failed proposals, Rounds 1-8



Newer application types also struggle with grant approval process

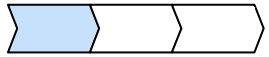
Percentage of regional applications submitted



- **TRP noted that many regional applications were rejected due to lack of countries' common epidemiological situations**
- **A number of regional proposals were screened out prior to reaching TRP**

SOURCE: Global Fund website, team analysis

Comparison of models for current pre-award TA coordination (1/2)



	HIV/AIDS	TB	Malaria
Major coordinator	▪ 70% Success Coalition[1] formed in 2008, partners held weekly conference calls to coordinate assistance to 71 countries and two regions (~90% of proposals to the Global Fund) ▪ Additionally, multiple individual coordinators include pre-award assistance in mandate; these include UNAIDS TSFs and CoATS, WB ASAP, GTZ Backup (not discussed here)	▪ TB Team: helped coordinate/track TA provided to all 59 countries applying in Round 8 ▪ Individual providers who are part of the TB Team vary in their approach to TA provision	▪ HWG: supporting 18/41 of proposals in Round 8 ▪ Countries who do not get direct support from HWG often go to RBM SRNs for support and/or participate in broader mechanisms e.g mock TRPs which are open to all countries
Success rate	▪ 40% (49% overall) ▪ Rates for partners within coalition varied with some much higher ▪ UNAIDS 70% success (38 proposals)	▪ 51% (51% overall) ▪ Rates for TA providers for TB Team varied with some much higher ▪ TB CAP 75 % success rate (4 proposals	▪ 78% (68% overall)
Mandate	▪ To coordinate technical support and intensify support provided to countries in order to achieve a 70% success rate in HIV proposal approval	▪ To facilitate planning of technical assistance according to needs ▪ To promote available TB expertise ▪ To provide a platform for coordination of technical assistance and avoid duplication of efforts ▪ To encourage collaboration of partners at every level	▪ To develop a formal partnership mechanism to facilitate and harmonize partners' timely support in response to countries identified needs ▪ To support the establishment of the 'three ones' (one coordinating mechanism; one plan and one M&E system) at country level
Approach (driver)	▪ All countries who request assistance via partners or UNAIDS are provided with TA (no strategic targeting)	▪ Largely country-driven, responding to requests except TB Cap (countries proactively identified by USAID)	▪ Uses proactive strategic approach to partner with high need countries which could benefit from increases in resources

1 Members during Round 8: AIDSpan, CHAI, CSAT, GAA, GTZ Backup, ICSS, IHAA, ILO, Health Gap, OSI, PAI, PSI, RESULTS, TSF Southern Africa, UNAIDS, UNDP, UNICEF, UNFPA, WHO

SOURCE: Interviews, McKinsey analysis

Comparison of models for current pre-award TA coordination (2/2)

	HIV/AIDS	TB	Malaria
Activities	▪ Organizes weekly conference calls to harmonize support provided, bring to attention countries requesting support ▪ Held Round 8 oriented regional capacity building workshops ▪ Provides and occasionally funds TA, often via UNAIDS-sourced consultants ▪ Provides WHO-led peer review of proposals prior to submission	▪ Provides/funds TA consultants ▪ Runs capability building workshop ▪ Brokers TA for 32 partners through online databases/tools	▪ Provides/funds TA consultants ▪ Holds mock TRPs ▪ Runs capability building workshop
Funding	▪ No separate funding for 70% Success Coalition—partners/PRs cover costs	▪ $1M spent on proposal assistance from 07-08 ▪ $2M from OGAC through USAID for TA across phases ▪ The timeliness in terms of availability of funding for TB Team has made a difference in ability to plan for and support countries	▪ $1.3M spent by HWG on Round 8. BMGF provided $300k to fill gaps in Round 8
Innovative models	▪ TSF databases have listings of providers for specific areas ▪ TSFs prioritize local / regional consultants ▪ WHO/UNAIDS have developed a web-based tool for assistance with Round 9 proposal writing ▪ WHO provided peer review mechanism for Round 8	▪ Detailed online database tracking TA providers, cut by expertise, country presence, and past engagements	▪ Worked with Global Fund to establish consensus on malaria proposals ▪ Twinning program, pairing each country with a local and international consultant ▪ Countries provide feedback on HWG consultants ▪ Peer review mechanism at mock-TRPs that helped build capacity broadly ▪ Catalytic role to encourage reaching 2010 targets

1 Members during Round 8: AIDSpan, CHAI, CSAT, GAA, GTZ Backup, ICSS, IHAA, ILO, Health Gap, OSI, PAI, PSI, RESULTS, TSF Southern Africa, UNAIDS, UNDP, UNICEF, UNFPA, WHO

SOURCE: Interviews, McKinsey analysis

Approaches to Round 9 differ between diseases

HIV

- 70% Coalition will continue comprehensive approach in providing TA to all countries who ask for it
- Inclusive approach largely based on direction by UNAIDS, per interviews by other members
- Individual members may be approaching countries who failed, but no known targeted approach as a coordinated community of providers
- 70% Coalition will include push for earlier and broader WHO-led peer review process of applications

TB

- TB Team's overall approach is to respond to all countries but may prioritize those with greatest need if funding is inadequate
- Will continue to use planning tools but in response to TRP identifying many Round 8 proposals as "too formulaic" they will encourage users to have better preparation before using tools so context is more clear
- Focusing on finding TA providers with more local knowledge

Malaria

- Targeting a limited set of countries, will likely turn away some countries to focus on highest need
- Similar approach as Round 8 (14 countries to be targeted)
  - Targeting some countries who were encouraged not to apply in Round 8
  - Targeting some countries with rejected Round 8 proposals / high need
- Will increase emphasis on rapid signature and implementation support building on needs assessments that were conducted with RBM SRNs over last year

Pre-implementation stage is complex and involves completion of several activities

PSI CHECKLIST EXAMPLE

- **Address TRP comments**
- **Budget**
  - Budget revisions
  - Workplan revisions
  - Get approval from the Global Fund
- **Monitoring and evaluation (M&E)**
  - Revise attachment A/performance framework
  - Get approval from the Global Fund
  - Organize M&E systems strengthening process and complete the assessment
  - Write M&E plan
  - Get approval from the Global Fund
- **Procurement and supply**
  - Contracts review
  - Get approval from the Global Fund
- **LFA assessment**
  - Financial and management systems (FMS) assessment
  - Pharmaceutical and health product management (PHPM) assessment
  - Program management capacity (PMC) assessment
  - SR management assessment
  - M&E capacity assessment
- **SR management**
  - Design or confirm SR selection/confirmation process
  - Issue EOIs if needed
  - Assess and select SRs
- **Preparing for program management (internal platform preparations)**
  - Perform platform assessment
  - Recruit staff
  - Train staff
  - Revise policies and procedures
- **Grant negotiation**
  - Negotiation between PR and CCM
  - Contracts review
  - Sign contracts with SRs (after grant signed)

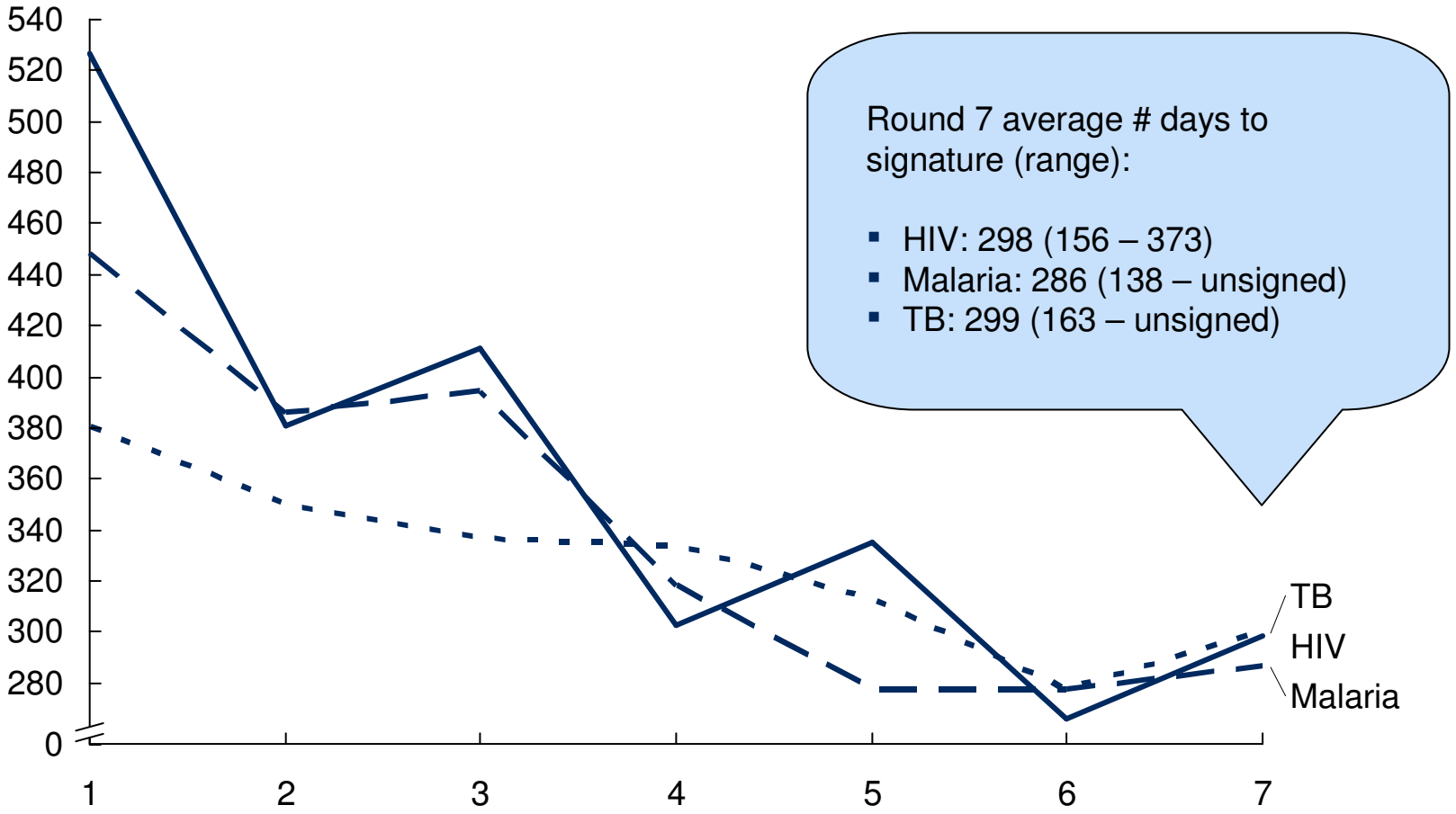
For countries that have multiple grants, SWAPs, or pooled donor funding, this phase may also require time-intensive processes such as

- Grant consolidation
- Harmonization with other donors
- SWAP negotiations

SOURCE: Interviews; PSI

The time necessary to complete these activities remains high at nearly 300 days

Average number of days from approval to signature[1]



1 For all grants with available data from Rounds 1 through 7, average time for each disease between grant approval and signature was calculated. For those Round 7 grants not yet signed, 2/5/2009 was used as signature date.

SOURCE: Global Fund website; McKinsey analysis

Interviews demonstrate conflicting opinions about best practices for this phase

"Signature has historically taken an embarrassing amount of time, which can be easily compressed. We are targeting four months for Round 8."
- Malaria TA provider

"In many cases the PR is setting the pace for this period. Some PRs are planning around a year delay before grant signing to harmonize with an existing program."
- Global Fund Secretariat

"We don't really focus on this phase, we let the PRs handle it."
- TB TA provider

"If you start to dissect it, each situation has a good story for the delay. In some cases for example this is related to the capacity of the LFA to do the assessment which can add months
- Global Fund Secretariat

"I just don't know if four months is enough time to complete everything."
- Malaria PR

"Signature time is long now, but it probably needs to be given the number of activities required. Most countries won't be able to do all of them in fewer months."
- Global Fund Secretariat

"In HIV, four months may not be enough time for the PR to finish all the necessary steps and build capacity in order to ensure success of the grant."
- HIV TA Provider

SOURCE: Interviews

There are many open questions and issues regarding this phase

Several areas emerged for further work in discussions with key partners

- A better understanding of the dynamics operating here is needed before large scale systematic efforts are undertaken to shorten this phase
- Analysis of relationship between types and models for proposal support and the length of time of signature phase could be helpful to understand if some of issues can be addressed by TA early on
- Further analysis could also be helpful to understand relationship between shorter times to grant signing and implementation on Phase 1
- It will be important to note that introduction of new PRs with dual track financing will also require additional time for signature
- TA in this arena can likely accelerate the timeline and lay the groundwork for earlier disbursement for some grants, although few providers focus on this area currently
- To fully realize the potential of TA in this phase, it will be important to understand which grants this is most helpful for, to not over focus on absolute number of days and clarify the dynamics to uncover barriers from the Global Fund and countries themselves

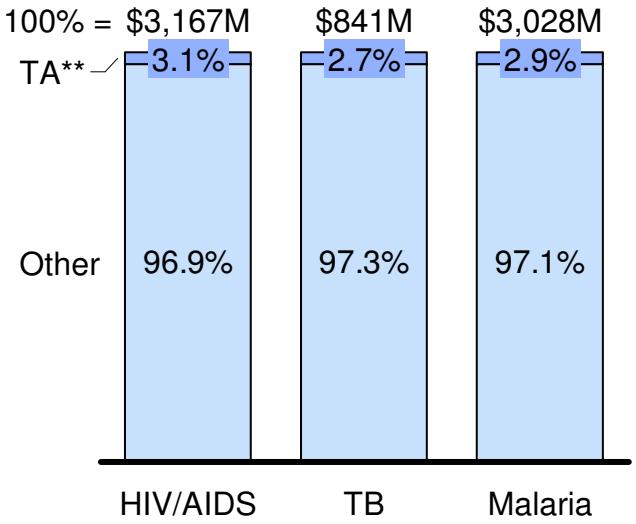
SOURCE: Interviews and discussion with key partners

Global Fund Round 8 proposals allocate average 3% of budget to planned TA[2], but there is wide variation between grants

PLANNED TA

Proposals in each disease allocate an average 3% of budget to TA …

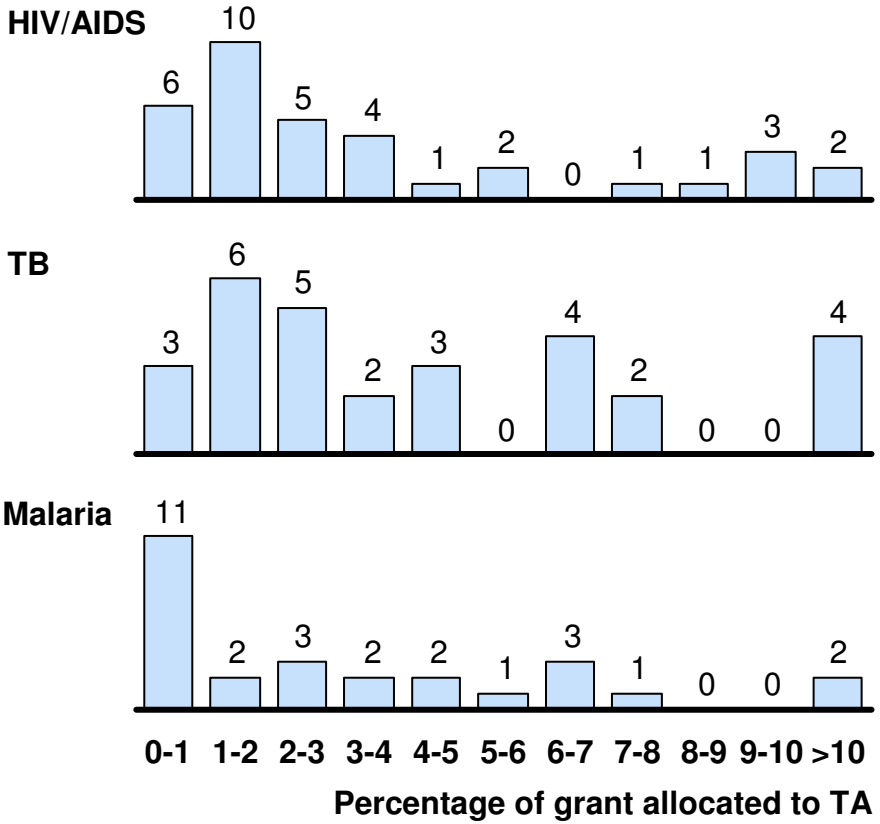
% of TA[1] in all approved Global Fund Round 8 grants[2,3]



This does reflect TA in actual budget that is part of grant signing or expenditure for TA

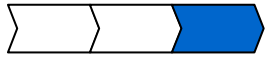
… But there is significant variation between proposals in % allocated

Number of grants allocating a % of budget to TA[1]



1 As of December 2008, 73 programs were approved and signed (3 remain unsigned), with a Phase 1 (2 year) commitment of $ 1.06 billion
2 Technical and management assistance
3 Actual funding not determined until signed. $ based on Phase I upper ceiling. Excludes Health Systems Strengthening (HSS) grants.
SOURCE: Report of the technical review panel and the secretariat on round 8 proposals; team analysis. Round 8 grants included a budget line for technical assistance—team calculated this budget line as percentage of total grant amount approved by disease for all approved grants.

Several areas for further work have emerged through discussions with partners

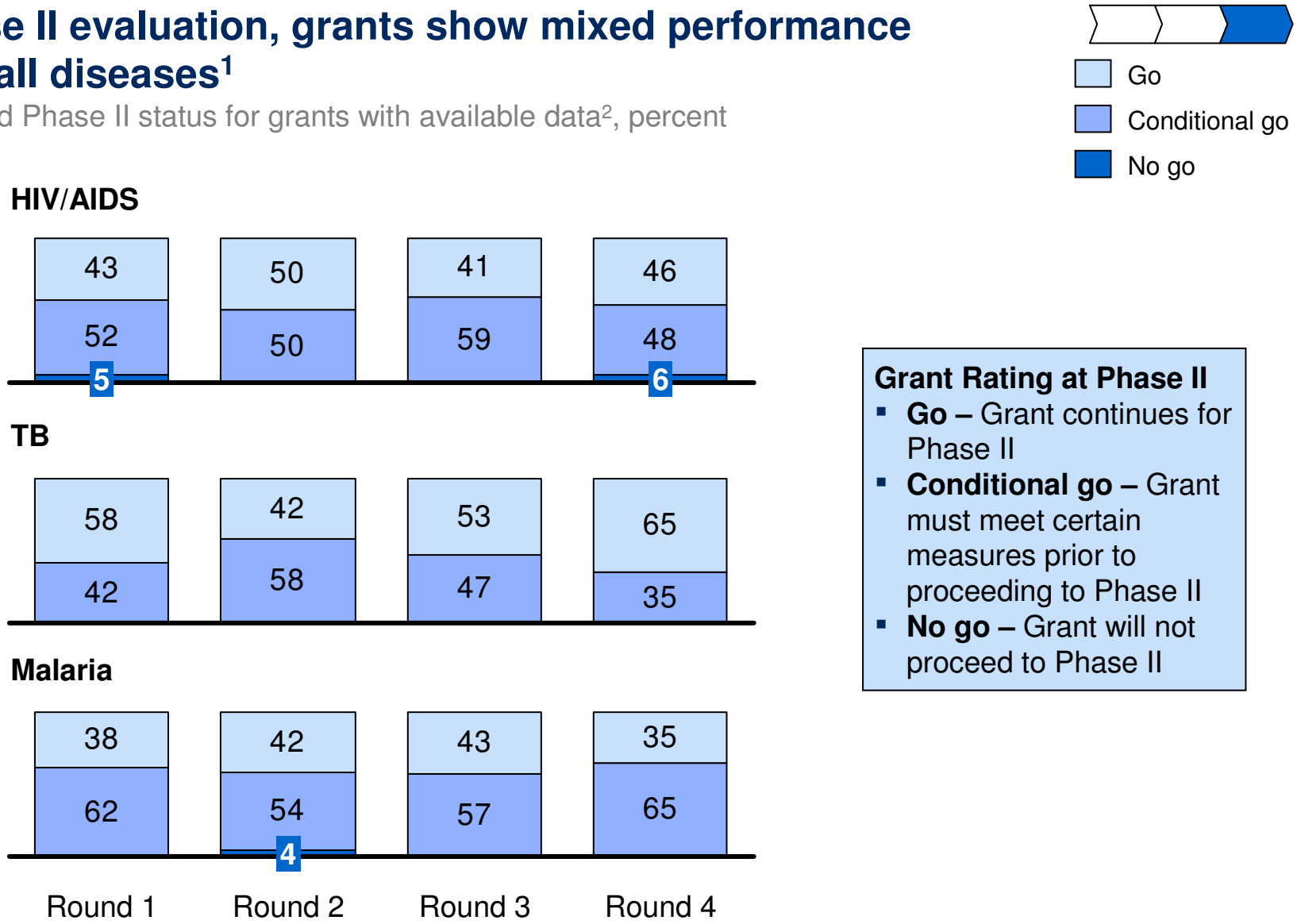


- Further analysis on expenditure data could be helpful to understand extent of barriers for countries to effectively pay for and demand TA
- An understanding of how TA budgets are impacted during grant negotiation could also provide insight into how PRs view TA money
- Understanding in country of how implementation TA is accessed as well as difference between the three diseases in available TA mechanisms
- Describing the dynamics in play regarding coordination of implementation TA, which mechanisms are approached directly versus suggested by FPMs, in country partners etc.
- Further discussion with countries/PRs on the ability budget for TA and predict implementation challenges up front

SOURCE: Interviews and discussions with key partners

At Phase II evaluation, grants show mixed performance across all diseases[1]

Global Fund Phase II status for grants with available data[2], percent



Grant Rating at Phase II

- **Go –** Grant continues for Phase II
- **Conditional go –** Grant must meet certain measures prior to proceeding to Phase II
- **No go –** Grant will not proceed to Phase II

1 Aidspan's analysis of grants corroborates this analysis of mixed performance, with the fact 40.6% of grants are >6 months behind schedule (includes signature delays as well as implementation issues)

2 Data for ~50% of grants was unavailable, used available data from Global Fund website, excludes integrated HIV/TB, HSS, and other cross-cutting grants

SOURCE: Global Fund website; Team analysis. Phase II grant reports provided information on grant status. This information was cut by disease and round for this analysis.

Lower ratings at Phase II are related to problems that TA can address

Tanzania's Round 4 malaria grant rated "conditional go" at Phase II

TANZANIA ROUND 4 MALARIA EXAMPLE

TA-related problems identified in Phase I

- "Bottlenecks [that stalled Phase I implementation] included: protracted procurement delays; slow release of funds by the PR ot SRs due to protracted bureaucratic procedures; and a **lack of technical human capacity to effectively support the program**."
- "The performance of the PR to date has been greatly **dependent on TA from the Italian Cooperation, for which the contract has now expired. Accordingly, the PR must submit an action plan detailing the recruitment of replacement TA** to support the program in Phase 2."
- "A number of strengthening measures are required. These include the **provision of adequate technical staff to support implementation**, the strengthening of quantification and monitoring of ACT consumption, and the **strengthening of the reporting framework**."

TA-related conditions precedent for Phase II extension

- Prior to the signing of the Phase 2 extension, the PR shall submit a **plan of action detailing the recruitment of technical expertise to support program implementation**; "We would recommend that either the same Technical Advisor be contracted under the grant to continue providing TA or similar TA is obtained to ensure continuity and technical support."
- Prior to the second disbursement after signing the Phase 2 extension, PR shall submit a **plan to strengthen its monitoring and reporting of ACT consumption**
- Prior to Phase 2 grant signing, the PR shall submit a **revised work plan and budget** taking into account program relaities, such as the avaialbility of ACTs purchased in phase 1 to be used in phase 2

Earlier disbursement ratings

1	2	3	4
N/A	B1	B1	N/A

SOURCE: Tanzania Round 4 Malaria Grant Scorecard and Grant Performance Report

Countries can generally be grouped by performance across rounds and diseases

Ahead of schedule
Behind schedule

EXAMPLE

Country	Number of grants	Average months ahead of or behind schedule[1]
Madagascar	8	0.1
Albania	2	4.4
Armenia	2	0.7
Azerbaijan	4	0.8
Bosnia	2	0.5
Kenya	9	19.9
Nigeria	7	25.5
Swaziland	5	15
Uganda	8	31.2
East Timor	5	13.8

Countries with strong performance in one round have often performed well across multiple rounds and diseases, while those with weaker performance have often demonstrated mixed performance across their portfolio.

1 Rated grants only

SOURCE: Aidspan's Global Fund grant schedule analysis (http://www.aidspan.org/index.php?page=gfgrants)

Current trends are reshaping the future need for TA

Key trends	Implications for TA
▪ Grants are growing larger and more complex, with an increasingly varied mix of SRs and SSRs (in Round 8, 10 proposals submitted included 2-year budget ceilings > USD $100M)	▪ Increased need for project/program management TA to coordinate complete network of SRs and SSRs
▪ PRs will segment into two camps – older, experience PRs who are looking to scale programs and new PRs from civil and private sector	▪ Decline in need for proposal support for experienced PRs but increase in more targeted support for new PRs
▪ PRs will be able to access some funding pre-signature, creating a "pre-implementation" phase	▪ Some TA will be accessed earlier, potentially tying signature support to implementation support more directly
▪ Emergence of National Strategy Applications will change how Global Fund proposals are integrated with other donor plans (first learning wave in 2009, with TRP conducting validation/review of national strategies)	▪ TA for national strategies now becomes a core need, with a shift in proposal approach
▪ Shifting strategies and the emergence of new technology will represent continued challenges for knowledge dissemination and implementation (current examples include shift to universal coverage for LLINs, male circumcision, new TB lab approaches, RDTs)	▪ Proactive TA coordination required to shape country uptake for these new technologies and strategies – *Reprogramming-* – *Implementation-* – *Pre-award-* ▪ Likely growing role for TA to facilitate adoption of new strategy/technology across phases of the grant ▪ Need to define and communicate "good" for these new technologies / strategies across TA providers, coordinators, and country actors

SOURCE: Interviews

TA will be important to address emerging new approaches for each disease

Major shifts in strategies and technologies . . .

- Male circumcision
- Shift towards universal coverage of bednets
- Roll-out of rapid diagnostic tests for malaria
- Combination prevention for HIV
- Diagnosis and treatment of XDR/MDR TB
- Expansion of second-line drug susceptibility testing in TB

. . . will require countries to be responsive in new and existing grants, shaping TA needs

- New grant
  - Experts/scientists, TA providers, CCM, PR, and TRP must agree on "what is good"
  - TRP may require preparation/training
  - TA providers may require training
  - Existing tools (e.g., needs assessment tools) may need to be modified to include new technology/strategy
- Existing grants
  - Countries must understand ability to reprogram, process of reprogramming
  - FPMs can facilitate reprogramming
  - TA providers can assist in harmonizing new area with existing country strategy

SOURCE: Interviews

While some challenges were specific to each of the diseases …

	HIV	TB	Malaria
Pre-award	▪ Multiple coordinators ▪ Lack of agreement around approach e.g. strategic, proactive, broad, etc. ▪ Lack of alignment around "what good looks like" among technical experts, TRP, TA seekers, and TA providers on key prevention strategies. – Particularly relevant for rollout of new interventions (e.g., male circumcision) – Examples exist of providers giving conflicting advice on a program ▪ High reliance on international providers	▪ Question of adequacy of resources to meet demand for TBTeam support ▪ Questions around best approach to TA provision e.g. reactive, broad ▪ Providers over-reliance on existing tools leading to formulaic proposals without specific country context, ▪ High reliance on international providers	▪ Concern that HWG may be too directive in its approach ▪ Potential over-focus on top notch proposals with possible disconnect for implementation challenges
Pre-implementation	▪ Providers not focused on this area and gaps in some core skill sets needed (PSM, M&E) ▪ Lack of consensus on the appropriate amount of time needed to operationalize proposals / build PR capabilities ▪ No strategic effort by coordinators to reduce signature time	▪ Providers not focused on this area and gaps in some core skill sets needed (PSM, M&E) ▪ Lack of consensus on the appropriate amount of time needed to operationalize proposals/build PR capabilities ▪ No strategic effort by coordinators to reduce signature time	▪ Lack of agreement on proactive approach and broad 4-month target by HWG
Implementation	▪ Gaps in specific provider skill sets, including new prevention strategies (including male circumcision); general behavioral change; HIV / TB; PSM; M&E; program management ▪ Fragmented provider and coordinator space, making it difficult for PRs and CCMs to know who to approach with request for TA ▪ High degree of variability in providers	▪ Gaps in specific provider skill sets, including MDR / XDR; HIV / TB; lab setup and training (though emergence of Global Laboratory Intiative is beginning to address this); M&E; program management ▪ Overall lack of providers for TB	▪ Gaps in specific provider skill sets, including PSM; M&E; program management; new technologies (e.g. RDTs) ▪ Some models exist for long-term TA, but there are questions about scalability

1 Members during Round 8: AIDSpan, CHAI, CSAT, GAA, GTZ Backup, ICSS, IHAA, ILO, Health Gap, OSI, PAI, PSI, RESULTS, TSF Southern Africa, UNAIDS, UNDP, UNICEF, UNFPA, WHO

2 Per evaluation of the 70% Success Coalition in Friends of Africa / GTZ report

… there were several key challenges that cut across

	Pre-award	Pre-implementation	Implementation
Demand	▪ Demand is shaped by PR/CCM capacity gaps and lack of clear communication between the Global Fund and country/PR of Global Fund processes, policies and evaluation criteria (need to respond to TRP comments, applying before clear results have been demonstrated, need for strong CCM oversight of process and review of grant)	▪ FPMs have wide flexibility of in proactively aiding countries during this phase (and there is wide variation between FPMs)	▪ Use of TA when hiring or outsourcing would be more appropriate ▪ PRs/CCMs do not strategically assess TA needs and plan for TA – Confusion around ownership roles of CCMs, FPMs, PRs, and in-country TA coordinators – Uncertainties about Global Fund processes/policies limits demand – Lack of planning leads to Insufficient "in time" demand – Highly dependent upon FPM to shape demand, high variability in FPMs pro-activity
Marketplace	▪ Challenges with coordination models – either overlapping coordinators, "too draconian," not proactive enough; there is potential for more strategic matching and targeting of support to meet greatest needs but a consensus on the "right" approach has not yet emerged ▪ Lack of alignment around "what good looks like" among technical experts, TRP, TA seekers, and TA providers on key prevention and treatment strategies. Particularly relevant for the rollout of new interventions (e.g., male circumcision)	▪ Lack of consensus on the appropriate amount of time needed to "operationalize" proposals/build PR capabilities and the need for TA to do so ▪ Marketplace – No strategic effort by coordinators or providers in HIV and TB to reduce signature time	▪ Lack of an overall strategy for implementation phase – agreeing on goals for TA providers, identifying countries in need, and targeting them for support – Difficulty with matching – Lack of clarity on funding source ▪ Lack of accountability mechanisms
Supply	▪ Some variability in supplier quality and suppliers without local context leading to formulaic proposals	▪ Providers not focused on this area and gaps in some core skill sets required (PSM, M&E)	▪ Gaps in provider skill sets ▪ Insufficient capacity building and lack of clarity around models for long-term implementation TA delivery, especially as the Global Fund moves towards National Strategy Applications (NSA)

Summary of key challenges

- TA is used broadly and often inappropriately instead of hiring, out sourcing, or true capacity building. It is a viewed as a solution to a variety of problems that is often more “acceptable” and easy to execute than other possible solutions

- PR and CCM driven demand for TA is low and not timely, instead there has been emergence of ad hoc and supply driven TA.
  - There is some disagreement on ability of PRs and CCMs to predict and plan for TA upfront in grants, but there is consensus that there is a need to eliminate the perception that requests for TA indicate issues with programs.
  - Even when TA is budgeted for within grants, PRs can be unwilling to spend TA budget due to political and cultural constraints.

- There are concerns about quality of TA, conflicting TA, and the sense that money gets spent on TA that is not always useful although there are no broad mechanisms establishing standards or better transparency on TA that is provided

- There are supply gaps among current providers. These include
  - Management assistance: program, financial, project management
  - General technical expertise: M&E, PSM, ACSM, etc.
  - Certain diseases-specific expertise: MDR-TB, TB labs, new approaches (e.g. male circumcision, RDTs)
  - Lack of providers with local knowledge
  - Limited supply of providers with non-English language capabilities

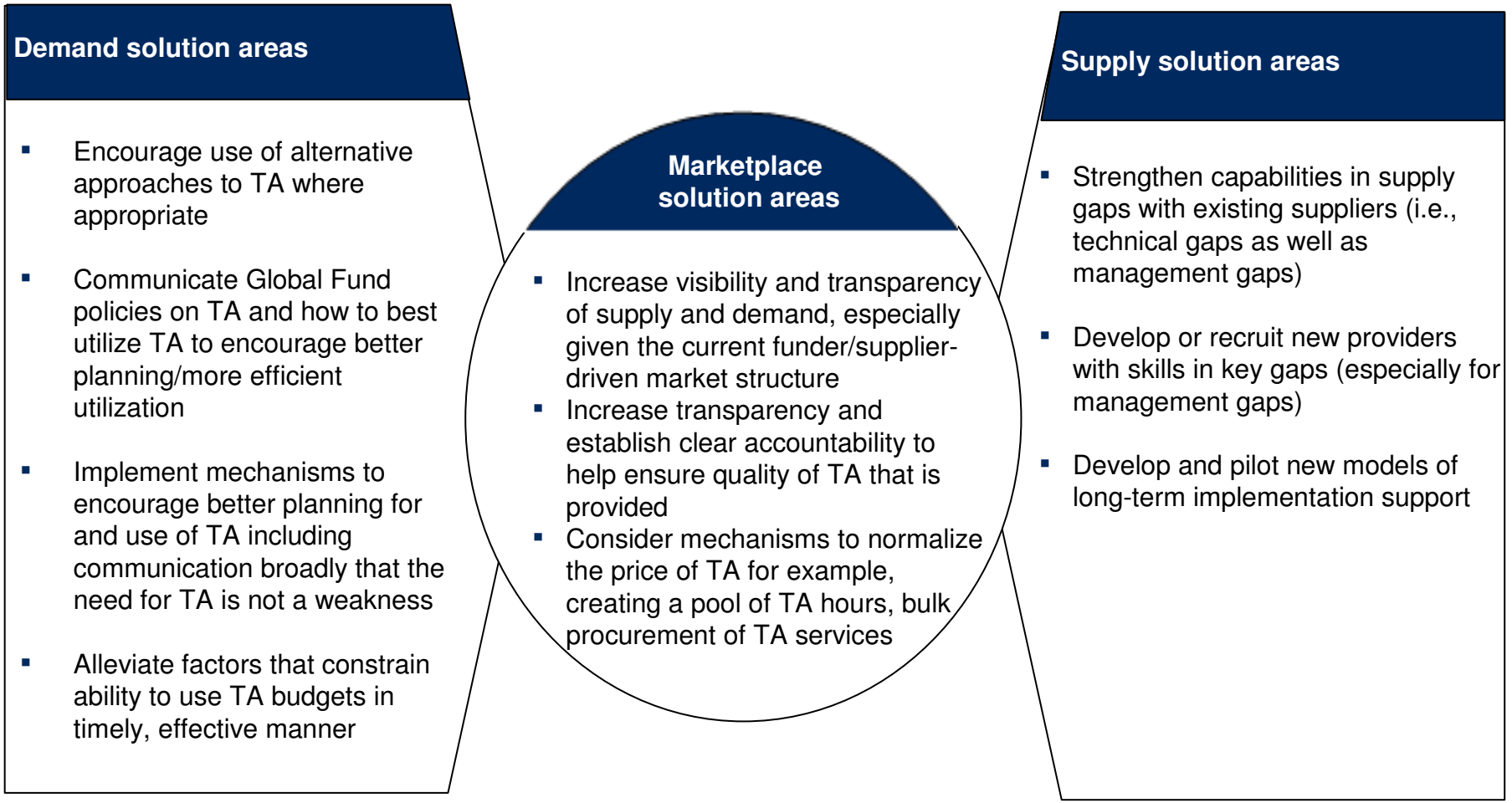
- Current models for accessing implementation TA do not adequately address the distinction on the need for management versus technical assistance with the default often that technical providers address a range of issues

- There are a variety of coordinating mechanisms for TA. Some focus on diseases and others on activities of certain elements of Global Fund grants, but there is no one stop shop to connect these various mechanisms and PRs and CCMs and even FPMs often do not know who is best to approach for specific issues.

- Repeat requests for similar TA and lack of real capacity building are ongoing deficiencies in current TA provision

Summary of improvement opportunities

This effort was intended to be a landscape to identify issues with respect to TA provision for Global Fund grants using available data. In the course of the interviews, several areas emerged as possible solution areas. This preliminary list is meant to be a discussion starter.



SOURCE: Interviews

Literature reviewed (1/2)

General

- Actionaid International, “Real Aid: Making Technical Assistance Work”, 2006
- Aidspan, “Providing Improved Technical Support To Enhance The Effectiveness Of Global Fund Grants”, 2008
- Aidspan (Garmaise), “An Analysis Of The Strengths And Weaknesses Of Proposals Submitted To The Global Fund Rds 3-6”, 2006
- Aidspan (Rivers), “Aidspan Guide To Obtaining Gf-related TA”, 2004
- DFID/HRC, “TA Pooling: Tools And Lessons Learned”, 2005
- European Centre For Development Policy Management, “Joint Evaluation Study Of Provision Of Technical Assistance Personnel: What Can We Learn From Promising Experiences?: Synthesis Report On The Study On Promising Approaches To Technical Assistance”, 2005
- GAVI , “HSS”, 2007
- GAVI/McKinsey, “GAVI TA Final Report”, 2008
- Global Fund, “TA For HSS: Global Fund Round 9”
- Global Fund, “Identifying And Managing Implementation Challenges In Global Fund Grants (Presentation)”, 2006
- Global Fund, “Report Of The TRP And The Secretariat On Round 8 Proposals”, 2008
- Global Fund, “TERG 5 Year Evaluation Study Area 2 Report”, 2008
- Global Fund, “Report Of The Global Fund Board Retreat On Partnerships”, 2008
- Global Fund, “Options Paper On Optimizing Grant Performance”, 2006
- Global Fund, “Reconsidering Options For Optimizing Grant Performance”, 2008
- Global Fund, “Ad-hoc Working Group on Technical Support for Grant Implementation and Performance”, 2004
- GTZ, “Technical Support Mechanisms For GF Processes”, 2008
- Health Partners International, “Technical Profile: HSS”
- HLSP Institute, “Global Health Initiatives And Health Systems Strengthening: The Challenge Of Providing Technical Support”, 2007
- IMF, “Africa Regional Technical Assistance Centers (Afritacs) Independent Mid-term Evaluation: Volume I – Final Report (2005)”, 2005
- OECD, “2005 Development Cooperation Report: Chapter 5 – Technical Assistance”, 2005
- Radelet, Siddiqi, “Global Fund Grant Programs: An Analysis Of Evaluation Scores”, 2007
- USG, “Fact Sheet: U.S. Government-funded Technical Support To Global Fund Grants”

Literature reviewed (2/2)

HIV/AIDS

- ASAP, “Progress report”, 2008
- CSAT, “Civil Society Action Teams: Improving the Performance of Global Fund Grants”, 2008
- IHAA/Wilkinson, “A Healthy Partnership: A Case Study Of The MOH Contract To KHANA For Disbursement Of World Bank Funds For HIV/AIDS In Cambodia”, 2005
- International HIV/AIDS Alliance, “2008-2010 National Strategy”, 2008
- PEPFAR, “2008 Annual Report to Congress”, 2008
- Rob Moodie, “Report To The Global Implementation Support Team (GIST)”, 2007
- UNAIDS, “20th Meeting Of The UNAIDS Program Coordinating Board: Report Of The GTT Independent Assessment”, 2007
- UNAIDS, “2008-09 Unified Budget”, 2008
- UNAIDS, “Guidance Note On Intensifying Technical Support To Countries”, 2008
- UNAIDS, “Making The Money Work”
- UNAIDS/Global Fund, “Memorandum of understanding”, 2008
- UNAIDS/UNDP/WB, “Mainstreaming AIDS In Development Instruments And Processes At The National Level: A Review Of Experiences”, 2005

TB

- Stop TB, “Stop TB Evaluation: Final Report”, 2008
- Stop TB (Presentation to the Global Fund Board), “Building And Sustaining A Tuberculosis Response To Achieve The MDG And Stop TB Partnership Targets”, 2008
- Stop TB, WHO (Pierre-yves Norval, Andrea B. Godfrey, Catherine Lijinsky), “TB Technical Assistance Mechanism Of The Stop TB Partnership (TBTEAM) Support To Countries To Prepare For And Implement Global Fund TB Proposals”, 2008
- TBCTA, USAID (Andrée Willemse), “TRAINING OF TB CONSULTANTS”, 2008
- Tim Ryan, “TBTEAM Assessment, 2007-2008”, 2009
- WHO, “Stop TB Partnership, Stop TB Coordination Of Technical Assistance To Countries: TBTEAM”, 2007

Malaria

- Global Fund, “Overview Of Global Fund Malaria Financing In Round 6”
- RBM, “Achieving Malaria Control Scale-up By 2010 – Plan For International Partners With Focus On The Malaria Implementation Support Team (MIST)”, 2008
- RBM Harmonization Working Group, “A Proposed Shift In Partnership Focus: From Change-management To Country Implementation Support”, 2007
- RBM (Presentation to the GF Board), “The Global Fund’s Role As A Strategic And Responsible Investor In Malaria (paper From The Chair Of The Board)”, 2008
- UNICEF, “UNICEF Strategic Framework for Malaria Programme Implementation in Africa: Achieving Impact with the RBM Partnership”, 2003
- WHO, “World Malaria Report”, 2008
- The World Bank, “ROLLING BACK MALARIA: THE WORLD BANK GLOBAL STRATEGY & BOOSTER PROGRAM”, 2005

Over 80 interviews were completed during the course of this work

Global Fund
- Christa Arent (Secretariat)
- Rifat Atun (Secretariat)
- Nicole Delaney (Secretariat)
- Naina Dhingra (asst to Board Chair)
- Helen Evans (Secretariat)
- Blaise Genton (TRP member)
- Oren Ginzburg (Secretariat)
- Matias Gomez - (Secretariat)
- Rajat Gupta (Board)
- Brad Herbert (former staff)
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- Sandii Lwin (Secretariat)
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BMGF
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- Carmine Bozzi
- David Brandling-Bennett
- Heather Harrison
- Michael Kimerling
- Luke Nkinsi
- Todd Summers

Other
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- Jim Kim (Harvard)
- Bernard Rivers (Aidspan)

Country
- Ebere Anyachukwu (DFID, Nigeria)
- Uzo Gilpin (DFID, Nigeria)
- Jerome Mafeni (CCM, Nigeria)
- Susan Mshana (DFID, Nigeria)
- Yemi Sofola (NMCP, Nigeria)

Providers/Coordinators/Funders
- Susan Bacheller (USAID)
- Andrew Ball (WHO)
- James Banda (RBM)
- Protik Basu (World Bank)
- Leopold Blanc (TB Team)
- Lori Bollinger (Futures Institute)
- Denis Broun (UNAIDS)
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- Pierre-Yves Norval (WHO)
- Susan O'Leary (UNAIDS TSF)
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- Melanie Renshaw (UNICEF, RBM)
- Christina Roberts (Malaria No More)
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- Claude Emile Rwagacondo (RBM SRN)
- Caroline Ryan (PEPFAR)
- Oliver Sabot (Clinton Foundation)
- Celina Schocken (PSI)
- Catherine Severo (GMS)
- R.J. Simonds (CDC)
- Naawa Sipilanyambe (UNICEF)
- As Sy (UNAIDS)
- Cheri Vincent (TB CAP)
- Peter Weis (GTZ BACKUP Initiative)
- Karin Weyer (GLI)
- Jason Wright (GMS)
- Timothy Ziemer (PMI)

Funding assumptions for confirmed Global Fund-specific TA funding

Data point	Approach / methodology for calculations	Sources
▪ Budgeted in Global Fund grants	▪ Assumed that in 2008, operational grants were from Rounds 2, 3, 4, 5, and 6 ▪ Calculated average yearly amounts approved from each of those rounds ▪ Applied 3% to the above number (assumed 3% of grant budgets were allocated to TA, based on team analysis and TERG report analysis that approximately 3% of grants in Round 7 and 8 allocated to TA)	▪ Global Fund grant allocation data, Global Fund website
▪ GMS	▪ Received direct budget information, assumed based on interview that FY 2006 budget for GMS = amount spent in CY 2008	▪ Interview / spreadsheet from Jason Wright, USAID
▪ US government funding to UNAIDS, RBM	▪ Received direct budget information. Includes $1.5m to UNAIDS, $3m to UNAIDS TSFs, and $3m to RBM	▪ Interview / spreadsheet from Jason Wright, USAID
▪ GTZ Backup	▪ Found budget of Euro 9M on GTZ website ▪ Converted to USD using average 2008 USD – Euro exchange rate	▪ http://www.gtz.de/de/dokumente/en-backup-charts-2007-2008.pdf
▪ HWG	▪ Received direct budget information in interviews ▪ Includes $2m from UNICEF, $0.7m from Gates Foundation, $0.3 from USG (PMI). Does not include $3m USG funding to RBM	▪ Interview with Bernard Nahlen, USG ▪ Interview with Suprotik Basu, RBM
▪ TB Team (proposal support)	▪ Received copy of budget and direct budget information in interview with Stop TB Coordinator	▪ 2008 budget provided by Keri Lijinsky ▪ Interview with Dr. Leopold Blanc, coordinator of Stop TB

Funding assumptions for other TA funding

Data point	Assumptions	Source
▪ WHO	▪ Examined WHO annual budget 2008 for budget lines related to TA specifically for HIV, TB, and malaria ▪ Added the relevant budget lines: 1) Policy and TA towards prevention, treatment and care interventions for HIV/AIDS, TB and malaria 2) Global guidance and TA to promote equitable access to essential medicines, diagnostic tools and health technologies for the prevention and treatment of HIV/AIDS, TB and malaria and 3) Ensuring political commitment and mobilization of resources through advocacy on HIV/AIDS, tuberculosis and malaria; country support to develop or strengthen and implement mechanisms for resource mobilization and utilization; and engagement of communities and affected persons ▪ Assumed funding evenly spread over 2008 and 2009 and divides 2008/2009 total by 2 to reach number	▪ http://www.who.int/gb/ebwha/pdf_files/AMTSP-PPB/a-mtsp_7en.pdf
▪ UNAIDS and associated agencies budget for HIV/AIDS TA	▪ Summed core and supplemental budget for all line items within 2008/2009 UNAIDS Unified Budget by outcome referring to “technical assistance” or “technical support” ▪ Removed any budget from the WHO to avoid double-counting ▪ Includes Secretariat, Interagency, UNICEF, ILO, UNESCO, UNHCR, WFP, UNDP, World Bank, UNFPA, and UNODC ▪ Assumed funding evenly spread over 2008 and 2009 and divides 2008/2009 total by 2 to reach number ▪ Included both core budget (~$60m) and supplemental (~$85m) to reach total; excluded “Global and Regional resources” to avoid double counting	▪ UNAIDS Unified Budget 2008-09

Abbreviations used throughout this document

Abbreviation	Description
ACSM	Advocacy, Communications, and Social mobilization
ASAP	AIDS Strategy and Action Plans
BCC	Behavioral Change Communication
BMGF	Bill and Melinda Gates Foundation
CCM	Country coordinating mechanism
CoATS	Coordinating AIDS Technical Support
FPM	Global Fund Portfolio manager
Global Fund	Global Fund for AIDS, Tuberculosis, and Malaria
GIST	Global Implementation Support Team
GMS	Grant Management Solutions
GPH	Global Public Health
HWG	Harmonization Working Group
LFA	Local Fund Agent
LLINs	Long-lasting insecticidal nets
M&E	Monitoring and Evaluation
NAC	National AIDS Council
NSA	National Strategy Application
OGAC	Office of the Global AIDS Coordinator
PEPFAR	President's Emergency Plan for AIDS Relief
PR	Principal recipient
PSM	Procurement and Supply Chain Management
RBM	Roll-Back Malaria
RDT	Rapid Diagnostic Tests
RCC	Rolling Continuation Channel
SR	Sub-recipient
SSR	Sub-Sub-recipient
TA	Technical Assistance
TOR	Terms of Reference
TRP	Technical Review Panel
TSF	Technical Support Facility
WB	World Bank
XDR/MDR	Extreme-Drug Resistant/Multi-Drug Resistant