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First NFM Regional Meeting Draws Questions and Concerns from High Impact Africa 2 Countries

Representatives from all seven countries in the Global Fund's High Impact Africa 2 cohort plus South Africa met for two days in November to understand the nuances and idiosyncracies of the new funding model roll-out ahead of its launch in 2014.

Participants from government, non-government, civil society and private sector organizations from Ethiopia, Kenya, Mozambique, Tanzania/Zanzibar, Uganda, Zambia and Zimbabwe, along with international partners including UNAIDS, WHO and disease-specific technical agencies joined the Secretariat's country teams to unpack the processes that will drive each country to robust, approvable proposals to fight AIDS, TB and malaria.

The meeting emphasized the role of the country coordination mechanism (CCM) in the country dialogue and concept note development process for each of the three diseases. It served as a high-profile launch of the mechanics of the process entering its final stages at the Secretariat and presented an opportunity for Secretariat staff to engage at the country level with their CCM counterparts and identify where the trouble spots are likely to occur following the expected release of the country allocation envelopes in March 2014.

In touting the advantages of the new funding model for these seven countries – all of which have high burdens of disease and low ability to domestically fund a concerted response – the Secretariat representatives emphasized that unlike the rounds-based proposal process of the past, the new model afforded the opportunity for regular and consistent engagement with the Fund's country teams.

Technical assistance from partners including the German development agency GIZ, the US government and others, was also on offer for CCMs for every stage of the process; countries can access up to $150,000 for the development of their country dialogue and concept notes, although it was strongly encouraged that these processes be done domestically without necessarily engaging the help of external consultants.

Zimbabwe, which has served as a test case for the NFM, presented its proposal process and estimated that, "including a lot of tea and chocolate" the cost for proposal development was under $40,000. When

pressed, however, representatives of the Zimbabwe CCM avowed that external costs for consultations drove that price tag higher, for up to $100,000.

Plenary sessions engendered lively debate about the mechanics of the upcoming transition into the new model. One CCM member summed up the feelings of many in expressing trepidation about the “low level of orientation towards the architecture of the NFM” within the CCM and the country as a whole.

It was when the country-specific sessions began that the real challenges with the roll-out emerged. Countries that have received interim funding expressed confusion about where the spigot turned off and back on – when interim was over and ‘new’ began.

Many CCMs expressed concern about the new demands being made on them – both in terms of time and in terms of the minimum requirements they would be expected to achieve before being certified as fully eligible even to apply for new grants.

The distinction between indicative and incentive funding remained opaque for many, despite repeated explanations. Some CCM members, when asked after a particularly heavy technical session, to explain the process as they understood it, admitted that some of the language felt complicated and meant that they were unclear even as to what it meant to develop an ‘investment case’ as the basis for their concept note.

How to engage civil society and representatives of the affected populations was chief among the concerns of the CCMs. The new requirements for participation in CCMs – from representatives of the three diseases, from youth and an enhanced focus on gender with a minimum 30% representation of women – evoked concern from some countries where it was widely acknowledged that stigma against people living with disease, particularly HIV, would make it very difficult to encourage a public stand and regular participation in meetings with government officials. It was widely agreed that the majority of representation of disease communities in-country was from global organizations with local offices, rather than indigenous groups.

Also voiced was apprehension about the more stringent requirements for complete and timely data to justify proposals as evidence that countries were targeting the most vulnerable populations. While some countries acknowledged that they had available but unanalyzed data to identify gaps, others feared that their data were not good enough.

Commodity management was another area where countries expressed low confidence in their domestic ability to monitor and set up a transparent mechanism to feed into their concept note development.

But for all of their concerns, none of the CCM members, principal recipients, technical advisors or Secretariat staff who spoke with Aidspan had any misgivings about the direction the Fund was taking its fight against AIDS, TB and malaria.

The timelines are tight and the responsibilities for the CCMs are pronounced – but the possible impacts of efficient, country-driven programming that fits into national strategic plans bring new energy and enthusiasm into the arena, one Fund Portfolio Manager said.

And, added one CCM member, somewhat ruefully, there’s not much choice in the matter.

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