Engaging Faith-Based Organisations in the Global Fund

Conference Report

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Table of contents

Conference Report ........................................................................................................ 1
Table of contents ............................................................................................................. 2
ABBREVIATIONS ......................................................................................................... 4
Workshop programme ................................................................................................. 7
Workshop objectives .................................................................................................... 8
OPENING DEVOTION .............................................................................................. 9
Welcoming remarks ................................................................................................... 12
Role of FBOs in scaling-up towards universal access and strengthening health services ........................................................................................................................ 14
Open forum: ............................................................................................................... 17
Overview of Global Fund and status report on the Involvement of FBOs in the GF .................................................................................................................................. 18
Overview of the African Christian Health Associations Platform ......................... 22
Involvement of FBOs in Country Coordinating Mechanisms (CCMs) .................... 24
Open forum................................................................................................................ 26
List of CCM’s ........................................................................................................... 27
Election and participation by CCM’s ........................................................................ 30
Round 8 guidelines and proposal format ................................................................ 33
The budget ................................................................................................................ 35
Role of donor funds in FBO’s .................................................................................. 36
New Developments in for R8 ................................................................................ 36
Community systems strengthening ......................................................................... 37
Open forum ............................................................................................................... 40
Country Experiences: Multi-Country Experiences ............................................... 42
Planning and Managing GF Proposal Development .............................................. 45
RESOURCES ............................................................................................................. 47
Institutional and programmatic capacity of PRs ...................................................... 48
Management of sub-recipients .............................................................................. 49
Programme implementation ................................................................................. 50
Performance-based funding ................................................................................... 50
Accessing GF funds ................................................................................................. 52
Open forum ............................................................................................................... 53
Country Experience of FBOs as PRs .................................................................... 56
Selection of SRs ........................................................................................................ 57
Results and achievements: ................................................................................... 58
Lessons learnt ........................................................................................................... 58
Why CHAZ has been successful as a PR ............................................................... 59
Challenges ............................................................................................................... 59
Requirements for aspiring FBO’s ......................................................................... 60
Zimbabwe Association of Church Hospitals (ZACH) ......................... 60
Open forum .................................................................................... 61
Questions ....................................................................................... 61
Group work: .................................................................................. 64
Involvement of CHAM in GF: ......................................................... 65
Challenges: .................................................................................... 66
General challenges in HIV/AIDS project: ....................................... 66
Open forum .................................................................................... 67
Country Experience on management of sub-recipients – Cameroon .. 68
Open forum .................................................................................... 69
Questions ....................................................................................... 70
Recommendations from the group: .................................................. 71
Country Experience on management of sub-recipients – Tanzania: ... 72
Recommendations .......................................................................... 74
Overview of performance Monitoring and Evaluation indicators in the
Global Fund ..................................................................................... 75
M&E system strengthening tool ....................................................... 77
Strengthening M&E Systems ......................................................... 77
WHO perspective ........................................................................... 79
UNAIDS Perspective ..................................................................... 82
PEPFAR Perspective ...................................................................... 83
ABBREVIATIONS

FBO.................................Faith Based Organization

TACAIDS...........................Tanzania Commission for AIDS

CSO.................................Civil Society Organization

CSSC.................................Christian Social Service Commission

CHAK.................................Christian Health Association of Kenya

WCC.................................World Council of Churches

PHC.................................Primary Health Care

PLHA.................................People Living With HIV/AIDS

GFATM..............................Global Fund to fight AIDS, TB, Malaria

TSF.................................Technical Support Facility

CSAT.................................Civil Society Action Team

GFTS.................................Global Fund Technical Support

USGFTS..............................US Global Fund Technical Support

PHC.................................Primary Health Care

MDGs.................................Millennium Development Goals

TB.................................Tuberculosis

PP.................................Public Private Partnerships
ABBREVIATIONS CONTD…

TRP...........................................Technical Review Panel
CSO...........................................Civil Society Organizations
EHP...........................................Emergency Hiring Programme
M&E........................................... Monitoring and Evaluation
ZANAC........................................Zambia National AIDS Council
CHAZ.................................Christian Health Association of Zambia
GFATM............................Global Fund to Fight AIDS TB & Malaria
SDAs........................................Service Delivery Areas
TRP...........................................Technical Review Panel
NACPs..................Not sure
RFA...................Request for
LFA.............................Local Funding Agent
UNAIDS............................United Nations Joint Programs on HIV/AIDS
PBF..............................Performance based Funding
RCC.................................Rolling Continuation Channel
TA..........................Technical Assistance
LWF...........................Lutheran World Federation (LWF),
CHIs..................Christian Health Institutions
ABBREVIATIONS CONTD…

VCT........................................Voluntary Counselling and Testing
OI..........................................Opportunistic Infections
SSR..........................................Sub sub Recipient
USGFTS................................US Global Fund Technical Support
TB..........................................Tuberculosis
CCM........................................Country Coordinating Mechanism
TA...........................................Technical Assistance
PEPFAR.................................Presidents Emergency Plan for AIDS relief
CDC.................................Centres for Disease Control and Prevention
WHO.........................World Health Organization
PR...............................Principle Recipients
SR............................Sub-Recipients
Workshop programme

Day One
- Setting the scene and reviewing resource investments made so far by the Global Fund to faith-based implementers and to HIV/AIDS, TB and malaria in general
- Reflecting on CCMs: current experiences vs. guidelines and requirements
- Proposal development processes: new developments vs. learning from previous proposals

Day Two
- Provide guidance on the minimum requirements of the Global Fund on performance based funding
- Share experiences of faith based organizations as implementing principal recipients and sub-recipients of Global Fund resources
- Provide guidance on indicators for monitoring and evaluation
- Provide guidance on available facilities and modes of technical support

Day Three
- Provide a platform to examine the contributions made by faith based organisations to strengthening primary health care systems
- Share experiences of FBOs on the systems of delivery
- Examine how best to accelerate delivery of services to vulnerable groups
Workshop objectives

1) Review resource investments made so far by the Global Fund to faith-based implementers

2) Provide a platform to learn from the contributions of FBOs, to Country Coordinating Mechanisms and to implementation

3) Provide guidance and share experiences on developing ambitious but effective proposals for funding by the Global Fund

4) Provide guidance on the minimum requirements of the Global Fund on performance-based funding (financial, monitoring and evaluation etc)

5) Provide a platform to examine the contributions made by faith-based organisations to strengthen primary health care systems and how to best effectively scale up future contributions to PHC
OPENING DEVOTION

Opening devotion and official opening by the Most Reverend Njongokulu Ndungane, former Archbishop of the Anglican Church of South Africa

The Archbishop began by reading from Joshua 1:5. He said the Christian Church, which was born during the Easter period, had a significant role to play in the work of faith-based organisations working in the area of health. Adding that without the resurrection there would not have been a Christian Church, he urged participants to work hard towards propagating the call of Christ for healing in the World.

Archbishop Ndungane
Official Opening

Archbishop Ndungane began by observing that since 2002 when the Global Fund was created, it had invested more than US$7 billion in 136 countries, proving to donors that it could deliver effectively and efficiently. He noted that in the last pledging round in September 2007, donors promised a total of US$9.7 billion for the fund over the next three years, the largest single financing for health ever. In Round 7, the last round of approving spending, GF had endorsed 73 grants worth over US$1.1 billion, the first time in history that an approved funding went beyond the US$1 billion mark. Of note is that 80 per cent of this funding was destined for low-income countries.

He added that GF was now set to move towards annual commitments of between US$6-8 billion by 2010 following last year’s pledges. A major challenge of this enormous increase in GF funds was to spend the money responsibly, professionally and transparently in ways that are effective and sustainable. This was necessary to ensure that lasting support was provided to those who needed it and donor confidence was maintained.

Archbishop Ndungane noted that FBOs were at the forefront of fighting malaria, TB and HIV/AIDS, adding estimates indicated that faith communities could reach every individual in sub-Saharan Africa in a week or two due to their far-reaching networks. He urged FBOs to take courage while offering their services as God was on their side as they supported the sick, suffering and marginalized.

He said times had changed and donors were now more willing to work with FBOs upon realising that religious communities were vital partners in development. This conclusion was notably reached by the former
president of the World Bank James Wolfensohn and the Commission for Africa.

Saying FBOs were the ones on the ground, not the experts, he added that the doors were wide open to partner with those interested in fighting poverty and disease in Africa.

The Archbishop explained that the GF had taken steps to ensure civil society groups, including FBOS, received more resources. These included the decision by the GF Board that the Fund must ensure effective participation by civil society especially in in-country implementation of programmes. In addition, the civil society angle must be considered in all funding proposals, and if not, reasons given. In addition, he noted that the Fund had made a commitment to support programmes directed at building the capacity of organisations working at the community level, something from which FBOs could benefit. Further, he noted that GF would be able to contribute to:

- Large-scale strengthening of in-country health systems
- Upgrading infrastructure
- Purchasing equipment
- Reinforcing procurement and supply management systems in the health sector
- Building up human resources at every level
Welcoming remarks

Dr. Fatma Mrisho – Executive Chair, TACAIDS

Dr Mrisho began by explaining the role of TACAIDS in the fight against HIV/AIDS in Tanzania. She said the organisation, which is under the Prime Minister’s Office, coordinates all activities related to HIV/AIDS in the country, especially those relating to CSOs and FBOs.

She explained that FBOs by virtue of their relationships and proximity to the communities that they serve had a great role to play in the fight against HIV/AIDS.

She also thanked CSSC, CHAK, WCC and Global Fund (GF) for organising the workshop, saying it was timely.

She pointed out that Tanzania had been enjoying GF support for five years, adding the discussion on PHC scheduled for the final day would be welcome given that PHC was the best approach in supporting People Living with HIV/AIDS.

She pointed out that Global Fund works systematically and timely and appropriate reporting were fundamental.

She also appealed for assistance to respond to negative messages by religious leaders in Tanzania on condom use, adding this would complicate the fight against HIV/AIDS in the country.
Rt. Rev. Joseph Wasonga – Chairman, CHAK

Bishop Wasonga explained that CHAK had been called upon to coordinate the workshop as it hosted the Africa Christian Health Associations Platform, which facilitates networking among Christian Health Associations in Africa. The Bishop thanked the world community for their support to Kenyans during the post-election violence in the early part of 2008. He noted that the violence had led to change of venue for the workshop from Nairobi to Dar es Salaam.

Dr. Manoj Kurian – WCC

Dr Kurian thanked the Global Fund for empowering FBOs with resources to carry out health programmes. He said FBOs not only needed to work towards acquiring GF support, but also to be accountable and responsible. He noted that there was need to help those serving the people to do so in a professional manner.
Role of FBOs in scaling-up towards universal access and strengthening health services

*Dr. Banda Mazuwa, WHO, and Dr. Luc Barriere-Constanti, UNAIDS*

Dr. Mazuwa started off with an overview of the MDGs and health challenges in regions around the world. He then expounded on issues concerning universal access towards the elimination of Malaria, control of TB and HIV prevention, treatment and care.

The workshop heard that health systems in areas mostly affected by disease are overburdened and hence unable to deliver services to the people who need them most. It is for this reason that GF Round 8 would target health systems strengthening. Among the challenges faced are inequalities, inefficiency, lack of financial and human resources, exclusion e.t.c. Dr Mazuwa urged FBOs to push towards attaining universal access and ultimately meeting the MDGs.

The WHO was founded 60 years ago with the objective of the attainment by all peoples of the highest possible health levels. Among the six WHO agendas, Dr Mazuwa added, was partnership.

Given FBOs’ contribution to health care the world over, it was important for both governments and international organisations to build partnerships with them. Some areas of collaboration, he pointed out, include:

- Developing the concept of primary health care consensus
• Developing relationships among FBOs and governments & international organizations

• Supporting FBOs to mobilize resources and build capacity

• Promoting constructive relationships between FBOs and government

Dr. Luc Barriere-Constantin from UNAIDS expounded on the principles of universal access to health care as follows:

• **Equitable**: available to rich and poor, mainstream and marginalized

• **Accessible**: locally relevant and meaningful, used without fear of prejudice or discrimination

• **Affordable**: cost should not be a barrier to commodities

• **Comprehensive**: prevention, treatment, care and impact mitigation must be linked and delivered with the full inclusion of civil society

• **Sustainable**: Services must be available throughout people’s lives. New technologies and approaches must be developed.

He further explained the achievements and gaps to universal access in HIV/AIDS in sub-Saharan Africa, saying communities of faith were critical in assisting the global community to achieve universal access to prevention, treatment, care and support services for HIV.

Given increased resources in the fight against HIV/AIDS, FBOs needed to position themselves and tailor-make their responses to the pandemic to access such funds.

He noted that faith communities continued to provide a large proportion of prevention, treatment care and support services for HIV patients including spiritual encouragement, giving knowledge, compassionate care,
moral information, respectful relationships, curative interventions and material support, going way beyond service provision. Faith communities were also vital to the global advocacy movement, helping to hold governments accountable to their promises on AIDS and continued to provide leadership for responses to HIV/AIDS.

Given that faith communities were present at every level of HIV/AIDS responses, shaping thinking and values, it was essential to work with faith leaders to ensure their interventions had a positive influence.

Entry points for FBOs:

At country level, these include

- Revision/development of national and decentralized strategic and operational plans
- National and decentralized M&E mechanisms
- 2008 mid-term review of progress
- National UNGASS reporting process
- Partnership forums/committees
- Increased and mutual accountability

Tools and support to build the capacity of FBOs to access resources and engage at the national level include:

2. The Ecumenical Advocacy Alliance “Keep the Promise Campaign” hold leaders accountable for promises on AIDS. [http://www.e-alliance.ch/keepthepromise.jsp](http://www.e-alliance.ch/keepthepromise.jsp)

3. Technical support for civil society- UNAIDS TSF’s and CSAT


Open forum:

**Questions:**

i) How does WHO ensure health security?

ii) Things are complicated in some countries. There are several NGOs in some places, especially post war areas like Southern Sudan. How can we ensure that funds reach the grassroots? What about the sustainability question?

**Responses and discussions:**

Resources must get to the grassroots and we need to find a mechanism for facilitating this. Through active participation and representation, we can register success in advocacy, lobbying and other activities. If FBOs are delivering about 40% of the services, they must be full partners to Governments. It is important to remember that health is part and parcel of human security.
Overview of Global Fund and status report on the Involvement of FBOs in the GF

*Dr. Christoph Benn – Director of External Relations, Global Fund*

Dr. Benn spoke on shared values, the GF Model, results of involvement of FBOs to date and steps for the future.

On shared values, he said GF and FBOs believe in the unconditional value of human life, have a passion for justice and equity and global solidarity. He explained that the GF was an independent organisation applying the PPP principals and mandated to raise and spend money in the fight against AIDs, TB and Malaria. The GF is operating in 136 countries with 520 programmes. So far, US$.19.7 billion has been pledged and US$.10.7 committed towards this goal. GF is the only Institution which has gone
beyond the donor limit of US$.1 billion. For round 8, US$ 2 billion has been set aside but can be beyond depending on the requests presented.

Explaining the GF’s guiding principles, Dr Benn said GF offered as a financial instrument and was not an implementing entity. The GF makes available financial resources, supports programmes in a balanced manner and propagates balanced prevention and treatment.

He further explained that several bodies ensure support is not provided in a biased manner. Proposals received at GF go through the Technical Review Panel (TRP) before they reach the Board for decision-making, then to the Secretariat for execution.

Currently, 11 FBOs are Principal Recipients (PRs) while 488 are Sub-Recipients (SRs). About 5.4% of funding worldwide goes to FBOs. Although this percentage may look small, the gains are huge. Dr Benn added that though not many FBOs are funded as PRs or SRs, they receive drugs and supplies through central the supply systems of their countries’ Ministries of Health.

Out of 120 CCMs worldwide, FBOs are represented in 94, representing 78.3% of the total representation. The average percentage of FBO membership in the CCM is 6%.

Dr Benn challenged participants to explore opportunities for Round 8 and beyond, adding that new innovations including dual track financing, community systems and health systems strengthening would be explored.
Open forum

Questions:

i) Given the variety of FBO capacities, is it important to distinguish between international and local FBOs?

ii) Can multi-country approaches be considered?

iii) If FBOs are contributing 40% of services in Africa, why not have different CCMs for FBOs? The resources made available to FBOs in EA do not relate to representation in CCMs.

iv) What about supporting traditional methods of healing as they are accepted and contribute greatly to health care?

v) Can the TPR be considered to be objective?

vi) What are the criteria for funds distribution? Why do we have 11.6% funding for West Africa and 4% for East Africa?

vii) On financial needs to support different programmes from other bodies like UNAIDS, what is the state of ownership between UNAIDS and GF?

viii) Advocacy and lobbying for accessing GF is not adequate. Please comment.

ix) Could you revise GF guidelines to suit African problems?

x) On evaluating FBOs, what is the success rate in implementing projects? Do FBOs have the capacity to utilise the funds?

xi) Can GF earmark certain funds for CSOs and FBOs keeping in mind that they are marginalized in CCMs? (Gave an example of the Kenya CCM)
xii) What channels can GF utilise to deliver information about application for funds for FBOs on time?

xiii) Why not consolidate into one grant management and reporting body?

**Responses and discussions:**

i) There is enormous FBO capacity at national and regional levels. Most international FBOs provide technical assistance.

ii) Multi-country proposals can be honoured; the challenge is how much value they add.

iii) Dual tracking is not intended to create parallel support but to help in utilising all capacities available in the country. It has been noted that there are advantages in FBOs being PRs.

iv) Supporting traditional methods poses a great challenge. Those in TRP and boards work with international standards and it would be difficult to measure traditional healing methods against such.

v) Support to East Africa is consumed by the large contribution to Ethiopia where there is no FBO involvement. In West Africa, the percentage of funding is high due to the presence of more FBOs which are PRs.

vi) The TRP’s objectivity is ensured through selection of the panel using strict procedures. The TRP members are not allowed to review proposals they have interest in including those from their countries of origin.

vii) The GF works with other organisations like UNAIDS. The GF does not have the mandate to calculate global needs but this role is played by UNAIDS. The GF is then given this information and starts looking for donors to fund the various programmes.
viii) There is no need for special guidelines for Africa as the continent’s programmes are performing at par with the rest of the world.

ix) Analysis of the success of FBOs in implementing programmes through GF support will be contained in the report of an impact study being carried out.

x) The experience with Kenya CCM is unfortunate. However, setting aside some funds for FBOs or CSOs is not possible at the moment. The important thing is to improve on proposals.

xi) Calls for proposals are widely disseminated. The FBOs need to look for information from CCMs as well as visit the GF website (www.theglobalfund.org).

xii) Managing multiple grants is a challenge which the GF is currently working on.

xiii) Those intending to apply for funds need to start before the call for proposals is made. Certain sections of the proposal can be prepared well in advance as the organisation awaits information on country priorities.

Overview of the African Christian Health Associations Platform

Dr. Samuel Mwenda, CHAK and Dr. Manoj Kurian, WCC

Dr Mwenda began by explaining that Christian Health Associations are ecumenical networks dealing with health programmes and sharing common features and values. Their shared features include:

- Their ecumenical nature and promotion of ecumenical collaboration
They are national networks

- Membership of churches and church-sponsored or affiliated health institutions and programs

- Core mission is the promotion of the church health ministry

- Recognition and engagement by governments particularly Ministries of Health on policy and service issues

- Accountability to members

The Africa Christian Health Associations Platform was created by a declaration of the CHAs bi-annual Conference held in Bagamoyo, Tanzania in January 2007. The conference reaffirmed commitment to continue with the healing ministry of Jesus Christ, serving the poorest of the poor and marginalized but also recognizing the need to care for the carers.

At the Bagamoyo Conference, CHAK was asked to host the CHAs Secretariat to facilitate networking and information sharing. During the conference, it was emphasised that CHAs have to propagate the healing ministry of Christ through sharing and partnership. They also needed to enhance the work of the Technical Working Group of the CHAs for Human Resources supported by IMA.

Since the decision to form the platform was made, a secretariat has been established. The secretariat produces a quarterly electronic bulletin and has already designed and put up a web page that is being hosted on the CHAK website. The platform has also been mandated to produce Contact Magazine of the WCC for distribution to various partners.
Involvement of FBOs in Country Coordinating Mechanisms (CCMs)

Discussants: Bishop Mambo – Zambia; Mr Kamara – Uganda; Dr Kimambo – Tanzania; and Dr Rwagasana – Rwanda

Tanzania:

- Different groups including FBOs are represented in the CCM.
- Christians and Muslims are represented in the CCM.
- The FBOs in Tanzania operate like public institutions.
- CCM membership currently stands at 14, a reduction from a previously huge number.
- Some GF supported interventions for the Government including the Emergency Hiring Programme (EHP) were extended to FBOs although the assistance was small compared to what went to the Government.
- There are delays in getting information for proposal development, especially with regard to themes. The process is thus usually delayed and proposals hurriedly developed. This can be overcome if the process begins early.
- FBO facilities are hampered in implementation by lack of preparedness.
- M&E systems are available but not performing well.

Zambia:

- Failure of proposals is caused by lack of determination and not lack of resources.
- In Zambia, FBO representation in the CCM is ecumenical.
• The CCM has 23 members and is chaired by the Principal Secretary, Ministry of Health. The PRs are MoF, MoH, CHAZ and ZANAC
• The FBOs have learned to be accountable and put away the theological notion of heavenly accounts. They have realised that because they are in the world, they also need to be accountable in the world.
• The FBOs have agreed to avoid competition among themselves and work towards being blessed on accomplishing the work of God.

_Uganda:_

• Coordination in the fight against HIV/AIDS was established well before GF came along and worked very well.
• The partnership structure was also present and working
• MoH had its own mechanism of coordinating the health sector
• When the CCM came, it operated in parallel with the existing structure, resulting in operational problems. This led to Uganda being suspended by GF for one year after which a new CCM was appointed. The two now co-exist.
• FBO representation at the CCM is through the HIV/AIDS Interfaith Organ.

_Rwanda:_

• Coordination is by Government policy.
• One cannot begin a project without consulting the Government.
• FBO participation in the CCM is a bit weak.
• The FBOs have three members in the CCM, a 30% stake.
• Rwanda had some initiatives before GF on HIV and Malaria.

Open forum

Questions/Comments:

i) How do you ensure that your role in CCM is primarily to contribute to performance?

ii) CHAZ organises a press conference with its partners on the funds available for each round and invites applications. The FBOs in Zambia are working with communities and all are applying to the same CCM.

iii) How many FBOs are on the CCM in Tanzania and Uganda?

iv) Can a certain percentage of funds be set aside for FBOs?

v) There are many problems in the constitution of CCMs from one country to another. May be dual financing is the solution.

vi) New direction from GF on CCMs brought some positive results in terms of balance. GF should come up with guidelines on the best ways of accessing funds.

vii) One of the critical issues for implementing institutions is capacity building especially for PRs and SRs. What is being done to address this?

Responses:

i) In Tanzania, the CCM has 14 members of which three are Government, six are CSOs including two from FBOs. The rest are DPs, PLHA, media, trade unions and the private sector.
ii) In Tanzania, call for applications through media adverts led to a lot of problems.

iii) Capacity building in CHAZ is done through training. However, it is difficult to retain those who have been trained. The GF should address this as well as infrastructure.

iv) In many countries, CSOs are greatly abused. There is also confusion between CSOs and FBOs. This needs to be addressed.

v) Given that FBOs have proved their commitment to service through the years, there must be a clear proportion of FBO representation in CCMs. The FBOs were there when the public sector failed and their structures should be recognised.

List of CCM's

Below is an analysis of various CCMs.
<table>
<thead>
<tr>
<th>Country</th>
<th>Membership</th>
<th>Contribution</th>
<th>Procedures</th>
<th>Participation</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanzania</td>
<td>6%</td>
<td>Good</td>
<td>Semi democratic</td>
<td>Participate in proposal development and implementation</td>
<td>- Lack of准备 and effective participation in proposal development and implementation</td>
</tr>
<tr>
<td>Zambia</td>
<td>20%</td>
<td>Very good. Deals directly with the Head of State and works as a team.</td>
<td>Non partisan, Accountable, Does continuous M/E, Gives people the information they need.</td>
<td>Very good and multi-dimensional.</td>
<td>- Lack of understanding between stakeholders</td>
</tr>
<tr>
<td>Rwanda</td>
<td>15%</td>
<td>Good coordination in CCM put in place by the State. Sustainability will be done through strong capacity building.</td>
<td>Uses three ones. Priorities defined by the state. Does a lot of capacity building on structure, health services, management etc.</td>
<td>Feeble membership but best contribution is done by the way HS put in place by FBOs work. Best organized structures in the</td>
<td>Other partnerships existed before WHO workers asked them. Much left to be done.</td>
</tr>
</tbody>
</table>
| Uganda | Diverse management groups. Two CCMs and one PR and many different bureaus. | Contrasting bodies led to competition and misunderstanding. Inability to hold PR and government accountable. | Long-term arrangements. Now working with a PR identified through a transparent process. Not enough dialogue between FBOs and the Government. | Had an existing mechanism through GF. CS representation was not very strong nor accountable. Inability of GF to set clear priorities for new funding because of the program that now affect funding. | **Recommendations**  
- FBOs should make their voices heard.  
- Begin to identify themes and develop proposals early.  
- Integration of services /programs can be more efficient.  
- Finance CCMs for better functioning.  
- Plan ahead of time and agree on what to do.  
- Do capacity building.  
- Identify gaps and needs early and before writing the proposal.  
- GF should give priority to some activities and be flexible.  
- Have a country plan and not wait for the GF to send out a call. |
Election and participation by CCM’s

_Election, selection and active participation including grant oversight by CCMs_

_Bonnet Mkhweli – Global Fund_

He started by explaining the meaning and roles of CCMs. Guidelines for formation of CCMs were also explained. The conference heard that the structure of the CCM is determined by what is best for the country in question.

However, the agreed structure has to include Government, NGOs, CSOs, Development Partners, People Living with HIV/AIDS (PLHA), Private Sector, FBOs, academicians and other affected and infected groups. The NGO representation in the CCM should be at least 40%.

The six minimum requirements for eligibility include:

1) Non-Governmental Representation
2) Including PLHAs
3) Membership selection to be as transparent as possible
4) Nomination of PR should be transparent
5) Stakeholders’ involvement
6) Conflict of Interest policy must be in place.

Core functions of CCMs include developing and submitting proposals and giving oversight in grant implementation. He highlighted some of the factors affecting participation in CCMs including:

- Strength of CCM partnerships
- Strength of FBO membership
- Informed membership, constituency and representation
• Access to public funding
• Country environment

The CCMs are allowed to utilise funds for salaries, office administration, meeting costs, communication, facilitation and transport. On strengthening of CCMs, participants were urged to look into the possibility of utilising online forums, workshops and retreats, case studies available online and technical support facilities.

**Summary:**

• From the GF Secretariat perspective, the more countries spend responsibly and the more accountable they are, the more funds they get.
• The determinant of GF success is the CCM. Consider:
  o Your numbers and representation
  o Your proposals, your money, your accountability
  o Modifying your plans for what is working
  o Your decision on the Technical Assistance you need
  o Your accountability to the vulnerable.

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**COUNTRY COORDINATING MECHANISM**

**Principles**
Public-private multi-stakeholder partnership mirrors GF

**Guidelines of CCMs:**
Broad representation, democratically elected members
Composition:
- Government
- NGOs/CSO
- Development partners
- PLHA/affected by the disease
- Private sector
- FBO
- Academic
- Key affected populations

Recommended 40% of non-government

Gender
Become gender sensitive

Challenges
Clarity and application of governance
Selection processes
Management of resources
Sharing leadership
Inclusion of too many religions. Who represents who?
Non-conducive environment.

Minimum eligibility requirements
Non-government representatives
People living with or affected by the diseases
Grant implementation
Oversight

Core Functions
Develop and submit proposals
Oversight of grant implementation

Factors affecting participation in CCMs
Strength of the CCM partnership
Strength of FBO membership
Communication and information
Access to public funding
Country environment

Round 8 guidelines and proposal format

Encouraging gender equality, dual track financing and community systems strengthening in Round 8
The presentation focused on ways in which FBOs could access funds available in R8. The meeting heard that the Board would meet in November 2008 to decide on which proposals would be funded.

Only quality and ambitious requests would be considered. To ensure quality, applicants needed to know their epidemiology, existing interventions, existing gaps and how to engage in national and international processes to raise money to bridge the gaps.

Explaining GF Principles, Mr Boateng said they were country driven and shaped by country needs and policies. Other principles are inclusiveness and collaboration, harmonisation and alignment with the country system. The GF support is performance based with impact on disease, morbidity and mortality and routine reporting being used to measure performance.
Mr Boateng added that GF continued to scale up previous interventions and encouraged innovative service delivery to improve access to services.

The meeting heard that R8 guidelines would be shorter, get rid of duplication, use simpler language and have less complex and more streamlined instructions.

The timeline would be as follows:

- Launch of R8 – March 1, 2008 (meaning that launch of R9 is March 1, 2009)
- Submission by July 1, 2008
- Screening for eligibility will be six weeks after closing
- TRP reviews will be held in the last week of August or first week of September
- The Board meeting will be in November 2008.

Health systems strengthening, the meeting heard, was crosscutting and requests touching on such could be made. Although recipients would not be allowed to build new structures using GF monies, renovation, extension and repair would be accommodated.

The budget

- Include a detailed budget for two years
- Include unit cost of items and indicate sources. Also include quantities and indicate how you arrived at them. Also include
assumptions, references and time frame for implementation indicating how you arrived at this information.

- The detailed budget is summarised by Service Delivery Areas (SDAs).

A template to be used as a guide in preparing the budget will be provided. Organisations that want to succeed need to think beyond project approach, consider existing GF grants, bilateral donors and the national budgets.

Role of donor funds in FBO’s

**What is the role of donor funds in FBOs?**

Most FBOs provide services at a fee although not at cost. Clients on the other hand access services provided through funded or special programmes free of charge. The question of sustainability therefore arises.

In many countries, there is no clear mechanism for reimbursing money to SDAs with only some groups benefiting from policy exceptions. There is need to strengthen health systems but policy exceptions are consuming resources. Services supported by GFATM are policy exempted and offered free. Donor support needs to be integrated within the system to help FBO programmes to become sustainable.

**New Developments in for R8**

R8 proposal guidelines are encouraging gender sensitive responses, dual tracking financing and community systems strengthening.

**Gender Sensitivity:**
Gender sensitivity is necessary in order to promote particular needs on gender, reduce gender inequalities and empower women. Proposals should support work on and address inequalities and develop frameworks on gender policy.

_Dual-track financing:_

Dual-track financing is aimed at helping to pool resources to build capacity for local CSOs and encouraging their participation in design and implementation of programmes. In addition, it is also aimed at encouraging the inclusion of marginalised groups.

There has been lack of coordination of CSOs and only 19.7% of CSOs are PRs globally. About 30% of grants went to CSOs. In Africa, CSOs who are PRs are very few. However, 83% of CSO PRs are performing greatly with only 2% under performing. The FBOs are categorised as CSOs.

Dual Track Financing is aimed at helping to create space to absorb country capacities, accelerating implementation and performance of grants and strengthening weaker sectors.

The GF Board recommends that in any country, both Government and NGOs should be PRs. Where this is no so, the Board will need some explanation as to why. In this context NGOs include CSOs, FBOs, private sector and all other groups outside the Government.

**Community systems strengthening**

The community strengthening component has been included because there are gaps exhibited at the community level. There is need to scale
up resources and efforts to turn needs into demands and improve access to services.

This component is also intended to strengthen the capacity of the organisation in physical infrastructure, obtaining and retaining staff, M&E systems, financial systems, building partnerships around communities and sustainable financing.

**Lessons Learnt from the Technical Review Panel and Previous Rounds**

*Wilson Were – Global Fund*

In his presentation, Mr Were elaborated on common reasons why proposals fail to be funded, the proposal development process, review process by TRP and common weaknesses in proposals.

Proposal development failures were due to lack of basic requirements at country level including:

- National Strategic plan with an operational plan
- Lack of consultation and transparency
- Lack of inclusiveness in CCMs
- Choice of PRs and SRs
- Timelines of proposals
- Coordination, harmonisation and lack of quality technical support
- Lack of essential background documents on GF policies (the tools are available on the website)
- Lack of thorough review of documents before submission
- Failure to provide good review of implementation status of efforts to date.
The Technical Review Panel processes include reviewing soundness, focus and potential sustainability of the proposal. All components are separately reviewed by experts who if satisfied make recommendations to the Board. Substantially weak proposals are not recommended for funding.

He highlighted common problems with proposals as:

- Lack of clear information on levels of implementation
- What actions have been taken to overcome challenges encountered.
- Inability to show feasibility and likelihood of effective implementation.
- How the new proposal will complement existing grants.
- Lack of focus on day to day integration of activities
- Insufficient gap analysis
- Insufficient details on proposed activities and approaches. Some activities may not be appropriate.
- Weak articulated components.
- Inability to show capacity to absorb new funds
- Incomplete and incorrect proposals, hurriedly made with no proof reading and no consistency in information
- Insufficient targets
- M&E not well elaborated. It is advised that applicants should spend 5 – 10% of resources on M&E.
- Outcome indicators poorly described.
- The budget not accurate, questionable, imbalances, too much or too little allocated to one or more sectors, not using the available tools.
Open forum

Q: How is the TRP oriented on the budgeting tools of the proposal?

A: Tools are available to help in budgeting. They are there to help you go through the task in an easy way, thinking about critical areas you need to budget for. However the thinking and conceptualising is yours and the TRP looks into the clarity of the details.

Q: Can you speak on Malaria proposals in round 5 and 6, and successes in round 7.

A: GF is also learning how to support countries to go through the processes. In round 7, GF started by identifying countries with problems and a number of close consultancies were done. Where proposals are done early, things can go very well. Organisations should look into hiring consultants while keeping in mind that good consultants are grabbed early.

Observation: What has been shared is country weaknesses. Institutional weaknesses have not been tackled.

Q: What is the theme for next year’s proposals?

A: The theme always addresses Malaria, TB and HIV. Themes are decided in CCMs and not at the GF level. It is the country that identifies the gaps
in the CCMs and decides on the theme. Delays are always in-country engineered.

Q: How do we apply for R9 when we do not know yet what to apply for in R8?

Comments:

- FBOs do not have adequate voice.
- GF are always changing regulations for funding.
- Dual track financing is in recognition of excellent performance of FBOs. Requiring CCMs to give some explanation if no other PR is found places NGOs in a better position with regard to inclusion.
The FBO representatives heard that to succeed, they needed to:

- Spread word, talk to each other on the available resources
- Verify in-country registered FBO consortiums
- Identify and document individual FBO capacities
- Agree on the way forward, probably through an MoU
- Identify leaders
- Make themselves known to CCMs, MoH, NACPs and others.
• Meet often to deal with current issues
• Create sub-committees to lessen the work
• Hire external consultants to facilitate the process

To write a good proposal, one needs to:
• Have an analytical approach to data
• Pay attention to details
• Have masterly of language used
• Have logical linking
• Be open to external input
• Have good organisational skills
• Have team work skills
• Be time conscious
• Have technical leadership
• Have political skills (play politics of service)

Production skills that could hasten the application process, he added, include preparing easy items such as cover pages and appendices before hand. Organisations also needed to anticipate that application deadlines could be very short. Multitasking is an essential skill as is developing sensitivity to external political process.

Elements of a good proposal:

1) Responsive to the RFA
2) Complete, clear, concise, creative, proponent, cost-competitive
3) Good analysis of the problem, especially using data
4) Logical low
5) Good track records of the organisation
6) Openness to critiques
7) Clear understanding of the project document
8) Innovative approaches
9) Well described project design
10) Project leaders with appropriate skills
11) Realistic budgets and time frames
12) Team work
13) Technical leadership: It is not enough for FBOs to be technically competent. They should be technical leaders and must demonstrate vision vis-à-vis their Ministries of Health
14) Format provides clarity
15) Proofed for errors in grammar, punctuation and calculations.
16) There must be a balance between sustainability, accountability and impact.

There is need for FBOs to check on technical writing, programmatic firmness, presentation skills, time frame and M&E systems.

For more details, refer to: Engaging with the Global Fund: A primer for Faith-based Organizations, by Milton Amayun

System strengthening among FBOs include the need to develop results measurement, ensuring trust among professionals, budgeting for and creating a data-gathering system, deepening understanding of indicators, impact, outcome, output and input processes and welcoming evaluations. This M&E will show impact of goals and outcomes through indicators. The GF recommends that 7-10% of budget should be set aside for evaluation.
To be good PRs, FBOs were advised to:

- Strengthen their systems including financial, procurement, human resources and communication
- Have technical teams that provide strong leadership
- Have strong links especially with partners sitting at the CCMs such as WHO and UNAIDS
- Evaluate their programme internally to explore strengths and weaknesses. Also analyse the programmes and create a forum for discussion.
- Create a forum for discussion about the GF among FBO’s if one does not exist.
- Determine what disease to target; malaria is always easy for FBOs
- Begin early, may be a year before
- If participating for the first time, do not aspire for PR or multi-country proposals.

Planning and Managing GF Proposal Development

*Dr. Mazuwa Banda – WHO*

He started off by advising FBOs to read the GF guidelines, understand them and stick to them.

He added that it is important to consider:

- Requesting for funding to fill existing programme gaps
- Covering efforts of numerous partners i.e. FBOs, NGO’s, civil society.
• Making a compelling well.

Dr Mazuwa highlighted in-country process, saying it is the CCM that decides on the areas to prioritise, the composition of the writing team and dates for internal calls for submission.

The steps involved in the proposal development process are:

• The CCM decides to apply for funding.
• The CCM decides the areas in need of funding and constitutes the proposal writing team.
• CCM organizes and submits the proposal and other data.

The following steps apply for the actual proposal:

• Make the drafts a proposal
• Reach a consensus on the draft
• Send the draft for peer review for the purpose of QC
• Obtain final draft
• Send to CCM for endorsement
• Submit to GF for funding

Composition of the technical writing team

• Representative of the National disease programme
• Disease experts
• Representatives from CSOs and FBOs
• Health system strengthening expertise
• HSS experts
• CCM representative
• Consultant writer
RESOURCES

UNAIDS and WHO have been working together to compile a number of resources to help applicants in the proposal writing process. These can be found at www.who.int/globalfund

GF minimum capacity requirements on PRs and PBF

John Ochero and Samuel Boateng – GF

The presentation highlighted requirements for PRs and the meaning and application of PBR (Performance Based Funding).

The meeting heard that PRs are responsible for implementation of grants, results and financial accountability. They receive funds, use them as approved and are responsible for regular progress reports.

Selection of PRs:

They are nominated by the CCMs and their financial capacity accessed by the Local Funding Agent (LFA). However, the GF makes a decision before an agreement is reached.

Minimum requirements for the PR include:

i) Institutional and programmatic legal arrangement

ii) Procurement and supply system in place. This includes how the PR procures, processes and manages supply systems, especially medical supplies.
iii) M&E management; how the PR collects data and analyses it for QC purposes
iv) Management of SRs
v) Management of financial systems: Keeps records of transactions, and ensures balanced disbursements efficiently and in a timely manner. Proper auditing must also be done.

Institutional and programmatic capacity of PRs

1. Legal status to enter into grant agreement

2. Proven record of effective leadership, management, transparent decision-making and accountability systems

3. Adequate infrastructure and information systems to support proposal implementation, including the monitoring of performance-based evaluation.

Procurement and supply management systems

- Provide a basic procurement supply and management plan which outlines how the PF will adhere to GF procurement principles

- Deliver to the end-user adequate quantities of quality products in a timely fashion. The products should have been procured through a transparent and competitive process.

- Provide adequate accountability for all procurement conducted

Monitoring and Evaluation

- Collect and record programmatic data with appropriate quality control measures
• Support the preparation of regular reliable programmatic reports
• Make data available for the purposes of evaluations and other studies

Management of sub-recipients

• Experience of in managing SRs
• Existing partnerships with potential SRs
• Transparent system of choosing SRs
• Assessment of SR capacity
• Verification of legal status of SRs

Financial management systems

• Can correctly record all transactions and balances
• Can disburse funds to SRs and suppliers in a timely, transparent and accountable manner
• Can support the preparation of regular reliable financial statements
• Can safeguard PR assets
• Subject to acceptable audits

The process of selecting PRs

• PR prepares draft implementation plans, work-plan and budget and negotiates grant agreement
• Local Fund Agent (LFA) assesses PRs minimum capacity and financial systems
• GF approves PRs and implementation plans

Programme implementation

• PR implements grant, provides periodic reports on performance to CCM, LFA, GF (progress update and disbursement request)

• LFA receives and reviews PR’s reports, performs onsite data verification and ad-hoc verifications, advises GF on PR performance, advises on Phase 2 renewal process

• GF decides on disbursements and/or other actions, approves changes to work plan and budget

• GF decides on funding beyond the first two years

Performance-based funding

It is aimed at being an incentive. Disbursements are effected with achievement of targets. It provides a chance to identify opportunities, provide a tool for monitoring and CCM oversight and free up committed resources from non-performing grants for re-allocation.

There are three pillars of PBF:

a) Performance based disbursement: The GF decides on the periodic release of funds based on demonstrated programmatic progress and financial accountability (i.e., every 3 or 6 months, depending on the grant)
b) Phase two: Whereas Proposals are approved for 5 years, the GF initially commits funds for only 2 years. Funding for the remaining 3 years is based on performance and contextual considerations.

c) Rolling Continuation Channel (RCC): Extension for a further 6 years (3 plus 3 years). This is for high performing grants only (A-rating or B1 with demonstrated impact).

How can FBOs access more funding from the GF?

- Continue to strengthen engagement in the processes used by GF to channel funds to countries. FBOs need to write their capability statements and decide what they can offer.

The capability statement may describe:

- A good and well-functioning financial management system including a qualified and experienced team
- Policies and standards that guide performance of duties by the team
- Segregation of duties and responsibilities
- A system of preparing budgets
- Good accounting system usually available through software packages
- Good asset management system including asset registers, periodic inventory of assets, checking the condition of assets
- Purchasing system that will allow you to put together tenders

- Budgeting arrangements with adequate controls in place

- Treasury management systems: who are your bankers? Are you anti-terrorism compliant?

- Cash management arrangement: how do you manage cash flow?

Accessing GF funds

*Samuel Boateng – GF*

In managing financial systems, FBOs should focus on the 7 principles:

1) Have a good and well functioning financial management system (qualified team on managing donor resources)

2) Well managed budget system

3) Good accounting system

4) Asset management system including having registers, ledgers e.t.c

5) Purchasing system allowing for tenders for supplies, contracting and on time deliveries

6) Audit system, both internal and external

7) Good treasury management system as described above.
As GF grows, so will the resources at its disposal. The FBOs need to position themselves to better benefit from these resources by strengthening their capacities.

Open forum

Questions:

1) How can an FBO negotiate with others to become a PR?
2) How can one deal with a slashed budget?
3) The discussions here were supposed to focus on FBOs, most of which are neither CCMs nor PRs. Please comment.
4) Is Technical Assistance (TA) available for small FBOs and is it free?
5) Expound on the GF performance grading system.
6) If the Country does not comply with the Dual Tracking System, what are the consequences?
7) Is there a chance of one sending a draft proposal to the GF then it gets rejected?
8) Can you give examples of FBOs that can be PRs?

Responses and comments:

1) CCMs play a big role in the screening process.
2) The FBOs can get clarification from CCMs on the reduced budgets or adjust their activities accordingly.
3) The grading system is available on the GF website. However, A is the highest score and is followed by B1. Both of these qualify for the RCC. They are followed by a B2 then a C, which is below average (below 50%). A = 80 and above; B1 = 60 to 79; B2 = 50 to 59 and C is below 50. Those who score a C do not qualify to go to stage two of the funding.

4) Small FBOs can be assisted with their proposals although they are advised to look into presenting joint proposals.

5) One needs to demonstrate the added value of a multi-country proposal. There also can be multi-CCMs in a country like is the case in Tanzania for the mainland and Zanzibar and DR Congo which is quite large. However, this is usually a country process.

6) The idea of reviewing proposals is good. However, the GF cannot do this due to regulations. Peer review and some assistance to understand the guidelines can be obtained from WHO Country Offices.

7) Dual track financing can address hitches to do with funds disbursement.

8) Some of the countries that have qualified for RCC are Rwanda which scored an A, Tanzania and Burundi which scored B1.

9) The amount of money given in the RCC depends on the proposal. However, scaling up is possible as long as a good argument is put forward.

10) It is possible to work as a consortium of FBOs. Tanzania’s CSSC is a good example as a sub-recipient managing five SSRs.

11) There is guarantee of access to funds as GF releases money according to work plans. Where SRs do not receive funds they can raise the issue with their CCM.
12) Although each country has its own system of collecting information, all information can be obtained on the GF website www.theglobalfund.org.

13) Although the GF board requires dual tracking, this is not a requirement as long as there is evidence of transparency. However, the board’s decision is what counts.

14) Approved proposals cannot be changed to include new implementers.

15) On the discussions about CCMs and PRs, the GF recognises FBOs’ importance in its work. It is also appreciated that the GF cannot make special provisions for FBOs with regard to disbursement of funds. It is therefore paramount that FBOs grasp the regulations and systems used by the GF so that they can improve their chances of accessing funding. The FBOs can also benefit from networking with others who have been PRs and SRs.

16) Given the GF requirements on accounting systems and procedures, participants felt this would make NGOs work as business entities despite their limited resources. However, it was agreed that accountability in the use of funds and proper accounting procedures were inevitable. Participants heard that it was possible to request assistance to set up a credible accounting system through their proposals.

17) The FBOs were urged to stop competing among themselves and church leaders asked to accept that experts must handle technical issues. The FBOs were also asked to make themselves visible and utilise their strength in mobilising volunteers. Dealing with political blocks needs strategising.
18) The CCMs are country-owned and FBOs must be part of them. Small CCMs are generally seen as more viable than large ones. The GF advises that the constituents of the CCM elect their own representatives. However, to be effective, FBO representatives to the CCM need to be strong persons such as bishops.

Country Experience of FBOs as PRs

Mrs Karen Sichinga – CHAZ, Zambia and Lynde Francis – ZACH, Zimbabwe

CHAZ – Mrs. Sichinga

The Zambia CCM nominated CHAZ as a PR because the Government recognised the organisation’s contribution to health services. CHAZ already had a good track record in HIV/AIDS, TB and Malaria programmes. CHAZ had experience in sub-granting and enjoyed public confidence and visibility. It also had a strong network of facilities and health programmes serving rural and hard to reach areas.

Also leading to CHAZ selection as the fact that in Round One, there was no system and all were learning. In addition, there was strong advocacy and lobbying by church leaders who saw CHAZ service as a PR a social responsibility. CHAZ finally qualified for the role of PR after assessment by the LFA.

The main tasks for CHAZ before qualifying as a PR included:
• Critically thinking about the tasks ahead and recognising their weaknesses
• Consultations with church leaders and the board
• Systems strengthening and updating (financial management systems, grants manual, M&E framework, procurement manual among others)
• Working towards flexibility and embracing other faiths
• Creating room for growth, especially with regard to human resources and office space
• Creating new partnerships. One of the most important partners in this regard was the media.
• Creation of the FBO Forum in 2003 to create awareness on the GF resources and build consensus on the disbursement model
• Assessment of potential SRs

Selection of SRs

The FBOs’ forum was first convened to create awareness on the GF resources and build consensus. Prospective SRs were then assessed. Such prospective SRs were required to have existing programmes, legal status as FBOs and be implementing HIV/AIDS activities. The potential SRs also needed to have experience in handling donor funds including having credible auditing systems and infrastructure. Currently, CHAZ has 15 SRs who can sub-grant to SSRs. Their membership stands at 100 church health facilities.

To work with these facilities, CHAZ has had to strengthen them, receive and analyse their reports and allocate quarterly funds based on performance. Review meetings are organised quarterly and onsite
technical support provided. CHAZ is currently working with more than 400 FBOs.

Results and achievements:

The results as verified by the LFA, PriceWaterHouse & Cooper, by December 31, 2007 showed that over 369,000 PLWHA were assisted with care treatment and support through the GF support. Over 48,000 Orphans and Vulnerable Children (OVC) were assisted to attend school while 37 new care and treatment centres were established. About 31 CHIs had established ART and PMTCT services and over 12,000 PLWHA received ART. Trainings were conducted as part of HSS. In the TB programme, over 1943 smear positive cases were detected and 1319 treated. Distribution of ITNs surpassed set targets.

Other achievements included a chance to share with other CHAs in the region, strong advocacy for GF partnership with the Friends of the Fight in Washington DC, invitation to apply for RCC and a joint finance agreement with other partners.

Lessons learnt

- There are opportunities for new partnerships, local and international
- Poor overall absorption capacity can affect highly performing PRs
- Criteria for Rolling Continuation Channel (RCC) for strong performing grants needs revision for multiple PR countries
- Government and CCM Commitment to partnership is important
• Long history of civil society involvement in Zambia helped to facilitate the process

• Participatory approach in the proposal formulation process is helpful

**Why CHAZ has been successful as a PR**

• The Government and the CCM are committed to partnership

• Long history of CHAZ in civil society work especially in HIV/AIDS

• Participatory process in the proposal formulation processes

**Challenges**

CHAZ faces a number of challenges including:

• Developing CCM proposals is quite a demanding process and takes a long time.

• The transition was also quite demanding.

• Insecurities in the system as high performance does not guarantee continued funding, despite huge resources involvement

• Fragmentation of grants can be confusing

• Delays in disbursement of funds, sometimes due to delayed reporting

• Weak health systems

• Inadequate financing of the health sector

• High expectations by FBOs

• Unhealthy competition

• Working with FBOs is a great challenge due to their placement, capacities and limited resources

• Late reporting by SRs

• Inadequate human resources leading to burn out and high staff turnover. Given this scenario, training should be continuous. The
Government also tends to transfer its seconded staff at will, compounding the human resource challenges.

• How to manage growth

Requirements for aspiring FBO’s

**What do FBOs aspiring to become PRs need to do?**

• Government approval and recognition, maybe in the form of MoUs
• Start with the minimum and manageable
• Cultivate or build on donor confidence
• Ensure you are visible and ensure your national presence is felt. Involve the media.
• Be proactive and aware of events and trends nationally and globally
• Consider strategic partnerships
• Intensify lobbying and advocacy and involve church leaders. However, you need to equip the church leaders with information on the areas at which the lobbying and advocacy is targeted. Also ensure that the FBOs representative in the CCM is constantly briefed.
• Strengthen capacity of prospective SRs
• Be transparent and inform stakeholders on the availability of funds
• Encourage team work
• Above all, pray without ceasing, as this is the Christian character.

**Zimbabwe Association of Church Hospitals (ZACH)**

ZACH was registered in 1974 as an NGO and has 126 hospitals and clinics. ZACH is a member of the Zimbabwe CCM and was an SR in R1 for
ART. It was also a PR in R5 for HIV/AIDS and TB in 22 districts and an SR in R5 for malaria working nationally.

Problems and challenges:

- There was a tug of war with the MoH
- CCM representation had to take others into consideration
- A PR has serious responsibilities and preparedness is needed for the role
- The GF needs to make it a requirement for 40% civil society representation in CCMs in the region.
- Delays in agreeing on the LOAs as local organisations were faster to respond while international ones took longer
- The SRs sometimes do not have the capacity to generate reports as required.
- The organisation is still implementing R1
- No matter how much energy you put in a proposal, it is presumed by the national proposal
- There is need for consistency in representation in the proposal writing and review team

Open forum

Questions

1) How much money and time did CHAZ use before the grant was given?
2) How long did it take to sign the contract?
3) How do you manage contracts with SRs?
4) RCC Malaria has failed. What problems were seen in the RCC for Zambia?

5) The notion that there is a lot of money from GF can create conflict with SRs. Comment.

6) How are you working with the non-Christian groups?

7) Is there a possibility of separate CCMs being created for FBOs?

8) Can GF reallocate funds to performing PRs?

9) Has the Government of Zambia’s support to FBO health services affected your role as PR?

Responses:

1) Between US$ 10,000-20,000 was used. Expenditure included hiring consultants, strengthening systems and other required precursors before becoming a PR. The GTZ provided about US$25,000. However, this required initiative and planning. It took four to six months to come up with the proposal.

2) The SR contracts should put forward basic performance and operational issues. The SRs are equipped with budgeting and reporting formats using the GF template. CHAZ organises meetings with SRs for technical support and checking for indicators. The contracts are signed according to year plans and funds disbursed quarterly.

3) Over 90% of funds goes to SRs while 3% remains at the PR Secretariat.
4) In Zimbabwe, the CCM also accommodates the interfaith forum, ZINCO. Unhealthy competition has been eliminated and performance is good. The problem has been with accessing funds.

5) Government support to FBO health services has affected CHAZ due to irregular and impromptu transfers of State-seconded staff. Provision of medical supplies by the Government also sometimes conflicts with disbursement of funds.

**Comments from GF Secretariat**

It is important to note that GF gives one year for signing of grants. This is due to such factors as need for explanations, TPR approval, negotiations on procurements, M&E, indicators, among others. However, in some cases, this can be done within a month especially where systems are good.

Though there is some flexibility, moving funds from a non-performing PR to a high performing one is not possible in the first year. In phase two review, the CCM can send recommendations to the GF board. Movement of the money is not very easy and requires justification especially on the fate of already running projects.

It is only possible to have one CCM although sub-CCMs can be created in very special cases.

Setting aside a special fund or percentage of money for FBOs is not possible although it can be discussed. For now, we need to work with what has been proven.
Group work:

Country experiences focusing on Malawi, Tanzania and Cameroon

Participants were divided in three groups to discuss issues and experiences in three Countries implementing GF supported projects. Reports from these groups are as follows:

Country Experience on management of sub-recipients – Malawi:

CHAM is an ecumenical NGO established in 1966 and houses the Christian Council and the Episcopal Conference of Malawi.

CHAM’s contribution to health services in Malawi stands at 40%. In 2002, an MoU was signed with the Government stipulating that:

- Government would provide personnel emoluments (PE) to CHAM units with approximately 7,000 health workers
- Government would support training colleges
- Government would second tutors to these training colleges
- CHAM would provide services under National Health Programmes for free
- CHAM would participate though the Sector Wide Approach (SWAp)

A Service level Agreement (SA) was instituted and has been signed by over 60 units. CHAM provides the Secretariat to the PPP.
Involvement of CHAM in GF:

CHAM is involved in health care across the country especially in rural-based facilities.

CHAM requested support for 51 facilities (totalling about 1 billion Malawi Kwacha). Support for 21 facilities was approved with only US$.40,000 for one year.

Some activities supported by GF are:

- Training for infection prevention
- HIV counselling centres (VCTs) have been established
- Youth behaviour change programmes
- Renovation of infrastructure
- Capacity building

Objectives included:

- Gender sensitivity
- Institutional capacity
- Integrated gender
- Behavioural change

Successes realised so far include:

- Renovated VCT structures
- Support of 6 VCT and lay counsellor training
- Two youth behaviour change international visits
- Supervision in infrastructure
• CHAM has a reliable fleet of vehicles (5 Land Cruisers and 6 utility vehicles)

Challenges:

The project is currently being implemented although it could have been done in 2005/2006. Reasons for the delay include:

• Lengthy procurement procedures
• Submission of reports
• Funds disbursement was slow
• Inadequate availability of HIV/AIDS supplies
• Opportunistic infections (IOs) drugs have been a big problem
• Certain organizations did not have capacity to do M&E
• Relying on MoH trainers was a challenge and CHAM realised that it needed to have a pool of trainers.

General challenges in HIV/AIDS project:

• Lack of HRH in hard to reach areas
• Increased staff turnover
• De-motivated staff
• Inadequate resources
• Lack of access to new knowledge on HIV/AIDS
• High prices of HIV/AIDS resources
• Lack of adherence to infection prevention due to lack of resources
Open forum

Q: Why is it that the proposal targeted 1bn Kwacha in funding yet you only managed to get a few millions?

A: This was not a CHAM proposal but was presented by the consortium. The NAC was looking at a different angle.

Q: How do you deal with representation in the CCM by two organisations?

A: Representation was previously by CHAM. For now, the Malawi Interfaith Health Services of which CHAM is a member sits in the CCM.

Q: How did you deal with reporting in the hard to reach areas?

A: Reporting is a big challenge. However, for the programme, it is done by the secretariat.

Q: What are the challenges especially when you have to charge those exempted by policy?

A: Political pressure brought about signing of MoUs and the SA. We have to provide for the EHP which must be provided by the Government. However, if it is not available, we explain to our clients that they have to get alternative supplies.

Q: What is CHAM’s mandate?

A: Our mandate is to facilitate and coordinate member units in capacity building, mobilising resources and guidelines and policies.
Q: How do you deal with challenges such as staff turnover and procurement problems?

A: It is difficult but by faith we are managing. It is also a challenge to access funds.

Where an organisation submits a proposal and gets less than 10% of what they had requested, something is grossly wrong. In such an instance, the organisation needs to get explanations and experts to assist.

**Country Experience on management of sub-recipients – Cameroon**

Cameroon is currently implementing GF Rounds 3, 4, and 5. Round 3 was proposed by Government and involves scaling up response to HIV, TB, and Malaria. Protestant churches and civil society came together to submit a proposal. For this, the PR was Care Cameroon and Primary SR, IRESCO.

For Rounds 3 and 5, the PR was the Government and churches, which provide 37 per cent of health services in the country, did not receive money.

Church structures however benefited from the money received by government. For Round 4, a call for proposals from churches and the private sector was launched. The churches asked for a specific call for the FBOs and were thus able to participate in selection of the recipients.

Rounds 3 (2nd cycle) and 4 are ongoing in Cameroon. A number of church structures are specialized in certain areas of the HIV/AIDS response and even the Government looks to them for help.

**Challenges and Experiences:**
• FBOs are members of the CCM and take part in national committees for AIDS, TB, and Malaria
• Different faiths and denominations (Protestant, Catholic, Muslim) are referred to their respective religious structures
• They insist that members of the CCM review proposals. Each group (govt, civil society, international partners) gives a report at the meetings. Each group has a voice in recommending proposals and voting is on group as opposed to individual basis.
• Often, organizations do not the capacity to do M&E.
• The government could present obstacles in the process

Open forum

Major lessons coming from Cameroon were identified as:

• Separation of FBOs from the rest of society is commendable
• In Kenya, FBOs are put together with civil society making it difficult to give priority to FBOs.

Group voting was particularly appreciated. It was noted that the concerns raised about the CCM could be the same ones at organisational level. Different denominations have to be represented at the CCM at coming up with names of representatives poses a problem.

Where a certain religion constitutes the majority, the minority are rarely taken into consideration. For example, it was noted that Cameroon, which is mainly Christian, does not seem to take into account Muslims. In Niger which has a Muslim majority and voting in the CCM is on an individual basis, Christian churches’ projects do not have a chance to be accepted.
The Congolese Faith Network in the Response to AIDS was given as an example in inter-religious participation. The forum heard that all faith communities take part in the network. All the faiths are consulted communal concern represented by a Secretariat. A General Assembly is held among the leaders of each faith community. A common position is taken after reactions of the respective faith communities have been considered.

For the Islamic Association of Uganda, the district-level leaders of the Muslim community are consulted. Local level collaboration is excellent but there is a problem with receiving support from higher-level structures especially at national level.

The meeting also noted that the GF works a great deal through Internet but in Cameroon as in several other countries, even some chiefs of provinces or cities do not have access to the internet.

Questions

- Are other faiths included in the training of pastors that was mentioned?
- Is FBO participation in CCM of Cameroon difficult?
- Sometimes the PR is an agency of the UN. Many SRs are international agencies and there is practically no national platform in some countries. What can be done to overcome this situation?
- Is the Association of People Living with HIV/AIDS represented in the Cameroon CCM?
• Do the beneficiaries of faith-based services understand these services well enough that they could advocate for FBOs?

Responses

1) The fact that they decided to train pastors did not mean that they had to leave out other faiths. However, there are doctrinal differences between Christians with regard to prevention.

2) With regard to a CCM for the Government and a CCM for the FBOs, the Cameroon experience has shown that it is possible for the two sectors to work together.

3) People living with AIDS are represented in the Cameroon CCM. This is the only group having 2 representatives on the CCM. It was also noted that members of CCM representing specific groups needed to disseminate information to their respective networks. Such representatives were further asked to be pro-active in getting out information.

4) It is necessary to have some official representation of the churches in the CCM.

Recommendations from the group:

1) Given the heterogeneity of countries with regard to faith structures, there cannot be a blueprint solution.

2) GF should make a policy that UN agencies cannot serve as PRs.

3) International organizations should not compete with local ones for funding at country level. They should get funding at the international level. Many of these international organizations speak a great deal but have little to show on the ground.
Country Experience on management of sub-recipients – Tanzania:

Dr. Josephine Balati-CSSC

The CSSC was one of the lead recipients in Rounds 3 and 4. The organization participates in the CCM (Tanzania National Co-ordinating Mechanism) and serves several other SSRs offering services to health facilities. Key programme areas include HBC, OVC, Care and Treatment, sensitization, and community mobilization.

Achievements

- The Tanzania CCM model advocates for transparency, accountability and improved access to GF
- The performance-based model is good, with targets and indicators as key elements
- ARVs have been distributed to over 144,500 patients including those served by 63 FBO hospitals.
- Services offered include provision of ARVs, establishment of Care & Treatment centres, VCT services, HBC services and community support
- Religious leaders have been reached and sensitized on various issues

Challenges

- Lack of transparency by some SSRs in revealing their other sources of funding
• Poor flow of information from government to SRs and SSRs

• Lengthy in-country fund disbursement procedures

• Limited capacity in SSRs especially in financial management

• Wanting accountability and reporting

• FBOs at SSR level do not fully appreciate the rigors of performance based funding

• Deviation from agreed plans: SSRs sometimes change implementation strategies without prior consultation or approval from SR or PR.

  - Slow disbursement of supplies, especially drugs

  - Lack of co-ordination especially in HIV/AIDS activities

  - Communication problems

Other group participants shared the following challenges:

1. CCMs are generally difficult to work with.

2. There is need for technical support with regard to financial management procedures.

3. FBOs have difficulty accessing GF funds locally for their health programmes.

4. Much work goes into writing proposals and programme implementation yet incidences of unspent funds still occur.
Recommendations

- More funds should be allocated for capacity building in FBOs
- Collaboration with Government needs to be improved
- Co-ordination among FBOs needs to be enhanced
- Referral systems need to be strengthened
- Communication and information systems need to be strengthened
- Tanzania needs more than one PR

Other group participants further recommended the following:

- GF should have local technical arms to support CCMs, PRs, SRs and even SSRs
- GF should consider the value of increasing the number of PRs in each country
- GF should consider non-CCM proposals
- GF should be more critical of CCMs rather than leave it as an in-country procedure
- PRs and SRs roles should be confined to Monitoring and Evaluation. They should not be involved in implementation.
- Dual track financing should be a requirement but should not mean a parallel mechanism.
- Both government and FBO representatives should be brought together under one roof in future workshops.
Overview of performance Monitoring and Evaluation indicators in the Global Fund

Ms. Margaret Kugonza – Global Fund

The role of M&E

Monitoring and Evaluation can be summarised by a circle with three sets of words: RAISE IT, INVEST IT, PROVE IT. The purpose of M&E is to measure impact, outcome and output. M&E evaluates intervention and is used to produce strategic information for demonstrating achievements and correct interventions.

GF M&E principles

- Leads to Performance Based Funding (PBF)
- Has country ownership
- Alignment with existing national systems
- Harmonization with that of partners
- Consistency
- Simple
- Balance between routine health statistics data and survey data
- Ensure impact and outcome measurement

An example is that of a programme with a goal of reducing HIV spread and related mortalities. Objectives may include:

1. To increase condom use among youths
2. Distribute ARTs to 80% to those needing them.
Service Delivery Areas (SDAs) in this case may include distribution of condoms and ART monitoring. From here, indicators, impact and outcome can be formulated.

A Performance Framework (PF) is a legal statement of the expected performance and impact over the proposal term. It includes an agreed set of indicators and targets consistent with the proposal to be reported on a regular basis depending on measurement methods.

An M&E plan is typically a nationally agreed document that describes the functioning of the national (or Global Fund grant specific) M&E system and the mechanisms to strengthen it during a determined period of time. Normally, a PR should submit the national M&E plan unless submitting a multi-country proposal in which case a specific regional M&E plan should be submitted. If the national M&E Plan does not include details required for the GF grant, an annex with complementing information can be submitted. Where a national M&E plan does not exist, a draft for grant signature can be submitted and a full national M&E plan subsequently elaborated.

When assessing M&E plans, the GF looks at what an organisation can and cannot do and its M&E capacities.

A good M&E plan will have information on:

- M&E framework
- Data collection
- Information dissemination
- Data QA,
- Action plans
• Budget (M&E should take 5 – 10% of the total budget)
• Evaluation and research
• Data management
• Capacity building and coordination between agencies and units

**M&E system strengthening tool**

This is aimed at diagnosing M&E systems to help identify capacity gaps, develop a costed action plan to strengthen M&E, harmonize systems with partners and align around national systems.

There are three assessment areas, namely:
• Monitoring and Evaluation (M&E) Plan
• Program Management Unit (i.e. capacities to collect, analyse and report data related to program implementation).
• Data-collection and reporting systems per program area (e.g. ART, ITN, TB Treatment)

**Strengthening M&E Systems**

The GF supports in:
• Diagnosis through a PR self-assessment using the partner designed MESS tool. Strengths and weaknesses are identified.
• Identification of capacity gaps and corresponding strengthening measures. Need for technical assistance is identified.
• Development of a costed M&E action plan
• Agreement among in-country partners to share initiatives and funding- Implementation and follow-up through lifetime of grant
- Open channel to access funding for CSS under the HSS
- Engaging partners in a discussion to refine indicators and agree on strengthening approaches

Open forum

Questions

1) How can organisations achieve M&E plans when they have no capacity?
2) How are PRs expected to get RCC where no impact baselines exist?

Responses

1) On M&E capacity, an organisation applies when it has minimum requirements. One must have the potential to put things in order and be proactive.

2) RCC is given to those graded at level A or B1 where it is thought that impact studies have been done. In cases where they are not available, potential data is used. However, we need to remember that “What you cannot measure, you cannot manage”

As we implement the programs there are stages of supervision:

GF – Secretariat level
CCM – Monitoring PRs
PR – Monitoring the SRs
SR – Ensure money reaches implementation
SSR – They work
Of importance to note is that:

- The reporting of indicators is simpler at lower level and complex at upper level.
- Indicators are for your use up to National level
- M&E is critical in order to access funding
- There is money in the grant to develop M&E so organisations can hire consultants, train staff or take other necessary action to improve their M&E.

Helping faith based organisations access technical support – PEPFAR, WHO, UNAIDS

- Kimberley Bardy – Office of the US Global AIDS Coordinator
- Kimberley Konkel – Centre for Human and Health Services for FB and Communities Initiatives
- Shushu Tekle-Haimanot – UNAIDS
- Leopold Blanch – WHO
- Sally Smith – UNAIDS

WHO perspective

Introduction

Substantial additional financial resources have been made available, presenting an opportunity to strengthen country programs to achieve both national and international health goals.

Focus is on scaling up of key health sector based ATM interventions. There are also opportunities for strengthening health systems and local
partnerships in the implementation of activities by Government, civil society including FBOs and the private sector

**Basic principles**

- Global strategies: Malaria Elimination/Eradication, Stop TB, Universal access to HIV Prevention, Treatment & Care
- Firmly embedded in national medium term plans for the control of each of ATM
- Partners coordination mechanisms at national and international levels to contribute to the implementation of national plan
- Harmonization and Alignment

**Global Fund related Technical Assistance include:**

- Grant application
- TRP clarifications
- Grant negotiation (related plans: work plan, M&E)
- Grant implementation (phase 1 and phase 2)
- Monitoring & Evaluation systems strengthening
- Rolling Continuation Channel
- Grant consolidation
- Ongoing support to address bottlenecks in implementation

**WHO support for GF activities**

This is two-fold: supporting development of country proposals and supporting programme implementation. Support to development of country proposals includes supporting strategy development for disease control and prevention, regional briefing meetings and training for
countries/consultants on proposal writing, direct technical support to countries and remote technical backstopping (technical expertise available at HQ, RO, ICP and other partner institutions).

On the other hand, support to implementation of programmes includes grant negotiations, technical guidelines and delivery models, technical support to ongoing implementation, development of technical assistance plans and monitoring of progress.

To access Technical Assistance, one needs to send an official national request through Country offices, regional office even at the ISTs which are available in three countries (Burkina Fuso, Gabon and Zimbabwe). However, TA is available from many other agencies and providers such as STOPTB, RBM, TSF, UN agencies, PEPFAR, international NGOs and others. The WHO brokers the provision of technical support from other partners e.g. TBTEAM.

*Types of TA offered are:*

- Normative functions; e.g. policies, strategies, guidelines, training materials
- Program development and planning
- Development of intervention tools for prevention and treatment
- HRD- assessment and training
- PSM- plans, strengthening systems, price negotiations (GDF and AMDS)
- M&E of interventions - strengthening of systems including operational research

The WHO contributes to national plans and works with Governments using same policies, strategies and guidelines. Quality TA is very important and optimisation of resources for technical support is required by close coordination between various actors. The WHO is able to offer direct help to NGOs and FBOs in coordinating and offering technical support.

**UNAIDS Perspective**

*Leopold Blanch and Jacqueline Daldin*

A Technical Support Facility (TSF) has been established by UNAIDS. There are two in Africa; one in southern Africa and another in East Africa. These are providing quality technical assistance for HIV programmes.

They are there to respond to the growing demand for quality short-term assistance in strategic areas such as IDS Coordinating Authorities, health officials and community service organizations.

TSF is funded by UNAIDS and among their duties is to manage quality consultancy. They also contract consultancy and take part in M&E. Their services are however not free.

However, there are some funds available at UNAIDS and organisations can apply directly for them. For southern African, for instance, contact the TSF directly through Anthony Kinghorn (akinglhorn@tsfsoutherafrica.com).
The Civil Society Action Team (CSAT) helps CSOs with Global Fund proposals. A gender team at the UNAIDS Secretariat is compiling a list of consultants who could assist with Round 8 proposals. A resource kit for GFATM R8 is available on the WHO website and also at www.theglobalfund.org.

PEPFAR Perspective

US President’s Emergency Plan for AIDS Relief (PEPFAR) is a US government programme dedicated to building capacity in certain focus countries. Technical Assistance is aimed at building capacity and organizational development. Global Fund Technical Support (GFTS) programme (Grant Management Solutions) is country driven. They work with Umbrella organisations, prime sub-partner relationship and country specific TA mechanisms.

GFTA from PEPFAR delivers short-term technical support for CCMs and PRs to help in unblocking bottlenecks. They help build capacity of local TS providers to assist them to support GF activities. They also assist in building capacity of CSOs so that they can participate effectively in GF activities.

US Global Fund Technical Support (USGFTS) provides short-term technical support, not for proposal development but to aid grant management and implementation. They build capacity of local TA providers with their areas for TA provision including:

- CCM support on organizational development and leadership development
• Building capacity for grant management for local PRs and SRs and facilitating transition from external to local PRs.
• Pharmaceutical management and identifying viable CSO and private sector options
• Monitoring and Evaluation by involving local experts from academia and the private sector
• Capacity-building for CSOs

For more information, visit [www.pepfar.gov/coop/9135.htm](http://www.pepfar.gov/coop/9135.htm). This TA programme started in 2007 and is working in 20 countries in Africa. There is a simplified formal application process to access the TA.

Other US supported GFTA is also available through:
• Green Light Committee targeting TB, especially on MD-R or XD-R TB
• Stop TB partnership
• UNAIDS Technical Support Facilities (Africa)
• Roll Back Malaria Program

The most effective way for small organisations to get TA is to have one voice by coming together.

References: PEPFAR website: [www.pepfar.gov](http://www.pepfar.gov)
CDC Global AIDS Program: [www.cdc.gov/nchstp/od/gap](http://www.cdc.gov/nchstp/od/gap)

Open forum

Questions:
1) How can country programme access remote technical support?

2) How quickly do responses to TA requests come?

3) Accessing TA from PEPFAR seems to be through CCMs and PRs. The SRs need to group together. However, SRs have diverse needs and their requests may take time. However, they need such assistance greatly.

4) Have we looked at the number of activities between GF and implementers?

Responses and comments:

1) TA should be aimed at transferring skills to the local experts.

2) A database of consultants is available in for some countries. FBOs should ensure they get quality consultants. Funds for this can be availed as indicated in earlier discussions.

3) There was a lot of inherent power to manage diseases even before TA and money came in.

4) It is difficult to measure TA and sometimes a problem may be both technical and political.

5) This forum was for FBOs. However, the presentations were geared towards Governments, PRs etc. It should have been a joint advocacy consultation with our sister FBOs in the north on ways that GF can assist FBOs in sub-Saharan Africa.

6) The solution is to make GF procedures and guidelines simpler. Everyone in should understand them, write proposals and implement projects without intermediates.

7) GF is in the process of revising procedures and guidelines to make them simpler. It takes time and some may not be simplified as
expected. In the mean time, organisations should use available TA/TS.

8) We all have a responsibility to solve political problems. Development partners cannot do it; we must do it in our context.

9) Guidelines are there for a reason. One of the reasons proposals fail is the composition of the CCM.

10) We need to advocate for things that are not working. We should not underestimate the work to be done.

The participants.

Ends