

Sexual and Reproductive Health Organizations and the Global Fund

Research into the experiences of IPPF Member Associations in relation to the Global Fund to fight AIDS, Tuberculosis and Malaria



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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CBO	Community Based Organization
CCM	County Coordinating Mechanism
CCP	Country Coordinated Proposal
GIPA	Greater Involvement of People living with HIV/AIDS
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GCE	Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
MA	Member Association (of IPPF)
NGO	Non-Governmental Organization
PLHIV	People Living with HIV
PR	Principal Recipient
SR	Sub-Recipient
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Guidelines for Proposals **Guidelines for Proposals: Fifth Call for Proposals**
Global Fund to Fight AIDS, Tuberculosis and Malaria (2005)

Revised Guidelines **Revised Guidelines on the Purpose, Structure and
Composition of Country Coordinating Mechanisms and
Requirements for Grant Eligibility**

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Executive summary

HIV/AIDS has infected and affected millions of people worldwide. To date, few governments have been willing and/or able to invest the level of resources needed to respond, especially as the epidemic disproportionately affects developing countries. In April 2001, the Secretary General of the United Nations made a public call for a 'war chest' to fight the disease. His voice was soon joined by many others and, in January 2002, the **Global Fund to Fight AIDS, Tuberculosis and Malaria** was created.

The Global Fund aims to make a significant and sustainable contribution to combating the three diseases by channelling large amounts of additional funds – from public and private sources, including governments, multilateral agencies, foundations and businesses – to countries most in need. By May 2005, it had signed agreements worth US\$ 2.4 billion for 279 grants in 125 countries.

The Global Fund is a unique funding mechanism because of the strength of its commitment to the participation of **civil society**. However, both nationally and internationally, putting that commitment into practice has proved challenging. In particular, the experiences of organizations working on **sexual and reproductive health (SRH)** have been both highly varied and relatively unexplored. Little is known, for example, about the extent to which such groups are getting involved in their Country Coordinating Mechanisms (CCMs) and the lessons that they are learning.

The research project summarised here aimed to contribute to responding to that gap. The report is divided into five sections:

Section 1 introduces the research project which was part of **Models of Care**, a partnership between the International Planned Parenthood Federation (IPPF) and German Technical Cooperation (GTZ) to contribute to the success of global alliances to respond to HIV/AIDS by strengthening the involvement of SRH non-governmental organizations (NGOs) in prevention, care and support and treatment programmes. The research aimed to discover **the degree of involvement of IPPF Member Associations (MAs) in the Global Fund's CCMs and the challenges, opportunities and successes that such collaborations present**. Its methodology combined desk-based research with a questionnaire (completed by 85 MAs) and interviews (carried out with 19 MAs).

Section 2 of the report provides an overview of the **Global Fund**, outlining its aim and structure, as well as the content of proposals and the process for grant-making.

Section 3 summarises the first group of findings from the research project¹, relating to the **participation of MAs in CCMs**. The findings include that:

- There is often a considerable gap between the multi-sectoral 'ideal' outlined in the Global Fund's 2005 Revised Guidelines and the reality. For example, despite a target of 40%, in Benin only 18% of CCM members are from civil society.
- Similarly, there is still limited involvement of people living with the diseases, with only 60% of MAs reporting CCM members who are openly HIV positive.
- While half of MAs have an equal, or near equal, gender balance in their CCMs, many report that there are considerably more male than female members.
- Having a modest size of CCM membership (usually 16-30 according to MAs) needs to be balanced with including all sectors involved in all the three diseases.
- Most CCM Chairs are from the government. Exceptions include Mongolia (with a government/NGO share) and Nicaragua (with a rotation system).
- Although most MAs recognise the Global Fund as an important mechanism, only 31 are currently involved in their CCM and only 18 of those are members.
- Among those involved in their CCM, many MAs feel that their opinions are listened to – which indicates the potential to influence decision-making.
- Some MAs have difficulty joining their CCM. The reasons include competition among NGOs and only groups experienced in the three diseases being selected.
- MAs that are CCM members have usually either: been involved in the Global Fund from the start, had a track record in HIV/AIDS and been invited to join; or had more difficulty and taken up their position only recently.
- The advantages of CCM membership include access to funding and information and being involved in decision-making. The disadvantages include increased demands on time and resources, sometimes with little direct reward.
- The largest factor preventing MAs from joining CCMs is lack of information (about the Global Fund and CCMs). There can also be a sense that CCMs are solely for those organizations focused on HIV/AIDS, TB or Malaria.

¹ Note: Not all MAs answered all questions. As such, the data and percentages in the findings are based on the number of MAs responding to each particular question, rather than all 85 involved in the project.

- MAs often collaborate with CCM members. In countries such as Kenya, they have been part of consortia established to monitor the Global Fund and its work.
- MAs in ineligible countries do not tend to be highly aware of the Global Fund, involved in advocacy or providing support to their peers in eligible countries.

Section 4 summarises the findings in relation to MAs **being Principal Recipients (PRs)** of the Global Fund. They include that:

- Many MAs are unclear about the role of PRs. For example, some incorrectly think that PRs can not receive funding from the Global Fund.
- 69% of MAs reported that PRs had been appointed by their CCM.
- Some MAs prefer the election of PRs (for example, because it is democratic), but others prefer appointment (for example, because it is more objective).
- Many MAs report PRs and Chairs/Vice Chairs of CCMs being from the same organization and no plan in place to mitigate such conflicts of interest.

Section 5 summarises the research findings in relation to MAs' experiences of **accessing funding** from the Global Fund. They include that:

- 59% of MAs have submitted a proposal through their CCM. Although a large percentage, this shows that many MAs have still not accessed the Global Fund.
- Just over half of MAs that have submitted a proposal have been successful, significantly increasing their resources for HIV/AIDS work.
- Once grants are approved, MAs often experience long delays in receiving their funds. This can have negative impacts on both organizations and programmes.
- MAs have varied capacities to produce high quality proposals for the Global Fund, with 19 stating that they require capacity building in this area.
- 64% of failed proposals from MAs were due, either totally or in part, to lack of information and/or understanding, for example about the process and deadline.
- 95% of MAs' proposals have focused on HIV/AIDS or HIV/AIDS and Malaria. This is because the theme corresponds most closely to their strategic plans to respond to the epidemic and/or their mandate to link SRH and HIV/AIDS.

Based on the findings of the Models of Care research project, the report makes a series of **recommendations** for IPPF and its MAs. These are that:

- 1 MAs in eligible countries that are not currently engaged with their CCM should take one or more steps to **get involved** with the Global Fund, influence the process and/or access funding. These might include:
 - **'Skilling up'** about the Global Fund, such as learning at least the basics about how the institution is structured internationally and how the CCM operates in their country; and/or
 - Becoming a **member** of their CCM; and/or
 - Forming a **partnership** with an existing member of their CCM; and/or
 - Becoming involved in an NGO **network** that advocates to their CCM.
- 2 MAs and IPPF should advocate to the Global Fund for the involvement of **civil society and people living with the three diseases** in its CCMs and other mechanisms, in accordance with the Revised Guidelines. Particular attention should be paid to the involvement of PLHIV, due to the high level of stigma associated with the epidemic.
- 3 MAs and IPPF should advocate to the Global Fund and collaborate with NGO networks to ensure that **civil society representatives** on CCMS and other mechanisms are selected according to transparent and documented processes, in accordance with the Revised Guidelines.
- 4 MAs and IPPF should advocate to the Global Fund for the **relevance and inclusion of SRH organizations** in CCMs and other mechanisms. Particular attention should be paid to organizations working with women, young people and other vulnerable populations.
- 5 MAs in eligible countries should advocate to their CCMs to enact the transparent and accountable **selection of PRs** for the Global Fund, in accordance with the Revised Guidelines. In particular, this should address the development and implementation of procedures to avoid conflicts of interest, for example whereby PRs and CCM Chairs/Vice Chairs are the same.
- 6 MAs considering becoming a **PR** for the Global Fund should start by carrying out a thorough analysis of the organizational advantages and disadvantages of the role. This should include an honest and accurate

assessment of the true level of work and resources that would be involved and whether the administrative fee would be adequate.

- 7 MAs and IPPF should advocate to the Global Fund and its international contributors for the role of **civil society** organizations as PRs and SRs of grants. This should include providing 'real life' case studies of NGOs, including those focused on SRH, that have performed the role efficiently and effectively.
- 8 MAs and IPPF should proactively advocate to the Global Fund on the **comparative advantages** – both financial and programmatic – of mainstreaming SRH and HIV/AIDS responses.
- 9 MAs in ineligible countries should support those in eligible countries by taking one or more steps to get involved with the Global Fund and influence the process and/or access to funding. These might include:
 - Offering **capacity building**, such as in proposal writing, to MAs in eligible countries that require support; and/or
 - **Advocating** to their own government to provide increased funding to the Global Fund.
- 10 MAs and IPPF should provide feedback on funding and other issues by starting/continuing involvement in the Global Fund's **Partnership Forum**. This should include maximising opportunities for involvement not only in, but between, the Forum's formal bi-annual meetings.
- 11 IPPF should act as a **'global watchdog' and 'clearing house'**, identifying, analyzing and disseminating information about the Global Fund and how MAs can access its resources. It should also promote the cross-regional exchange of both financial and programmatic lessons learned among SRH organizations that are currently, or potentially, involved in the Fund's mechanisms.

In **conclusion**, the report urges that these recommendations should be assessed by IPPF, its MAs and their partners and acted upon as soon as possible. It also suggests that the findings of the research project confirm the experiences reported by other NGOs that there are significant bottlenecks in the disbursement of Global Fund resources to civil society organizations. While not exclusively so, many of the problems lie in-country. As such, MAs have both an interest and vital role in advocating for more efficient and timely processes among the relevant agencies and, ultimately, achieving the Global Fund's goal of being **'a new way of doing business.'**

Finally, the report suggests that, although their involvement in the Global Fund has, to date, been extremely varied, MAs are clearly interested in becoming more involved in the processes that the mechanism has catalysed, as well as accessing its resources. The integration of SRH into HIV/AIDS responses and vice versa is clearly beneficial for organizations and recipients alike, as well as consistent with the core work of IPPF. The Global Fund offers a vital opportunity to realize and expand the Federation's services globally, reaching millions of people. **It is an opportunity that should not be missed.**

Introduction



SECTION 1: Introduction

Summary:

This section introduces the Models of Care project and outlines the aims, objectives, outcomes and methods of the research project.

Models of Care project

This report is part of Models of Care, a collaboration between the International Planned Parenthood Federation (IPPF) and the Back-Up Initiative of Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ). The project aims to contribute to the success of global alliances to respond to HIV/AIDS by strengthening the involvement of sexual and reproductive health (SRH) non-governmental organizations (NGOs) in programmes relating to HIV/AIDS prevention, care and support and treatment.

The project has several key areas:

- Development of a **global course** for SRH professionals focusing on vulnerable groups, human rights and HIV/AIDS to support the SRH movement as it re-orientates its focus to the challenges posed by the pandemic.
- Systematic **sensitization** for IPPF Member Associations (MAs) to enable them to recognise themselves as partners in meeting the challenges of HIV/AIDS.
- Development of a **handbook** on the workings of Country Coordinating Mechanisms (CCMs) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), providing detailed suggestions of how MAs can become involved and case studies of ones that have been successful.
- Support to five **pilot projects** to develop models of best practice for MAs to increase their involvement in various aspects of HIV/AIDS programming and assure the work of CCMs.

Aims, objectives and outcomes of research

The aim of the research project summarised in this report was to **discover the degree of involvement of MAs with CCMs, and the challenges, opportunities and successes that such collaborations present.** Its objectives were to:

- **Increase knowledge** of CCMs throughout MAs, with a specific focus on IPPF's 17 HIV/AIDS focus countries.²
- **Make recommendations** for MAs on how to become involved in CCMs.
- **Strengthen the capacities** of those MAs that are involved, or wish to be further involved, in the procedures and management of the Global Fund.

- **Identify the successful strategies** used by MAs to become CCM members.

The anticipated outcomes of the research project were:

- **Building alliances:** SRH and HIV/AIDS organizations to increase their collaboration, enhancing participation in CCMs and access to Global Fund resources.
- **Creating knowledge:** SRH organizations to recognise and act on their role in responding to HIV/AIDS, enabling increased participation in CCMs and access to Global Fund resources.
- **Updating partners:** SRH organizations to increase their awareness of the working of CCMs and the Global Fund and how they can increase their involvement, participation and funding. Also, to develop and disseminate information on model projects of MAs' involvement in CCMs and the Global Fund, as well as methodology to access funding for HIV/AIDS programmes.

Methodology of research

The research methodology was divided into two:

- **Part 1:** This focused on **desk-based research** on CCMs. It looked at their formation, which MAs belong to CCMs and the levels of available funding. The information gathered helped to prepare a questionnaire for MAs.
- **Part 2:** This focused on finding out what MAs knew and thought about the Global Fund and its funding mechanisms. They were asked to complete the prepared **questionnaire** which asked general questions, such as about MAs' level of knowledge about, and involvement in, CCMs. Further information was sought on: the number of members in a country's CCM; the gender division of members; the involvement of people living with HIV (PLHIV) and/or people affected by tuberculosis (TB) or malaria; the categories of members; who chairs the CCM; and whether the CCM listens to the views of MAs. As many MAs are not part of their CCMs, the questionnaire sought to find out:
 - How MAs can become more involved in CCMs, learning from the experiences of those that are already involved.
 - The challenges and obstacles for MAs in having an effective role in CCMs.
 - The capacity development needs of MAs in terms of becoming Principal Recipients (PRs).

Having over 150 MAs and working in 183 countries, IPPF sent questionnaires to all six regions and to countries with varying HIV/AIDS and socio-economic trends. IPPF also sent them

² Africa Regional Office: Cameroon, Kenya, Malawi, Rwanda and South Africa. Arab World Region: Morocco and Sudan. European Network: Estonia and Russia. East and Southeast Asia and Oceania Region: Cambodia, China, Indonesia and Thailand. South Asia Regional Office: India and Nepal. Western Hemisphere Region: Dominican Republic and Mexico.

to its 17 HIV/AIDS focus countries, all of which are CCM members (except Mexico, which is not eligible for the Global Fund). A total of 85 MAs completed the questionnaire³, a response rate of over 50 per cent⁴. Following on from the questionnaire, 19 MAs were selected for telephone interviews⁵, on the basis that they were either already a CCM member or had had an HIV/AIDS or SRH proposal funded by the Global Fund.

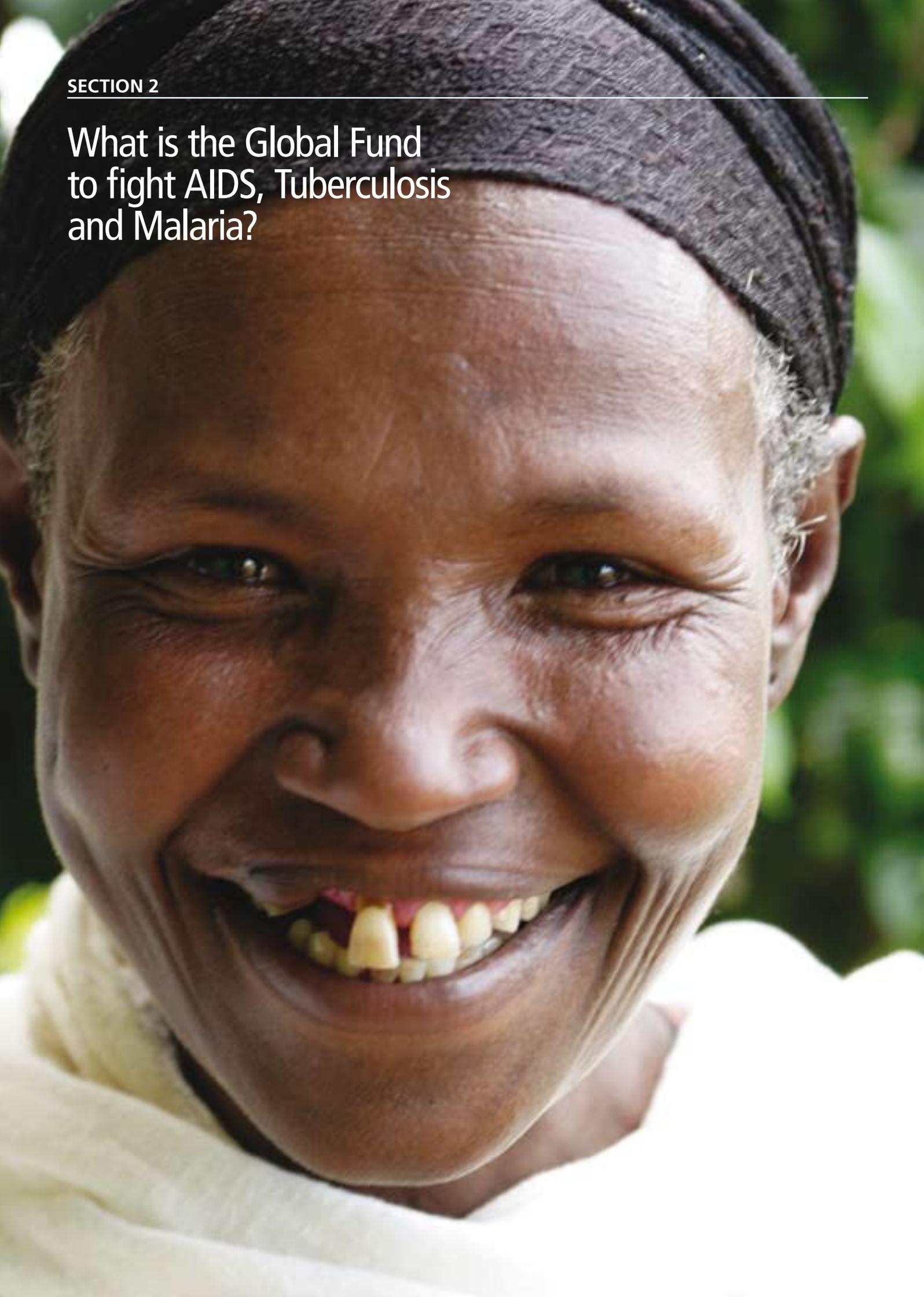
This report summarises the key findings of the questionnaire and the interviews. The full, tabulated responses to all of the questions are available from IPPF.

³ See Annex 1 for a list of the MAs that completed the questionnaire.

⁴ Note: Not all MAs answered all questions. As such, the data and percentages in the findings are based on the number of MAs responding to each particular question, rather than all 85 involved in the project.

⁵ See Annex 1 for a list of the MAs that were interviewed.

What is the Global Fund to fight AIDS, Tuberculosis and Malaria?



SECTION 2: What is the Global Fund to fight AIDS, Tuberculosis and Malaria?

Summary:

This section provides an overview of the Global Fund. It outlines the aim and structure of the organization, as well as the content of proposals and the process for grant-making.

Background to the Global Fund

HIV/AIDS has infected and affected millions of people globally. Few governments have been willing and/or able to invest the level of resources to respond, especially as the epidemic disproportionately affects developing countries.

In April 2001, Kofi Annan, Secretary General of the United Nations, made a public call for a 'war chest' to be organized to fight HIV/AIDS. His voice was soon joined by many others, including PLHIV. In January 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria⁶ was created, based in Geneva, Switzerland. By 15 May 2005, it had signed agreements worth US\$ 2.4 billion for 279 grants in 125 countries⁷.

Aim of the Global Fund

The Global Fund is a financing mechanism. It aims to combat HIV/AIDS, TB and Malaria by channelling large amounts of additional funds to countries and communities most in need. It aims to make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by the diseases and also contributing to poverty reduction as part of the Millennium Development Goals.

The Global Fund collects donations from public and private sources: governments; multilateral institutions; foundations; and the business sector. These are distributed to countries on the basis of their disease prevalence. Organizations within countries

submit proposals through their CCM in a Country Coordinated Proposal (CCP). Successful proposals subsequently receive funding.

Structure of the Global Fund

The structure of the Global Fund includes several key institutions at global and country levels.

These include:

- **Board:** An international governance body, including representatives of donor and recipient governments, NGOs, the private sector (including businesses and foundations) and affected communities. Key international development partners also participate, including the World Health Organization (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Bank. The latter also serves as the Global Fund's trustee.
- **Country Coordinating Mechanism (CCM):** A country-level partnership that develops and submits a CCP, monitors its implementation and coordinates with other donors and domestic programmes. It is intended to be multi-sectoral, involving government agencies, NGOs, community and faith-based groups, private sector institutions, multilateral agencies and people living with the three diseases.
- **Local Fund Agent (LFA):** An independent organization hired by the Global Fund Secretariat to assess PRs' capacity to administer funds, as well as provide ongoing oversight and verify reported data on financial and programmatic progress.
- **Partnership Forum:** A broad group of international stakeholders, many of which do not usually take part in the Global Fund's governance processes. Through and between bi-annual meetings, they provide feedback and guidance on the mechanism's impact in fighting the three diseases. The Forum also serves as an opportunity for the Global

⁶ See Annex 2 for a list of useful resources on the Global Fund.

⁷ Global Fund (2005). *Making Performance-Based Funding Work: Mid-Year Progress 2005*.

Country Coordinating Mechanisms

CCMs lie at the heart of the Global Fund's vision – as they aim to be a manifestation of multi-stakeholder country ownership, public-private partnership and the greater involvement of people living with HIV/AIDS (GIPA).

The role of a CCM is to:

- Coordinate the submission of a CCP, drawing on the strengths of various stakeholders to agree on strategy, identify funding gaps, prioritize needs and identify the comparative advantages of partners.
- Select one or more appropriate

organization(s) to act as the PR for the Global Fund grant.

- Monitor the implementation of activities in Global Fund programmes, including approving any major changes in plans.
- Evaluate the performance of Global Fund programmes, including the work of PRs and SRs, and submit a request for continued funding prior to the end of the two years of initially approved financing.
- Ensure links and consistency between the Global Fund and other development and health assistance programmes in

support of national priorities, such as Poverty Reduction Strategy Papers or Sector Wide Approaches.

Although not specified by the Global Fund, there are many organizations relevant to MAs whose contribution can be valuable to a CCM. These include those addressing the SRH needs of women, young people and other vulnerable groups, such as injecting drug users, men who have sex with men, sex workers and migrants, refugees or displaced persons.

SECTION 2

Fund to inform stakeholders of progress and challenges. The first Forum was convened in Bangkok, Thailand, in 2004.

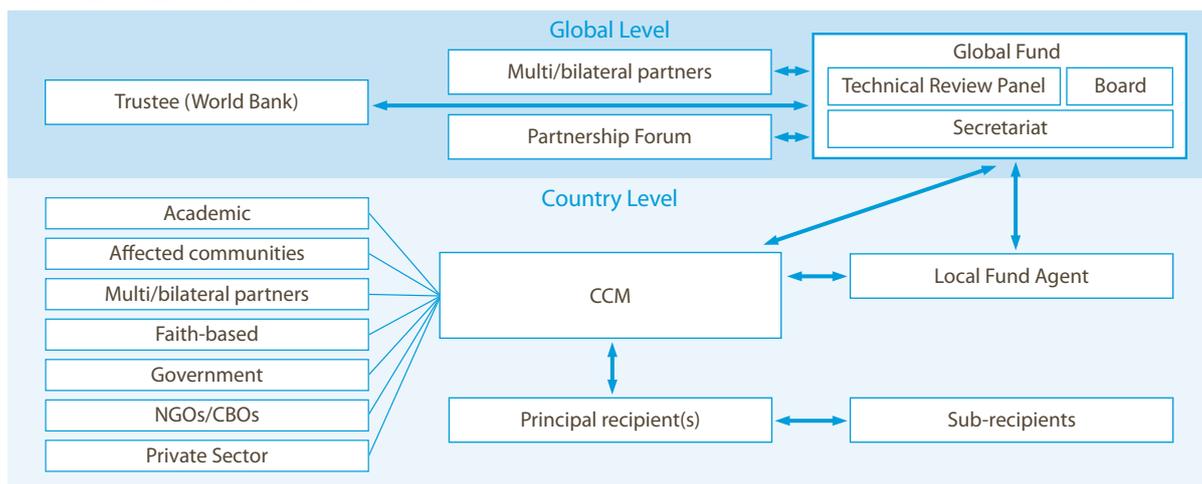
- **Principal Recipient (PR):** A local entity nominated by the CCM and confirmed by the Global Fund to be legally responsible for grant proceeds and implementation in a country. Once the Board approves a proposal, the Secretariat negotiates a two-year grant agreement in which the

Content of proposals for the Global Fund

Proposals to the Global Fund can address one or more of four components:

- 1 HIV/AIDS
- 2 TB
- 3 Malaria
- 4 Health systems strengthening

Global Fund structure



disbursement of funds to the PR is based on achieving measurable results. There may be multiple public and/or private PRs in one country.

- **Secretariat:** A group of about 170 staff based in Geneva, Switzerland. They are responsible for the Global Fund's day-to-day operations, including mobilizing resources, managing grants, providing support (financial, legal and administrative) and reporting on activities to the Board and the public.
- **Sub-Recipient (SR):** An entity chosen by a PR to implement parts of a Global Fund grant. They often do not have the capacity to take on the responsibility of a PR, but are usually more involved in community-level work.
- **Technical Review Panel (TRP):** An independent panel of disease-specific and cross-cutting health and development experts that rigorously reviews the technical merit of CCPs. It may recommend to the Board of the Global Fund that a proposal be: funded without condition; approved conditionally; re-submitted; or not approved. To date, it has recommended funding for 40 per cent of all CCPs.

SRH issues tend to be incorporated under HIV/AIDS or health systems strengthening. The latter component was introduced recently and focuses on enhancing country-level health systems.

In addition, proposals to the Global Fund must include information about: broader system-wide and/or cross-cutting aspects; social and gender issues; balance of interventions; implementing partners; and examples of activities.

Grant-making process for the Global Fund

Grant-making process for the Global Fund (www.theglobalfund.org/en/apply/proposals)

The steps involved in the grant-making process for the Global Fund usually include:

- Secretariat announces a call for proposals.
- CCM prepares a proposal based on local needs and funding gaps. It also nominates one or more PRs.
- Secretariat reviews the proposals to ensure they meet the criteria. It forwards eligible ones to the TRP.
- TRP reviews all eligible proposals for technical merit. It recommends whether the Board should: 1) Fund; 2) Fund if certain conditions are met; 3) Encourage resubmission; or 4) Not fund.
- Global Fund approves grants based on technical merit and availability of funds. An Internal Appeal Mechanism allows applicants

whose proposals have been rejected in two consecutive rounds to appeal the second decision.

- Secretariat contracts an LFA to certify the financial management and administrative capacity of the nominated PR(s). The PR may need technical assistance to strengthen its capacities. Such strengthening might be a condition of disbursement of funds in the grant agreement.
- Secretariat and PR negotiate a grant agreement that identifies specific, measurable results to be tracked using a set of key indicators.
- Grant agreement is signed. Based on a request from the Secretariat, the World Bank makes an initial disbursement to the PR which then makes disbursements to the SRs.
- Programme and services begin. The CCM oversees and monitors progress.
- PR submits periodic disbursement requests with updates on programmatic and financial progress. LFA verifies information and recommends disbursements. Lack of progress triggers a request by the Secretariat for corrective action.
- PR submits fiscal year progress report and an annual audit of programme and financial statements to the Secretariat through the LFA.
- Regular disbursement requests and programme updates continue, with future disbursements tied to on-going progress.
- CCM requests funding beyond the approved two-year period. Global Fund approves continued funding based on progress and available funds.

Research findings: Participating in Country Coordinating Mechanisms of the Global Fund



SECTION 3: Research findings: Participating in Country Coordinating Mechanisms of the Global Fund

Summary:

This section summarises the findings of the research project in relation to Country Coordinating Mechanisms. It outlines MAs' experiences of the involvement of civil society and people living with the diseases in CCMs, as well as the Mechanisms' gender balance, size and leadership. It shares Associations' different types of involvement in CCMs as well as their lessons learned, for example about issues relating to funding, influence and joining, as well as the advantages and disadvantages of membership. It concludes by sharing further lessons, including about the factors that prevent MAs from getting involved in CCMs and about collaborating with other members.

Civil society involvement in CCMs

The Global Fund is a unique funding mechanism because of the strength of its commitment to the participation of civil society.

Potentially, the sector is active at all levels of the institution. At the Secretariat, there is a designated staff member for civil society, while, on the Board, there are voting rights for the delegations of the communities living with the three diseases, developing country NGOs, developed country NGOs, private foundations and private sector.

At the country level, there are also now requirements for the effective involvement of civil society and people living with the diseases. The **Guidelines for Proposals: Fifth Call for Proposals** issued in 2005 significantly strengthened the position of the sector, particularly by making grants conditional on CCMs having non-governmental sectors select their own representatives, based on a documented and transparent process developed within each one. Furthermore, paragraph 10 of the Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility, also produced in 2005, recommends that: (quote in far right column)

However, as the Models of Care research project showed, there is still, in reality, a considerable gap between this 'ideal' and the practice on the ground. According to the 37 MAs answering the relevant section of the questionnaire, there are very different levels of success in achieving the 40 per cent target in their countries (see chart to the right).

Civil society involvement in CCMs, Colombia:

In Colombia, those involved in the CCM, including PLHIV, have worked together in an environment of mutual respect. However, the mechanism still lacks representation from some sectors of civil society that could provide vital input into the country's work with the Global Fund. These include those working with key target groups, such as women, young people and men who have sex with men.

As just one example, while in Ethiopia 50 per cent of the members of the CCM are representatives of NGOs/community based organizations (CBOs), people living with the diseases or academic institutions, in Benin only 18 per cent are from NGOs/CBOs or religious/faith-based organizations (see box). As such, while Ethiopia is fulfilling the Global Fund's new guidelines (both in terms of the 40 per cent target and the involvement of people living with the diseases), Benin is not and would be ineligible for funding.

Civil society involvement in CCMs, Benin and Ethiopia

Sector	Number of CCM members	
	Ethiopia	Benin
Government	17	41
Multilateral/bilateral organizations	20	33
NGOs/CBOs	33	15
Faith-based organizations	-	3
International NGOs	13	8
Academic institutions	10	-
People living with the diseases	7	-

SECTION 3

“The membership of the CCM comprise a minimum of 40% representation of the non-government sectors such as NGOs/ community based organizations, people living with the diseases, religious/ faith-based organizations, private sector, academic institutions.”

Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility

Civil society involvement in CCMs		
Sector	Countries where sector is involved in the CCM and, where stated by MAs, number of members (37 MAs responded)	Number of countries
Government	Bahrain, Benin (16), Bulgaria, China (13), Colombia (2), Comoros (10), Costa Rica (4), Democratic Republic of Congo (8), Djibouti (13), Dominican Republic (8), Ethiopia (5), Fiji (4), Georgia (11), Iran, Lebanon (3), Madagascar (12), Mauritania, Mongolia (8), Morocco (4), Namibia (8), Nicaragua, Niger (7), Panama (4), Philippines (11), Russian Federation (1), Rwanda (9), São Tomé, Sri Lanka, Sudan (4), Tanzania (4), The Gambia (3), Togo (12), Tonga (3), Trinidad and Tobago (13), Tunisia, Tuvalu, Yemen (9)	37 countries
NGOs/CBOs	Bahrain, Benin (6), Bulgaria, China (9), Colombia (5), Comoros (7), Costa Rica (1), Democratic Republic of Congo (more than 40), Djibouti (3), Dominican Republic (3), Ethiopia (10), Fiji (4), Georgia (2), Iran, Lebanon (10), Madagascar (7), Mauritania, Mongolia (2), Morocco (7), Namibia (5), Nicaragua, Niger (1), Panama (4), Philippines (8), Russian Federation (6-9), Rwanda (1), Sri Lanka, Sudan (4), The Gambia (4), Togo (3), Tonga (5), Trinidad and Tobago (5), Tuvalu, Yemen (3)	34 countries
Multilateral and bilateral organizations	Bahrain, Benin (13), Bulgaria, China (20), Colombia (3), Comoros (5), Democratic Republic of Congo (9), Djibouti (8), Dominican Republic (2), Ethiopia (6), Georgia (3), Iran, Lebanon (2), Madagascar (9), Mongolia (4), Morocco (4), Namibia (5), Niger (7), Panama (4), Philippines (5), Rwanda (8), Seychelles (1), Sri Lanka, Sudan (5), Tanzania (3), Togo (10), Trinidad and Tobago (7), Vanuatu, Yemen (6)	29 countries
Academic institutions	Bahrain, Bulgaria, China (5), Colombia, Comoros (1), Costa Rica (1), Ethiopia (3), Fiji (1), Iran, Lebanon (2), Mauritania, Mongolia (2), Morocco (3), Namibia (1), Nicaragua, Niger (1), Panama (1), Philippines (2), Russian Federation (1), Rwanda (1), Sri Lanka, Sudan (2), Tanzania (1), Togo (1), Trinidad and Tobago (3) Tunisia, Tuvalu, Yemen (2)	27 countries
People living with the diseases	Bahrain, Bulgaria, China (2), Colombia (2), Costa Rica (1), Djibouti (2), Dominican Republic (1), Ethiopia (2), Fiji (1), Georgia (1), Madagascar (1), Niger (1), Namibia (19), Philippines (1), Rwanda (1), Sri Lanka, Sudan (1), Tanzania (1), Togo (3), Trinidad and Tobago (22), Tunisia	21 countries
International NGOs	Bahrain, Benin (3), Bulgaria, China (3), Colombia (1), Democratic Republic of Congo (6), Dominican Republic, Ethiopia (4), Georgia (3), Mauritania, Mongolia (1), Namibia (1), Nicaragua, Niger (1), Philippines (3), Russian Federation, Rwanda (1), Seychelles (1), Sri Lanka, Sudan (3), Yemen (3)	21 countries
The private sector	Bahrain, Bulgaria, China, Comoros (1), Fiji (1), Iran, Lebanon (2), Mongolia (2), Namibia (3), Panama (1), Philippines (1), Rwanda (1), Sri Lanka, Sudan (1), Togo (2), Trinidad and Tobago (6), Tunisia, Tuvalu, Yemen (2)	19 countries
Religious groups/ faith-based organizations	Bahrain, Benin (1), Comoros (1), Dominican Republic (1), Fiji (3), Madagascar (3), Mongolia (2), Morocco (1), Namibia (1), Niger (2), Rwanda (3), Seychelles (2), Sudan (1), Tanzania (2), Togo (1), Tonga (1), Trinidad and Tobago (1), Tuvalu, Yemen (1)	19 countries
Other	Bahrain, China (5) Democratic Republic of Congo (2), Morocco (2), Panama (1), Tanzania (5), Togo (1), Tonga (1), Trinidad and Tobago (4), Vanuatu	10 countries
No information/ do not know	Lesotho, Malawi, unidentified Western Hemisphere Region country	3 countries

Involvement of people living with the diseases in CCMs

Similarly, considerable importance is attached to the involvement of people living with HIV/AIDS, TB or Malaria in the Global Fund. The Revised Guidelines incorporate the GIPA Principle⁸ and the Declaration of Commitment's support for the role of PLHIV⁹. Specifically, Paragraph 12 states that "The Global Fund requires all CCMs to show evidence of membership of people living with and/or affected by the diseases."

In practice, however, only 29 MAs (from the 55 that responded to the relevant question) stated that there are people on their CCM who are openly living with HIV/AIDS. Meanwhile, 19 said that there are no such representatives and 7 had no information or did not know the situation. As such, only 60 per cent of the CCMs covered by the research currently appear to involve people living with the diseases.

Gender balance in CCMs

The Global Fund's Revised Guidelines on CCMs also state, in paragraph 10, that "In particular, the Global Fund encourages CCMs to aim at a gender balanced composition."

In practice, however, only 18 MAs (under half of the 50 responding to the question) reported that there is an equal, or near equal, number of men and women on their CCM. Indeed, 22 stated that there is an unequal division, with 18 having more men than women, 2 more women than men and 2 not providing clarification. Meanwhile, 10 MAs said that they lacked information or did not know about the gender balance.

Of interest, MAs from Benin, the Philippines and Sudan noted that CCM members work in their organizational rather than personal capacity and, as such, the gender balance depends on who attends a particular CCM meeting. Meanwhile, other respondents emphasised that it is not gender parity that matters, but whether gender-related issues are raised by members within the CCMs.

Size of membership of CCMs

As the Global Fund does not prescribe the composition of CCMs, there is, as yet, no clear guidance on a useful size for them. In the 39 countries of the MAs responding to the question, the majority of CCMs have 16-30 members (see box). Generally, experiences would seem to indicate that having 45 members on a CCM is too many. However, it is also evident that the benefits of placing any sort of 'ceiling' on the number of members has to be weighed against the need to ensure broad representation of all national stakeholders.

Leadership of CCMs

Forty six MAs (from the 47 that responded to the question) could identify the Chair of their CCM. For the majority (44) of them, it is the government or is shared between the government and another sector. Examples of the latter include Mongolia (where the position is shared between the government and NGOs/CBOs) and Nicaragua (where it rotates between the government, NGOs/CBOs, academic institutions, people living with the diseases and multilateral/bilateral organizations). Other exceptions include Vanuatu (where an international NGO is the Chair) and Sudan (where the United Nations Development Programme (UNDP) is the Chair). Meanwhile, in Colombia, the position of Vice-Chair is held by a PLHIV.

While the Global Fund does not prevent a government from chairing a CCM, MAs – including those in Costa Rica, Georgia and São Tomé – report that such a scenario can have implications for stakeholder participation, as well as overall transparency and accountability, if the government also holds the position of Vice-Chair and/or PR.

Leadership of CCMs, Georgia

In Georgia, the processes around and within the CCM have proved to be dominated by the government. The consequences of this have included an inadequate flow of information about the country's proposal in general and the criteria for the acceptance/rejection of NGO proposals in particular.

Types of involvement in CCMs

The Models of Care research project showed that MAs have a considerable variety of involvement in CCMs. The vast majority (60 of the 73 responding to the question) recognise that the Global Fund is an important mechanism for accessing funding in their country. However, only 31 are currently involved in their CCM, while even fewer (16) are members (see chart top right).

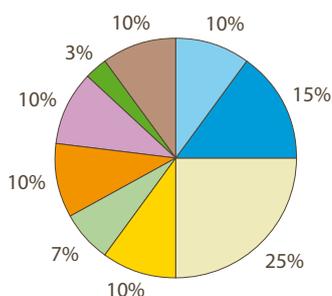
"The Global Fund requires all CCMs to show evidence of membership of people living with and/or affected by the diseases."

"In particular, the Global Fund encourages CCMs to aim at a gender balanced composition."

⁸ UNAIDS (1999) From Principle to Practice: Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA). www.unaids.org/html/pub/publications/irc-pub01/jc252-gipa-i_en_pdf.pdf.

⁹ United Nations General Assembly Special Session on HIV/AIDS. The Declaration of Commitment. New York, United States, 25-27 June 2001. http://www.unaids.org/Unaid/EN/Events/UN+Special+Session+on+HIV_AIDS/Declaration+of+Commitment+on+HIV_AIDS.asp.

Joining CCMS
(32 MAs responded)



- Nominated
- Chosen against established criteria
- Already working in field with good reputation
- Expressed interest
- Asked by CCM
- Asked by National AIDS Committee
- Asked by Ministry of Health
- Replied to expression of interest
- NGOs selected / elected their member

Types of involvement in CCMs

Type of involvement in CCM	Number of MAs (31 MAs responded)	Countries
Member	16	Bulgaria, China, Colombia, Ethiopia, Fiji, Georgia, Panama, Rwanda, Sri Lanka, Sudan (former member as another NGO has rotated onto the CCM), Togo, Tonga, Trinidad and Tobago, Tunisia, Turkey, Yemen
Vice-Chair	2	Mongolia, Tuvalu
Chair	1	Vanuatu
PR	2	Comoros, Dominican Republic (for TB)
SR	4	Iran, Morocco, Namibia, the Gambia
Other (such as taking part in meetings)	6	Democratic Republic of Congo, Kenya, Lebanon, Seychelles, Tanzania, Thailand

Lessons learned from experiences of CCMs

Funding from CCMs

Fourteen MAs reported that they had had an HIV/AIDS-related proposal funded by the Global Fund. As such, while there are clearly funds available in many countries, a large number of MAs are outside of the decision-making process and not gaining access to them.

Influencing CCMs

When asked if their opinions are being listened to by their country's CCM, 13 of the MAs (35 per cent of those who responded) specifying an answer said all the time, while 11 said most of the time, 8 sometimes and 1 never. This would seem to indicate that, where they are involved in their CCM, an MA can have significant potential to influence the decision-making process.

Joining CCMs

The 27 MAs providing information about joining their CCM had varying experiences. While 59 per cent of those who responded had little difficulty in the process, 19 per cent had a neutral experience and 22 per cent had difficulties. As such, while the overall experience is positive, one fifth of MAs go through significant challenges in becoming CCM members. Associations identify that the factors that increase those challenges include: competition between NGOs (Rwanda); ignorance about the role of NGOs (Mongolia); only NGOs experienced in the three diseases being selected (Sri Lanka); and lack of information (Haiti).

As data from 32 MAs shows (see box), CCMs use a variety of processes to select their members. In general, however, MAs that are currently involved have either:

- Been involved in the Global Fund since its inception (14 MAs) and/or active in and well-respected for HIV/AIDS work, and were then invited to become a CCM member.
- Had a more difficult experience and only taken up their position as a CCM member in the last year (7 MAs).

When added together, those MAs that were already known to the Government through their work, had a good reputation or were asked to join, account for 52 per cent of CCM memberships. As such, while there is much discussion about transparency and accountability in the mechanisms' processes, it would also seem to be true that, in many countries, the number of agencies working on HIV/AIDS, TB and malaria is quite small and, as such, those that are known and respected are very likely to gain a seat at the table. It is also interesting to note that, despite the Guidelines for Proposals, in only 10 per cent of cases had NGOs selected their own members for a CCM and, in only another 15 per cent, were they chosen against established criteria.

Joining CCMs, Colombia and Georgia

In **Colombia**, Asociación Pro-Bienestar de la Familia Colombiana (PROFAMILIA) was invited to join the CCM at its inception, alongside others working in sexuality, health, HIV/AIDS and displacement. The Association was selected due to both its status as national organization and its 15 years' experience of programmes on displaced youth and HIV/AIDS.

In **Georgia**, in 2002, the Association for Health, Education, Rights and Alternative 21 (HERA 21) applied to become a member of the CCM. It did this because it:

- Knew that NGOs were entitled to membership under the Global Fund's guidelines.
- Identified CCM membership as being in line with its strategic plan, the main aim of which is HIV prevention among young people.
- Recognised among its Board and staff that, through its experience of working on HIV prevention, it had information on grassroots experiences to share with others.
- Saw that the Global Fund provided an opportunity for funding.

The process took over a year. Initially, HERA 21 met with the Health and Social Projects Implementation Centre (part of the Ministry of Health and the LFA) which requested documentation (such as about the MA's fields of activity, expertise and Constitution). After this was reviewed by the Centre, a formal letter was written to the Ministry of Health, followed by a formal interview process.

Advantages of membership of CCMs

Within the research, 29 MAs outlined their reasons for becoming involved in their CCM. These included:

- Securing funding (Fiji, Mongolia, Seychelles, Singapore, the Gambia, Togo).
- Accessing information about opportunities for funding (Rwanda).
- Being involved in decision-making processes (Tonga).
- Sharing experiences (Turkey).
- Having an opportunity to help (Ethiopia).
- Collaborating to strengthen efforts (China, Fiji, Lebanon).
- Strengthening existing and future programmes (Bulgaria, Colombia, Comoros, Morocco).
- Supporting monitoring and ensuring that funds go to credible groups (Kenya).

In addition, CCMs are seen as an opportunity to strengthen an MA's capacity. For example, Sudan suggests that participating in a mechanism provides experience in programme implementation and monitoring and evaluation, as well as policy strategies. Meanwhile, in keeping with IPPF's mandate, Trinidad and Tobago highlight that CCMs are an opportunity to create links between HIV/AIDS and SRH work.

Advantages of membership of CCMs, Vanuatu

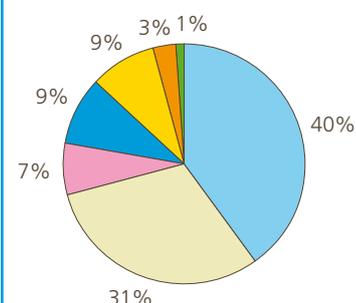
In 2004, the Ministry of Health selected the Vanuatu Family Health Association (VFHA), with which it had been working very closely for a number of years, as a member of the CCM alongside two other NGOs. For the MA, being involved in the mechanism has brought several advantages. These include increasing its knowledge of different partners' responses to HIV/AIDS, TB and malaria and improving its coordination with other sectors.

Disadvantages of membership of CCMs

The research indicated that involvement in CCMs can also have challenges, particularly when expectations are not met. Among the 32 MAs responding to the question, the most significant of these is the increased demands on time and resources that work with the mechanisms can bring (see graph, bottom left).

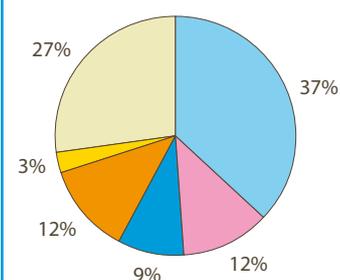
It is interesting to note that most of the MAs that cited this challenge have not received Global Fund funding. This seems to indicate that such input, with little financial reward, is likely, over time, to exacerbate feelings that the CCM process is draining resources. However, some MAs, including those in the Dominican Republic and Fiji, noted that, while they have not received funding and participation has involved considerable work, their CCMs have created more transparency and collaboration within their country's response. Indeed, it is argued that, if the overall aim is to have a significant impact, then success should not be measured by whether an MA has received funding, but whether the process has improved overall action on the three diseases.

Advantages of membership of CCMs (45 MAs responded)



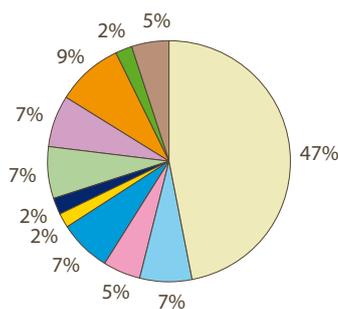
- Involvement in national programmes
- Source of information and funding
- Networking/partnerships
- Increased capacity
- Improves MA's public profile
- Way of responding to issues
- Opportunity to input SRH issues

Disadvantages of membership of CCMs (32 MAs responded)



- Increased demands
- CCM operations
- Conflicts of interest
- Representation issues
- Affects finances
- None

Factors preventing involvement in CCMs (45 MAs responded)



- Lack of information (even of CCM existence)
- Do not have a CCM
- No selection criteria
- Other entity selected
- CCM formed from existing coordination mechanism
- CCM already formed
- CCM bureaucracy
- Government controlled
- Not invited
- MA not registered
- CCM membership is for NGOs, which focus mainly on HIV/AIDS

Disadvantages of membership of CCMs, Sri Lanka and Bulgaria

The involvement of the Family Planning Association of Sri Lanka (FPASL) in their CCM has been mixed. The Association has not received any funding through the Global Fund and there have been several delays in the process, with many meetings that seem to discuss TB and Malaria more than HIV/AIDS. There is also a need to address the dominant role of the Ministry of Health in the CCM, in order to enhance collaboration and cooperation between the government and NGO sectors.

The **Bulgarian** Family Planning and Sexual Health Association (BFPA) receives US\$ 14,500 per year from the Global Fund for its work on decreasing risk-taking sexual behaviour among in and out of school young people and adolescents. It also receives in-kind resources for a voluntary counselling and testing (VCT) programme. In practice, however, the MA has found that the work-to-funds ratio is disproportionate, particularly in terms of the time and effort involved in meeting the requirements for narrative reports. Also, rather than adding to resources, the Global Fund has displaced other sources of funding for the MA. For example, The United Nations Population Fund (UNFPA) and Population Services International (PSI) – which could provide resources ten times the scale – are reluctant to do so for fear of duplicating the efforts of the Global Fund.

Factors preventing involvement in CCMs

Of those MAs that are not CCM members, 14 (from the 36 that responded to the question) stated that they have sought membership. Furthermore, the vast majority of MAs (42 of the 45 that responded to the question) expressed a desire to become a member, while only 3 (São Tomé, Hong Kong and Surinam) did not.

In terms of becoming, or trying to become, a member of a CCM, 16 MAs (from the 52 responding to the question and not currently members) reported difficulty.

The most significant factor preventing MAs from joining CCMs is the lack of information about the Global Fund and the roles of the CCM (see box). Meanwhile, some MAs view the mechanism as strictly dealing with organizations responding to HIV/AIDS, TB and malaria. This is despite the fact that the Revised Guidelines state the case for an inclusive CCM that incorporates SRH organizations and others with a role to play in action on the three diseases.

Collaboration with organizations in CCMs

In terms of whether MAs collaborate with organizations that are members of their CCM, 32 (from the 47 responding to the question) stated that they did, while 15 said they did not. The reasons outlined by the latter included:

- Not knowing who the CCM members are (Hong Kong, Zambia).
- Lack of information, even about the existence of a CCM (Cook Island, Djibouti, Kiribati, Singapore).
- Not being sure whether collaborating agencies are CCM members (Malaysia).
- CCM not being discussed in other forums with partners (Philippines).

In general, MAs clearly have a potentially vital role in monitoring the implementation of in-country Global Fund projects – and one way to do this is by maintaining good relationships with CCM members. Sudan and Kenya (see box) provide examples of where MAs have taken part in national networks of NGOs that have been specifically set up to monitor and provide information on their country’s CCM.

Meanwhile, it is interesting to note that, among MAs from countries that are ineligible for Global Fund resources, there appears to be a lack of advocacy in terms of their peer Associations being included in their CCMs or, more broadly, SRH-related programmes being included in CCPs. Indeed, only the New Zealand MA indicated that it had some knowledge of the CCMs in other countries in its region.

Furthermore, there has been no technical or capacity building exchange by non-eligible MAs to support those in countries that qualify for funding. This situation can, in part, be explained by the lack of awareness of the Global Fund reported by MAs in high-income countries. However, such Associations do have the ability to advocate on issues relating to the Global Fund, either directly (for example to their own government about levels of funding) or indirectly (for example on behalf of MAs within their region).

Collaboration with organizations, Kenya

In Kenya, many NGOs and CBOs were not happy with the way that funds received during Round 1 of the Global Fund were distributed. They felt that some credible implementers were left out. As a result, the Kenya Consortium of Organizations Fighting AIDS, Tuberculosis and Malaria (KECOFATUMA) was set up, with the Family Planning Association of Kenya (FPAK) as a co-founder and senior member. The Consortium aims to be an independent monitor of the CCM. It is a member of the mechanism and appoints key members (including, on two occasions, FPAK) to represent it in meetings.

The failure of Kenya's proposals to the Global Fund in two subsequent rounds has limited the benefits of KECOATUMA. However, the Consortium's achievements including bringing 500 non-governmental groups together and increasing collaboration across the sector. With the support of GTZ/IPPF, FPAK has already held a consultation with key stakeholders and plans to hold a workshop for KECOATUMA members to build their capacity in developing innovative proposals for the Global Fund. Furthermore, the Consortium is expected to support some implementing NGOs that have previously been sidelined by the CCM, to access funding.

Recommendations:

Participating in Country Coordinating Mechanisms of the Global Fund

- 1 MAs in eligible countries that are not currently engaged with their CCM should take one or more steps to **get involved** with the Global Fund, influence the process and/or access funding. These might include:
 - **'Skilling up'** about the Global Fund, such as learning at least the basics about how the institution is structured internationally and how the CCM operates in their country; and/or
 - Becoming a **member** of their CCM; and/or
 - Forming a **partnership** with an existing member of their CCM; and/or
 - Becoming involved in an NGO **network** that advocates to their CCM.
- 2 MAs and IPPF should advocate to the Global Fund for the involvement of **civil society and people living with the three diseases** in its CCMs and other mechanisms, in accordance with the Revised Guidelines. Particular attention should be paid to the involvement of PLHIV, due to the high level of stigma associated with the epidemic.
- 3 MAs and IPPF should advocate to the Global Fund and collaborate with NGO networks to ensure that **civil society representatives** on CCMs and other mechanisms are selected according to transparent and documented processes, in accordance with the Revised Guidelines.
- 4 MAs and IPPF should advocate to the Global Fund for the **relevance and inclusion of SRH organizations** in CCMs and other mechanisms. Particular attention should be paid to organizations working with women, young people and other vulnerable populations.

Research findings: Being a principal recipient of the Global Fund



SECTION 4: Research findings: Being a principal recipient of the Global Fund

Summary:

This section summarises the findings of the research project in relation to Principal Recipients. It covers the role and selection of PRs, as well as MAs' experiences of being PRs within their countries.

Role of PRs

Within its CCP, a CCM should nominate one or more suitable PRs to be responsible for implementing the proposal and being accountable for the grant to the Global Fund. A PR may come from the governmental or non-governmental sector. Often, governmental PRs are Ministries of Health or subsidiaries. Meanwhile, examples of non-governmental PRs for HIV/AIDS and TB grants include: **Centro de Investigación, Educación y Servicios (CIES)** in Bolivia; **Association Comorienne pour le Bien-Etre de la Famille (ASCOBEF)** in Comoros; and **Asociación Dominicana Pro-Bienestar de la Familia (PROFAMILIA)** in Dominican Republic.

It is the PR, not the CCM, that enters into a legally binding grant agreement with the Secretariat of the Global Fund. Before this is signed, the PR is expected to prove to the LFA that it has the capacity to carry out all the tasks involved in managing the resources and supervising the implementation of the programme. The PR may identify and appoint multiple SRs to implement different aspects of the grant.

From the interviews carried out during the Models of Care research, it became clear that many MAs are not clear about the roles of PRs and SRs. For example, a common misunderstanding is that PRs cannot receive funds, whereas, in fact, it is they that sign the grant agreement, are accountable for the grant and select the SRs – for which they normally receive an administration fee to cover their related costs.

Role of PRs, Comoros and Dominican Republic

As a PR for a Global Fund grant in **Comoros**, the Association Comorienne pour le Bien-Etre Familial (Ascobef) receives a 5 per cent administration fee. However, the MA has found that this is insufficient to cover the true costs involved in carrying out the role required and is now trying to have the fee raised to 10 per cent.

In the **Dominican Republic**, Profamilia became a CCM member in 2004 when it was appointed as the PR for a TB proposal for the Global Fund. The proposal covers 18 of the country's 31 provinces, involves US\$ 4.5-5 million for 2004-2008 and enables the reach of the government's national TB programme to be extended. While Profamilia does not receive any programmatic money, it does receive 10 per cent administrative costs which it is using to finance the staff and other expenses needed to implement the work.

Profamilia finds its role as a PR challenging, including because it has responsibility for the finances, but does not, ultimately, have the power to control the situation. Also, as an NGO, it finds it difficult to administer funds for the government and feels that the Global Fund does not always fully understand the local situation that has, for example, been further complicated by a change in the government.

Selection of PRs

Within the Models of Care research, 29 MAs stated that the PR in their country is appointed, while 13 said it is elected and 4 did not know. Furthermore, 16 MAs said that they are in favour of continuing to select their PR, while 6 were against. Some of the comments on the subject included that:

- Election creates transparency and adheres to democratic principals (Panama, Sri Lanka, Tuvalu).
- Election ensures that the PR has credibility and the confidence of various stakeholders (Colombia, Dominican Republic).
- Election is important as the CCM is the national body recognised by the Global Fund to supervise the PR (Comoros, Morocco, the Philippines, Tonga).
- Election is appropriate, but some members of CCMs might use their powers or influence to vote for a PR in which they have a stake (Kenya).
- Appointment enables the choice of PR to correspond to objective and verifiable criteria, rather than sentimentality (Mauritania).

SECTION 4

Paragraph 15 of the Global Fund's Revised Guidelines state that:

“CCMs are required to put in place and maintain a transparent, documented process to nominate the Principal Recipient(s) and oversee programme implementation. The Secretariat will, as part of the proposal screening process, review the documentation setting out the nomination process and the minutes of the CCM meeting on the nomination of one or more Principal Recipients (PRs).”

“To avoid conflict of interest, it is recommended that PRs and Chairs or Vice Chairs of CCMs not be the same entity.”

Clearly, with the research showing that 69 per cent of 42 CCMs had appointed their PRs, many mechanisms will need to adjust their current practice if they are to meet the Global Fund’s Revised Guidelines and Guidelines for Proposals.

Experiences of being PRs

As noted, in many countries, the PR of grants from the Global Fund is the government. However, paragraph 20 of the Revised Guidelines states that:

When the PRs and Chair or Vice Chairs of the CCM are the same entity, the CCM must have a written plan in place to mitigate against this inherent conflict of interest. This plan must be documented and made public to ensure the highest levels of transparency and integrity. This plan should include, at a minimum, that the PR, or prospective PR, shall reclude itself from participation at the CCM meeting and shall not be present during deliberations or decisions related to the CCM’s monitoring and oversight of the PR, such as decisions related to:

- The selection of the PR.
- PR renewal for Phase 2.
- A substantial reprogramming of grant funds.
- Those that have a financial impact on the PR, such as contracts with other entities, including Sub-Recipients.”

According to the MAs participating in the research, 34 stated that the PR in their country was a CCM member, while 10 stated that it was not. Furthermore, 21 MAs stated that the PR is from the same organization as the Chair or Vice-Chair of the CCM. Finally, no MA reported any plan in place, in keeping with the Revised Guidelines, to mitigate conflicts of interest.

Experiences of being PRs, Dominican Republic and Togo

In the **Dominican Republic**, the HIV/AIDS proposal for the Global Fund was developed in 2002-3. Funding was due to be released in May 2004, but only some \$US 5 million has been received from the US\$ 47 million approved for 2004-2008.

As a PR, Profamilia will receive a percentage of funds to cover its administration and staff costs, plus resources for two programmatic areas:

- 1 condom social marketing programme for US\$ 2.5 million over 5 years to buy and distribute condoms to all other key agencies involved in the country’s Global Fund proposal, including NGOs and the government as well as non-traditional selling points such as motels and hotels.
- 2 youth-based HIV prevention programme for US\$ 400,000 over 2 years that extends existing efforts and focuses on HIV and pregnancy in barrios. This involves peer education among youth who provide sexual education to their peers in schools, communities or on the streets.

In **Togo**, The Association Togolaise pour le Bien-Etre Familial (ATBEF) is part of the Fédération des ONG du Togo which is a member of the CCM. ATBEF was involved in the development of the government’s proposal to the Global Fund in 2002 which was approved in 2003. The disbursement of two-year funding of \$US 14,185,638 began in 2004.

As an SR of the grant, ATBEF received US\$ 60,000 in 2004 and approximately US\$ 20,000 in 2005. This was to implement: training of some 200 peer educators for young people in and out of school; treating 30 HIV-positive women with anti-retroviral therapy; providing information on nutrition and social support to PLHIV; running a national telephone HIV/AIDS counselling hotline; and providing counselling at two VCT centres.

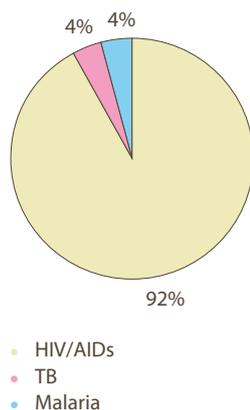
Recommendations Being a Principal Recipient of the Global Fund

- 5 MAs in eligible countries should advocate to their CCMs to enact the transparent and accountable **selection of PRs** for the Global Fund, in accordance with the Revised Guidelines. In particular, this should address the development and implementation of procedures to avoid conflicts of interest, for example whereby PRs and CCM Chairs/Vice Chairs are the same.
- 6 MAs considering becoming a **PR** for the Global Fund should start by carrying out a thorough analysis of the organizational advantages and disadvantages of the role. This should include an honest and accurate assessment of the true level of work and resources that would be involved and whether the administrative fee would be adequate.
- 7 MAs and IPPF should advocate to the Global Fund and its international contributors for the role of **civil society** organizations as PRs and SRs of grants. This should include providing ‘real life’ case studies of NGOs, including those focused on SRH, that have performed the role efficiently and effectively.

Research findings: Accessing funding from the Global Fund



Themes of funding: Areas for which MAs normally seek funding (48 MAs responded)



SECTION 5: Research findings: Accessing funding from the Global Fund

Summary:

This section summarises the findings of the research project in relation to accessing resources from the Global Fund. It covers MAs' experiences in relation to the levels of funding that can be secured, the process of developing proposals, the barriers to accessing funding, the themes of funding and the availability of funding for work on SRH.

Levels of success in accessing funding from the Global Fund

The Models of Care research showed that 59 per cent of MAs have submitted a proposal through their CCM. While high in percentage terms, this shows that a significant proportion of Associations are yet to use the Global Fund as a funding mechanism. Meanwhile, of those submitting a proposal, only just over half have had it approved.

Although a minority among MAs, for those that have successfully received support from the Global Fund, the experience has significantly increased their resources for HIV/AIDS-related work. The research also showed, however, that, once a grant has been approved, the release of funds is commonly delayed, in some cases by years. Some MAs, for example in Bulgaria, have been able to cope with the situation by providing bridging funds. However, the majority, such as in the Dominican Republic, Namibia and Sudan, do not have this capacity and have had to wait for the disbursement of funds – a situation that has both disrupted the implementation of their programmes and created uncertainty within their organizations.

Levels of success in accessing funding from the Global Fund, Morocco and Namibia

In **Morocco**, the Association Marocaine de Planification Familiale (AMPF) is an SR of the government's Global Fund grant of US\$ 5 million over 2005-6. In June 2005, the MA received US\$ 100,000 for two years to strengthen existing activities and implement a programme focusing on: training volunteer youth leaders and members of female-oriented NGOs; encouraging young people's creativity by organising concerts and festivals; and distributing condoms and contraceptives to young people in 12 regions.

The funds were disbursed only one month later than planned and have provided secure funding for two years. The intention that the next proposal, to be submitted in 2007, will enable new activities to be implemented, including the development of a network of PLHIV.

In **Namibia**, for the second Round of the Global Fund in 2002, the Namibia Planned Parenthood Association (NAPPA) developed a five year proposal covering 2003-2007, which was included in the CCP and subsequently funded. The programme is worth US\$ 150,000 over two years. It includes a staff member, a regional office, training of trainers in condom promotion and setting up a referral system with the Ministry of Health for treatment.

While the proposal was successful, the flow of resources has been slow, with the government only just releasing the first funds from the 2002 proposal. Due to the size of NAPPA's budget, the MA has had to wait for this release of funds before starting its operations. Furthermore, a fall in the US dollar during this period has decreased the overall value of the level of funding.

Developing proposals for funding from the Global Fund

Producing high quality proposals that meet the guidelines is central to accessing the Global Fund. However, the research showed that the capacity of MAs to undertake such work varies greatly. For example, the Sudan Family Planning Association (SFPA) is one of five agencies in the Sudan AIDS Network with the capacity to develop high quality proposals and is willing to give technical assistance to fellow members. Meanwhile, 19 other MAs say that they need support to develop proposals. As the Rwandan MA notes: "Writing a proposal will be a challenge for Association Rwandaise pour le Bien-Etre Familial (ARBEF). While the government and international NGOs have access to consultants to develop competitive proposals, ARBEF will be left to write its own proposal unless external technical support is provided."

The research also showed that MAs seek ways to simplify the proposal development process. For example, the Namibian Association found that developing a simplified template enabled it to deliver its proposal on time. However, as the Fijian MA experienced, even templates are not always a complete solution: "The proposal writing process was simplified through the use of a template, though this meant that proposals submitted to the Government conformed to the Government's focus rather than that of the Reproductive and Family Health Association of Fiji (RFHAF)."

Barriers to accessing funding from the Global Fund

The research indicated that MAs are under-utilizing the Global Fund, as well as having significant difficulty in developing proposals that are accepted by either their national CCM or the international Secretariat. Out of the 25 Associations that commented on why their proposals had been unsuccessful, the reasons included:

- Lack of information (40%).
- Proposal not being included in the CCP (18%).
- Proposal not meeting requirements (12%).
- National disagreement with the Global Fund (12%).
- Proposal not meeting the submission deadline (6%).
- Not being eligible to submit a proposal (6%).
- Proposal not following submission requirements (6%).

When added together, 64 per cent of unsuccessful proposals from MAs were due, totally or in part, to a lack of information and/or a lack of understanding, for example about the proposal process, submission deadline, etc.

Themes of funding from the Global Fund

As the research showed, the vast majority of MAs (95 per cent of those that have successfully submitted proposals to the Global Fund) have focused on either HIV/AIDS or a combination of HIV/AIDS and malaria.

This focus on HIV/AIDS is even clearer when a comparison is made to areas for which an MA would normally seek funding (see boxes). Indeed, many Associations noted that, in relation to TB and malaria, they either do not possess the required expertise and/or the government is seen as the lead agency for those diseases in their country.

When asked why they had chosen the thematic area of their proposal, the largest groups (44 per cent and 41 per cent of the 34 MAs that responded) said that it was because of their organization's strategic plan or because of the link to SRH (which is within IPPF's mandate and incorporates HIV/AIDS) (see box). As such, 85 per cent of those MAs are seeking funding according to their strategic priorities.

Interestingly, even when a CCP is successful, an MA may decide to reject an offer of funding, particularly if the work would not correspond to their strategic direction (see box).

Themes of funding from the Global Fund, Colombia and Sudan

In **Colombia**, the CCM requested that Profamilia receive Global Fund resources. However, the MA did not accept the offer. This was because the conditions of the grant would have caused it to diversify into non-core areas, taking it away from its priority of providing SRH services and implementing programmes for the most vulnerable people.

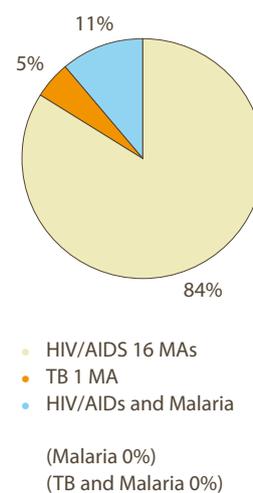
In 2004, the **Sudanese** Government's proposal for US\$ 20 million over five years for the North of the country was approved by the Global Fund. The initial proposal by the Sudan Family Planning Association (SFPA) had been for US\$ 300,000 for one year to provide services to a range of target groups, including sex workers, prisoners, tea sellers and truck drivers. However, the approved proposal was for US\$ 60,000 for one year to provide services such as: comprehensive sexually transmitted infection (STI) management; VCT; outreach, including the provision of condoms and information, education and communication materials in Arabic; and HIV awareness by service providers, volunteers and peer educators. Subject to a mid-term review, the activities will continue for the coming four years.

Originally, SFPA's funding should have been released in February 2005, but, due to problems with documentation, it was the subject of delay. This, in turn, postponed the start of the programme. However, despite these challenges, the Global Fund's resources are welcomed by the MA as they enable both SFPA and the government to significantly increase their responses to HIV/AIDS.

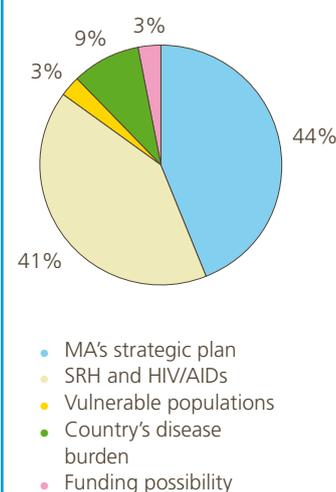
Funding for sexual and reproductive health from the Global Fund

Within the Models of Care research, 15 MAs (33 per cent of those responding) stated that there had been a call for proposals on SRH issues in their country, while 30 (67 per cent) said that there had not and 9 did not know. Two MAs (Tonga and Tuvalu) reported that they had successfully submitted proposals for SRH work (as SRs), but 7 reported being unsuccessful and 11 did not yet know the outcome.

Themes of funding: MAs successful proposals (19 MAs responded)



Themes of funding: Reasons why MAs chose the thematic area (34 MAs responded)



Funding for sexual and reproductive health from the Global Fund, Turkey

In Turkey, the CCM submitted a CCP to the Global Fund that included an SRH component focusing on sex workers. However, the Executive Board of the Family Planning Association of Turkey (FPAT) decided not to accept the funding – as sex workers were a target group with which the Association did not have experience.

Recommendations

Accessing funding from the Global Fund

- 8 MAs and IPPF should proactively advocate to the Global Fund on the **comparative advantages** – both financial and programmatic – of mainstreaming SRH and HIV/AIDS responses. (See Annex 3 for advocacy points).
- 9 MAs in ineligible countries should support those in eligible countries by taking one or more steps to **get involved** with the Global Fund, influence the process and/or access to funding. These might include:
 - Offering **capacity building**, such as in proposal writing, to MAs in eligible countries that require support; and/or
 - **Advocating** to their own government to provide increased funding to the Global Fund.
- 10 MAs and IPPF should provide feedback on funding and other issues by starting/continuing involvement in the Global Fund's **Partnership Forum**. This should include maximising opportunities for involvement not only in, but between, the Forum's formal bi-annual meetings.
- 11 IPPF should act as a **'global watchdog'** and **'clearing house'**, identifying, analyzing and disseminating information about the Global Fund and how MAs can access its resources. It should also promote the cross-regional exchange of both financial and programmatic lessons learned among SRH organizations that are currently, or potentially, involved in the Fund's mechanisms.

Conclusion

To date, the involvement of members of IPPF in the Global Fund has been extremely varied. Overall, however, MAs are clearly interested in becoming more involved in the processes that the Fund has catalysed, as well as accessing funding. Relevant and timely communications by IPPF about the Global Fund, as well as among NGOs and other in-country stakeholders about their CCM, are key to expanding that engagement.

The findings of this report confirm the experiences reported by other NGOs that there are significant bottlenecks in the disbursement of Global Fund resources to civil society organizations. While not exclusively, many of the related problems lie in-country. As such, MAs have both an interest and vital role in advocating for more efficient and timely processes among the relevant agencies and, ultimately, achieving the Global Fund's goal of being 'a new way of doing business.'

The recommendations proposed throughout this report, and consolidated in the Executive Summary, should be assessed by IPPF, MAs and their partners and acted upon as soon as possible. The integration of SRH into HIV/AIDS responses and vice versa is clearly beneficial for organizations and recipients alike, as well as consistent with the core work of IPPF. The Global Fund offers a vital opportunity to realise and expand the Federation's services globally, reaching millions of people. It is an opportunity that should not be missed.

Member Associations that participated in the research

Member Associations that completed the questionnaire		
Region	Countries	Total
Africa Regional Office	Benin, Botswana, Burkina Faso, Burundi, Comoros, Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Lesotho, Madagascar, Malawi, Mauritania, Mauritius, Namibia, Niger, Rwanda, São Tomé, Seychelles, South Africa, Tanzania, The Gambia, Togo, Zambia	24
Arab World Region	Bahrain, Djibouti, Egypt, Iraq, Lebanon, Morocco, Palestine, Sudan, Syria, Tunisia, Yemen	11
European Network	Austria, Bulgaria, Cyprus, Finland, Georgia, Ireland, Netherlands, Russian Federation, Turkey, Slovakia, Switzerland, United Kingdom	12
East and Southeast Asia and Oceania Region	China, Cook Islands, Fiji, Hong Kong, Indonesia, Kiribati, Malaysia, Mongolia, New Zealand, Papua New Guinea, Philippines, Samoa, Singapore, Solomon Islands, Thailand, Tonga, Tuvalu, Vanuatu, Vietnam, unidentified ESEAOR country	20
South Asia Regional Office	Bangladesh, India, Iran, Maldives, Nepal, Pakistan, Sri Lanka	7
Western Hemisphere Region	Costa Rica, Colombia, Dominican Republic, Haiti, Guatemala, Nicaragua, Panama, Saint Lucia, Surinam, Trinidad and Tobago, unidentified WHR country	11
Total		85

Member Associations that were interviewed		
Region	Countries	Total
Africa Regional Office	Comoros, Ethiopia, Kenya, Namibia, Rwanda, Togo	6
Arab World Region	Lebanon, Morocco, Sudan	3
European Network	Bulgaria, Georgia, Turkey	3
East and Southeast Asia and Oceania Region	Fiji, Thailand, Vanuatu	3
South Asia Regional Office	Sri Lanka	1
Western Hemisphere Region	Colombia, Dominican Republic, Trinidad and Tobago	3
Total		19

Useful Resources on the Global Fund

- Global Fund to Fight AIDS, TB and Malaria. www.theglobalfund.org
- Global Fund (2005). Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility. http://www.theglobalfund.org/pdf/5_pp_guidelines_ccm_4_en.pdf
- Other Global Fund policies and guidelines: http://www.theglobalfund.org/en/about/policies_guidelines
- Global Fund pledges – a note for use by advocacy groups. http://www.theglobalfund.org/en/media_center/press
- USAID and GTZ (2004). The Global Network of People Living with HIV/AIDS (2005). Challenging, Changing, and Mobilizing: A Guide to PLHIV Involvement in Country Coordinating Mechanisms. http://www.policyproject.com/pubs/policyplan/CCM_Handbook.pdf <http://www.gnpplus.net/files/CCM-Handbooks/handbook-EN.pdf>. GNP+ has released translations in French, Russian and Spanish. <http://www.gnpplus.net/files/downloadpage.html>
- Global Fund Observer (GFO) Newsletter – a bi-monthly, independent source of news, analysis and commentary about the Global Fund. To receive it, send an email (subject line and text can be left blank) to: receive-gfo-newsletter@aidspan.org. For GFO background information and previous issues, see www.aidspan.org/gfo
- A collection of papers on the Global Fund, see www.aidspan.org/globalfund and www.theglobalfund.org/en/about/publications. Global fund financing – key messages <http://www.aidspan.org/globalfund/appeal/messages-en.htm>
- Health, Population, and Nutrition: News & Notes. A weekly newsletter supported by GTZ. Email Dieter Neuvians dieter.neuvians@gtz.de
- Global Fund (2004). The CCM-Forum of the Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM): Towards Transparency Through Information Sharing. <http://www.theglobalfund.org/pdf/ccms/CCM%20Forum%20of%20the%20Pacific%20Islands.pdf>
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- Global Fund (June 2004). Country Coordinating Mechanisms Building Good Governance. Global Fund to Fight AIDS, Tuberculosis And Malaria. Discussion Paper. <http://www.theglobalfund.org/pdf/ccms/CCM%20Building%20Good%20Governance.pdf>

Facts and figures

- Nearly 50 per cent of all adult PLHIV are women. Nearly 60 per cent of those are in Sub-Saharan Africa.
- In Sub-Saharan Africa, 76 per cent of young PLHIV (aged 15-24 years) are female.
- Women are more physically susceptible to HIV infection than men. Male-to-female HIV transmission during sex is about twice as likely to occur as female-to-male transmission.
- Millions of young people are becoming sexually active each day, without access to HIV prevention services.
- For many women in developing countries, the HIV prevention approach of 'ABC' (abstinence, being faithful/reducing the number of sexual partners and condom use) is ineffectual.

The starting point for integrating SRH into HIV/AIDS programmes and vice versa must be an acknowledgement that most HIV transmission is sexual.

Mainstreaming HIV/AIDS into SRH programmes

- SRH providers serve millions of women in developing countries, many of which have significant HIV epidemics. Many women come into contact with the health care system seeking reproductive health services, either within clinical settings or through community-based distribution programmes. These points of contact are opportunities to reach women with HIV prevention information and services.
- Providers of SRH services have knowledge and skills that form a solid basis upon which stepped-up interventions for HIV prevention, care and support and treatment can be built. Although there are many things that providers of SRH can do, they can begin by emphasizing: HIV counselling and testing; condom promotion; management of other STIs; and contraceptive services.
- As such, providers of SRH services are poised to play an important role in reducing the incidence of new HIV infections over the coming years.

Including SRH in HIV/AIDS programmes

- Key steps include that:
 - Projects to prevent mother-to-child HIV transmission should include contraceptive services to offer the choices/means to avoid future pregnancies.
 - HIV VCT centres should provide men and women who are engaging in risk-taking sexual behaviour(s) with information and the means to help prevent all unintended outcomes of unprotected sex, including unwanted pregnancies.
 - Providers of HIV/AIDS-related care and treatment need to be aware that, for most HIV-positive men and women, diagnosis does not mean an end to their sexual lives or reproductive aspirations. PLHIV will have continuing SRH wants and needs that must be responded to. For example, some may want to have a baby, whereas others may want to avoid pregnancy.
- To date, integration has been largely in one direction. For example, while equipping SRH providers with HIV/AIDS counselling facilities is discussed, equipping HIV/AIDS VCT centres to offer SRH is not. Pointing out the benefits of two-way integration is an important part of expanding the possibilities for supporting integrated SRH and HIV/AIDS responses within CCMs and the Global Fund.

Case Study: Monitoring Civil Society Involvement in the Global Fund, Kenya

Introduction to project

This case study describes a one-year project between the Family Planning Association of Kenya (FPAK) and the Kenya Consortium to Fight AIDS, Tuberculosis and Malaria (KECOFATUMA). The project aimed to monitor the management of the Third Round of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), particularly in relation to the participation of civil society in all aspects of the relevant processes.

Background to project

Since 1962, FPAK has played a key role in reproductive health in Kenya. It has collaborated with the government to improve the health status of the population and currently has programmes focusing on sexual and reproductive health (SRH) in nine districts. As HIV/AIDS has escalated, NGOs/CBOs have looked to the Association to provide leadership on the relationship between SRH interventions and the epidemic.

As the Global Fund became established in Kenya, concerns began to emerge about the processes involved in distributing its resources. These included claims that some organizations had received funding due to their close relationship with the government. While this information could not be verified, it was powerful enough to potentially have far-reaching effects on the country's action on the three diseases.

In response, in 2003, FPAK became a co-founder of KECOATUMA. Since its formation, the Consortium has been at the forefront of sensitizing civil society about the Global Fund and, in particular, closing the information gap between the sector and the government. It currently has 500 NGO/CBO members, 370 of which are active.

Issues from Round 2

In the previous, second round of the Global Fund, the Ministry of Finance was the sole Principal Recipient (PR). Resources flowed directly from the Ministry to government implementers – the National AIDS Control Council (for HIV/AIDS) and the Ministry of Health (for TB and Malaria). Meanwhile, for civil society, they went through a Financial Management Agency.

During the Round, alongside the vast majority of funds being allocated to government bodies (see box), civil society had other concerns. These included that there was a general lack of transparency and sharing of information within the processes related to the Global Fund, for example with reports of the Country Coordinating Mechanism (CCM) not being accessible to all stakeholders.

Percentage of funds allocated during Round 2 of the Global Fund						
Sector	Budget year					Total
	1	2	3	4	5	
Government	76%	77%	80%	80%	81%	71%
NGOs/CBOs	14%	13%	10%	10%	9%	11%
PLHIV	4%	4%	4%	4%	4%	4%
Faith-based organisations	2%	2%	2%	2%	2%	2%
Private sector	2%	2%	2%	2%	2%	2%
Academic/ educational groups	1%	1%	1%	1%	1%	1%
Others	1%	1%	1%	1%	1%	1%
Total US\$ million	\$16.8	\$19.9	\$24.4	\$30.3	\$37.6	\$129.1

Project purpose, objectives and levels

The **purpose** of the one-year FPAK/KECOFATUMA project was to improve the management of Global Fund grants in Kenya, including the disbursement of resources to civil society organizations implementing HIV/AIDS projects. Its **objectives** were:

- To **improve accountability and transparency** in the application, appraisal and approval of proposals submitted to the Global Fund by monitoring the process and reporting to the Ministry of Health, members of the Consortium and donors.
- To **strengthen the capacity** of local NGOs/CBOs to manage Global Fund resources.

The project worked at **three levels**:

- 1 National/policy-making level** This included: sensitizing the government about the project; sensitizing key members of the CCM on the need for independent monitoring; and monitoring equity and efficiency in Global Fund resource allocation and/or programme implementation.
- 2 Middle management level** This included: developing common mechanisms for advocacy around Global Fund/CCM processes; and working with national networks and other lead agencies, including KECOFATUMA and other consortiums and NGO umbrella organizations.
- 3 Community level** This included: empowering civil society actors to effectively participate in Global Fund processes, working indirectly through middle-level lead agencies to enable them to make informed applications for funding and to then implement programmes as described in their proposals.

Project process

To implement the project, FPAK/KECOFATUMA planned a range of strategies:

- 1 Defining the project process and operation:** Holding a two-day planning meeting, resulting in a work plan, terms of reference and roles for the consortium.
- 2 Enhancing capacity to deliver the project:** Buying data processing equipment to set up a database of KECOFATUMA members and facilitate ongoing discussions and information flow.
- 3 Advocacy work with the CCM as a unit:** Holding a one-day advocacy meeting with the CCM secretariat to discuss the complementary role of KECOFATUMA and share the consortium's final terms of reference and work plan. To follow-up, it was planned to hold regular consultative meetings to review the progress made by the CCM in analyzing proposals submitted by various agencies and to then give feedback during the quarterly meetings.
- 4 Advocacy work with the CCM as small groups:** Lobbying the other members of the CCM in smaller groups or on a one-to-one basis. Two sensitization meetings were planned with government ministries and agencies (such as the Ministry of Health and NGOs Bureau) where KECOFATUMA would explain its new mandate and solicit their support.
- 5 Training and capacity building of civil society players:** Holding a one-week capacity building exercise for KECOFATUMA members to build skills (such as proposal development, grant management and monitoring and evaluation) to support the management of Global Fund projects.

The project's activities were estimated to cost US\$ 24,000, with funding solicited from KECOFATUMA's members and the Global Fund's local office.

Project steps

The project included the following key steps:

- **Preparing as consortium members:** Holding a two-day planning meeting for members of KECOFATUMA's steering committee to redefine the consortium's role and develop an advocacy plan to sensitize key government ministries and other stakeholders on the purpose of the project.
- **Mobilising other stakeholders:** Holding a one-day meeting for other consortiums and NGO umbrella organizations – including those focused on church groups, orphans and vulnerable children and people living with HIV/AIDS – to orientate them to the project.
- **Engaging with the CCM:** Holding a sensitization meeting for 20 representatives of relevant government ministries, including the National AIDS Control Council, National AIDS and STD Control Program, Ministry of Health, Ministry of Education and Ministry of Home Affairs.
- **Involving donors:** Holding a meeting with donors to inform them about the aim of the project, share outcomes from previous meetings and solicit their support.
- **Supporting selected civil society implementers:** Holding a two-day orientation meeting for 40 KECOFATUMA members from different regions of the country. This aimed to introduce them to the Global Fund and its application process and to share the outcomes of the first meetings. The participants were asked to share what they learned with other members who were not present.

Project monitoring and impact analysis

It was planned that the project would be monitored through performance review meetings involving the Ministry of Health, National AIDS Control Council, NGO Council and KECOFATUMA. The key performance indicators included: the number of people trained; the number of consultative

meetings held; and the number of responsive actions taken by the CCM and/or KECOFATUMA as a result of the project's recommendations. Meanwhile, at the outcome level, the indicators included the number of NGOs funded, and the number of stakeholders reporting confidence in the work of the CCM.

In terms of impact, the project established a forum that will continue to support collaboration between government and civil society stakeholders in their respective umbrella organizations. This will facilitate the exchange of information and, in turn, develop ways to work together and enhance impact. Furthermore, the project has led to FPAK and KECOFATUMA gaining the mandate to:

- Develop ethical standards for civil society actors in the Global Fund process.
- Establish self-regulating mechanisms within civil society organizations to increase the legitimacy of programmes and organizations.
- Be represented on the national HIV/AIDS monitoring and evaluation committee.
- Provide links between communities and government to enhance information flow.

Challenges and lessons learned

During its implementation, the project experienced a number of **challenges**. These included the degree to which KECOFATUMA could continue to be an 'independent' monitor once it had been co-opted onto the CCM, as well as misunderstandings among NGOs/CBOs that participation in capacity building activities would guarantee funding.

Meanwhile, the project also produced a number of **lessons learned**. These included that:

- Despite the availability of print and electronic information, community actors often know little about the Global Fund. As such, setting up forums to facilitate direct contact is vital for dispelling misinformation and building understanding.
- To develop direct contact forums and ensure that messages reach the community level, a variety of different civil society networks and umbrella organizations need to work in a collaborative and complementary way.
- Involving a wide range of stakeholders promotes ownership and ensures a strong advocacy network that facilitates transparency, inclusiveness and the smooth flow of information. This enables consensus to be reached quickly which, in turn, increases the potential to influence the government and the CCM.
- The government's acceptance of a project of this nature largely depends on how it is 'marketed'. Dialogue and lobbying tend to achieve more than confrontation.
- To get more funding, civil society needs to demonstrate its comparative advantage and how it can complement the efforts of the government and other stakeholders.
- A project such as this requires a longer timeframe. This is because credibility and relationships have to be built before any strategies can be implemented.

