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The Aidspan Guide to Round 10 Applications to the Global Fund

Volume 2: The Applications Process and the Proposal Form

Version B: Multi-Country Applicants

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by

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Note: The headings in *Chapter 4: Guidance on Specific Sections of the Round 10 Proposal Form* are exactly the same as the headings on the Round 10 proposal form. In this guide, Aidspan provides guidance on many of the questions on the Round 10 proposal form, but not all. This explains why there are some gaps in the section numbers shown in this part of the Table of Contents above.

Preface

Aidspan

Aidspan is a Kenya-based NGO whose mission is to reinforce the effectiveness of the Global Fund to Fight AIDS, Tuberculosis and Malaria, by serving as an independent watchdog of the Fund and its grant implementers through providing information, analysis and advice, facilitating critical debate, and promoting greater transparency, accountability, effectiveness and impact.

Aidspan also publishes the *Global Fund Observer (GFO)* newsletter, an independent email-based source of news, analysis and commentary about the Global Fund. To receive *GFO* at no charge, send an email to receive-gfo-newsletter@aidspan.org. The subject line and text area can be left blank.

Aidspan finances its work primarily through grants from foundations. Aidspan does not accept Global Fund money, perform paid consulting work or charge for any of its products.

Aidspan and the Global Fund maintain a positive working relationship, but have no formal connection. *The board, staff and other structures of the Global Fund have no influence on, and bear no responsibility for, the content of this report or of any other Aidspan publication.*

Acknowledgements, permissions, feedback

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Aidspan publications

This guide is one of over a dozen free Aidspan publications written for those applying for, implementing or supporting grants from the Global Fund. The following is a partial list of Aidspan's publications.

- ***Global Fund Observer:*** A free email newsletter providing news, analysis and commentary to nearly 8,000 subscribers in 170 countries. (more than 120 issues over the past six years; currently available in English only)
- ***The Aidspan Guide to Round 10 Applications to the Global Fund – Volume 1: Getting a Head Start*** (April 2010, available in English, French, Spanish and Russian)
- ***Aidspan Report: Key Strengths of Rounds 8 and 9 Proposals to the Global Fund*** *(January 2010;* available in English, French, Spanish and Russian)

- ***A Beginner's Guide to the Global Fund*** (July 2009; available in English, French, Spanish and Russian)
- ***The Aidspan Guide on the Roles and Responsibilities of CCMs in Grant Oversight*** (March 2009; available in English, French, Spanish and Russian)
- ***Aidspan Report: An Analysis of Global Fund Grant Ratings*** (November 2008; available in English only)
- ***Aidspan Report: Do Global Fund Grants Work for Women? An Assessment of the Gender Responsiveness of Global Fund-Financed Programmes in Sub-Saharan Africa*** (July 2008; available in English only)
- ***Aidspan White Paper: Scaling Up to Meet the Need: Overcoming Barriers to the Development of Bold Global Fund-Financed Programs*** (April 2008; available in English only)
- ***Aidspan White Paper: Providing Improved Technical Support to Enhance the Effectiveness of Global Fund Grants*** (March 2008; available in English only)
- ***The Aidspan Guide to Round 8 Applications to the Global Fund – Volume 2: The Applications Process and the Proposal Form*** (March 2008; available in English, French and Spanish)
- ***Aidspan Documents for In-Country Submissions*** (December 2007; available in English, French, Spanish and Russian)
- ***The Aidspan Guide to Building and Running an Effective Country Coordinating Mechanism (CCM)*** (Second edition September 2007; available in English, French and Spanish)
- ***The Aidspan Guide to Understanding Global Fund Processes for Grant Implementation – Volume 1: From Grant Approval to Signing the Grant Agreement*** (December 2005; originally titled "*The Aidspan Guide to Effective Implementation of Global Fund Grants."* Available in English only.)
- ***The Aidspan Guide to Understanding Global Fund Processes for Grant Implementation – Volume 2: From First Disbursement to Phase 2 Renewal*** (November 2007; available in English, French and Spanish)

Downloads

To download a copy of any of these publications, go to www.aidspan.org. If you do not have access to the web but you do have access to email, send a request to publications@aidspan.org specifying which publications you would like to receive as attachments to an email. Aidspan does not produce or distribute printed copies of these publications.

List of Abbreviations and Acronyms

The following is a list of the most common abbreviations and acronyms used in this guide:

CBO	Community-based organisation
CCM	Country Coordinating Mechanism
CSO	Civil society organisation
DOTS	Directly observed therapy
FAQs	Frequently asked questions
FBO	Faith-based organisation
GDF	Global TB Drug Facility
GFO	Global Fund Observer
HSS	Health sector strengthening
IEC	Information, education and communication
LFA	Local Fund Agent
M&E	Monitoring and evaluation
NGO	Non-governmental organisation
Non-CCM	Non-Country Coordinating Mechanism
PEPFAR	[U.S.] President's Emergency Plan for AIDS Relief
PLWHA	Person(s) living with HIV/AIDS
PR	Principal Recipient
PSM	Procurement and supply management
RCM	Regional Coordinating Mechanism
RO	Regional Organisation
SDA	Service delivery area
SR	Sub-Recipient
Sub-CCM	Sub-National Country Coordinating Mechanism
SWAp	Sector-Wide Approach
TB	Tuberculosis
TRP	Technical Review Panel
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNICEF	United Nation's Children's Fund
VCT	Voluntary counselling and testing
WHO	World Health Organization

Chapter 1: Introduction

This chapter outlines the purpose of this guide and describes the contents of the guide. It also contains short notes on terminology and on what initiatives the Global Fund will support.

Purpose of This Guide

The Aidspan Guide to Round 10 Applications to the Global Fund is intended to be useful both to those who need *less* than is provided in the proposal guidelines produced by the Global Fund (for example, because they may just want to find out whether they should even consider applying), and to those who need *more*.

The guide discusses factors that lie behind some of the questions asked in the "Proposal Form – Round 10" (hereinafter, the "proposal form").

This guide is not intended to tell readers what they should say in their applications to the Global Fund. Rather, the objective is to de-mystify the application process and to provide a clearer idea of what is expected. The guide is based on the premise that there is no single "correct" way of completing the proposal form. It encourages applicants to clearly describe their plans to tackle HIV/AIDS, tuberculosis (TB), or malaria; and to make a convincing case that the plans are viable, capable of delivering the anticipated results, and something that the applicants are (a) committed to, and (b) capable of implementing.

This guide is very long. We suggest that readers use whatever parts they need, or use the guide as a reference tool, rather than trying to read it all in one session.

Once again, Aidspan has produced its applying guide in two volumes. *Volume 1: Getting a Head Start*, provides information that applicants can use in the period before the Global Fund issues its call for proposals for Round 10. Some of the information in Volume 1 is generic and so could apply to any round of funding.

Volume 2: The Applications Process and the Proposal Form, (this document), provides guidance that is specific to the Round 10 applications process and proposal form. There are two versions of Volume 2: Version A (for single-country applicants) and Version B (for multi-country applicants). This is Version B.

Terminology Used in This Guide

Throughout this guide, the term "proposal" is used to describe the application that is being submitted to the Global Fund, and the term "programme" is used to describe the activities that will be implemented if the proposal is accepted for funding. The term "in-country submission" ("submission" for short) is used to describe mini-proposals that in-country stakeholders may submit for possible inclusion in a CCM proposal.

The term "NGO" refers to non-governmental organisations – i.e., not-for-profit organisations that operate outside the government sphere. Community-based organisations (CBOs) are one type of NGO. For the purposes of this guide, references to "NGOs" generally include CBOs.

The Global Fund identifies five types of proposal, categorized by source:

- Country Coordinating Mechanism (CCM)
- Sub-National Country Coordinating Mechanism (Sub-CCM)
- Regional Coordinating Mechanism (RCM)
- Regional Organisation (RO)
- Non-Country Coordinating Mechanism (Non-CCM)

At times, the Global Fund uses the term "CCM" to include not only CCMs, but also Sub-CCMs and RCMs. This can be confusing, but the context usually makes the meaning clear. The Global Fund also uses the term "coordinating mechanism" to denote CCMs, Sub-CCMs and RCMs. In this guide, we also use this term in this fashion.

The Global Fund uses the term "Non-CCM" to refer to proposals submitted by in-country organisations other than the CCM and Sub-CCM. In this guide, we also use this term in this fashion.

Note, also, that the Global Fund tends to use the terms "CCM" and "national CCM" interchangeably. In this guide, we generally use only "CCM," unless we are quoting or paraphrasing from other sources.

What Initiatives Will the Global Fund Support?

Volume 1 of this guide provided a list of the types of initiatives that the Global Fund will support, based on what was contained in the Global Fund's guidelines for Round 9. The Global Fund has subsequently made some changes to its list. The changes do not alter the broad scope of initiatives that the Global Fund supports; they simply provide more and better examples. Applicants should familiarise themselves with the list of initiatives (see Annex 3 of the R10 Guidelines for Proposals). That annex also contains a description of the types of initiatives that the Global Fund does not support.

Contents of This Guide (Volume 2)

Chapter 2: What's New for Round 10? describes the main changes to the applications process for Round 10, compared to previous rounds.

Chapter 3: General Information on the Round 10 Applications Process describes the guidelines document that the Global Fund has produced for Round 10, and the different versions of the proposal form; and explains where to obtain copies of the guidelines, the proposal form and its attachments. The chapter also outlines the process for submitting proposals, explains some key concepts used in all proposals, and provides general guidance concerning how to fill out the proposal form. Chapter 3 also contains short notes on the process for developing a proposal, on where to obtain guidance on the technical content of proposals, on the funding available for Round 10, and on relevant documents and links.

Chapter 4: Guidance on Specific Sections of the Round 10 Proposal Form, the core of this guide, provides guidance from Aidspan on many (but not all) of the questions on the proposal form. It contains numerous extracts from proposals that were approved in previous rounds and that were praised by the Technical Review Panel (TRP). See the "Note to Readers" at the beginning of Chapter 4 for more information.

Annex I contains the criteria that the TRP will use to review Round 10 proposals.

> ***Special Note:*** *We wanted to ensure that we released Volume 2 as soon as possible after the launch of Round 10 on 20 May 2010, so that it would be of use to applicants preparing their Round 10 proposals. This was a challenge because we had little time to work with the final versions of the proposal form, its attachments and the R10 Guidelines for Proposals. We have done our best to provide useful guidance in the time that was available to us.*

Chapter 2: What's New for Round 10?

This chapter describes the major changes to the Round 10 applications process as compared with previous rounds.

Single Stream of Funding

The biggest change on the Round 10 proposal form is that applicants may choose to submit a "consolidated" proposal instead of a "regular" proposal if they are eligible and ready to transition to a single stream of funding. This is in line with the decision by the Global Fund to move towards a single stream of funding per disease per PR.

If applicants are submitting a proposal for a particular disease, and if they already have one or more existing grants for that disease, and if at least one of those existing grants will have at least 12 months of implementation time remaining from the proposed start date for the programme covered by their Round 10 proposal – then these applicants are eligible to transition to a single stream of funding. (By definition, applicants that do not meet these criteria are not eligible to transition to a single stream of funding in Round 10.)

Round 10 applicants that are eligible to transition to a single stream of funding are given three options:

> **OPTION 1:** Transition to a single stream of funding by submitting a consolidated proposal in Round 10. In a consolidated proposal, proposed new activities are consolidated with existing grants for the same disease. This would result in the applicant signing one or more single-stream-of-funding grant agreements, should its proposal be approved for funding.
>
> **OPTION 2:** Transition to a single stream of funding during Round 10 grant negotiations. Under this option, the applicant would submit a regular proposal in Round 10, but indicate that it wishes to consolidate its Round 10 proposal with existing grants for the same disease during grant agreement negotiations. This would also result in the applicant signing one or more single-stream-of-funding grant agreements, should its proposal be approved for funding.
>
> **OPTION 3:** Defer, for the time being, any decision about transitioning to a single stream of funding. Applicants that choose this option will be able to transition to a single stream of funding some time after the Round 10 funding applications period. If they have not done so by the start of Round 11, they may be required to submit a consolidated proposal at that time, depending on whether they submit in Round 11, what they submit and what the status of their existing grants is at that time.

Note that in order to transition to a single stream of funding in Round 10 (i.e., Options 1 or 2), applicants do not necessarily have to re-nominate an existing PR in their Round 10 proposals. Applicants have several choices. They can (a) redistribute continuing existing grant activities among existing PRs; (b) allocate continuing existing grant activities to a newly nominated PR; (c) allocate new activities to an existing PR; or (d) allocate new activities to a newly nominated PR – or some combination of the above. This information, which is contained in the Round 10 Guidelines for Proposals, is significant and may be new to many readers. It means that while a country would end up with a single-stream-of-funding grant agreement per disease per PR, the grants being consolidated wouldn't necessarily have the same PR as before.

If the applicant selects Option 1, this is what it would mean with respect to preparing the Round 10 application:

- The applicant must describe, in a consolidated fashion, objectives, service delivery areas (SDAs) and activities for both the new activities being proposed and the activities of existing grants for the same disease and PR(s). However, the applicant must distinguish between new and existing activities.
- The applicant must also describe what changes in activities or targeted populations, if any, have occurred for those activities that are from existing grants; what links there are, if any, between the new activities and existing activities; what links there are, if any, between the proposed activities and existing Global Fund grants for other diseases or for health systems strengthening; and how duplication will be avoided where there are linkages.
- The applicant must list the SDAs and activities of existing grants being consolidated within the Round 10 proposal; explain whether and to what extent each SDA and activity from an existing grant will be included in the Round 10 consolidated proposal; and provide justification for any proposed changes.
- The applicant must describe any major changes in indicators and targets for activities from existing grants that are being consolidated, and must provide a rationale for changes that are significant.
- The budget must include costs for the consolidated disease proposal – i.e., for both new and existing activities. The applicant must also provide the requisite budgetary detail (budget assumptions, unit costs, etc.) for the entire Round 10 funding request, not just for the new funding.
- The indicators and targets shown in the Performance Framework must be for the consolidated disease proposal – i.e., for both new and existing activities.

[See “Advice from Aidspan Concerning Consolidated Proposals” on the next page.]

Note: If you are submitting a MARP proposal (see below), and if you are eligible and ready to transition to a single stream of funding, the Global Fund strongly suggests that you select Option 2 (transitioning during Round 10 grant negotiations) rather than Option 1 (submitting a consolidated proposal).

Prioritisation Criteria

If there is not enough money on hand to fund all Round 10 proposals recommended by the Technical Review Panel (TRP), then the recommended proposals will be ranked according to the Fund’s prioritisation criteria and will be funded based on their ranking (as funds become available).

The prioritisation criteria, which were recently amended by the Global Fund, are based on a composite index that takes into account the proposal's technical merit, as determined by the TRP, the country's poverty level and the country's disease burden. Proposals can score up to four points for each of these three factors. For details on the composite index, see “New Prioritisation Criteria Give Less Weight to Technical Merit” in *Global Fund Observer (GFO)* Issue 122, available at www.aidspan.org/gfo. See also the Global Fund’s information note on prioritisation for Round 10 at www.theglobalfund.org/en/applicationfaq.

Advice from Aidspan Concerning Consolidated Proposals

The rationale for transitioning to a single stream of funding is sound. For one PR to have several grants for one disease creates a lot of bureaucracy for both the PR and the Global Fund. Much of this can be avoided if multiple grants are consolidated into one.

Applicants that are certain that they want to transition into a single stream of funding in Round 10 will save considerable time during the grant negotiations process if they choose Option 1 (submitting a consolidated proposal) rather than Option 2 (transitioning during Round 10 grant negotiations), because most of the work relating to consolidation will have already been done by the time grant negotiations start. Therefore, Option 1 might be attractive to applicants that are already working on grant consolidation.

However, Aidspan believes that most applicants would be better off *not* submitting a consolidated proposal in Round 10, for the following reasons:

1. Transitioning to a single stream of funding is a complicated process, and there is as yet very little guidance available on how to do it.
2. This is the first time that the Global Fund has designed a proposal form to accommodate consolidated proposals, so there are likely to be some glitches.
3. Choosing to submit a consolidated proposal makes a complicated proposal form even more complicated.
4. Applicants only have three months in which to prepare their proposals, instead of the usual four.

Applicants that are eligible to transition to a single stream of funding, but that decide not to submit a consolidated proposal in Round 10, can still transition to a single stream of funding in Round 10 by selecting Option 2 (transitioning during Round 10 grant negotiations). Or they can choose Option 3, and put off transitioning until after the Round 10 applications period.

In this guide, we do not provide any guidance on how to fill out those sections of the proposal form that relate specifically to consolidated proposals. We have had a limited amount of time to review the Round 10 documents, and we don't have the benefit of previous experience with consolidated proposals.

Previously, technical merit was accorded considerably more weight. Under the "old" criteria, when there was not enough money, the proposals were first filtered by technical merit, and then a composite index was applied.

In the past, when the prioritisation criteria have had to be used, all recommended proposals were eventually funded. However, there is no guarantee that this will happen in Round 10; it depends on the total cost of proposals recommended for funding and on how much money the Global Fund is able to raise from donors.

MARP Proposals

In Round 10, for the first time, applicants from countries that have concentrated HIV/AIDS epidemics within "most-at-risk populations" (MARPs) will have the option of applying for funding specifically for MARPs under a new funding stream (the "MARPs reserve"). This stream is open to all applicants (CCMs, Sub-CCMs, RCMs, ROs and Non-CCMs). However, the applicant has to choose whether to submit a MARP proposal or a "regular" HIV/AIDS proposal; it cannot submit both in the same round. Nor can the MARP proposal include a cross-cutting HSS component.

(An applicant that submits a proposal through the MARP stream can still submit separate TB or malaria proposals through the regular stream; the TB or malaria proposals can include a cross-cutting HSS component.)

There is a ceiling on much an applicant can apply for in a MARP proposal: up to $5 million for Phase 1 and up to $12.5 million for the entire lifespan of the proposal. There are limits as well on the size of the funding stream for Round 10: The total amount to be approved across all Round 10 MARP proposals is capped at $75 million for Phase 1 and $200 million for the entire lifespans of the proposals.

MARP proposals can focus on one or more most-at-risk populations. The Global Fund defines these as "populations at high risk for HIV infection which demonstrate a higher HIV prevalence than the general population, with particular emphasis on men who have sex with men, transgender people and their sexual partners; female, male and transgender sex workers and their sexual partners; and people who inject drugs and their sexual partners."[1] Applicants submitting MARP proposals must meet the same eligibility criteria that apply to applicants submitting regular proposals.

The MARP funding stream was established because of concerns that the new prioritisation criteria (see previous section) would place lower- and upper-middle-income applicants with concentrated epidemics at a disadvantage. The new funding stream seeks to address this disadvantage by providing a separate channel where proposals from middle-income countries do not have to compete against proposals addressing generalised epidemics in low-income countries.[2]

When it established the MARPS funding stream, the Global Fund said it was "strongly recommending" to applicants from middle-income countries that are submitting MARP proposals that they clearly demonstrate increasing government contribution over the proposal lifetime. The Board said that this was something the Technical Review Panel (TRP) would consider in formulating its recommendations.

Theoretically, it would be possible for a Non-CCM applicant to submit a MARP proposal for Round 10 even though the CCM for that country is submitting a regular HIV/AIDS proposal – because they are not the same applicant. And, in theory, both could be approved. However, a proposal from a Non-CCM applicant would still have to meet the stringent eligibility criteria for Non-CCM applications. (See "Deciding Whether to Submit a Non-CCM

[1] According to the FAQs issued by the Global Fund, this emphasis does not limit applications to these groups alone. For example, applicants wanting to work in prisons or with migrant communities that demonstrate higher HIV prevalence than the general population can apply for funding under the MARPs reserve. The FAQs also say that "of course, applicants that can demonstrate links to injection drug use, sex work and/or male to male sexual behavior would be advised to do so."

[2] *Understanding the New HIV Funding Stream for Most-at-Risk Populations in Round 10,* Friends of the Global Fund, Latin America and the Caribbean.

Proposal" in Chapter 2 of Volume 1 of this guide; see also the Global Fund's new information note on Non-CCM proposals at www.theglobalfund.org/en/applicationfaq.)

In the event that there is insufficient money on hand to pay for all recommended MARP proposals, prioritisation criteria will be used to rank proposals. These criteria are similar to those used for regular proposals (see previous section), except that the country's poverty level is not included in the composite index. For more details, see Decision No. GF/B21/DP18 in the Board Decisions document available at www.theglobalfund.org/en/board/meetings/twentyfirst.

In the event that a TRP-recommended proposal is not able to be funded under the MARP stream because the maximum resources allocated for this stream have been exhausted, the proposal will be grouped together with proposals in the regular funding stream, using the prioritisation criteria established for that stream.[3]

Applicants wishing to submit a MARP proposal should use the same proposal form that is being used for regular proposals. On the first page of the proposal form, applicants are asked to indicate if what they are submitting is a MARP proposal. The Global Fund has issued an information note on MARPS proposals, at www.theglobalfund.org/en/applicationfaq.

Community Systems Strengthening

Increased emphasis has been placed on community systems strengthening (CSS) in Round 10. A new question has been added to the proposal form, asking for a description of weaknesses and gaps in existing community systems. Applicants are also required to provide information on what is being done to address these weaknesses and gaps.

Also, the Global Fund's information note on CSS has been updated (see www.theglobalfund.org/en/applicationfaq.) The Information note defines "community systems" as "community-led structures and mechanisms used by community members and community-based organizations and groups to interact, coordinate and deliver their responses to the challenges and needs affecting their communities."

Finally, an 81-page *Community Systems Strengthening Framework* document has been developed. The CSS Framework is primarily aimed at strengthening civil society engagement with the Global Fund. It should be useful to applicants who want to ensure that their proposal includes solid strategies to strengthen community systems. The CSS framework is available at www.theglobalfund.org/documents/civilsociety/CSS_Framework.pdf.

Both the CSS Framework and the information note referred to above contain sections on how CSS can be integrated into Global Fund proposals.

Conditional Recommendations by the TRP

In Round 10, for the first time the TRP can recommend approval of a proposal conditional on the removal of a limited set of elements. The removal of these elements is not subject to appeal.

[3] Ibid.

Review Criteria

At its meeting in April 2010, the Global Fund Board made some changes to the criteria used by the Technical Review Panel (TRP) to review proposals. The changes were designed to ensure that the criteria reflect recent policy decisions by the Global Fund on topics such as gender equality, sexual orientation and gender identities, and community systems strengthening. The criteria that will be used for Round 10 are shown in Annex I of this guide.

"Value for Money"

The Global Fund has included two new questions on the Round 10 proposal form related to the concept of "value for money" (Sections 4.5.3 and 5.4.4). The Global Fund defines "value for money" as "using the most cost-effective interventions" and "the optimal use of resources to achieve the intended outcomes." In its Guidance for Round 10, the Global Fund recognises that "robust in-country evidence on the value for money of key interventions does not yet exist in many local contexts," and it says that the TRP will not penalize applicants for not providing this evidence in Round 10." The Global Fund has produced an information note on this topic at www.theglobalfund.org/en/applicationfaq.

TA Plan

Applicants whose Round 10 proposals are approved for funding will be required to prepare a Technical Assistance Plan (TA Plan) describing in considerable detail the TA that is included in its proposal. The TA Plan should be prepared at the time of grant negotiations. However, if the country context does not permit that, the applicant will have up to the end of the first years of the grant to submit the plan. The TA Plan does not have to be submitted with the proposal (though it can be), but a summary of what will be in the TA Plan does have to be included on the proposal form. This is similar to the existing rules that require that the PR prepare a Pharmaceutical and Health Products Plan and a Monitoring and Evaluation Plan prior to grant signing, and that summary information on these topics be provided in the proposal.

Other Changes

Other changes to the proposal form are not significant. Generally, as with the review criteria, the changes reflect recent Board policy decisions. We note two such changes here:

- Questions about the capacity and experience of the applicant on gender issues – Sections 2.1.3(b) and 2.3.2(b) – have been strengthened.
- A new question has been added – Section 4.6.2 – on impact and outcome measurement systems. Applicants are asked to provide information on surveys, surveillance activities, and routine data collection that will be used to measure impact and outcome indicators relevant to the proposal.

In addition, the priorities table that had been used in previous rounds has been removed. This was the section where applicants were asked to indicate which of their proposed interventions were the main priorities and to provide additional information on these priorities.

Chapter 3: General Information on the Round 10 Applications Process

This chapter describes the guidelines document that the Global Fund has produced for Round 10; contains short notes on the process for developing a proposal, on where to obtain guidance on the technical content of proposals, on the funding available for Round 10, and on relevant documents and links; describes the different versions of the proposal form; and explains where to obtain copies of the proposal form and its attachments. The chapter also outlines the process for submitting proposals; explains some key concepts used in all proposals; and provides some general guidance concerning how to fill out the proposal form.

Guidelines for Proposals – Round 10

The Global Fund has produced guidelines on preparing Round 10 proposals (referred to in this guide as "R10 Guidelines for Proposals").[4] The first part of the guidelines contains general information on what documents need to be submitted in your application; how to obtain the proposal form and other Round 10 documents; the language of proposals; what kinds of activities the Global Fund will support; and some of the changes for Round 10 that were made to reflect recent Global Fund Board policy decisions. This part also lists the information notes on Round 10-related topics that the Global Fund has prepared, summarises the Fund's guiding principles, and outlines the steps required to develop a strong proposal. Finally, this part explains in detail what a consolidated proposal is, what are the benefits of submitting a consolidated proposal in Round 10, and what are the steps involved in completing a consolidated proposal.

We recommend that you read this part of the guidelines carefully before you start to fill out the proposal form. Copies of the R10 Guidelines for Proposals are available in the six UN languages – Arabic, Chinese, English, French, Russian and Spanish – at www.theglobalfund.org/en/applynow.

The main part of the R10 Guidelines for Proposals provides guidance to help applicants fill out each section of the proposal form. At a minimum, applicants should refer to this part as they complete each question on the proposal form. But this part also contains a lot of information that applicants should be aware of while they are developing the programme that will be described in their proposal, so we recommend that applicants also read this part of the R10 Guidelines for Proposal before they start to fill out the proposal form

In Annex 1 to the R10 Guidelines for Proposals, the Global Fund has provided lists of the countries whose economies are classified as low income and lower-middle income by the World Bank; a list of countries whose economies are classified as upper-middle income by the World Bank, and who are eligible to apply in Round 10 for one or more of the three disease elements; and a list of small island states who are eligible to apply.

In Annex 2, the Global Fund lists the criteria that the TRP will use to review proposals submitted for Round 10 and screened in by the Global Fund Secretariat. Applicants should familiarize themselves with these criteria before completing their proposals.

[4] There are actually two sets of guidelines, one for single-country applicants, and one for multi-country applicants. Large parts of the two sets of guidelines are very similar. When we need to distinguish between the two sets, we refer to the guidelines for single-country applicants as "R10 Guidelines for Proposals–SCA", and to the guidelines for multi-country applicants as "R10 Guidelines for Proposals–MCA."

In Annex 3, the Global Fund provides a list of the types of activities it will (and will not) support. In Annex 4, the Global Fund describes the process for screening and reviewing proposals submitted in Round 10. Annex 5 contains a list of acronyms and abbreviations.

Process for Developing the Proposal

In Volume 1 of this guide, Aidspan suggested that you develop an action plan for the development of your proposal. The action plan should include all of the steps that you have to go through to get the proposal written, approved and submitted, along with timelines for each step. If you have not already undertaken the in-country process of soliciting submissions for possible inclusion in the proposal, these steps should be included in your action plan. All coordinating mechanisms should build enough time into their action plan to allow all members of the coordinating mechanism to provide input and to endorse the proposal.

Please see Volume 1 of this guide for more detailed guidance on the proposal development process.

Guidance Concerning the Technical Content of Proposals

The Global Fund does not provide guidance on the technical content of proposals. Nor does Aidspan attempt do so in this guide. In Volume 1 of this guide, Aidspan listed a number of organisations that applicants can consult for guidance on technical content.

Funding Available for Round 10

There is considerable uncertainty concerning whether sufficient funds will be available to pay for all of the Round 10 proposals that will be recommended for funding by the Technical Review Panel (TRP). In both Rounds 8 and 9, initially there were insufficient funds to cover all recommended proposals, and some proposals had to be "waitlisted." However, eventually, as more funds came in, all recommended proposals were approved. This may happen again in Round 10, or it may not: It depends on the total cost of the TRP-recommended proposals and on how much money the Global Fund is able to raise from donors. At its meeting in April 2010, the Global Fund Board decided that only funds received by the end of 2011, for use in 2011, can be used to finance recommended Round 10 proposals. (For details, see "Round 10 to Be Launched on May 20" in *GFO 122* at www.aidspan.org/gfo).

Round 8, in 2008, was the largest round ever, representing costs of $3.1 billion for the first two years of approved proposals. For Round 9, the costs were $2.2 billion. (These figures are prior to the 10% "efficiency gains" mandated by the Board.)

The Global Fund says that, currently, based on confirmed pledges, no money is available for Round 10. However, the Global Fund is in the middle of a "replenishment," with donors due to specify in October how much they expect to give to the Fund over the next three years. Thus, the amount of money available for Round 10 will certainly increase by the time the Global Fund Board approves Round 10 proposals at its meeting in December 2010.

The determination of how much money can be used for Round 10 will be based on uncommitted money that donors provide for use up to 31 December 2011. The Global Fund says that it "hopes for a successful Replenishment process which will enable all Round 10

TRP-recommended proposals to be funded," but that "no assurances regarding the level of available resources can be made at this time."

(The Global Fund's full statement on resources available for Round 10 can be found at www.theglobalfund.org/en/applicantsimplementers/resources.)

The uncertainty around funding should not deter applicants from submitting an ambitious proposal. If there are insufficient funds to pay for all recommended Round 10 proposals, the Board's recently revised prioritisation criteria will be invoked (see "Prioritisation Criteria" in *Chapter 2: What's New in Round 10?*). Proposals will be ranked using a composite index that takes into account the proposal's technical merit, as determined by the TRP, and the country's poverty level and disease burden. Proposals that score highest on the composite index will be funded first; other proposals will be funded if and when additional funds become available, in descending order based on their ranking in the index. The amount of funding being requested is not a criterion for prioritisation. So, there is no advantage to the applicant in reducing the size and scope of its proposal. Furthermore, if the size of the funding request for all recommended Round 10 proposals is very large, this will send a strong message to donors about the need to increase their contributions.

Eligibility Requirements

All applicants to the Global Fund have to meet certain requirements. These requirements are outlined in the section on "Who Is Eligible to Apply" in Chapter 2 of Volume 1 of this guide. The Global fund has issued a document entitled *Important Notice to all Round 10 Applicants: Eligibility*, available at www.theglobalfund.org/en/applynow. The notice urges applicants to pay close attention to each of the eligibility requirements applicable to their applicant type, particularly in light of the tight timelines for Round 10 (applicants have only three months to submit their proposals). The notice says: **"It is important to note that failure to comply with any of these minimum requirements may lead to a proposal being determined ineligible by the Secretariat. Ineligible proposals will not be forwarded to the Technical Review Panel (TRP)."**

It is very important, therefore, to ensure not only that you meet the eligibility requirements, but also that you submit adequate documentation to the Global Fund to demonstrate that you meet the requirements. The notice also says that in the weeks following submission of their proposals, applicants may be contacted by the Secretariat requesting clarifications on eligibility; that the timelines for responding will be very tight; and that applicants must respond within the deadlines.

Relevant Documents and Links

There are a number of other documents that the Global Fund recommends applicants become familiar with before they complete their proposals. They are listed in Chapter 2 of Volume 1 of this guide. That same chapter also contains a list of resources and sources of information that applicants can access to assist them in developing the technical content of their proposals.

In addition, the Global Fund has produced a series of 17 information notes on various topics related to Round 10. The list of topics is as follows:

- Community systems strengthening
- Dual track financing
- Harm reduction

- Health systems strengthening
- Improving aid effectiveness
- Most at risk populations (MARPs) reserve
- Multi-country applications
- Non-Country Coordinating Mechanisms (Non-CCM)
- Pharmaceutical systems strengthening and pharmacovigilance
- Prevention of mother to child transmission (PMTCT)
- Prioritization in Round 10
- Sexual orientation and gender identities in the context of the HIV epidemic
- Strengthening implementation capacity
- TB/HIV co-infection
- Unit costs for selected key health products
- Value for money
- Women, girls, and gender equality

The Global Fund has also issued an FAQ document on the Round 10 applications process. The information notes and the FAQ document are available at www.theglobalfund.org/en/applicationfaq. They should be available in all six UN languages.

Versions of the Proposal Form

For Round 10, there are two separate proposal forms (Sections 1-5) – one for single-country applicants (CCMs, Sub-CCMs and Non-CCMs), and another for multi-country applicants (RCMs and ROs). The proposal forms come in only one format – a Word file.

The Word file contains some macros. The Fund has included them in order to make it easy for you to select the check-boxes or buttons that are contained in a number of the items on the proposal form.

If you have a PC and if your computer has security set at a high level, these macros may be automatically disabled when you open the files containing the proposal form. Or, you may be asked whether or not you want to enable the macros in the proposal form. If you are asked about the macros, we suggest that you enable them, if it is possible to do that (enabling them just for these documents should not pose a security threat).

If the macros are disabled, you will probably find that you cannot easily select the check-boxes or buttons. If this is the case, we suggest that you type "X" or "Yes", or whatever is required, as close as you can to the relevant box or button in question, and that you ensure that your response is clearly visible.

If you are working with Office for Mac, the macros will probably not work, so you should follow the suggestions in the previous paragraphs for when macros are disabled.

You will be able to format any text that you enter into the Word file. You can also split up the Word files and reassemble them again later; this may be useful if different people are completing different parts of the proposal forms. It is also possible to edit the questions on the proposal form, but we advise against doing that. It would just confuse the people who have to read your proposal.

Where to Obtain Copies of the Proposal Form and Its Attachments

Copies of both versions of the proposal form in Word format are available in the six UN languages – and can be downloaded from the Global Fund website at www.theglobalfund.org/en/applynow.

The proposal form comes in four parts:

1. **Sections 1 and 2** (Funding Summary and Contact Details, and Applicant Summary and Eligibility). (These are labelled "Sections 1-2 Eligibility" on the Global Fund website.) There is only one version of Sections 1 and 2, whether you applying for HIV, TB or malaria. If you are applying for more than one disease element, you should full out Sections 1 and 2 only once.
2. **Sections 3, 4 and 5** (Proposal Summary, Program Description and Funding Request). There are separate Sections 3-5 for each of the three diseases.
3. **Section 4B** (Program Description – HSS Cross-Cutting Interventions). You will need this section of the proposal form if you are including an HSS sub-component in your proposal. Section 4B can be included in only one disease component in your proposal.
4. **Section 5B** (Funding Request – HSS Cross-Cutting Interventions). If you need to include a Section 4B in your proposal, you will also need to include a Section 5B.

There are three mandatory attachments to the proposal form for which the Global Fund provides templates:

- **Performance Framework** or **Consolidated Performance Framework**
- **Pharmaceuticals and Health Products List** (if the proposal requests funding for these products). This is listed as "Preliminary List of Pharmaceutical Products" on the Global Fund website.
- **Membership Details** (required only for CCMs and RCMs)

There is also an **Eligibility Form**, which must be submitted by certain CCMs and RCMs, depending on their circumstances. See the instructions in Section 2 of the proposal form.

The Consolidated Performance Framework should be used only by applicants submitting a consolidated proposal.

There are three versions of the Pharmaceutical and Health Products List, one for each disease.

All of these documents can be downloaded from the Global Fund website at www.theglobalfund.org/en/applynow. When you click on "Application Materials," you are taken to a page where the Global Fund has helpfully provided a "menu" that allows you to indicate what type of proposal you are applying for, and generate a list of all of the documents you will need for complete your application. You can even download all of these documents in a zip file.

You may also download a budget template (an Excel document) at the same website, though, when we went to press, it had not yet been listed among the Round 10 documents. There is a link to the English versions of a fully automated template and a partially automated template in Section 5 of the R10 Guidelines for Proposals. Versions in languages other than English may also be available. Use of this template is optional.

Copies of the proposal form, its attachments and the budget template can also be obtained by contacting local offices of UNAIDS, WHO and the UN Population Fund (UNFPA). (The documents will be on a CD-ROM.) If you have any problems obtaining the proposal form, you can also write to the Global Fund at the following address:

> The Manager, Country Proposals Team
> The Global Fund to Fight AIDS, Tuberculosis and Malaria
> 8 Chemin de Blandonnet
> CH-1214 Vernier-Geneva
> Switzerland
> Email: proposals@theglobalfund.org

Process For Submitting a Proposal

The deadline for submitting proposals for Round 10 is 20 August 2010. Submissions must include both an electronic (or soft) copy and a paper (or hard) copy version of the proposal form. The two copies must be identical. The paper version of the proposal form must contain all necessary signatures.

The electronic version must contain Word files (not PDF files) for the various parts of the proposal form, and Excel files for attachments for which the Global Fund provided Excel templates.

The electronic version must be received by the Global Fund no later than 12h00 Noon Geneva, Switzerland time on 20 August 2010. It should be sent via email to proposals@theglobalfund.org.

The paper version of the proposal must have been sent to the Global Fund no later than 12h00 noon Geneva time, 20 August 2010, as evidenced by the stamp of a postal or other courier service. Proposals should be submitted to the following address:

> The Manager, Country Proposals Team
> The Global Fund to Fight AIDS, Tuberculosis and Malaria
> 8 Chemin de Blandonnet
> CH-1214 Vernier-Geneva
> Switzerland

Proposals in any of the six UN languages will be accepted and will be treated equally. Because the review of the proposals by the TRP will be conducted predominantly in English, unless an applicant submitting a non-English proposal also submits its own English translation of the identical proposal, the Secretariat will arrange to have the proposal translated into English. This applies to the proposal form and all documents that the Global Fund has labelled as “mandatory,” “additional” or “optional.” However, the Secretariat will not arrange for translation into English of other annexes, including those that the applicant decides (on its own) to attach. See the discussion on annexes in “General Guidance on Filling Out the Proposal Form” below. See also the section on “Before starting to write a proposal” near the beginning of the R10 Guidelines for Proposal.

Each applicant can submit only one proposal, but that proposal can cover one, two or all three diseases. If a proposal contains more than one disease component, the TRP will review each component separately.

To be complete, your application must contain filled-out copies of:

- **Sections 1-2** of the proposal form – **only one** per proposal
- **Sections 3-5** of the proposal form – one for each disease component included in your proposal
- **Sections 4B and 5B** of the proposal form (**IF** you are submitting a cross-cutting HSS sub-component within one of the disease components) – **only one** per proposal
- **Performance Framework** (or **Consolidated Performance Framework**) – one for each disease component included in your proposal
- **Pharmaceuticals and Health Products List** – one for each disease component included in your proposal (**IF** you are requesting funding for these products)
- **Detailed budget and workplan** – one for each disease component included in your proposal, and one for the cross-cutting HSS sub-component (**IF** you are including one in your proposal)
- **Membership Details** form (mandatory for all RCMs) – one per proposal
- **Eligibility Form** (mandatory for some RCMs, depending on their circumstances) – one per proposal

plus any eligibility documents the Global Fund requires; other annexes that the Global Fund has asked for; and any annexes that you decide to include.

The Global Fund Secretariat will screen proposals for completeness and eligibility. The Secretariat will also ensure that all proposals have been appropriately endorsed (i.e., signed off by all members of the coordinating mechanism). The Secretariat may contact applicants to seek clarifications on eligible proposals. Applicants whose proposals were screened out will be notified of this fact, and of the reasons they were screened out.

The Technical Review Panel (TRP) will convene in the last two weeks of October to review eligible proposals and make recommendations to the Global Fund Board. The Board will consider the TRP recommendations and make funding decisions at its meeting scheduled for 13-15 December 2010.

NEED HELP?

If you have questions about the proposal form or the applications process, you can:

(a) consult the list of FAQs (Frequently Asked Questions) that the Global Fund has issued, available in all six UN languages at www.theglobalfund.org/en/applynow. The FAQs may be updated periodically during the period when Round 10 proposals are being accepted;

(b) contact existing in-country partners, and/or look up partner contact details, through the Global Fund's Round 10 partner links at www.theglobalfund.org/en/technicalassistance (under "Technical Partner Information"); or

(c) contact the proposals hotline at the Global Fund Secretariat through the My Global Fund website at http://myglobalfund.org (click on "Ask the proposal team a question"); or by sending an email to proposals@theglobalfund.org. The hotline operates in all six UN languages. The Global Fund says that all enquiries will be answered within five working days.

Some Key Concepts Used in All Proposals

The Global Fund application form makes extensive use of terms such as "goals," "objectives," "service delivery areas," "activities," "indicators (impact, outcome, coverage and output)," "baseline data," and "targets." Most of these terms are described in Section 4.4.1 of the R10 Guidelines for Proposals. Here is a summary of what the Global Fund means when it uses these terms:

- A goal is a broad achievement, often at a national level, that you want to happen as a result of the programme for which funding is being sought and, often, as a result of other projects as well – e.g. "Reduced HIV-related mortality."
- Objectives are more specific things, linked to the goal, that you want this particular programme to achieve – e.g. "Improved survival rates in people with advanced HIV infection in four provinces."
- Service delivery areas are the broad services or program areas within which activities will be implemented to achieve the objectives – e.g. "Antiretroviral treatment (ARV) and monitoring."
- Activities are the more specific actions that will be taken within each service delivery area – e.g. "Develop an adherence support programme for people taking antiretroviral therapy."
- Indicators are items that you can measure to show the extent to which goals or objectives are achieved, services have been delivered, or activities have been successfully carried out. Impact and outcome indicators measure the extent to which benefits result among the people to whom the services are being delivered. Both types of indicators are very similar; impact indicators tend to be higher level than outcome indicators (e.g., "men and women aged 15-24 who are HIV-infected" is an impact indicator, whereas "percentage of never married young men and women aged 15-24 who have never had sex " is an outcome indicator). Coverage indicators

measure how many people the services are reaching. Output indicators measure the results of an activity (e.g., number of drugs shipped).

- Baseline levels are values that indicators have before the programme starts.
- Target levels are values that you anticipate indicators reaching at different times in the proposal term as a result of the programme.

General Guidance on Filling out the Proposal Form

The following are some general tips concerning how the proposal form should be filled out:

- Ensure that you create a backup copy of the empty proposal form before you start filling out the form.
- Save your work frequently as you fill out the form. It is a good idea to regularly update the file name as you save the file, so that if you have mistakenly deleted some text, you can go back to an earlier version and retrieve it.
- It is a good idea to create a footer in the proposal form containing information that identifies your proposal.
- ***Read each question very carefully, and provide only what is requested.*** For example, if you are asked to describe how your proposal will reduce stigma and discrimination, explain what your proposal will do to address stigma and discrimination, but don't write three or four paragraphs describing how stigma and discrimination manifests itself in your country. ***Not sticking to what the question asks for is by far the biggest problem observed in proposals submitted to the Global Fund.***
- Where the proposal form says "half page maximum" or "one page maximum," you should adhere to these instructions. Writing three pages of text when the Fund says "one page maximum" will not be viewed favourably by the TRP. If you feel that it is absolutely necessary to write at significantly greater length than what is called for, we suggest that you do it in the form of an annex. Note, however, that the TRP does not read most annexes.
- You may want to add a table of contents (with page numbers) at the beginning of the main part of your proposal – i.e., Sections 3-5. This will help TRP members quickly find a specific section of your proposal.

Annexes

The following is our understanding of the guidance on annexes in the sub-section "What documents must be submitted for a complete application" in the section "Before starting to write a proposal" near the beginning of the R10 Guidelines for Proposals.

There are certain documents, such as the budget, that must be included in your application. The Global Fund refers to these as "mandatory." It is fairly obvious which documents are mandatory; they are listed in this guide (see "Process for Submitting a Proposal" in this chapter, above), and in the R10 Guidelines for Proposal (close to the front), and they are mentioned frequently on the proposal form and in the relevant items in the R10 Guidelines for Proposals.

The Global Fund refers to two documents as "additional." One, the Pharmaceutical and Health Products List, is mandatory if your proposal requests funding for these products. The

other, the Eligibility Form, is mandatory for some coordinating mechanism applicants, depending on their circumstances.

The Global Fund refers to Sections 4B and 5B of the proposal form as "optional" documents, but they are really mandatory if you are including a cross-cutting health systems strengthening sub-component in your proposal.

The Global Fund refers to all other documents as "supplementary." This includes annexes that you decide (on your own) to include. (For the purposes of this explanation, we'll call these "applicant-initiated annexes," though no one else is using that term) "Applicant-initiated annexes" are sometimes useful when you don't have enough room on the proposal form to answer a question as completely as you would like. But we suggest that you keep "applicant-initiated annexes" to a minimum because the TRP will probably not read most of them anyway. The TRP has said on several occasions that if applicants want the TRP to see something important, they should make sure that the information is included on the proposal form.

"Supplementary" documents also include annexes that the Global Fund asks you to include or invites you to include as you work your way through the questions on the proposal form and the corresponding guidance in the R10 Guidelines for Proposals. (For the purposes of this explanation, we'll call them "additional annexes," though no one else is using that term.) Not all of the "additional annexes" apply to every proposal or applicant. The "additional annexes" are listed in the document checklists at the end of Sections 2 and 5. (Note, however, that some "additional annexes" listed in the documents checklists are not mentioned in the corresponding item on the proposal form or in the R10 Guidelines for Proposals.) Aidspan believes that most of these "additional annexes" are mandatory, but they are not labelled as such. Nevertheless, we suggest that you check the list of "additional annexes" in the documents checklists very carefully, and that you make sure that you have attached whichever of these annexes you think need to be attached.

The Global Fund says that you need to number each annex, thought this does not appear to apply to the mandatory documents. We suggest that you number each of the supplementary annexes (i.e., each "applicant-initiated annex" and each "additional annex"), that you provide both the name and the number of each annex in the space provided in the right-hand column of the document checklists, and that you include the name (or part of it) and number in the file name. Note that there is a separate section at the end of the checklists for "applicant-initiated annexes." In addition, each time you attach an annex, we suggest that you indicate this fact in your answer to the question on the proposal form to which the annex relates; and that you also indicate there the annex number and the full title of the document.

Chapter 4: Guidance on Specific Sections of the Round 10 Proposal Form

This chapter contains guidance from Aidspan on filling out the proposal form. The chapter covers many, but not all, of the questions on the proposal form. Please see the "Note to Readers" below for more information.

Note to Readers about This Chapter

The format of this chapter is different from what we have used in past applying guides. Previously, we covered every item on the proposal form and, for each item, we reproduced the texts from both the proposal form and the Global Fund's Guidelines for Proposals, before adding our own guidance. The quality of the instructions on the proposal form and the quality of the Fund's own guidelines have improved significantly in recent rounds. Consequently, in this guide, instead of reproducing the texts from the proposal form and the R10 Guidelines for Proposals, we have used this space to expand our own guidance.

In the process, we have significantly increased the use of relevant extracts from proposals approved in previous rounds of funding. These extracts are designed to show what needs to be included in your response, and what constitutes a well-written response. Obviously, the extracts should not be copied as is. But we hope that they will inspire you. Please note that the extracts are not verbatim; some of them have been condensed to save space.

If you wish to obtain copies of the full proposals from which the extracts are taken, they are available on the Global Fund website. Just go to the homepage at www.theglobalfund.org, and select the country from the drop-down menu under "Grant Portfolio." That will take you to the country page, where you should look for "Country Grant Portfolio" to select a grant that came from the proposal you are looking for. Once you are on the grant page, look for "Original proposal" under "Grant documents for download."

Many of the proposals extracted in this chapter are also cited in the Aidspan report, *Key Strengths of Rounds 8 and 9 Proposals to the Global Fund,* available at www.aidspan.org/aidspanpublications. The Aidspan report also contains references to other proposals praised by the TRP; we draw attention to some of these in this chapter, using purple-coloured "See also" boxes. The Aidspan report contains numerous links, both to the extracts cited in the report, and to full proposals.

For some of the questions on the proposal form, we have drafted some DOs and DON'Ts, contained in green-bordered boxes. We have done this for those questions where applicants in previous rounds tended to wander from the topic at hand.

We have tried to provide guidance for as many questions on the proposal form as possible. Where there is no guidance for a particular question, it is either because (a) it the question is already quite clear and/or the R10 Guidelines for Proposals provide sufficient guidance already; or (b) the question is new and we are not in a position at this time to provide guidance. Aidspan had a limited amount of time to review the final versions of the proposal form and the R10 Guidelines for Proposal.

We do not provide guidance on how to fill out those sections of the proposal form that are specific to consolidated proposals. (Submitting a consolidated proposal is optional for

Round 10.) The main reason we do not provide guidance on this is that these questions are all new for Round 10, and we have not had much time to think about them. As well, submitting a consolidated proposal is quite complicated and time-consuming, and Aidspan is recommending that applicants do not select this option (see the "Advice from Aidspan" box in *Chapter 2: What's New for Round 10*?).

There is not much guidance in this chapter specific to MARP proposals for the simple reason that MARP applicants use the same proposal form as "regular" applicants.

For Sections 3-5 of the proposal form, we have used the headings from the HIV version of the proposal form. But the malaria and TB versions of Sections 3-5 are almost identical. The main differences come in the section on epidemiology and in the checklist at the end. Our guidance applies to all three diseases.

Sections 4B and 5B of the proposal form, which are for the optional cross-cutting health systems strengthening sub-component of your proposal, are covered together at the end of this chapter, after Section 5 of the proposal form.

When potential applicants are reviewing this chapter, we suggest that they have open in from of them both the proposal form and the R10 Guidelines for Proposal. We have used the same numbering system that appears on the proposal form and in the R10 Guidelines for Proposals. Because we do not provide guidance for every question on the proposal form, there are some gaps in the heading numbers.

If you want to go directly to a particular section of the proposal form that is included in this chapter, please refer to the Table of Contents at the beginning of this guide. The links there should take you to where you want to go.

SECTION 2: APPLICANT SUMMARY AND ELIGIBILITY

2.1 Regional Coordinating Mechanism operations

2.1.3. Member knowledge and experience in cross-cutting issues

In 2.1.3 (a), (b) and (d), respectively, you are asked to describe the capacity and experience of RCM members in health systems strengthening (HSS), gender issues and multi-sectoral programme design. In previous rounds of funding, many applicants tended to wander when answering this question; you should ensure that you stick to what is being asked. However, if, after describing the capacity and experience of RCM members, you want to add something about additional steps being taken enhance the RCM's knowledge, which is not part of the question, that type of information would nevertheless be useful.

This is how a Round 9 proposal from Cambodia described the capacity and experience of CCM members in health systems strengthening:

> The CCM consists of experienced members belonging to government and NGOs, many of whom are programme implementers themselves, especially in the health sector. The CCM benefits from robust participation of development partners, such as the WHO, the World Bank and the Japan International Cooperation Agency, all of whom have a good realization of the importance of strengthening health systems. A number of them are, in effect, among the health sector leaders of the country, whose primary responsibility is ensuring the balanced and equitable allocation of resources to improve national health outcomes. As such, they are well aware of health system issues, and interpret the urgency of responding to the burden of disease as a call for strong leadership and effective health systems, and how to work towards that. Moreover, the participation on the CCM of UNAIDS and the national programme managers for HIV/AIDS, TB, and malaria means that there is a combination of experience of HSS and the specific three diseases, which ensures that the support to HSS will ultimately strengthen the outcomes in responding to the three infectious diseases – and vice versa.

This is how a Round 9 proposal from Myanmar described the capacity and experience of CCM members in gender issues:

> Many CCM members have capacity and experience on issues related to gender, sexual minorities, and adolescent males and females in the context of (a) access to knowledge and skills, and (b) health vulnerabilities, including to one or more of the three diseases. CCM membership includes a wide range of stakeholders, including affected populations, civil society organizations, women and children's organizations, international organizations and government. A number of members have direct experience in orienting health systems, programmes and service delivery towards the specific needs of women and adolescent males and females in the context of sexual and reproductive health (e.g., UNICEF, WHO, Population Services International [PSI], Marie Stopes International, Myanmar Women's Affairs Federation, Myanmar Maternal and Child Welfare Association). A number of members have capacity and experience in making health systems and programmes more relevant to the needs of sexual minorities, including men who have sex with men, and to the needs of female sex workers, as well as mobilising and strengthening community-based groups to be in a better position to influence health systems and service providers (e.g., Marie Stopes International, PSI, Save the Children).

In our review of approved proposals from recent rounds of funding, we found very few that adequately described the capacity and experience of RCM or CCM members in multi-

sectoral programme design. All that is required here is to say which members of the RCM have capacity and experience in multi-sectoral programme design and to briefly describe this capacity and experience. The following extracts from Round 9 proposals from Mongolia and Bosnia-Hercegovina illustrate how this can be done:

> Two members of the CCM currently work in government positions in which they have multi-sectoral functions: the Head of the Law Department at the Cabinet Secretariat of the Government of Mongolia, and the Head of the Secretariat of the National Committee on AIDS, at the Office of the Deputy Prime Minister. In addition, the CCM members who represent UN Agencies, particularly UNICEF, UNAIDS and UNFPA, also have experience with multi-sectoral planning and programme design….
>
> Partner members of the CCM have been engaged in a number of multi-sectoral planning process including: development of the Bosnia-Hercegovina Strategic Framework for the Prevention and Control of HIV/AIDS; development of the 2004-2007 Poverty Reduction Strategic Plan; and coordination of multiple proposals to the Global Fund.

If there are important gaps in the knowledge and experience of RCM members in any of the three areas described above, you should be honest about the gaps, but you should also say what the RCM is doing to address the situation.

DOs and DON'Ts

DO describe the capacity and experience of RCM members in the three areas covered by this question.

DO refer to the RCM's experience in designing multi-sectoral programmes for previous proposals submitted to the Global Fund, if this is relevant.

DO mention any training that has been provided to RCM members, if this is relevant.

DON'T describe the multi-sectoral composition of the RCM. Multi-sectoral composition of the RCM is not the same as RCM members' experience in designing multi-sectoral programmes.

DON'T describe the new gender strategy being developed by the Ministry of Health; that's not what the question is about.

DON'T say that the RCM is concerned about gender issues; it is assumed that all RCMs are concerned about gender issues.

2.2 Eligibility

2.2.2. Proposal development process

This is the first of a series of questions on how your RCM has fulfilled the minimum requirements for RCMs and CCMs established by the Global Fund. An RCM that has not fulfilled the minimum requirements – even if the RCM has missed only one requirement – could be determined to be ineligible by the Screening Review Panel.

You are being asked to describe three things: (a) the process used to invite submissions; (b) the process used to review submissions; and (c) the process used to ensure the input of people and stakeholders other than RCM members in the proposal development process. There is some overlap between item (c) and items (a) and (b). Thus, if you feel more comfortable answering all three items together in one text, this ought to be perfectly acceptable. However, in the guidance provided below, we deal with each item separately.

(a) Process for inviting submissions

Here is how the Kazakhstan CCM responded to this item in a Round 7 proposal:

> The announcement containing information on the call for proposals was posted in major national newspapers [list of newspapers provided here] in both Kazakh and Russian languages [copy of announcement provided in an annex] with instructions to contact the Republican AIDS Center for questions and applications. The announcement, along with details of the application procedure, was also placed on the web page of the Center. In addition, all the key sectors and stakeholders were officially informed on the call for proposals by email and orally during all major events held around the time of the launch of Round 7.

(b) Process to review submissions

If the RCM set up a committee to review the submissions, you should describe (a) the composition of the committee, (b) how the committee functioned, and (c) what role, if any, the entire RCM played in the process. The minimum requirements for RCMs and CCMs state that stakeholders from both inside and outside the coordinating mechanism need to be involved in the review process. If the committee established by the RCM included non-RCM members, you should explain this and describe how the non-RCM members were selected. If the committee did not include non-RCM members, you should describe what other process was used to enable stakeholders not represented on the RCM to participate in the review process.

If some other process was used to review submissions – i.e., other than the establishment of a committee – you should describe this process.

If criteria were developed for the review of the submissions, you should indicate this here. You may want to describe how the criteria were developed, especially if they were developed with the participation of multiple stakeholders. Similarly, if a rating system was established to grade the submissions, you should briefly describe the system and explain how it was developed.

See also:

Cote d'Ivoire HIV and TB (9), Honduras HIV and TB (9)

Links to these proposals are provided in Aidspan's *Key Strengths of Round 8 and 9 Proposals to the Global Fund*, available at www.aidspan.org/aidspanpublications. See Key Strength 13.

You can attach as annexes any documents that describe the review process, including, for example, the terms of references of the review committee, the criteria used to review proposals, and the rating system used to grade proposals.

This is how a Round 9 proposal from Mongolia described the review process:

> A three-member evaluation team independently reviewed and evaluated all concept notes. They used an evaluation form with five main selection criteria: (1) soundness of approach; (2) addresses indentified priorities and gaps; (3) technical capacity; (4) partnerships; and (5) other considerations such as sustainability, cost-effectiveness and social externalities. Each criterion had several sub-criteria. A score was given to each section and weighted according to the importance of the criterion. The scores of all of the evaluators were then consolidated to get total scores for each applicant [Evaluation Sheet attached]. The criteria and their relative importance were decided prior to the call for proposals and communicated to applicants in the announcement and during meetings with stakeholders…. On March 1, 2009, the CCM sent official letters to each applicant informing them of the decision made on their concept note with the evaluation attached. The evaluation scores and comments may help organizations write sounder concept notes and proposals in the future [annex attached].

(c) Involvement of stakeholders other than members of the coordinating mechanism

As we noted above, there is overlap between this item and the two previous items. In describing the processes used to invite and review submissions, you will likely be referring to stakeholders other than those represented on the RCM. However, this item talks about the entire proposal development process, which involves more than just inviting and reviewing submissions. Therefore, you may want to use this item to describe how non-RCM stakeholders participated in the process of putting the final proposal together. Readers may wish to refer to the guidance on proposal development provided by Aidspan in Volume 1 of this guide.

Alternatively, or in addition, you can briefly reiterate here how non-RCM stakeholders participated in the processes to invite and review submissions, without repeating everything you said in items (a) and (b).

DOs and DON'Ts

DON'T describe the entire process used by the RCM to put together the proposal. You are only being asked to describe very specific aspects of that process.

DON'T indicate how many submissions were received (or whom they were from), unless this information is relevant to your description of the review process.

2.2.3. Process to oversee program implementation

With respect to item (a), input from stakeholders outside the coordinating mechanism, this is how the Serbia Round 9 TB proposal described it:

> This kind of input is being realised at several different levels: (a) all relevant CCM issues are also discussed on the Republican AIDS Commission and National TB Commission; (b) civil society representatives on the CCM regularly hold meetings with organisations and networks from their sector to discuss relevant issues; (c) CCM members from government sector regularly hold meeting with their supervisors or others in their ministries; and (d) UN representatives on the CCM regularly hold meeting of the UN Thematic Group for HIV/AIDS, where also many relevant issues are discussed. There have been several cases where input from civil society organisations, not part of the CCM, significantly influenced decisions. Additionally, for majority of important tasks (such as selection of SRs, project proposal development, large procurements), membership of the working groups, appointed by CCM for that purpose, is drawn not only from CCM, but also from many other relevant institutions.

With respect to item (b), the oversight process, the following extract adapted from the China Round 7 TB proposal illustrates how this can be described:

> Each CCM meeting will include report and discussion of project progress on each grant since the previous meeting… The CCM HIV/AIDS, TB and Malaria Working Groups will discuss the report prior to CCM meetings… Furthermore, the working groups provide routine supervision, evaluation and oversight of the project's implementation, including: reviewing the PR six-monthly progress reports and providing feedback to the PR; reviewing proposals from the PR for major changes to work plans and funding allocations; undertaking an annual independent assessment involving site visits; and undertaking additional, unannounced site visits.

2.2.4. Process to select Principal Recipient(s)

This is what a Gambia Round 9 proposal said about its process to select PRs:

> The draft advertisement for the Expression of Interest was developed by a task force set up by the CCM. An advertisement was published in the most circulated newspapers in The Gambia for three days per week. The adverts started from the 12th of January 2009 to 28 January 2009. Applications were kept in sealed envelopes and in a secured place until the executive, set up by the CCM, met to evaluate them. Evaluation of applications was done on March 20th 2009. Each executive scored applicants separately using a pre-designed score sheet. The results were collated, analyzed and discussed. The results of selection were presented to the entire CCM for review and approval. Finally, the two applicants with the highest scores were unanimously selected as PRs during the CCM meeting.

2.3 Regional Organizations

2.3.2 Regional Organization knowledge and experience in cross-cutting issues

See guidance for Section 2.1.3 above.

2.3.3 Partnerships with regional stakeholders

With respect to Section 2.3.3(a), the following is a condensed extract from a Round 9 proposal from the Southern African Development Community (SADC) Secretariat:

> The SADC Secretariat has been part of strategic review processes involving consultations on issues that affect mobile populations in the region since its inception. In the pursuit of regional economic integration, SADC identified HIV and AIDS as a major threat to attaining its goals, which led to the development and signing of a number of regional, continental and global agreements and protocols by the member states. The SADC Secretariat has been tasked with the responsibility of ensuring that member states plan, objectively track and report on progress towards these commitments and prepare an annual regional report on the response to the epidemic.
>
> The SADC HIV and AIDS Business Plan for 2005-2009 allocated 50% of all resources in the total budget to cross border programming along the transport corridors in the SADC region. Implementation of cross border interventions from the Business Plan has included collaboration with other regional and international organisations. The SADC Secretariat has been working with the International Organisation for Migration (IOM) on the implementation of a number of cross-border HIV and AIDS activities. The collaboration with IOM included the facilitation of a regional workshop in September 2007 which brought together key regional partners. SADC Secretariat also collaborated with World Vision International to implement a SADC HIV prevention and mitigation initiative and with International Labour Organisation to implement a programme known as the HIV and AIDS Prevention in Transport Sector of Eight SADC Countries.
>
> The countries targeted for this proposal are a natural region for programming because they lie at the epicentres of the global HIV epidemic, and are all members of SADC. They form a natural region geographically, and in terms of cross-border trade and population movement, with both increasing in recent years. There are particular ties between South Africa and other states in the region.

With respect to Section 2.3.3(b), here is another condensed extract from the same proposal:

> The SADC Secretariat has the Partnership Forum and the Technical Advisory Committee (TAC) as the established mechanisms through which it ensures the coordination with other regional bodies on cross border issues. The Partnership Forum embodies all SADC's bilateral and multilateral partners, international and regional NGOs, the Pan African Business Coalition, CSOs, research institutions and higher education. The TAC is multisectoral, comprising key technical people in the sub-region who provide technical advice to the Secretariat, representatives from SADC Member States, Civil Society Organisations (CSOs), People Living With HIV/AIDS (PLHIV), UN agencies, and multilateral and bilateral organisations.

SECTION 3: PROPOSAL SUMMARY

3.1 Transition to a single stream of funding

Applicants are required to select one of three options. It is a little complicated, so here is a road map:

IF YOU ARE SUBMITTING A PROPOSAL FOR A PARTICULAR DISEASE, AND YOU ALREADY HAVE ONE OR MORE EXISTING GRANTS FOR THAT DISEASE, AND AT LEAST ONE OF THOSE EXISTING GRANTS WILL HAVE AT LEAST 12 MONTHS OF IMPLEMENTATION TIME REMAINING FROM THE PROPOSED START DATE FOR THE PROGRAMME COVERED BY THIS PROPOSAL:

A. You can, if you wish, submit a consolidated proposal in Round 10. If you want to go this route, you should select Option 1. If your proposal is approved for funding, this will result in the signing of one or more single stream of funding grant agreements.

B. You can, if you wish, submit a regular proposal in Round 10, but indicate that you want to transition to a single stream of funding during grant negotiations. If you want to go this route, you should select Option 2. If your proposal is approved for funding, this will result in the signing of one or more single stream of funding grant agreements.

C. You can, if you wish, decide not to transition to a single stream of funding at this time (i.e., in Round 10). If you want to go this route, you should select Option 3. You will be able to transition to a single stream of funding some time after the Round 10 applications period. If you have not done so by the start of Round 11, you may be required to submit a consolidated proposal at that time, depending on whether you submit in Round 11, what you submit and what the status is of your existing grants at that time.

In order to transition to a single stream of funding in Round 10 (i.e., Options 1 or 2), you do not necessarily have to re-nominate an existing PR in your Round 10 proposal. As explained in the R10 Guidelines for Proposal, applicants have several choices. They can (a) re-distribute continuing existing grant activities among existing PRs; (b) allocate continuing existing grant activities to a newly nominated PR; (c) allocate new activities to an existing PR; or (d) allocate new activities to a newly nominated PR – or some combination of the above.

Note: If you are submitting a proposal for a particular disease, and you do not have one or more existing grants for that disease – or you have one or more existing grants for that disease, but none of them will have at least 12 months of implementation time remaining from the proposed start date for the programme covered by this proposal – then you are not a candidate for transition, and you must select Option 3.

3.3 Alignment to existing cycles

In response to Part (a) of this question, this is how a Round 8 TB proposal from Indonesia described the alignment:

> The start date of R8 grant is expected to be around July 2009, while the Indonesian fiscal cycle is from January to December. The planning of the National Revenue and Expenditure Budget starts in the middle of the year (2008). Therefore the start date of the grant can be easily accommodated in the planning process of the national programme. Recently, the Government of Indonesia has made a regulation to improve harmonization between external grant funding and national planning budgets in order to improve transparency and efficiency of funding disbursement. All funds available, including external funds, are registered and included in the national budget.

3.4 Summary and rationale for multi-country approach

The purpose of the summary, in Section 3.4(a), is to provide a short overview of the disease component. The natural tendency is to fill out the summary last, because it summarises the information in the rest of the proposal. Our own experience, however, has been that it is a good idea to produce a draft of the summary about half-way through the proposal-writing process. There is a lot of value in being forced to summarize the programme in a few short paragraphs, even though the summary may have to go through several drafts before it is satisfactory. That exercise leads to everyone having a clearer sense of the "story" that the proposal has to tell. Once the rest of the proposal has been completed, you can review your draft of the summary to ensure that it is consistent.

The following is our summary of what the R10 Guidelines for Proposals say you should include here.

1. Main goals
2. Main objectives
3. Main SDAs
4. Interventions/activities
5. Key populations targeted
6. Targets (planned outcomes)
7. References to key gaps in the national programme (Section 4.3.1) and the needs of key populations

For #4 and #5 (combined), your should include: (a) target populations or priority interventions or both; (b) why these have been selected as a priority; (c) differences in target populations by sex and age; and (d) the range of institutions or facilities needed to reach these people equitably and effectively.

In addition, in certain cases you also need to describe how the interventions will contribute improved outcome for the disease(s). See the R10 Guidelines for Proposals for details.

Guidance for this question has evolved over the different rounds of funding. China provided the following summary of its Round 7 HIV proposal, Although it does not provide everything the Global Fund is now asking for in this question, it is still a good model.

> China's migrant population is estimated at approximately 120 million, and growing. The Chinese Government places migrants high on its policy agenda. This project will scale up prevention and care for Chinese rural-to-urban migrant workers (*nongmingong*), a huge population that is particularly vulnerable to HIV, and a potential bridge to the general population.
>
> The proposal targets the provinces that receive the most migrants, including Beijing, Shanghai, Tianjin (Municipalities), and Guangdong, Zhejiang, Fujian, and Jiangsu (Provinces). As major centers of manufacturing and economic growth centers, these target provinces will provide a significant proportion of country counterpart funds, thus ensuring sustainability.
>
> The project approach integrates policy level actions with high-quality HIV prevention, treatment, and care. High quality Sexually Transmitted Infections (STI) and HIV services will be selectively designed and carefully targeted, but integrated within broader healthcare delivery systems and development approaches. Priority will be placed on zones of

concentrated vulnerability, economic sectors, or gender. Coverage will be ensured by partnerships between government agencies, participating businesses, Non-government Organizations (NGOs) and community healthcare providers. The project will mobilize the funds, in-kind resources and delivery networks of the private sector.

Some innovative aspects of the proposed work include:

- Service delivery through multiple channels with strong NGO and private sector participation.
- Prevention will emphasize behaviour change communication (BCC) approaches taking into account the special characteristics of the migrant population in each setting.

The comprehensive prevention package includes BCC, quality condoms and accessible STI, HIV testing and counselling and treatment services. An underlying priority will be to reduce pervasive stigma and discrimination in China through enforcement of existing non-discrimination policies, effective communication strategies, and partnerships with private sector and civil society.

The project is embedded in China's evolving institutional framework for health and HIV:

- The Principal Recipient (PR) is an established governmental agency in China with authority and means to ensure a multi-sectoral, harmonized approach.
- The program will add high technical value by pioneering and scaling up evidence-based methods for meeting the multiple needs of the migrant population.

In terms of concrete outputs, the program will deliver:

- HIV/AIDS prevention service to 3,200,000 vulnerable migrants, targeting risk behaviours that have led to high rates of sexually transmitted infections in migrant sourcing industries.
- The program will provide STI treatment to 350,00 migrants, HIV testing and counselling services to 800,000 migrants, and care and treatment to over 5,000 migrant People Living with HIV/AIDS (PLHAs).

In the above summary, China managed to provide a very succinct overview of the entire project; include some epidemiological information; indicate the geographic reach of the project; describe the overall approach of the project; refer to some innovative aspects of the project; explain how the project fits within China's health and HIV framework; and describe what outputs the project will produce. China did this in one page, which was the limit prescribed on the Round 7 proposal form; for Round 10, the page limit has been expanded..

With respect to the rationale, in Section 3.4(b), you need to explain (a) that the countries targeted by your proposal are a natural collection of countries; and (b) that the activities in your proposal will be coordinated with the planned activities of the respective national CCMs (where appropriate). You also need to explain (a) how your proposal will be able to achieve outcomes that would not be possible with only national approaches; and (b) how your planned activities complement the national plans of each country involved, and are consistent with those plans. For more information, see "Deciding Whether to Submit a Regional Proposal" in Chapter 2 of Volume 1 of this guide.

The following extract is adapted from a Round 7 HIV proposal submitted by REDCA+, the Central American Network of People Living with HIV/AIDS. The proposal covered four countries: El Salvador, Honduras, Nicaragua and Panama. This extract illustrates how REDCA+ justified the need for a regional approach:

> The Central American region shares common factors, such as: (a) poverty, which leads to under-employment, including selling one's own body or forced migration from places or countries of origin in search of new, better alternatives for survival; and (b) little access to

formal education: a phenomenon that applies more frequently to women, whose access to education has historically been dismissed.

The Central American population is very mobile due to the ease with which the immigration authorities allow passage from one country to another, a situation that is even more evident in Honduras, Nicaragua and El Salvador, due to agreements that allow the free circulation of citizens and foreigners resident in these countries, thus indirectly stimulating the spread of HIV.

Countries are looking for ways of fulfilling their agreed commitments, including gender equality, human rights, poverty reduction, reduction of the rate of new HIV infections and reduction in mother-child mortality, among others; therefore, REDCA+ believes that its involvement in this regional proposal will have a positive impact on the achievement of the commitments assumed by the countries.

Although the countries of Honduras, Nicaragua and El Salvador are preparing proposals for the Global Fund for HIV, these proposals have a strong care component, focused almost exclusively on achieving universal access to antiretroviral drugs, and largely ignore the social components that directly and indirectly affect the frequency and prevalence of the epidemic in the region, due to causes such as: the high level of migration among these countries; the high level of illiteracy, the scarcity of opportunities for sources of income, and the dominant social and cultural patterns.

Problems that are considered common to the region, include: (a) PLWAs' lack of knowledge about the countries' existing public policies; and (b) various human rights violations that the PLWAs suffer.

Although it is true to say that the region currently has a concentrated epidemic, it is also considered important to strengthen, from the community viewpoint, activities for training and raising awareness of human rights, broadcasting policies and working to fight the discrimination and stigma that affects the people suffering from the disease as, otherwise, the situation may become unbearable.

The foregoing demonstrates the importance of presenting a regional programme and thus approaching the problem with compatible strategies that employ an integrated approach, thus creating a greater impact at a lower cost, as well as making the PLWAs stronger and more visible in the Central American Region, thus creating for them an indispensable role in preventing and reducing the spread of the disease.

SECTION 4: PROGRAM DESCRIPTION

4.1 Current context for countries included in the proposal

Here is how a Round 9 proposal from the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) RCM responded to this question (the extract has been considerably condensed). Note how the response is organised into three sections, corresponding with the three parts of this question.

A. Priority needs in the national plans of the countries covered.

National Strategic Plans (NSPs) exist in all 16 participating countries. The priority needs identified in the recent NSPs align well with those of the Caribbean Regional Strategic Framework (CRSF), which establishes six Priority Areas, each with strategic objectives for national HIV responses along with a range of Regional Public Goods and Services required to support them. These form the backbone of this proposal.

The CRSF provides an up-to-date synthesis of national priorities. Finalized in September 2008, it is the product of a two-year process of analysis that included all the Caribbean countries. Though the CRSF is broader than this proposal in both thematic and geographic scope, covering topics and territories that have not been included here, it represents a reliable consensus on national priorities, needs, and gaps. The areas of action proposed in this project follow a central priority underlined by the national plans and the CRSF: **improved HIV prevention and access to HIV services among key vulnerable populations**.

In addition, it includes actions to support that on four essential and interrelated fronts, each covering priorities in the NSPs and the CRSF: 1) combating the stigma and discrimination that make those vulnerable groups hard to reach, 2) establishing policy and institutional environments that foster wider access to HIV services, 3) upgrading the human and laboratory resources available, and 4) strengthening the capacity to track and analyze the epidemic and the impact of the measures taken in response to it.

B. How this regional proposal will address needs/gaps in the national plans.

This proposal will address priority needs/gaps that are identified by the participating countries in their NSPs and in the CRSF, and that also meet four other criteria: 1) they require regional action or particularly benefit from it; 2) they coincide with Global Fund priorities; 3) they will not be covered by other regional programmes; and 4) they are within the implementing capacity of the regional organizations that proposed them.

The R9 regional project will strengthen national systems (including sub-national and community systems) that increase demand for, access to, and quality of services that defend against the HIV epidemic and mitigate its effects. In particular, it will focus on assuring equitable access to prevention, treatment, care and support services by key affected populations: male and female youth, men who have sex with men (MSM), sex workers (SW), prison inmates, drug users, migrants (especially mobile sex workers), and persons living with HIV (PLH).

C. Critical cross-border/regional needs addressed in this proposal.

Critical cross-border/regional needs stem from the salient characteristics of the region to be served. For example:

a. **Addressing migration as a factor**. Extensive migration among countries is important in the dynamics of the Caribbean HIV epidemic. Movement of people between countries (in pursuit of economic opportunity, family visits, cultural events, schooling, freedom from stigma and discrimination, etc.) is high relative to total population (among the world's highest). Both intra-Caribbean and extra-regional migration play an important role. This flow of persons, concentrated in some groups and kinds of activity (e.g., SW), makes harmonization of health policies and of HIV programs urgent, especially since undocumented migrants are particularly vulnerable to HIV and less able to access health services.

The influx of Spanish, Portuguese, and Creole speaking people into the English and Dutch speaking countries and of Creole speakers into the DR is a further challenge. Much of it occurs in populations that are seldom addressed in country response plans, such as migrant SW and MSM from other Caribbean countries, SW from Latin America, and MSM from North America and Europe. In the case of migrant SW, an unknown portion may be victims of human trafficking; others are individuals looking for economic opportunity and anonymity. Many travel back and forth between their native countries and one or more places of business. Peer-led campaigns to target migrant/mobile SWs, such as the 6,000-odd Dominicans who travel back and forth to Antigua, are proposed as pilot efforts to explore more effective ways of increasing access to HIV services for this stigmatized, underserved, and oft forgotten group.

b. **Socio-cultural factors: risk and stigma**. Sexuality and repression are recurrent themes in Caribbean culture. Practices exist that are taboo and thus hidden, none more so than men having sex with men. Commercial sex work (SW) and transactional sex, often with age mixing, are also more common than is often admitted, as are multi-partner relationships. Traditional small town and island societies, highly religious and prone to gossip, tend to strongly stigmatize those openly involved in MSM and SW. As a result, practitioners hide these activities, often migrating temporarily or permanently to gain anonymity. Discrimination can be extreme: violence is all too frequent in some places. Open discussion of sex-related topics is difficult; there is resistance to sex education and teaching about STIs. PLH are also stigmatized and discriminated against, losing jobs, social contacts, even family support. Many who need testing and treatment services avoid them, since confidentiality is poorly guaranteed. Legal and regulatory systems reflect these barriers, as do the attitudes of some health service providers (as when AIDS patients are refused entry to public hospitals). Information on vulnerable populations is difficult to obtain due to their fears about lack of confidentiality. Regional approaches in this project will help overcome local inertia and hasten adoption of means to reduce stigma and its paralyzing effects.

4.2 Regional epidemiological profile of target populations

Section 4.2(a) is new for Round 10. With respect to 4.2(c) and (d), the box below identifies some Round 8 proposals that the TRP identified as having solid information on epidemiology. Note that Sections 4.2(c) and (d) in the TB and malaria versions of Sections 3-5 of the proposal form contain different language for the population groups and epidemiology of target populations, as compared to the HIV version of Sections 3-5.

See also:

Indonesia HIV (8), Mali HIV (8), Bolivia malaria (8), Armenia TB (8), El Salvador TB (8)

Links to these proposals are provided in Aidspan's *Key Strengths of Round 8 and 9 Proposals to the Global Fund*, available at www.aidspan.org/aidspanpublications. See Key Strength 2.

4.3 Major constraints and gaps in disease, health, and community systems

4.3.1 HIV programs for countries included in the proposal

The following text is extracted from a Round 8 HIV proposal from Gabon. Notice that the three headings in the extract relate to the three parts of this question.

Main weaknesses in the implementation of current HIV strategies

Since 1987, State authorities have made political commitments resulting in the establishment of several response management and coordination arrangements. However, they have not been functional. A national strategic plan to fight AIDS was prepared and implemented for the period of 2001-2006. In January 2006, the Gabonese Government adopted the Strategic Document for Growth and Poverty Reduction which takes into account the issue of HIV. In order to revitalize the fight against HIV nationally, the President of the Republic created a Ministry exclusively dedicated to the issue of HIV, so as to strengthen coordination and enhance the national response.

Decentralization of implementation: Twelve Ministerial and nine Provincial Committees to fight AIDS were created, formed, and equipped with materials, but no implementation plan has been created.

Local and community response: There are 6 thematic networks and 4 large associations of the main participants of the civil society fighting AIDS. However, despite the many efforts made by these groups and the actions taken, the lack of resources and technical capacities is a serious limitation on the realization of the concrete projects of these structures.

Access to and coverage of prevention services: PMTCT structures are insufficient. Behaviour change communication activities were developed, especially in Libreville schools and in provincial capitals, but fewer in rural areas, due to the difficulty of geographic access, among other challenges.

Access to treatment and care: The structures have insufficient technical and financial capacities to address the needs. The capacity of the system of holistic care of orphans and vulnerable children (OVC) (health, psychosocial, educational, and legal protection) is still insufficient.

Epidemiological surveillance, behaviour studies and M&E: Lack of a national monitoring-evaluation plan; insufficiencies in the information system, as the national survey among the general population hasn't been conducted and behaviour studies are insufficient (6 of the 9 provinces).

Gender/children's rights aspects: These aspects were not widely taken into account during planning.

Gaps in the service delivery to target populations

The high priority targets for this proposal are the poorest populations affected by HIV, that is, pregnant women and young women, as well as their infants, PLWHA, out-of-school 10-24 year-olds, sex workers (SWs) and OVCs. The main weaknesses listed with respect to service delivery for pregnant women and young women are as follows:

- Facilities with insufficient human, material, and financial resources for testing (in 2007, 60.9% of women consulted were tested) and treatment of HIV-positive pregnant women and their newborns (of the 732 HIV+ women tested, 494 received ARV treatment), as well as the testing of their partners (19.8% of the 732 women tested).
- The insufficiency of the community monitoring system leads to an important number of lost cases among HIV-positive pregnant women and their children (in 2007, 14% of the

children born of 732 HIV-positive mothers were monitored during 18 months and 4.3% were tested).

How these weaknesses compromise the planned national HIV outcomes

- Discrepancies in the results of preventive actions and treatment of PLWHA between urban and rural areas could lead to an increase in the HIV prevalence in rural areas.
- The decreased coverage of PMTCT, especially regarding the identification of HIV-positive pregnant women (732 of 2,570 expected, or 28%), of prevention through antiretroviral therapy (ART) (494 of 732, or 67%), and the monitoring of children born to HIV-positive mothers (103 of 383 mothers having given birth in the health-care facilities, or 27%). This poor coverage results in the increase of the number of HIV-positive children, who will be a heavy burden for the country.
- Coverage insufficiency of the interventions prioritizing populations such as STI sufferers, SWs, MSM, out-of-school youth, carriers, etc., could result in the increase of the HIV prevalence among these populations.

The R10 Guidelines for Proposals recommend that in your reponse, you:

- Describe the ability of the national disease programmes to equitably reach women and men (and boys and girls) according to their different needs, as well as other key populations.
- Describe whether certain groups may face barriers to access, such as women and girls, key populations, adolescents, or barriers arising from geographic, urban/rural or other location issues.

This is new for Round 10. It is part of an effort by the Global Fund's to ensure that in the information you provide throughout the proposal form, you refer specifically to key populations, particularly women and men (and boys and girls).

See also:

Gabon HIV (8), Indonesia HIV (8), Myanmar HIV (9), Ethiopia malaria (8), Moldova TB (8)

Links to these proposals are provided in Aidspan's *Key Strengths of Round 8 and 9 Proposals to the Global Fund*, available at www.aidspan.org/aidspanpublications. See Key Strength 3.

4.3.2 Constraints and gaps

Below is an extract from Eritrea's Round 9 malaria proposal, describing the weakness and gaps in the country's health systems. The weaknesses and gaps are clearly listed and concisely described.

> The main weaknesses of and/or gaps in the health system that are affecting implementation of current malaria control strategies are:
>
> 1. **Lack of effective referral system:** Currently, there are no standard referral formats and feedback mechanisms. Moreover, lack of ambulances and other facilities for early referral purpose at most health facilities is greatly hampering the early referral of severe malaria cases to nearby health facility. This, in turn, will greatly increase the risk of malaria death.
>
> 2. **Human resources:** Most of the health facilities particularly health stations are mainly staffed by Associate Nurses who don't have enough capacity to handle each and every malaria patient, particularly severe malaria cases. Moreover, there is shortage of staff particularly in the remote health facilities.
>
> 3. **Unavailability of one central data bank:** Currently, the source of information/data in the ministry is not well integrated and coordinated. As a result, as for malaria for example, there are three sources of information [the sources are named] and there is always some discrepancies in the data collected by these three sources which creates some problems for the programme during planning and program implementation.
>
> 4. **Lack of diagnostic capacity at most health facilities:** Out of all malaria cases reported, only 20% of the cases are confirmed through the gold standard microscopy. Lack of electricity supply at most health facilities particularly at health station level is one of the bottlenecks for this low proper diagnosis.
>
> 5. **Inadequate utilization of RDTs by health workers:** Since, 2007, the National Malaria Control Programme has been distributing enough RDTs at all health facilities without microscopes. However, despite the high distribution of RDTs, treatment through proper diagnosis has not improved much. The major challenges that the program is facing with regards to the use of RDTs for proper diagnosis and prompt treatment are lack of confidence of health workers on the effectiveness of RDTs and considering it as additional work, not as part of their work.
>
> 6. **Lack of efficient use of available data at facility level:** This is primarily due to lack of dedicated health information officers or trained health workers on data management and analysis at health facility with the capacity to analyze available data for an appropriate and timely action.
>
> 7. **Weak community-based malaria reporting:** As the malaria situation in the country reduces further, most of the malaria cases at the community level will remain unseen. Therefore, unless a mechanism is created where cases can be tracked and reported at the early stage from the community, the possibility for severity of the disease and outbreak to arise will be high.
>
> 8. **Weakness in supportive supervision:** The Ministry of Health is expanding health services at health facility level as well as towards communities. As such services expand and improve in quality, close supervision will be necessary both malaria-focused and in an integrated manner with other programs. The MoH has already introduced Integrated Supportive Supervision system which needs to be strengthened in order to monitor appropriate implementation of interventions.

Section 4.3.2 says that you can include community systems in your discussion of the contraints and gaps. This is new for Round 10, so we cannot provide examples of how this question was answered in past rounds of funding. See *Chapter 2: What's New in Round 10?* for a discussion of how the Global Fund is increasing the emphasis on community systems strengthening (CSS) for Round 10. See also the Global Fund's updated information note on CSS at www.theglobalfund.org/documents/rounds/10/R10_InfoNote_CSS_en.pdf). That information note defines "community systems" as "community-led structures and mechanisms used by community members and community-based organizations and groups to interact, coordinate and deliver their responses to the challenges and needs affecting their communities."

Note: This is one of only a few places on the proposal form that mentions community systems. However, you are expected to include objectives and activities related to CSS in the description of your programme (in Section 4.4.1). In collaboration with a range of stakeholders, the Global Fund has prepared a *Community Systems Strengthening Framework* document, available at www.theglobalfund.org/documents/civilsociety/CSS_Framework.pdf. The CSS Framework is a valuable tool for building CSS-related activities into your proposal.

The CSS Framework focuses on six core components of community system:

- Enabling environments and advocacy
- Community networks, linkages, partnerships and coordination
- Resources and capacity building
- Community activities and service delivery
- Organisational and leadership strengthening
- Monitoring & evaluation and planning

For each of the core components, potential CSS interventions and activities are grouped within specific service delivery areas, and a number of recommended CSS indicators are shown.

The CSS Framework says that "in the context of the Global Fund, applicants are encouraged to consider CSS as an integral part of assessments of disease programmes and health systems, ensuring that they identify those areas where full involvement of the community is needed to improve the scope and quality of services delivery, particularly for those hardest to reach."

See also:

Indonesia HIV (8), Myanmar HIV (9), Swaziland malaria (8)

Links to these proposals are provided in Aidspan's *Key Strengths of Round 8 and 9 Proposals to the Global Fund*, available at www.aidspan.org/aidspanpublications. See Key Strength 3.

4.4 Proposal Strategy

4.4.1 Interventions

This is a very important part of your proposal, and should be completed in conjunction with the Performance Framework and the workplan, both of which are mandatory attachments to the proposal.

One way to organise your response would be to use a series of tables, one for each SDA. The tables could look something like the one shown below. The technical content for this example has been adapted from China's Round 7 TB proposal.

Goal 1: Reduce the morbidity and mortality of multi-drug-resistant TB (MDR-TB) in China			
Objective1 : Expand the PMDRT strategy in 50 sites in 10 provinces of China			
SDA 1.6: Supporting patients through direct observation to enhance adherence to treatment of MDR-TB			
Indicator(s): [to be inserted here]			
Major Activities	**Additional Information**	**Implementer**	**Target Population**
Activity 1.6.1: Provide DOT throughout the course of MDR-TB treatment using peripheral health workers and provide financial incentive for providing DOT.		[name of PR or SR]	TB patients
Activity 1.6.2: Provide transportation subsidy to very poor MDR-TB patients so they can travel to medical clinic for DOT.	Each PMDRT site will arrange for DOT for each MDR-TB patient and provide a case-management fee to DOT worker. The site will also provide transportation fee to approximately 20% of MDR-TB patients who are very poor so they can travel to the medical clinic for DOT.	[name of PR or SR]	TB patients
Activity 1.6.3: Provide counselling and psychological support.	Local NGOs will be contracted, to provide counselling and psychological support to patients and their families. The project will also stimulate the forming of patient groups, which are very important for early reporting of suspect's treatment adherence.	[name of PR or SR]	TB patients

Another option is to present the information in paragraph format, without the use of tables.

The following abbreviated extract is from a Round 8 HIV proposal from Chad:

> **Objective 5: Extend access to Voluntary Testing Centres (VTC) at national level**
>
> **SDA 5.1: Test and counselling**: To ensure universal access to treatment, everyone infected must be tested in order to be covered by healthcare. We wish first of all to regularly provide the already existing 46 VTC with reagents and consumables for the duration of the proposal. Supplies must also be provided for the 26 VTC to be created by the end of Round 3 in 2010

and the 22 VTC which will be operational after the suspension of financing by the World Bank. If we consider the figures for VTC visits and the mass awareness campaigns, the proposal will test and advise 726,500 people in the different communities. 96 new VTC have been planned throughout the national territory. 22 VTC are operational and 28 are registered within the Round 3 framework; this proposal thus supports the restoration of 46 new VTC covering all house districts: 4 of these VTC are to be mobile and 490 counsellors are to be trained for all levels (central and regional). We all wish to ensure regular supply of reagents and consumables for the total duration of the project. Supervision missions carried out by the reference structure will ensure that counselling directives and norms are enforced as required: 4 mobile VTC teams will be set up for zones which are difficult (refugees, displaced people, and nomads) and for young people located in the large cities of Ndjamena, Moundou and the 11 islands of Lake Chad. The Conseil national de lutte contre le sida (CNLS) will co-ordinate project implementation.

Principal activities linked to SDA 5.1
5.1.1: Restoring 46 VTC, of which 18 are owned by religious faith organizations, 20 NGO/Associations and 8 public organizations
5.1.2: Setting up 4 mobile VTC units for advanced strategies
5.1.3: Training 490 counsellors in overall care
5.1.4: Organizing 1 workshop for revising the VTC directives and counselling manual
5.1.5: Supplying the 96 VTC
5.1.6: Organizing a national and regional campaign for encouraging voluntary testing

Indicator
- Number of people benefiting from counselling with transmission of test results

Target population
- Young people and adults

Implementer in charge
- UNAD, Civil Society PR

The following abbreviated extract is from a Round 8 TB proposal from Thailand:

Objective 1: Pursue high quality DOTS implementation

SDA 1.1 Advocate for local political commitment to create a supporting and enabling environment for TB control activities and secure financial resources
Implementers: PR-DDC, SR-DHSS (Department of Health Services Support)
Target Population: Community Health Fund Committee members, Tambon Health Board members
Indicators: Number of agreements (to address TB) signed by tambon

1.1.1 Sensitization workshops for stakeholders at provincial and district levels for TB and TB/HIV.
To increase and strengthen political commitment, coordination among district administration, public health offices, NGOs, and civic society, and improve planning we propose provincial sensitization and planning workshops. During these workshops, attendees are expected to develop strategy map with implementation plans and budgets to ensure sustainability of TB control programs at district levels. This activity is linked to SDA Management and Supervision (Activities 1.3.2 and 1.3.3) for follow-up and monitoring of implementation plans.

1.1.2 Mobilize political commitment for TB in Community Health Fund Committee (CHFC)/ Tambon Health Board in order to secure TB funding at Tambon (minor district)
The CHFC/Tambon health board is an existing local body that oversees public health activities in the community and controls local health resources. The concept of advocating with CHFC/Tambon Health Boards to support community-based TB control activities has been documented as highly successful, and has been recommended by the 4th National TB Program Review. We propose to generate local advocacy at this level by inserting TB representatives into 2,648 CHFC/Tambon health boards. Representatives will be expected to

raise TB issues into the health board meeting agendas, lobby for local commitment to TB control, increase the accountability of local health services to the TB control activities, and support community mobilization efforts. To enable this activity, workshops will be held to build advocacy and TB promotion skills of two TB representatives per Tambon. A letter of agreement (LOA) for CHFC/Tambon Health Board to formalize collaboration will be developed to support TB control activities in the Tambons. This proposal will use the regular meeting of the CHFC/Tambon health boards to discuss the agreement preparation and other activities for empowering community. EXPECTED OUTCOME: After five years, 50% of tambons agree to fund some TB activities.

See also:

Chad HIV (8), Georgia HIV (9), Honduras HIV (9), Mauritius HIV (8), Eritrea malaria (9), Swaziland malaria (8), Ecuador TB (9), Thailand TB (8)

Links to these proposals are provided in Aidspan's *Key Strengths of Round 8 and 9 Proposals to the Global Fund*, available at www.aidspan.org/aidspanpublications. See Key Strength 1.

4.4.2 Addressing weaknesses from a previous category 3 proposal

The text below shows how a Round 8 malaria proposal from the CCM in Cameroon explained how it had addressed weaknesses from the first time the proposal was submitted. The weaknesses identified by the TRP are summarised in bold; under each one, the CCM provides its explanation.

1. No demonstration of how ITNs coverage will be sustained and expanded to scale for universal coverage (even while implementing indoor residual spraying [IRS]) within the targeted sub-population groups and/or the general population.

In the Executive summary, it is indicated that IRS is a complementary intervention in areas with a relatively high coverage of insecticide-treated nets and long-lasting insecticide-treated nets (ITNs/LLINs) to create synergy and achieve fast reduction in malaria transmission. It also is stated that areas of implementation will progressively increase (15% per year) to cover all endemic districts of the country and gradually give way for high use of LLINs to sustain achievements and continue to further reduce malaria burden. In order to achieve this, LLIN/ITN delivery using various funds [funders are listed] and other partners [partners are listed] will continue even in IRS-targeted communities while IRS is being expanded to achieve fast reduction in malaria transmission. It is with this understanding and background that this proposal is attempting to raise funding to scale up IRS within the context of integrated vector management (IVM) using the two major interventions in a complementary manner. IVM, which implies the utilization of a range of interventions, often concomitantly and synergistically is the nationally adopted strategy of malaria prevention in Cameroon. As a result IRS scaling up will not replace ITN expansion rather will facilitate by further developing the human and material resources needed to accelerate delivery of ITNs including insecticide treatment of nets, which are available in large numbers in Cameroon.

2. No information on whether physical reconnaissance is available to justify the proposed-interventions.

The broad epidemiological, environmental and entomological information needed to generally consider IRS and the other major intervention ITNs in any part of Cameroon is available.

As indicated in section 4.3.2 b, Cameroon divided into three major well known malaria geoclimatic zones which are properly documented as far as malaria transmission in concerned. In the same section an allusion is made to vector resistance study with a resultant mapping which permit to determine what insecticide to use in the different regions of Cameroon.

Generally, the current global strategy for malaria vector control recommends both ITNs and IRS in all epidemiological settings of malaria transmission. The strategy describes that in stable malaria/high transmission areas, such as in Cameroon. IRS can be used to rapidly reduce transmission through a time-limited campaign focusing on high coverage of the target area. Also, once transmission has been reduced, IRS can be continued at reduced levels in selected high risk areas and supplemented by other malaria vector control methods such as LLINs through IVM approach and parasite control interventions. The proposal is therefore based on this general principle and WHO's guidance on that IRS can be implemented in all epidemiological settings including in high transmission places when and where it is feasible under the local circumstances.

3. The costs for some budgeted items are inappropriate high (e.g., Vehicles) without justification

Unit cost of vehicle (Pick up 4x4 all seasons) includes customs clearance which in the past was absorbed by the Government of Cameroon.

4.4.3 Lessons learned from implementation experience

Cameroon's Round 9 malaria proposal provided a very-well organised response to this question, using a table format.

Domains	Lessons learned	Actions taken in Round 9
LLINs procurement and distribution	• Administrative bottlenecks in the public contract system in charge of international calls for tenders, which has resulted in prolonged delays of 7-8 months. • Integration of long-lasting insecticide-treated nets (LLINs) distribution with other promotional health activities (Immunization campaign, ante-natal care [ANC], etc.) increased LLIN coverage among pregnant women and children under 5. • Weak community involvement led to low LLIN coverage. • Low LLINs use among pregnant women and children under five due to cultural myths and beliefs.	• Voluntary Pooled Procurement (VPP) mechanism option. • Routine LLINs distribution will continue through ANC and health campaigns for pregnant women and children under five respectively. • Partnership strengthening with Civil Society and community-based organisations in the distribution and follow up at community level. • Reinforce behavior communication change (BCC) and advocacy at community level.
IPT2 coverage	• Low IPT2 (intermittent preventive treatment) coverage among pregnant women due to poor service delivery at health facilities.	• Capacity building on sulphadoxine-pyrimethamine (SP) stock management. • Reinforce BCC on SP uptake by pregnant women.
IRS implementation	• This strategy is very expensive and needs a lot of funds and technical know how for implementation.	• No action taken in this round. Nevertheless IRS where operationally feasible is planned to be implemented with Highly-Indebted Poor Country initiative (HIPCI) funds.
Stock management	• Poor stock management system led to poor quantification of needs and management supply responsible for frequent SP and Artemisinin-based combination therapy (ACT) stock outs.	• Capacity building in procurement management supply at all levels.
Case management	• Irrational use of ACT due to insufficient diagnostic facilities in health facilities and absence of diagnostic tools at the community level. • Health provider preference for unsubsidized ACT increased the cost of case management.	• Introduction of rapid diagnostic tests (RDTs) in health facilities and at community level. • Capacity building for health staff and community relays on ACT dispensation. • Reinforce BCC.

Domains	Lessons learned	Actions taken in Round 9
Monitoring and Evaluation	• Low completeness and timeliness of data at all levels led to insufficient decision. • Insufficient supervisory visits.	• New monitoring and evaluation tools to be put in place. • Operational research and evaluation have been planned.
Partnership Coordination and involvement	• Poor partnership coordination resulted in dispersed efforts in malaria control.	• Put in place a steering committee made up of government and Civil Society partners. • Organise regular periodic meetings.

The Cameroon CCM concentrated mainly on challenges that it identified in its implementation experience, and how these challenges are being addressed in the Round 10 proposal. We suggest that you also include several examples of how positive outcomes have influenced the development of your proposal. It would be a good idea to explain how the lessons learned were identified (for example, was a formal study conducted?).

4.4.5 Enhancing social and gender equality

The Global Fund expects that you will include in your proposal strategies and activities to address stigma and discrimination and to enhance gender equality. These activities should be clearly identified in Section 4.4.1 Interventions. In this section (4.4.5), you are being asked to provide a summary of these strategies and activities. You are also being asked to include in your response specific references to the objectives, SDAs and activities described in Section 4.4.1.

The R10 Guidelines for Proposals provide considerable information concerning what should be included in this section. Here is Aidspan's summary of what the Guidelines call for:

1. Whether the proposal includes activities specifically designed to ensure that women and men, boys and girls, and other key populations have **equitable access** to social support, protection, information and other services. (If yes, you should briefly describe these activities.)
2. Whether particular groups may receive **prioritised access** to services. (If yes, you should explain the rationale.)
3. How the strategies and activities in the proposal will help strengthen **social equality** by targeting groups most in need of interventions. If appropriate, include an explanation of the differences in equality of access different populations (e.g, girls and boys; see other examples in the R10 Guidelines for Proposals).
4. Strategies and activities in the proposal that specifically address **stigma and discrimination** as a barrier to accessing services. (See the examples in the R10 Guidelines for Proposals.)
5. Strategies and activities in the proposal specifically designed to reduce **gender inequalities** and change harmful gender norms.
6. Strategies and activities in the proposal that specifically address barriers imposed by **repressive laws and policies**.

We suggest that in your response you include a separate section on each of these six topics, even though there may be some overlap among the topics (particularly between Topics #1 and #3).

As you provide information on each of these topics, you should ensure that you explain:

- how the strategies and activities in your proposal related to social and gender equality respond to the epidemiological situation described in Section 4.2;
- how the strategies and activities in your proposal related to social and gender equality specifically address the weaknesses, gaps, and inequities outlined in Section 4.3; and
- how the proposed strategy addresses key population groups that can face barriers to access, including women and girls, men who have sex with men, sex workers, transgender people and injecting drug users.

Alternatively, you could include a separate section covering one or more of these three bullets.

Below we provide extracts from several proposals from earlier rounds of funding. Applicants should note that the Global Fund's guidance for this question has evolved over the years.

For example, this is the first time that the Fund has asked applicants to refer back to the sections on epidemiology and weaknesses and gaps while drafting their response.

This is how a Round 8 HIV proposal from Mauritius described how Topic #1 (**equitable access**) was being addressed:

> This proposal aims to expand preventive services by reaching out to injection drug users and commercial sex workers (CSWs), migrants, street children and prisoners. Indeed, poverty is an important risk factor that contributes to reduce access to existing services. In the case of Mauritius, the Rodriguans (due to poverty in Rodrigues), migrate to the Mauritius, a situation that poses a serious risk of HIV transmission, as they become destitute and take to crime, CSW and drug use. In order to increase access to services, this proposal has the plan of using paid outreach workers and community volunteers to do IEC (information, education and communication), counseling, and conduct health education, and link and encourage these marginalized groups to us the free health services. Through the selection and training of community volunteers, it will be possible to target vulnerable youths and women within the population.

And here is what a Round 9 Viet Nam HIV proposal said about the same topic:

> By nature of the epidemic in Viet Nam and its concentration between injection drug users (primarily men) and their primary sexual partners, female sex workers and their clients (young men), equitable access to both prevention and care/supportive services for women and men is critical to the success of this grant. To address gender equity in access to services, this proposal includes in particular the following activities: targeted prevention, referral, and care and supportive services for women in sex work, including building condom negotiation, health seeking behavior, and self-empowerment skills; referral to women's health clubs where possible to ensure women have access to HIV-related counseling and IEC (information, education and communication), and follow-up care. In addition, this proposal will also promote PMTCT services in conjunction with sexual and reproductive health services to ensure that female PLHIV are aware of PMTCT services and their right to bear children.

(In its research, Aidspan did not come across any proposals where the applicant was planning to **prioritise access** to some services for particular groups [Topic #2].)

In the Round 8 HIV proposal from Mauritius, this is how the CCM described how its proposal would strengthen Topic #3 (**social equality)**:

> Poverty and inequality are widespread problems: the poor often live alongside the non-poor and most inequality is accounted for by differences within districts. Thorough working with community based organisations. targeting and provision of services will be done at community level, through participatory assessments, with the identification of those most at risk (e.g., injection drug users, CSWs, street youths, and then those vulnerable like women and youths. Targeting of housewives will be helped by the government's identification of 229 poverty clusters, and about 7000 poor and vulnerable families.
>
> Inequalities between rich and poor people still exist in Mauritius. Thus, poverty particularly rural poverty, poses a serious inequality to access HIV & AIDS preventive services. This proposal tackles this problem by attempting to ensure that multi-sectoral HIV & AIDS and reproductive health advocacy committees located in social welfare centres, or in women's centres or any other community structure, are first established in the rural areas, the coastal fishing villages, the EPZ (export processing zone), and the areas where migrant garment workers lived, as well as targeting Rodriguan immigrants.

This is how a Round 6 HIV proposal from Paraguay explained how Topic #4 (**stigma and discrimination)** would be addressed:

> Human rights, discrimination and stigma will be among the topics included in the training that will be conducted among members of the health cares services in the six regions selected…. Specific advocacy activities will be undertaken to promote changes to the HIV/SIDA Act 102/91, and to promote the adoption of a bill prohibiting any form of discrimination.

If activities of the project will help to counter stigma and discrimination, even if the activities are not specifically focusing on stigma and discrimination, applicants should explain this. The following is adapted from the Kyrgyz Republic's Round 7 HIV proposal:

> The program is aimed at, among other things, mobilising communities of HIV-positive people, which will lead to their expanded participation in planning and implementation of the response to the epidemic. The project includes several measures which will be jointly implemented by the PLWHA community and other organisations, including state medical institutions. This will serve to facilitate the reduction of stigma and discrimination in the healthcare system and related institutions.

And this how a Round 6 TB proposal from Uganda put it:

> Increased awareness about TB, that it is curable and that services are available (and free) will reduce stigma and discrimination of patients by communities and health workers. The observation by districts that have successfully implement community-based DOTS is that stigma associated with TB is reduced with community participation and involvement… TB/HIV collaborative activities will further reduce the stigma.

Here is how a Round 9 HIV proposal from Bosnia-Hercegovina described strategies and activities to address Topic #5 (**gender inequality)**:

> HIV monitoring, surveillance and evaluation will ensure capturing of information about the gender dimensions of the HIV epidemic; periodically conduct stand-alone gender assessments to gather essential supplementary data; and assess the current AIDS response to see if and how it is addressing the gender dimensions of the epidemic.

See also:

Eritrea HIV (8), Myanmar HIV (9)
Nicaragua HIV (8), Tajikistan TB (8)

Links to these proposals are provided in Aidspan's *Key Strengths of Round 8 and 9 Proposals to the Global Fund*, available at www.aidspan.org/aidspanpublications. See Key Strengths 5 and 12.

> Gender will be integrated into the national AIDS strategy, annual action plans and sector plans, with specific attention being given to budgeting and allocation of funds. Special emphasis will be put on implementing and scaling up specific interventions to address the gender dynamics of epidemic in terms of HIV prevention, treatment, care and impact mitigation and for the purpose of better measuring the gender-related outcomes and impacts of AIDS programmes, targets and indicators will be developed and tracked.
>
> In order to build capacity and mutually reinforce links between action on HIV and broader action on gender equality, capacity building will be undertaken to increase the gender competence of those involved in HIV-related initiatives and the HIV competence of those involved in gender-related initiatives.

The following is from a Round 6 HIV proposal from Zanzibar, on the same topic:

> To address gender inequality issues, this proposal includes the following activities:
>
> - piloting the WHO's guideline on gender mainstreaming in HIV/AIDS health services in four districts, including capacity building for the health system and support system to respond to gender issues;
> - ensuring screening, care/treatment and referral of HIV infection of rape victims, specifically ensuring availability of post-exposure prophylaxis and counselling;

- incorporating violence-prevention strategies within the voluntary counselling and testing services and PMTCT services; and
- strengthening male involvement in sexual and reproductive health issues, through community outreach programmes and other means.

In its Round 9 HIV proposal, Cote d'Ivoire used a table to show how activities included its proposal would respond to gender inequalities. We reproduce a portion of the table here:

Object-ives and SDA	**Obstacles relating to gender relations and other social constraints that may hinder the achievement of the goals and objectives**	**Activities to lift these constraints to change gender relations to achieve the objectives**
SDA 1.2	- The exposure rates to mass media are very low for women in rural areas - Poor social mobilisation to change the behaviour of young people - The rate of school attendance by the general population is very low in CI - A large proportion of young people are outside the academic education system - Secondly, the net rate of education of girls is only 26.6%	- Completion of 36,000 talks for social mobilisation of young girls and boys aged between 15 and 24 - Completion of 18,000 local behaviour change communication (BCC) campaigns for women in rural areas - Training of 75 teachers and 20 NGO which are active in the educational sector on BCC activities - Organization of local BCC activities to reach young girls, mothers and uneducated young people - Organization of 25 tournaments for young girls and young boys
SDA 1.4	- Very poor social mobilization	- Support for the mobilization of NGO - Support for the training of prisoners on life skills by NGO
SDA 1.6	- Young boys do not use any means of prevention - Young boys often express their masculinity violently (fact that women do not manage to negotiate sexual relations with their partners)	- 8 training workshops for health professionals on the syndromic approach to STI and the strengthening of capacities on gender and HIV/STI - 500 sessions to raise awareness on STI, gender-based violence and its impact on STI and HIV
SDA 1.7	- Social and cultural barriers with regard to the use of condoms - Problems in relation to women wearing female condoms and negotiating the use of male condoms	- Support for the organization of community-based BCC activities which are specifically directed at prejudices in relation to the use of condoms
SDA 3.1	- The woman is often the first to be informed - Stigmatization and unequal relations in decision-making with regard to the household and family	- Revision of standards and guidelines on PMCT to include gender considerations

This is how a Round 9 HIV proposal from Bosnia-Hercegovina described plans to address Topic #6 (**repressive laws and policies**):

> The legislative and policy review will focus on rights protection for marginalized and vulnerable populations. Existing policies will be adapted where appropriate to address rights and protection for vulnerable groups within BiH. Where needed, new legislation will be formulated.

See also the Global Fund information notes on gender equality, and sexual orientation and gender identities. Both notes contain sections on how to address these issues in Global Fund proposals.

DOs and DON'Ts

DO explain how your proposal will address inequalities.

DO provide concrete examples of relevant strategies and activities in your proposal.

DON'T write an essay describing the inequalities.

DON'T describe what is needed, or what should happen.

DON'T explain what the Constitution of your country says about rights.

DON'T use very general statements, such as "Parts of the project will focus upon the penitentiary sector. As such, the needs of prisoners are addressed."

DON'T say that "all efforts will be made to ensure" X and Y; just say what activities are included in your proposal to address the inequalities.

4.4.6 Partnerships with the private sector

The following extract from a Round 8 TB proposal from Bangladesh describes a co-investment with the private sector:

> Since 2002, the private-for-profit sector (export processing zones, garments industries and private hospitals and private medical college hospitals and individual private practitioners) are increasingly involved in directly observed treatment, short course (DOTS). In 2002, Youngone, a Korean company established in Chittagong with more than 80 000 employees, started DOTS services to keep their staff healthy. They provide space and necessary human resources, including doctors, nurses and laboratory technicians while the National TB Programme (NTP) provides drugs and logistics and trainings, and supervises the activities. Following this good example, DOTS services were expanded to Dhaka and Chittagong Export Processing Zones (EPZs) by NTP. Export processing zones provided all facilities, including space. NGOs provided 1-2 staff to address the additional case load and coordinate with the programme together with EPZ medical officers, paramedics and lab-technicians. NTP provided training, drugs and logistics and supervise the activities. Subsequently, DOTS services expanded to industries in Khulna and gradually to many small- and medium-level garments and other factories in all metropolitan cities. A huge number of workplaces are still not covered. DOTS services are also expanded through private practitioners and private hospitals/clinics in limited scale. Physicians are oriented on DOTS and, in return, they follow the national guidelines in diagnosis and treatment and report back to NTP. DOTS centers are established in all private medical college hospitals. They provide space and NGOs provide 1-2 staff to assist medical college hospitals physicians and laboratory technicians in addressing additional case load, counseling and referral and linkage with the programme.
>
> Recently an MoU has been signed between NTP and the Bangladesh Garment Manufacturers & Exporters Association (BGMEA) for expanding DOTS in garment industries and to 12 health centers run by BGMEA. About 2.5 million workers mostly women are working in these industries. BGMEA will provide the space in the health centre and 1-2 additional staff will be provided to the centre from this grant if approved for expanding DOTS for expanding education programs in garments industries and managing additional cases and supervising DOTS. Physicians of BGMEA will supervise and monitor the activities. NTP provides the training, drugs and logistics. Some of these factories covered earlier, while most remain to be covered through Round 8 GF proposal. Through this intervention, workers and trade union leaders will have correct information about TB diagnostic and treatment services.

This is how a Round 9 malaria proposal from Cambodia described the non-financial contribution from the private sector to the proposal:

> The private sector will indirectly contribute the human resources and infrastructure for delivery of medical products and care. This is a non-financial contribution. The main contributions of the private sector include:
>
> - ***Subsidized sale through commercial sector outlets***: Highly subsidized sales through the private sector of nationally recommended malaria products to increase access for target populations would not be possible without vibrant, large, and effective private sector partnerships. Private sector outlets such as drug shops, clinics, pharmacies and markets, as well as community based organizations in areas where even markets cannot reach can be utilized as a sustained delivery channel.
> - ***Bundling long-lasting insecticide treatment with untreated nets:*** Untreated locally produced or imported nets are available through commercial sector outlets and markets across Cambodia. PSI aims to significantly increase health impact by working with local importers to bundle long-lasting insecticide treatment, transforming the untreated nets into long-lasting insecticide nets. This strategy will be piloted with reprogrammed funds from round 6 and its continuation will be dependent on the results of the pilot. If the results are not promising the round 9 funds will be used to find other ways to treat the

very high number of commercially obtained untreated nets with long lasting insecticide. This will significantly increase the proportion of people protected by treated nets.

- ***Inter-sectoral collaboration with farm owners:*** Family Health International (FHI), a sub-sub-recipient, will pilot a strategy to engage farm owners in identifying malaria cases among temporary workers, and ensuring that they receive prompt diagnosis and appropriate treatment from Village Malaria Workers (VMWs) or public health facilities. Farm owners will benefit if their employees are sick less often, and this can serve as a model for the collection of surveillance data for mobile/migrant populations.

See also:

Tanzania HIV (8), Nigeria malaria (8), Bangladesh TB (8), Cameroon TB (9)

Links to these proposals are provided in Aidspan's *Key Strengths of Round 8 and 9 Proposals to the Global Fund*, available at www.aidspan.org/aidspanpublications. See Key Strength 6.

4.4.8 Links to non-Global Fund resources

In its Round 8 HIV proposal, the Vietnam CCM started off this section by providing an overview of donor assistance programmes. The following is an extract. ("GF-8" refers to Vietnam's Round 8 proposal.)

> There are three major donor-funded prevention programs in Vietnam, including the U/K. Department for International Development (DfID), the World Bank (WB) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), with additional support from the Australian Agency for International Development (AusAID) likely to begin in 2009. Major donors working in care and treatment include PEPFAR, the Clinton Foundation Health Access Initiative (CHAI), and the Global Fund.
>
> Provincial level geographic coverage in the 10 GF-8 proposal provinces will coincide with support from one or two of the donors listed below, varying by province. GF-8 will not be the sole donor in any of the 10 provinces. Donors are often relegated to specific districts within provinces when their initiatives are programmatically equivalent.
>
> ***DfID***: The DfID-funded HIV prevention program (2004 - 2008) serves 21 provinces/cities, and operates in 3 of 10 GF-8 provinces. It focuses on four major aspects, including (1) capacity building for staff, (2) condom supply and social marketing, (3) behavior change interventions targeting female sex workers, their clients, and injection drug users, and (4) improvement of STI management and treatment. This program measures risk behaviors including needle sharing and condom use among drug users and sex workers and their clients.
>
> ***WB*:** The World Bank-funded HIV prevention project (2006 - 2011) provides support to 20 provinces, and operates in 5 of the 10 GF-8 provinces. Outcome indicators include the percent of vulnerable groups in participating provinces reporting safer injection practices (from an estimated 20% at baseline to 70% at project end), and the percent of vulnerable groups in participating provinces reporting condom use during sex (from an estimated 40% at baseline to 80% at project completion).

See also:

Viet Nam HIV (8), Democratic Republic of Congo malaria (8)

Links to these proposals are provided in Aidspan's *Key Strengths of Round 8 and 9 Proposals to the Global Fund*, available at www.aidspan.org/aidspanpublications. See Key Strength 10.

The CCM then described the linkages between its proposal and non-Global Fund donor assistance. The following is an extract:

> ***Harm Reduction (Objective 1)***
>
> National guidelines on major components of harm reduction interventions (e.g. needle and syringe, condom marketing/distribution, and peer outreach) are under development based on the field experiences of the DFID and WB projects and international guidelines and best practices. GF-8 will follow the forthcoming national guidelines to ensure that programs are implemented consistently in all provinces. Provincial leadership will be supported to coordinate interventions to avoid geographic overlap and to ensure commodities are available for all programs.

Care and Treatment, PMTCT and Voluntary Counselling and Testing (VCT) (Objective 2)

The PEPFAR-funded LIFE-GAP project is committed to support comprehensive care and treatment including ART, PMTCT and VCT at provincial hospitals in 5 of the 10 GF-8 provinces through September 2010. In these provinces, GF-8 will support clinics only at district levels and refer patients with complications to LIFE-GAP-supported provincial hospitals following national procedures. GF-8 will also assume responsibility of provincial hospitals at the close of the LIFE-GAP project.

DOs and DON'Ts

DO describe how this proposal complements programmes financed through non-Global Fund resources.

DO describe how this proposal does not duplicate programmes financed through non-Global Fund resources.

DON'T simply list the programmes supported by other sources of funding; that's not enough.

4.4.9. Strategy to mitigate unintended consequences of additional program support on health systems

This is how the Kenya Round 7 HIV proposal described unintended consequences and how they were being addressed:

> The health system actions might also have some **negative effects** on the rest of the health system. There might be continued perception of HIV and AIDS programmes as being better funded than many other programmes. This could lead to some tensions among programmes. In addition, some actions proposed such as training health workers in delivery of services will sometimes take staff away from their jobs for periods. One way this proposal counters the negative effects is through channeling funds to CSOs, so that overwhelmed health services do not need to do all of the activities.

4.5. Program Sustainability

4.5.1. Strengthening capacity and processes in HIV service delivery to achieve improved health and social outcomes

To reiterate what the R10 Guidelines for Proposals say: In this section, you are being asked to describe how the strategies and activities of this proposal will strengthen existing institutions providing services – not only in the government sector, but also in the private and community sectors. If your proposal includes funding for management and technical assistance, details concerning this assistance should be provided in Section 4.7.5.

The following is how a Round 9 malaria proposal from the Cameroon CCM described how service delivery would be strengthened. Notice how the CCM described what the impact of its proposal would be at local, regional and national levels, and how this, in turn, would help to improve sustainability.

> The GF R9 proposal will be implemented by both the government and the civil society according to their relevant comparative advantage, there is thus a need for an overall strengthening of the capacity of all stakeholders in this proposal to ensure a common understanding and effect the delivery of relevant, effective and sustainable programs on malaria control in Cameroon.
>
> At the community level, this proposal will recruit 15,500 existing community-based organizations nationwide with large female membership. They will be trained on community integrated management of childhood illness, the malaria competence approach and supported with flip charts, posters and registers to conduct home visits, health talks, behavior mapping in favor of malaria control, distribute long-lasting insecticide-treated nets (LLINs), manage malaria at home and collect data. Involvement of these organizations will enhance access and use of malaria control services in the community and health facilities. Resource mobilization capacity of these organizations will also be strengthened so that they will be able to mobilize resources from other sources to ensure sustainability to continue their activities after the GF R9. Community based organizations will be integrated into the district management team where health information is shared on regularly basis.
>
> At the regional and health district levels, 184 civil society organizations (CSOs) will work in close collaboration with the National Malaria Control Program. They will also be trained on the malaria competence approach, project management, resource mobilization and data management. They will be supported to supervise community-based organizations (CBOs), monitor LLIN distribution and collate malaria control data.
>
> At the national level, this project will reinforce the National Health Information Management System by training health staff on the new M&E tool put in place to monitor malaria indicators. They will be supported to conduct integrated planning and supervision at all levels. The national Roll Back Malaria committee has not been organizing regular coordination meetings due to limited funds. To address this, GF R9 has made provisions for funds to enhance coordination and follow up of resolutions taken during meetings. Committee members will be trained on advocacy and resource mobilization in favor of malaria control.
>
> The Principal recipients and sub-recipients will all benefit from capacity enhancement since each partner will bring specific skills from their area of intervention and these will be shared with the other members to ensure a holistic package to be delivered in each of the regions under the supervision of MOH. They will be trained on project development and proposal writing in order to enable them mobilize resources to sustain their work. Also to ensure timely reporting and justification of funds used, they will be trained on financial management and followed up to ensure proper reporting. At the end of this project, there will exist CSOs with capacity to mobilize resources and continue the implementation of malaria control project.

Sustainability is emphasised in this extract from a Round 8 HIV proposal from Thailand:

> The Round 8 proposal was developed with sustainability in mind. First, closer working relationships between the provincial coordinating mechanisms and the CSOs will facilitate a better understanding of problems and responsibilities related to sustainability of most-at-risk populations (MARP) programs. Second, the National Security Health Office (NHSO) will fund some specific programs for MARPs through civil society and government organizations. Third, the partial implementation of the injection drug use (IDU) strategy through pharmacies provides a possibly cost-efficient and ultimately more sustainable method of delivering HIV prevention commodities to IDUs compared to relying solely on fixed site needle and syringe programs. Fourth, the proposed cost effectiveness studies will be used in developing the case with the NSHO and other budgetary agencies on maintaining sustainability of effective activities. This will be viewed as a key extension of the government health system. Finally, capacity building activities for CSOs are included to help develop skills for fundraising in the future.

DOs and DON'Ts

DO describe how this proposal will help to strengthen organisations providing services.

DO remember to include private and community organisations, not just public ones.

DO make the link between strengthened organisations and sustainability.

DON'T provide information on what technical assistance is included in your proposal; this belongs in Section 4.7.5.

DON'T use this space to list the objectives of your proposal. You need to concentrate on how your proposal will contribute to sustainability by strengthening institutions.

4.5.2 Alignment with broader development frameworks

With respect to Section 4.5.2(a), this is how a Round 9 HIV proposal from Georgia described how the proposal aligns with broader development frameworks:

> The current Round 9 proposal is based on the national strategic framework for the response to HIV/AIDS, built on the governmental commitment to achieve globally and nationally endorsed strategic objectives, as stated in:
>
> - Millennium Declaration & Millennium Development Goal (MDG) 6 to combat HIV/AIDS, malaria and other diseases. The programme also contributes indirectly towards the achievement of the Georgian national Millennium Development Goals (MDGs), namely: 1) MDG 1: Eradicate extreme poverty, 2) MDG 8: Develop a global partnership for development and 3) MDG 3: Promote gender equality and empower women.
> - HIV/AIDS prevention targets integral to the 1999-2010 National Health Policy and Strategy Plan.
> - UN Development Assistance Framework for 2006-2010, endorsed by the Government of Georgia and UN Georgia in 2005, and updated in 2006.
> - The HIV/AIDS programme targets – Three Ones principles
>
> Indirectly, this project also contributes to *"National Economic Growth and Poverty Reduction Strategy"* of Georgia through protecting human capital (an identified priority in the strategy) as well as through relieving financial burden of illness from the population.

The R10 Guidelines for Proposals say that the applicant should describe how the broader development frameworks may be related to the capacity to absorb further potential resources from the Global Fund. It is not clear what this means.

With respect to Section 4.5.2(b), the following extract from a Round 9 proposal from the Southern African Development Community (SADC) Secretariat described how the proposal complements other regional initiatives:

> This Proposal is specifically aligned with the emergent "SADC HIV and AIDS Strategic Framework: 2009-2015," expected to be adopted in mid-2009, and the "Policy Framework for Population Mobility and Communicable Diseases in the SADC Region", issued in April 2009, and expected to be adopted in mid-2009 as well. The guiding principles of these two documents comprise an emphasis on areas of comparative advantage for a regional response to HIV and AIDS, multisectorality and partnerships, gender sensitivity, building responses on a strong evidence base, respect for human rights, and a commitment to the participation of people in the regional response.
>
> This initiative will integrate with previous initiatives [the initiatives are named] in three practical ways:
> 1. Under activities associated with objectives 1 and 2, a review of existing and emergent policies will take place, and decisions made on alignment as regards mobile populations.
> 2. Under activities associated with Objective 3, progress made in systems strengthening for M&E will be further elaborated.
> 3. Under activities associated with Objective 4, an inventory of existing and planned initiatives that affect mobile populations will also take place, and decisions made on complementarity and mechanisms to work together as possible.

4.5.3 Improving value for money

This is new for Round 10. See the information on this in *Chapter 2: What's New for Round 10?*

"Value for money" sounds simple, but it actually a complicated concept (as the guidance in the R10 Guidelines for Proposals clearly demonstrates!).

We suggest you think of "value for money" as "getting the best bang for your buck" – not in the sense of buying the cheapest product available, but in the sense of getting the most impact (or value) for money spent. This is very similar to saying "getting the 'best balance of costs and effectiveness,' " which is the wording used on the proposal form.

We suggest that you describe as best you can how the key interventions in your proposal represent the best balance of costs and effectiveness, and that you describe any information gaps that may prevent you from answering this question as fully as you might like.

We note that this information is not critical to your proposal – "the TRP will not penalize applicants for not providing this evidence in Round 10" – but it sounds like this concept will be around for a while, so perhaps this a good time to become familiar with it.

4.6. Monitoring and Evaluation System

4.6.1 Impact and outcome measurement systems

This is how a Round 8 HIV proposal from Nicaragua described the strengths and weaknesses of the national M&E systems:

Strong points:

1. The decentralization of the HIV program (component) in the country's 17 departments, to be headed by one person in each department.
2. The existence of Surveillance and Monitoring Units in the 17 departments, and a delegation with specific monitoring functions for healthcare personnel in the 153 municipalities forming part of these departments.
3. The political will of members of CONISIDA (national AIDS committee) to provide a structure for the single monitoring and evaluation unit, part of the national response to the HIV epidemic, in compliance with the Three Ones system.
4. The support of Cooperación Externa (external cooperation) for the development of the monitoring and evaluation processes of the national response to the HIV epidemic, leading to the commencement of the formulation of the Monitoring Plan for the National Response to the epidemic.

Weak points:

1. Not all members of CONISIDA have monitoring and evaluation units in their institutions, as part of the response to the HIV epidemic.
2. The absence of links between monitoring and surveillance procedures in the healthcare sector, alternative centres and civil society.
3. Incomplete registration of all indicators established by UNGASS (UN General Assembly Special Session on HIV/AIDS).
4. Insufficient analysis of existing data from the surveillance system, and the failure to link this data with possible determining factors for the epidemic.
5. The failure to register risky behavior in key populations: Transsexuals, men who have sex with men (MSM), indigenous peoples, orphans.
6. Insufficient monitoring of adherence to antiretroviral therapy.

You are also asked to describe the impact and outcome measurements systems themselves.

DOs and DON'Ts

DO describe the strengths of the country's M&E systems.

DO describe the weaknesses of the country's M&E systems.

DON'T describe the in-country M&E systems in detail; this would be overkill and, anyway, space is limited.

4.6.3 Links with national M&E systems

With respect to 4.6.3(a), this is how a Round 8 malaria proposal from Ethiopia described how the M&E arrangements for this proposal would use existing national indicators, data collection tools and reporting systems:

> The M&E arrangements in this proposal will use the current and revised Health Management Information Systems (HMIS) and Integrated Disease Surveillance and Response (IDSR) systems. Data are collected on a weekly, monthly, quarterly and annual basis based on the malaria transmission season; HMIS extends its data collection up to the lowest health system (i.e. health posts). In addition, data will be collected through large scale surveys such as the Demographic and Health Survey (DHS), the Malaria Indicator Survey (MIS) and the integrated health facility-based survey. DHS is conducted every five years and MIS is conducted usually every two years. The HMIS report will include five malaria-related indicators. M&E activities, as planned in this proposal, will integrate into and strengthen existing reporting systems so that they are used at all levels.
>
> There will not be a duplication or parallel reporting by PR and SRs, as most of the active partners of the Federal Ministry of Health have signed a code of conduct to stick to one plan, one budget and one report. In addition, the indicators chosen for reporting on in this proposal are those that can be collected with ease from the existing systems and approaches by all implementing partners.

With respect to 4.6.3(c), this question is worded a little differently compared to the proposal forms used in previous rounds. For example, this is the first time applicants are being asked to list SDAs here. Nevertheless, the following extracts from a Round 8 Indonesia TB proposal provides a sense of what the Global Fund is looking for here:

> Achievement of most SDAs in this proposal can be measured with the current uniform reporting system. However, for the new activities, slight adjustments are needed. For example, at the community level, a simple referral slip will be introduced to monitor effectiveness of the community TB care activities for identification and referral of people suspected to have TB. At the health facility level, the referral slip will be kept by the health facility and the source of referral will be recorded in existing registers. This information will enable the health facility to measure contribution of community, cadre, village clinics or private practitioners or other providers in case finding and case holding.

4.6.4 Strengthening monitoring and evaluation systems

With respect to 4.6.4(c), this is how a Round 8 malaria proposal from Ethiopia described how the proposal would strengthen national M&E systems:

> A comprehensive program M&E system to evaluate the performance of proposed malaria program activities is included (**see SDA 6**). Activities outlined under this service delivery area will not only significantly increase the capacity in program M&E, but will also ensure that the impact of planned program activities are appropriately evaluated, analyzed and documented.

M&E system gaps	Plan to overcome capacity gaps
Insufficient information on operational aspects of key malaria interventions such as the susceptibility of mosquitoes to DDT, susceptibility of malaria parasite to the drugs, longevity of long-lasting insecticide-treated nets (LLINs) under field conditions, and knowledge, attitudes and practices (KAP) on malaria interventions and services.	With the support from this Round 8 proposal; operational research will be conducted at regular intervals to inform the program on the efficacy of drugs and insecticides, longevity of LLINs and community KAP of key malaria interventions. The operational studies will be carried out at regular intervals in 25 of the 50 sentinel sites. In addition monitoring the longevity of LLINs collected around all sentinel sites will be done.
Lack of baseline and follow-up information on the magnitude of malaria, coverage of key malaria interventions and impact of the interventions.	The Federal Ministry of Health (FMOH), in collaboration with in-country partners, has conducted the first nationwide MIS in October-December 2007. In order to gauge the progress in coverage of the interventions and their impact on disease burden, follow-up MISs will be carried out in 2010 and 2013, and funding for this activity is sought under this proposal.
Weak and/or irregular program reviews at zone/district levels	Based on successful experiences of conducting annual meetings at national and regional levels to review the progress of the implementation of planned activities, the zones and districts, as the frontline implementers, will carry out bi- annual review meetings. All partners will participate, reports will be examined in relation to annual plans and actions will be recommended.
Underdeveloped malaria commodities tracking and logistics information system	In line with the Logistics Master Plan developed by the FMOH, the malaria commodities tracking system will be strengthened through funding included in this proposal. Appropriate guidelines, formats and databases will be used to make this initiative operational, as outlined in **SDA 6** and the attached budget sheet of this proposal.

See also:

Indonesia HIV (8), Nicaragua HIV (8), Mozambique malaria (9), Papua New Guinea malaria (8), Indonesia TB (8)

Links to these proposals are provided in Aidspan's *Key Strengths of Round 8 and 9 Proposals to the Global Fund*, available at www.aidspan.org/aidspanpublications. See Key Strength 7.

4.7. Implementation Capacity

4.7.1 Principal Recipient(s)

In its Round 9 malaria proposal, the Cambodia CCM described the capacities of its nominated PR. The following is an edited extract. Note that the applicant went beyond describing financial, managerial and technical capacities, and added human and physical capacities.

> The National Center for Parasitology, Entomology, and Malaria Control (CNM) is one of the three national centers for priority disease control in Cambodia. CNM is responsible for strategic planning for malaria, dengue and dengue hemorrhagic fever, schistosomiasis, helminthiasis, and filariasis. CNM also operates the national malaria reference laboratory and conducts a wide range of operational research projects in collaboration with non-governmental partners.
>
> The CNM is divided into two bureaus: the Administrative and Financial Bureau and the Technical Bureau. The Administrative and Financial Bureau is involved in administration, finance and logistics. It is also home to CNM's Procurement Department, which is responsible for the procurement of drugs, commodities, equipment, and goods required by the program. The Technical Bureau oversees treatment, training and supervision for the five disease specific units. The malaria unit is the largest of the five, accounting for 75 percent of the Technical Bureau's staff.
>
> Previous GF Rounds for the malaria component have contributed significantly to improving capacity at the national program office. Currently, CNM has sufficient human, physical, financial, managerial and technical capacities for assuming the additional responsibilities of the PR for this GF Round 9 Proposal.
>
> **Human Capacity:**
> With more than 90 employees, CNM is one of the largest national programs in Cambodia. Key staff members have studied at reputable institutions in Cambodia and abroad. CNM's staff members are trained in a broad range of skills, including project management, malaria case management, vector control, financial accounting, monitoring and evaluation, epidemiology, and research techniques. To handle the additional responsibilities related to being the PR under RCC, CNM will employ 19 staff to conduct financial/project management, procurement, and program monitoring and evaluation. CNM will also receive critical technical assistance from its partners.
>
> **Physical Capacity:**
> Under the Health Strengthening Support Program (HSSP) funded by DFID and WB, CNM has increased its physical capacity to handle its new responsibilities as PR. Construction of a new building (attached to the existing Center) will provide additional space for conferences and offices. Construction was completed in early 2008.
>
> **Financial Capacity:**
> CNM has capable finance and accounting officers with extensive experience managing multi-source funds. CNM is the largest sub-recipient in malaria Global Fund grants and will directly manage 4.1M (out of 9.9M) under R2, 3.8M (out of 9.7M) under R4, and approximately 19.9M (out of 31.1M) under R6. In 2007, CNM managed an additional 2.98M from other (non-Global Fund) internal and external funding sources [sources named]. Staff in CNM's finance unit is trained to use both QuickBooks and Excel.
>
> **Managerial/Coordination Capacity:**
> As a major sub-recipient under GF malaria component Rounds 2, 4, and 6, CNM has demonstrated its ability to implement its own programs as well as manage programs with 7 sub-sub recipients. CNM has also been responsible for coordinating malaria-related projects with a number of other government departments and ministries as well as with non-

governmental and bilateral/multilateral partners. Staff at the CNM is active in coordination bodies in Cambodia involving NGOs and ministries.

Technical Capacity:
In previous Global Fund Rounds, significant resources have been invested in improving the technical capacity of staff at CNM. Currently, there is staff at CNM with substantial technical expertise in vector control, behavior change communication, health education, and entomology, which will be beneficial for providing support to SRs during implementation. Under grants from Round 6 and RCC, two TAs will also be placed within CNM to provide technical input, assist CNM, and ensure local capacity is built to take over their responsibilities in a phased manner. CNM already has an established M&E mechanism meeting the needs of the national program, Global Fund, and other donors. M&E tools and standardized formats and reports will continue to be revised to meet changing needs by CNM and in collaboration with government staff at all levels and major partners.

DOs and DON'Ts

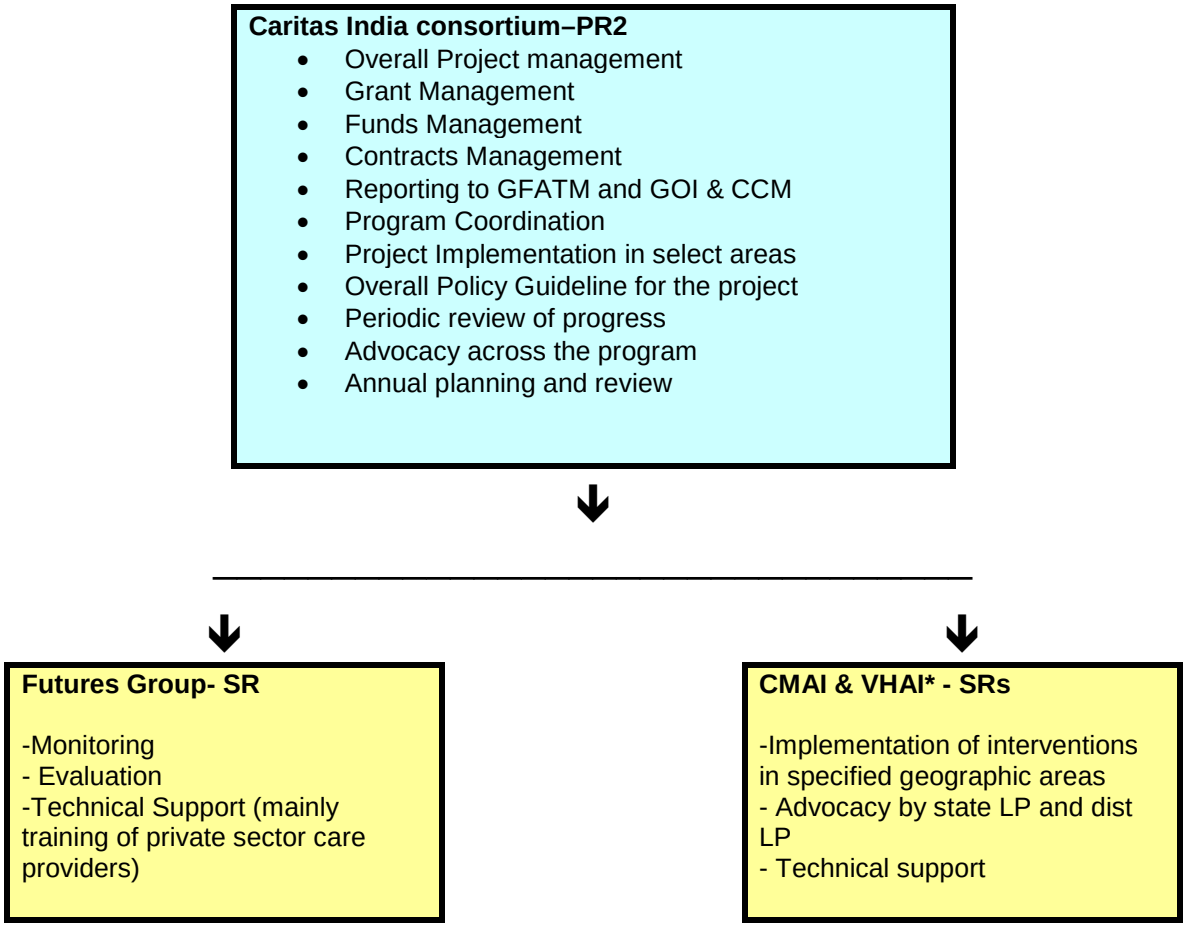
DO describe anticipated limitations to strong performance, if there are any. You will not "lose points" for this. But make sure that you include measures to address these limitations in Section 4.7.5.

DON'T include annexes documenting the educational levels of PR staff. This is overkill. The TRP seldom looks at annexes anyhow.

DON'T describe how the programme in your proposal will be coordinated; that's not what you are being asked here.

4.7.2 Sub-recipients

With respect to 4.7.2(e), this is how a Round 9 malaria proposal from India described the work to be undertaken by the two sub-recipients under one of the two nominated PRs:



* Christian Medical Association of India, and Voluntary Health Association of India

The following extract, adapted from Mozambique's Round 7 TB proposal, illustrates how the implementation experience of an SR can be described:

> Health Alliance International (HAI)
>
> The key element of HAI's approach involves partnering with Ministries of Health (MOH) to strengthen existing services and promote innovative new programs. HAI technical staff share offices and work side by side with local health system counterparts to develop and implement programs and services for integration into MOH strategies.
>
> This year HAI marks 20 years of supporting the MOH in Manica province, and 10 years in Sofala province, in the provision of clinical care, promotion of public health management, and the support of community linkages with health services. In 2007 HAI began supporting provincial health authorities in Tete and Nampula provinces. Activities have included general support for Primary Health Care, HIV/AIDS control (including integration with TB control activities), building laboratory capacity, integrated management of antenatal care, malaria control, child survival, among others..

> Since the inception of the National Strategic Plan for HIV/AIDS, HAI has collaborated with the Provincial Health Authorities in the design and implementation of the various components of HIV, including care and treatment for HIV/AIDS, voluntary counselling and testing (VCT), prevention of mother-to-child transmission (PMTCT), STI management (with a focus on pregnancy), home-based care (HBC), and general laboratory support….
>
> HAI has a strong financial and administrative management capacity to support the achievement of program goals. HAI's 2007 Mozambique budget totals over $12,000,000 USD, financed by over 8 different funding sources including the MOH Common Fund. HAI has had a flawless audit record with no findings within the last 15 years, and is widely regarded as having an efficient financial management system.

If you have a large number of SRs, we suggest that you describe the experience of the major SRs along the lines of the above extract, and that you provide 2-3 line summaries for each of the smaller ones. The following extract from a Round 9 HIV proposal from Tanzania illustrates how the latter can be done:

> **Institute of Developing Studies**
> IDS has qualified and experienced staff in conducting research in HIV/ AIDS and Gender dimension. IDS has the technical and financial capacity.
>
> **Vision in Action in Partnership**
> Has experience with donor funding from USAID, World Food Programs and UNICEF focusing on strengthening families affected with AIDS. In addition to this it has created a partnership to work with Diocese of Tanganyika and Faraja Centre.
>
> **Afya Media**
> Has financial policy and sub-granting experience of handling donor grants to from Rapid Funding Envelope. Has radio facilities which for HIV, Malaria and TB programs.

The following extract from a Round 9 HIV proposal from South Africa provides an explanation for how challenges that could affect performance will be addressed:

> Our description illustrates the strong capacity that exists in the PR and SR institutions. Where there is evidence of lack of capacity, remedial measure have been instituted. The NGOs lack capacity in behaviour change communication (BCC), thus a BCC Technical Adviser would be employed for 2 years to provide technical assistance to all SRs in BCC activities. Also the 2 PRs and all SRs need additional capacity in financial management and this training has been built into the proposal. Project implementation in most SDAs include orientation PRs and SRs personnel engaged in grant management and initial training of service delivery personnel, thus attending to all capacity gaps.

Section 4.7.2(f) is new for Round 10. Asking for an explanation of why the private sector or civil society are not involved as SRs, or involved in only a limited way, if that is indeed the case, is the Global Fund's way of saying that these sectors ought to be significantly involved in programme implementation.

See also:

Gabon HIV (8)

Links to this proposal are provided in Aidspan's *Key Strengths of Round 8 and 9 Proposals to the Global Fund*, available at www.aidspan.org/aidspanpublications. See Key Strength 1.

4.7.3 Sub-recipients to be identified

The following extract shows how a Round 9 TB proposal from Serbia explained why not all SRs had been identified yet, and what the process would be for selecting additional SRs. (Note, however, that in its guidance the Global Fund is sending a message that it strongly prefers most or all SRs to be identified before proposal submission.)

> For providing services related to Directly Observed Treatment (DOT) in continuation phase, the PR will make contracts with those TB units on which territory there are MDR TB patients for treatment in continuation phase. These contracts will regulate the way of service delivery and usage of incentives for patients and/or staff providing DOT.
>
> According to home addresses of currently registered MDR TB patients, there are 23 different TB units which will be in charge for providing DOT in continuation phase of MDR TB treatment. Of course, as these patients complete there treatment over time, the engagement of specific TB unit can stop if there are no new MDR TB cases in that area, and other can be engaged where MDR TB appear. In addition more SRs will be engaged for the work with vulnerable and hard-to-reach populations. The CCM estimated that identifying all sub-recipients at this point would not be appropriate, since it may reduce chances for new recipients that may appear at the time when the R9 starts.
>
> At the initiation of the program, CCM will issue call for proposals for implementation of activities envisioned in this program that will be opened for potential implementing agencies from governmental and non-governmental sector. The process will consist of the following steps:
>
> 1. Open the public call for proposals, requesting proposals for implementation of activities under particular SDAs.
> 2. CCM will establish an independent technical review panel (TRP) that will evaluate proposals and recommend them for approval to CCM. The panel will be assembled of representatives of national institutions and civil society representatives, bearing in mind the sensitivity of the thematic areas and relevant expertise of the selection committee.
> 3. TRP will assess all the proposals from technical point of view, and according to the below selection criteria.
> 4. TRP will recommend proposals to CCM for approval along with the detailed and revised work-plan for the first two year of the program implementation.
>
> The following selection criteria will be used for evaluating received proposals:
>
> 1. Organizational structure, experience, expertise and records:
>
> - Experience and expertise in implementation of similar projects and with the outlined target groups
> - Track record of implementing large scale programs with variety of donors
> - Outstanding audits and/or evaluations from similar projects/initiatives and/or general organization's work
> - Consistency of mission, mandate and values of the NGOs with the CCM and GF standards and values
> - NGOs transparency in policies, activities, structure, affiliation and funding
> - Proven sound human resources, financial management and control mechanisms, core funding and donor history
> - Documented history of cooperation with other agencies including local health care institutions
> - Scope of work and geographical focus

2. Thematic area expertise and experience:

- Record of projects and initiatives developed with and for the specific target groups or within the thematic area
- Experience and expertise in implementation of similar projects
- Capacity to implement the project agreement
- Participatory approach to planning, implementation and management of projects
- Proven understanding and sensitivity towards the target group
- Active engagement of NGO in networks and alliances, including local community
- Engagement of NGO in policy making and advocacy in the relevant field
- Clear position of NGO on non-discrimination and promotion of human rights-based approaches
- Visibility and credibility of organization in local community or government

4.7.4 Coordination between or among implementers

This how a Round 9 HIV proposal from Myanmar described coordination arrangements:

> This proposal includes two PRs. Save the Children will take responsibility for all SRs who are International NGOs. UNOPS will manage the government institutions and national NGOs. A number of SDAs have SRs from both PRs implementing activities. The responsibilities of each PR are clearly delineated and targets for indicators under specific indicators are split between the two PRs to allow the GF to track the progress and assess the performance of the PRs.
>
> A **PR Coordination Committee** will be formed that will include the Project Directors from the two PRs and other senior staff members from the two PRs. The CCM will be asked to identify a member to participate as an observer, and UN Technical agencies (UNAIDS and WHO) and a representative from the Three Diseases Fund will be invited as observers as well to maximize effective coordination among key stakeholders. The PR Coordination Committee will meet a minimum of monthly (and more frequently on an as needed basis, especially during grant start-up).
>
> The PRs will conduct joint training at the outset of the project in M&E for SRs. Training on procurement planning and monitoring will also be conducted. In order to ensure consistent planning and reporting to the GF, the PRs will conduct semi-annual project review meetings together with all SRs present throughout the life of the project.
>
> The PRs will conduct joint monitoring several times a year to townships where activities overlap. This will ensure that coordination issues at township level are being identified and addressed jointly. It will also assist in identifying potential areas of overlaps in service provision which will be used to improve the planning of service delivery.

See also:

Democratic Republic of Congo HIV (8), Gambia HIV (8), Cameroon malaria (9)

Links to these proposals are provided in Aidspan's *Key Strengths of Round 8 and 9 Proposals to the Global Fund*, available at www.aidspan.org/aidspanpublications. See Key Strength 9.

4.7.5 Strengthening implementation capacity

This question has been significantly re-worded for Round 10.

The Global Fund is recommending that applicants devote between 3% and 5% of their proposal budget to technical assistance (TA).[5] In addition, the Global Fund says that applicants whose proposals are approved for funding will need to prepare a TA Plan; however, the TA Plan itself does not have to be submitted with the proposal. See *Chapter 2: What's New for Round 10?* and the R10 Guidelines for Proposals for more information on this topic.

In 4.7.5(a), you need to provide a summary of the TA that in included in your proposal (in the table provided). The sample table in the R10 Guidelines for Proposals explains what information is required.

The following edited extract from a Round 9 malaria proposal from Cameroon provides some of the information that is requested, and some that it not requested (the questions were worded differently then):

> In this proposal, to ensure strong programme performance, it is planned:
>
> 1. **Technical assistance in training, procurement supply management, and resources mobilization:**
>
> The PRs and SRs will have staff recruited for the purpose of this project and they will be trained on project management with emphasis on timely reporting, accountability and transparency. External technical support will be required for this training.
>
> The PRs and SRs will require technical support on the procurement and supply management (PSM). Technical support will be needed to guide the bulk purchase of long-lasting insecticide-treated nets (LLINs) and rapid diagnostic tests (RDTs) and their supply to the health district level from where they will be distributed to communities. PSM support will also be needed for the follow up LLIN deliveries following the large scale campaign for years 2011-2014, to ensure that communities are provided with the nets they require to maintain 100% universal coverage. Technical support will also be needed for the mass campaign foreseen in this project, where all parts of the country will be covered at the same time in the LLIN distribution during a period of one week.
>
> The project plans to strengthen the capacity of CSOs in management, governance and resource mobilization. In order to carry out this activity, there is a need for external technical support in the form of training on institutional development and mentorship.
>
> PRs and SRs will require technical assistance in finance management to ensure proper management, justification and reporting to ensure timely disbursement of GF funds. All PRs and SRs will be trained by external experts and the former will subsequently train community organisations. PRs will require adequate regular auditing from accredited organizations to ensure accountability and transparency throughout the project implementation period. Once strengthened, the PRs will also help support the SRs for audits and inventories – where required.

[5] This is just a recommendation. In its FAQs for Round 10, the Global Fund says the request can be outside this range if the country context warrants it.

2. **Process used to identify needs within the various sectors:**

The aforementioned needs for technical assistance were identified from the following:

a. Evaluation of the M&E system of the National Malaria Control Programme (NMCP) carried out in November 2007

b. The NMCP 2007-2010 National Strategic Plan

c. Internal reviews of respective PRs and SRs

d. The NMCP annual report 2008

Following further organizational capacity assessments, any other gaps identified for each of the PRs and SRs will also be addressed.

3. **Technical assistance will be obtained on competitive, transparent terms:**

Technical assistance from Roll Back Malaria (RBM) and the GF will be requested directly from these organizations. Meanwhile other technical backstopping will be obtained through international/national call for tenders as necessary.

4. **Process that will be used to evaluate the effectiveness of that assistance, and make adjustments to maintain a high standard of support:**

Baseline review, mid-term and final evaluations of malaria indicators will measure the efficacy of the technical support offered to this project. Qualitative research will be carried out to examine bottlenecks and/or areas needing more support to ensure proper project performance.

See also:

Chad HIV (8), Moldova HIV (8), Thailand HIV (8), Belarus TB (9), Tajikistan TB (8)

Links to these proposals are provided in Aidspan's *Key Strengths of Round 8 and 9 Proposals to the Global Fund*, available at www.aidspan.org/aidspanpublications. See Key Strength 4.

4.8. Pharmaceutical and Other Health Products

4.8.4 Alignment with existing systems

This is how a Round 8 malaria proposal from Ethiopia described how and to what extent the planned programmes will use existing country systems:

> The management of additional pharmaceuticals and health products included in this proposal will mainly uses the existing in-country systems. Accordingly, the Pharmaceutical Funds and Supply Agency (PFSA) has been given the role and responsibility of handling and coordinating the overall procurement and supply management of health products in the country since 2007. The establishment of this agency is based on the Federal Ministry of Health's (FMOH) five-year Logistic Master Plan, which calls for the establishment of a new health commodities supply system for the public sector in Ethiopia. Thus, the new distribution structure will emphasize logistics efficiency by using a hub warehouse network system based on population density, geography and routing. Warehousing and transport costs are balanced and logistics capacity is concentrated in a relatively small number of hubs. Thus, the warehouse system consists of primary warehouse and secondary houses, which are distinguished based on geographical location and accessibility as well as population catchment area (the former usually serving a larger catchment area than the latter).
>
> All the health products included in this proposal will be procured through the PFSA. However, whenever the agency finds that it has not enough capacity to handle the procurement of certain items, or when it identifies bottlenecks that might delay the process, it will outsource the procurement to other capable agents such as UNICEF (as done, for example, for Round 2 and 5 grants). As PFSA is accountable to FMOH, it will work closely in identifications of the needs, planning of procurement and distribution of the products. Storage and delivery of the products to the beneficiaries also uses the existing system.
>
> The other existing government entity of relevance is the Drug Administration and Control Authority (DACA), which is fully accountable to the FMOH. DACA is responsible for the control of the quality of all health products, product registration as well as pharmacovigilance. It has a well structured system for follow-up of pharmacovigilance, including anti-malarial drugs.

4.8.5. Storage and distribution systems

With respect to item (b), storage capacity, this is how it was described in Azerbaijan's Round 7 TB proposal:

> The Research Institute of Lung Diseases (RILD), in its capacity as the National TB Programme (NTP) Central Unit (CU), is responsible for customs clearance, storage and inventory management of drugs and other health commodities and products within the National TB Programme, including those to be supplied with the Global Fund support. The procedure of airport storage, customs clearance and pick-up by the NTP CU has been functioning properly.
>
> At present, 1st line anti-TB drugs are stored at the central storage facility. At present, the capacity of this facility meets the current volume and conditions of storage; however, it needs renovation in view of increasing demand (in terms of space, temperature and humidity control, etc.), e.g. due to the need to accommodate the new deliveries of drugs and consumables for drug resistant (DR) TB management, requested in this proposal.
>
> The in-patient treatment sites for DR-TB patients (on the current premises of RILD and Baku City Dispensary No. 6) will be renovated and proper storage conditions will be ensured. At the fourth site, in the penitentiary sector, these conditions are already in place; the DR-TB ward in the penitentiary sector was recently renovated. As some of the second-line drugs to be used in Category IV treatment require special storage conditions (i.e. refrigerators), procurement of cold chain equipment is foreseen in this project (for in-patient treatment delivery sites as well as for out-patient facilities where the patients will be treated during continuation phase).

Section 4.8.5(b) says that if this proposal represents a significant change in the volume of products to be stored, the applicant should estimate the relative change in percentage terms, and should describe the plans for increasing the capacity. This is how a Round 9 HIV proposal from Benin responded:

> The present proposal must include an increase in the storage needs for CAME (the Essential Drugs Purchasing Agency) which can be estimated in terms of a percentage of about 15% in view of the volume of products to be acquired. The current storage capacities in CAME are already insufficient if the current needs and its purpose as serving as a storage point for products from the various national programmes are taken into account. This lack of space leads to a situation which no longer meets the good practice requirements for storage. The CAME storage areas will become insufficient with regards the quantity of products to be managed in view of its ever increasing partnership network and this, due to an increase in the health requirements in the country. Thus, CAME is more often renting stores to store its products. In order to alleviate this situation, CAME has built a large depot as an extension to its storage areas in the north of Cotonou. Within the present proposal, steps are being taken to restructure the CAME central warehouses, the regional warehouses at Parakou and Natitingou and the dispatch depots in the 34 health districts so as to increase their storage capacities and to make sure that they fall within the standards for Good Practice of Storage and Distribution. Moreover, a relocation of the CAME head office is planned, which will allow the current head office to be transformed into a regional depot which will serve the health care facilities in the south.

Section 4.8.5(c), about distribution capacity, can be answered in a way that is similar to the extracts above for (a) and (b).

SECTION 5: FUNDING REQUEST

5.1 Financial Gap Analysis

The table that leads off Section 5.1 is quite straightforward, but some applicants may be confused by the attempt to have the table apply to both regular and consolidated proposals. Section D, in particular, may cause confusion, given the profusion of D1s, D2s, D1-As, etc.

Applicants submitting a regular proposal should just ignore the parts of the table that relate to applicants submitting a consolidated proposal (what the Global Fund refers to as Option 1). If they are able to do so, they should have no problem.

Applicants submitting a consolidated proposal should read the guidance for this item in the R10 Guidelines for Proposals very carefully.

Note to MARP applicants: Remember that there is a ceiling on the amount of money you can request: $5 million for the first two years, and $12.5 million over the proposal lifetime.

5.1.1 Explanation of financial needs and additionality of Global Fund financing

This is how a Round 9 HIV proposal from Myanmar responded to 5.1.1(a) and (b):

> The resource needs for 2007-2010 are taken from the costed and prioritized Operational Plans of the National Strategic Plan (2006-2009 and 2008-2010). The Operational Plan includes packages of services for different areas of interventions as well as intended national targets for these interventions. The package of services is costed in order to be able to calculate national resource needs.
>
> The unit costs for major interventions of the National Strategic Plan were developed in respective Working Groups under the Technical and Strategy Group on AIDS, which serves as the multi-stakeholder coordination mechanism for HIV in the country. For 2011-2014, the estimated resource needs have been calculated using the same unit costs and assuming a continuing scale up for the number of people reached with prevention as well as treatment programs.
>
> The inclusion of government, non-government and community based organizations in the planning process (Working Groups and Technical and Strategy Group on AIDS) ensures that the needs of all constituencies are included….

Section 5.1.1(c) is new for Round 10; it relates to the "additionality" mentioned in the heading of this section. You are being asked to describe how the funding being requested in this proposal will contribute to programme outcomes that would not be possible if the countries included in this proposal had to rely on currently available or planned domestic resources.

5.1.2 Applicant funding

The wording of 5.1.2(a) is awkward. We suggest that you follow the guidance in the R10 Guidelines for Proposal – i.e., "The applicant should describe the current and planned resources to meet the funding needs of the regional disease program represented through the multi-country proposal."

This is how a Round 8 HIV proposal from Zambia responded to part (b) of this question:

> The Government has developed systems to ensure efficient, transparent and equitable utilisation of resources, e.g.:
>
> - Quarterly funding profile submitted to Ministry of Finance and National Planning showing funding priorities for the upcoming quarter as well as utilisation of prior quarter resources.
> - HIV and AIDS Sector Advisory Group comprising stakeholders from the public sector, cooperating partners, private sector and civil society. This Group will review and provide advice on programme implementation, resource utilisation and availability. It meets biannually.
> - Funding to sub national levels by Ministry of Health is done on a need based Resource Allocation Formula. This Formula takes account of population index, material deprivation index, remoteness of districts etc to ensure there is equity in distribution of resources.
> - The country has a National Monitoring and Evaluation Framework to ensure a uniform M&E system for all institutions working in HIV and AIDS.
>
> The HIV and AIDS Sector performs an annual Joint Annual Programme Review to monitor and evaluate the progress and activities of the previous year. The results of the review inform planning for the succeeding planning and implementation periods at national, provincial and district levels.
>
> On a monthly basis, National AIDS Reporting Forms are completed by all districts and provinces and submitted to the national M&E systems to show the performance for the reporting periods to show the performance and indicate areas where correction or adjustment in implementation may be needed.

5.1.3 External funding

This is how a Round 8 HIV proposal from Zambia described expected changes to external financial contributions to the national programme:

> The financial gap analysis which informed the budget took into account any anticipated reductions in external funding over the proposal term. In this context, the major external funding that will affect programme implementation is the World Bank-funded ZANARA project (National Response to HIV/AIDS), which has come to a close. The intent is to continue with the activities of the ZANARA project, particularly the Community Response to AIDS (CRAIDS) aspect of it, by placing this initiative under two PRs for this proposal, so as not to lose the gains made by the CRAIDS project over a five-year period.
>
> The PEPFAR programme (U.S. President's Emergency Plan for AIDS Relief) is coming to an end. PEPFAR has been a major contributor to provision of HIV and AIDS in Zambia. While there has been discussion about the commencement of a replacement programme (PEPFAR II), it is not certain when this will commence and the level of resources that would be available under this programme. In the financial needs analysis, it has however been assumed that funding will continue at current levels.

5.2 Detailed Budget

Key Strengths of Rounds 8 and 9 Proposals to the Global Fund, produced by Aidspan, cites two Round 8 proposals that the TRP praised as having particularly strong budgets: Ethiopia (malaria), and Madagascar (TB). Copies of these budgets are available at:

www.aidspan.org/documents/globalfund/trp/round_8/Madagascar-TB-Budget.xls
www.aidspan.org/documents/globalfund/trp/round_8/Madagascar-TB-Budget.xls

The full Aidspan report is available at www.aidspan.org/aidspanpublications.

5.4. Summary of Detailed Budget by Cost Category

5.4.1 Overall budget context

This is how a Round 8 HIV proposal from Indonesia explained variations in cost categories by year, and significant five-year totals:

> There are variations in cost categories for the last year due to high targets in the last year; corresponding cost for supplies; and cost for IBBS (Integrated Bio-Behavioural Survey), impact studies, and audit. The five-year total for procurement and supply is US$ 39,102,140, which represent 30% of the total grant amount. [breakdown provided]
>
> Another significant five-year total is the overall management budget including requests for technical assistance and M&E for the three PRs, at US$ 26,273,806. The proposal development team considered the need to provide additional assistance to the civil society PR as this is the first time that an Indonesian civil society entity will manage a Global Fund grant for AIDS. It is critical that this new PR receives optimal support in order to provide an opportunity to civil society in Indonesia to gain adequate grant management skills and become stronger in program implementation. If this PR performs well, it will demonstrate that there is local capacity to manage large grants, not limited only to the Global Fund.

5.4.2 Human resources

Section 5.4.2(a) is new for Round 10. It reflects concern on the part of the Global Fund that some salaries paid with, or topped-up by, money from the Fund may have been out of line – i.e., inconsistent with current compensation in the heath sector in that country.

With respect to 5.4.2(b), this is how a Round 8 malaria proposal from Swaziland responded to this question:

> As Swaziland scales up interventions as part of its transition from malaria control to malaria elimination, there needs to be a significant increase in human resource capacity for implementation, particularly in the scale-up of surveillance activities. Additionally, investments in human resources promote the long-term sustainment of an effective malaria elimination strategy.
>
> Table 1 outlines the human resource needs outlined in this proposal. All of the Full-Time Employees (FTEs) will be hired within the first year of proposal implementation based on pay rates of existing FTEs performing similar functions within the Swaziland government. Increasing pay rates over the 5 years accounts for an inflation rate of 10% in Swaziland. All contractors except for KAP (knowledge, attitudes, practices) survey analysts and collectors are hired on a recurring annually basis; KAP survey analysts and collectors will be hired biennially. Pay rates for contractors are also based on existing rates. Because consistent human resources are necessary to implement and maintain a comprehensive malaria program, the cost for these resources remains constant over the five years.
>
> [Table 1 is not reproduced here.]

5.4.3 Other large expenditure items

This is how a Round 8 HIV proposal from Indonesia explained other cost categories that represent significant amounts:

> A significant expenditure amount is the request for procurement of 4 PCR (polymerase chain reaction) machines and 1 sequencing machine. 1 PCR machine is US$120,000 and 1 sequencing machine is US$220,000. This is identified as a critical health equipment to prevent, diagnose, treat and manage HIV.
>
> Procurement of 4 PCR machines for measuring viral load: There are only 2 PCR machines that serve the whole country. This is inadequate to serve all the needs of different parts of the country. In order to improve response time and better provision of care to antiretroviral therapy patients, it is proposed that key services are decentralized to regional level.
>
> One sequencing machine for determining HIV drug resistance: Currently, Indonesia does not have this machine and all samples for determining drug resistance are sent abroad. This is very expensive and also time consuming. The prevalence of transmitted HIV drug resistance to all drugs and drug classes evaluated is less than 5%. To monitor drug resistance and effectively manage preventive measures, appropriate laboratory equipment is necessary.
>
> Another significant expenditure amount is the cost of the development of a supply management system (web-based information system/ database) that will serve as management tool for regional and central level supply management. This is estimated to cost around US$ 300,000 (software development and installation US$ 100,000; system design fee US$ 50,000; systems maintenance and data management costs US$ 150,000). This is under the health system strengthening area of improving supply and distribution system – technology management and maintenance. This is part of the strategy to continue the improvement efforts for antiretroviral supply and procurement management initiated through Round 4 activities under the Phase II grant. The budget for the information system is not covered under the Round 4 grant.

5.4.4 Measuring service unit cost and cost effectiveness

This is new for Round 10. It is related to Section 4.5.3 (Improving value for money). Please see the Aidspan guidance for that item (follow the link). The Global Fund recognises that not all of the information it is asking for may be readily available. But it would like to know, at a minimum, what efforts have been made to measure and estimate service delivery costs. Note, also, that the Global Fund suggests that applicants include in the proposal budget funding for the periodic measurement of service unit costs.

SECTION 4B:
PROGRAM DESCRIPTION – CROSS-CUTTING HSS INTERVENTIONS

Note to MARP applicants: If you are applying through the MARP funding stream, you cannot include a cross-cutting health systems strengthening component in your proposal. However, if you are also submitting a TB or malaria proposal, you can include a cross-cutting health systems strengthening component there.

4B.1 Description of cross-cutting HSS intervention

With respect to 4B.1(a), this is an edited version of how a Round 8 proposal from Zambia described the rationale for its intervention entitled "To strengthen community systems to bring health services as close to the household as possible":

> While increasing the enrolment capacity and consequent annual output of health worker training institutions will strengthen Zambia's ability to meet population health needs and make strides toward achieving Millennium Development Goals, expanded training capacity will not alone close the gap between the number of available professional health workers in Zambia and the number that are needed. To most effectively utilize the limited number of professional health workers, additional new health delivery models must be considered, including better utilization of community health workers (CHW) and agents. CHWs and agents provide a strong and vital link between the formal health system and households by improving access, patient communication and compliance, outreach, prevention and early diagnoses in underserved communities.
>
> Zambia has had CHWs and agents within its health system for many years. However, because there is no specific occupational code that can be used in official reports for CHWs and agents, and there are no official estimates of the number of CHWs in Zambia. Until now, this group has been reported under many different existing programs that have similar but not equivalent job descriptions. Many are serving as volunteers, receiving minimal or no incentives, and operating under "vertical" disease programs.
>
> CHWs and agents live in or are familiar with the community. They create a bridge between providers of health, social and community services and the underserved and hard-to-reach populations within the community. CHWs are trained to provide basic health education and referrals for a wide range of services, and to provide support and assistance in navigating the health and social services system. Among other services, CHWs provide outreach, health education, referral and follow-up, case management, advocacy and home visiting services to pregnant women (who are at highest risk for poor birth outcomes, particularly low-birth weight and infant mortality) and to chronically ill patients on ART and TB treatment.
>
> Community agents, on the other hand. focus more on specific functions such as commodity distribution, provision of health information and materials plus adherence tracking and support.

This is an edited version of how a Round 9 proposal from Benin explained the linkages to improved disease outcomes for its intervention entitled "Strengthening health care establishments with qualified human resources":

> This intervention is justified by the anticipated effects on the attractiveness of state health care establishments. Indeed, people living with HIV, as well as patients suffering from tuberculosis and malaria should use the services offered by the public health care providers

more and thus have the opportunity to receive more comprehensive care which is able to satisfy all of their health needs. Thus:

- The first activity package is intended to result in an improvement in the strategic and operational management of human resources in the health sector in order to restore the confidence of personnel in the governance of the Ministry of Health and their commitment to serving the patients.
- The second activity package is intended to result in an increase in the range of services offered at the operational level by the public establishments via a well trained and skilled staff.
- The last activity is intended to result in an improvement in the quality of the services offered within the public structures by means of a suitable personnel motivation system.

The actions put forward in this proposal will help to strengthen the efforts of the Benin government to develop human resources in the health sector.

See also the Global Fund's information note on HSS at www.theglobalfund.org/en/applicationfaq.

See also:

Belarus (8), Guyana (8), Swaziland (8), Zimbabwe (8)

Links to these proposals are provided in Aidspan's *Key Strengths of Round 8 and 9 Proposals to the Global Fund*, available at www.aidspan.org/aidspanpublications. See Chapter 3.

4B.2 Engagement of HSS Key Stakeholders in Proposal Development

This is how a Round 9 proposal from Benin responded to this question:

> The health system stakeholders who have been involved in the identification and development of HSS cross-cutting interventions, in particular the identification of shortcomings in the system and the key interventions were selected from the public sector, from civil society and from the multilateral stakeholders. Some are members of the CCM. They participated in the process based on their knowledge and expertise in the area. These persons represented:
>
> - the Ministry of Health: the National AIDS Committee, national malaria, tuberculosis and AIDS organisations;
> - international non-governmental organisations (Plan Bénin, Catholic Relief Service, Population Services International, Care, GIP Esther) and national non-governmental organisations (Caritas, Coalition of Benin Businesses and Private AIDS, Tuberculosis and Malaria Associations, Benin Association for Promotion of the Family, Network of Benin Health NGOs, Network of Benin Associations for Young People Involved in the Fight Against AIDS);
> - multilateral stakeholders: [stakeholders listed]
>
> These stakeholders were chosen based on the fact that they are financial stakeholders who provide institutional support to the Ministry of Health and others are frontline stakeholders who have control over the strengths and weaknesses of the health system. These institutions have already participated in the Forum on Health of November 2007 and also in the development of the new National Health Development Plan 2009-2018 which is the basis for all of the interventions planned in this proposal. They also participated in Benin's submission to the Global Alliance for Vaccines and Immunisation (GAVI), which allows them to make further contributions to the analysis of the programming and financial shortcomings for an additional funding request. Together the stakeholders have contributed to the preparation of the national proposal in the 9th round by undertaking a situational analysis of the health system based on the three priority diseases, namely AIDS, tuberculosis and malaria and have provided useful opinions on the integration of health system strengthening cross-cutting interventions in the proposal.

4B.3. Strategy to mitigate unintended consequences

This is how a Round 9 proposal from Zambia identified one potential unintended consequence and described how it would deal with it:

> One potential "disruptive consequence" of the cross-cutting HSS activities included in this application is that the amount of management and leadership capacity directed toward implementing these objectives will be tremendously time consuming, and potentially distracting to other key national priorities. To address this concern, several key measures have been put in place. First, it was determined that the activities included in this application would be the highest priority activities in terms of other needs and impact, and therefore, it was considered appropriate that the greatest amount of leadership and management attention be devoted to their implementation. Secondly, to mitigate the impact of less attention being dedicated to second-level priorities, it was recognized that successful implementation would not be possible without additional capacity at the central level. As a result, the first objective on health workforce improvements includes an activity related to hiring additional human resoruces for health (HRH) management capacity to lead the implementation of these initiatives.

SECTION 5B: CROSS-CUTTING HSS INTERVENTIONS

Section 5B closely resembles parts of Section 5. Applicants should refer to the table below to determine where to find the appropriate guidance:

Section 5B item	See the guidance for:
Section 5B.1: Detailed Budget	Section 5.2 in this chapter
Section 5B.2: Summary of detailed budget by objective and service delivery area	Section 5B.2 in the R10 Guidelines for Proposals
Section 5B.4.1 – Section 5B.4.3: Variations in costs etc.	Section 5.4.1 and following in this chapter

Annex I: Criteria for Reviewing Proposals

These are the criteria that the Technical Review Panel (TRP) will use to review Round 10 proposals. Criteria that were added or changed since Round 9 are underlined.

Soundness of approach:

- Use of interventions consistent with international best practices (as outlined in the Stop TB Strategy, the Roll Back Malaria Global Strategic Plan, the WHO Global Health-Sector Strategy for HIV/AIDS and other WHO and UNAIDS strategies and guidance) to increase service coverage for the region in which the interventions are proposed, and demonstrate a potential to achieve impact;
- Use of a situational analysis to assess the risk of, and vulnerability to, and impact of the three diseases on women and girls, as well as boys and men, and adopts appropriate programmatic responses, empowers women, girls and youth, promotes gender equity, addresses the structural and cultural factors that increase risk and vulnerability, and contributes to changing harmful gender norms;
- Give due priority, and appropriately target with programs, to key affected populations, including, although not restricted to, injecting drug users, men who have sex with men, transgender communities, sex workers, migrants and prisoners;
- Give due priority to strengthening the participation of communities and people infected and affected by the three diseases in the development and implementation of proposals;
- Demonstrate that interventions chosen are evidence-based;
- Show that interventions represent good value for money (which can be defined as using the most cost effective interventions, as appropriate, to achieve the desired results);
- Involve a broad range of stakeholders in implementation, including strengthening partnerships between government, civil society, affected communities, and the private sector;
- Address issues of human rights and gender equity and use human rights-based approaches to address the three diseases, including by contributing to the elimination of stigmatization of and discrimination against those infected and affected by tuberculosis and HIV/AIDS, especially populations that are marginalized or criminalized, such as injection drug users, men who have sex with men, transgendered communities, sex workers and other key affected populations; and
- Are consistent with international obligations, such as those arising under World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (the TRIPS Agreement), including the Doha Ministerial Declaration on the TRIPS Agreement and Public Health, and encourage efforts to make quality drugs and products available at the lowest possible prices for those in need while respecting the protection of intellectual property rights.

Feasibility:

- Provide strong evidence of the technical and programmatic feasibility of implementation arrangements relevant in the specific country context, including where appropriate, supporting decentralized interventions and/or participatory approaches (including those involving the public, private and non-government sectors, and communities affected by the diseases) to disease prevention and control;
- Build on, complement, and coordinate with existing programs (including those supported by existing Global Fund grants) in support of national policies, plans,

priorities and partnerships, including National Health Sector Development Plans, Poverty Reduction Strategies and sector-wide approaches (where appropriate);

- Demonstrate successful implementation of programs previously funded by international donors (including the Global Fund), and, where relevant, efficient disbursement and use of funds. (For this purpose, the TRP will make use of Grant Score Cards, Grant Performance Reports and other documents related to previous grant(s) in respect of Global Fund supported programs);
- Utilize innovative approaches to scaling up prevention, treatment and care and support programs, including to key affected populations, such as through the involvement of the private sector and/or affected communities as caregivers in service delivery and/or community strengthening;
- Identify in respect of previous proposals for the same component submitted to the Global Fund but not approved, how this proposal addresses any weaknesses or matters for clarification that were raised by the TRP;
- Focus on performance by linking resources (inputs) to the achievement of outputs (people reached with key services) and outcomes (longer term changes in the disease), as measured by qualitative and quantitative indicators;
- Demonstrate how the proposed interventions are appropriate to the stage of the epidemic and to the specific epidemiological situation in the country and are appropriately targeted to communities most affected (including issues such as drug resistance and gender differentiated vulnerability and impact); and
- Build on and strengthen country impact measurement systems and processes to ensure effective performance based reporting and evaluation; and
- Identify and address potential gaps in technical and managerial capacities in relation to the implementation of the proposed activities through the provision of technical assistance and capacity building.

Potential for sustainability and impact:

- Strengthen and reflect high-level, sustained political involvement and commitment, and an enabling policy and legal environment, including through an inclusive and well-governed CCM, Sub-CCM or RCM;
- Demonstrate that Global Fund financing will be additional to existing efforts to combat HIV/AIDS, tuberculosis, and malaria, rather than replacing them;
- Demonstrate the potential for the sustainability of the approach outlined, including addressing the capacity to absorb increased resources and the ability to absorb recurrent expenditures;
- Coordinate with multilateral and bilateral initiatives and partnerships (such as the WHO/UNAIDS “Universal Access” initiative, the Stop TB Partnership, the Roll Back Malaria Partnership, the “Three Ones” principles1 and UNICEF’s “Unite for Children. Unite against AIDS” campaign) towards the achievement of outcomes targeted by National Health Sector Development Plans (where they exist);
- Demonstrate that the proposal will contribute to reducing overall disease, prevalence, incidence, morbidity and/or mortality;
- Demonstrate how the proposal will contribute to strengthening the national health system in its different components (e.g., human resources, service delivery, infrastructure, procurement and supply management);
- Demonstrate how the proposal will contribute to the sustained strengthening of civil society and community systems in its different components (e.g., management capacity, service delivery and infrastructure) with an emphasis on key affected populations; and

- Demonstrate how continuous process and impact monitoring and evaluation will be implemented in order to improve on-going actions and determine overall program impacts.