

GUIDELINES FOR PROPOSALS – ROUND 11

SINGLE COUNTRY APPLICANT

Deadline for submission: 15 December 2011

Applicants must submit:

- (i) An electronic version of the application package to the following email address:
proposals@theglobalfund.org
- (ii) An identical paper version of the application package posted to the following address by **15 December 2011**, as evidenced by a stamp of the postal or other courier service:

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

Please note the following important dates related to proposal submission:

**Technical Review Panel Round 11 review meeting:
March 2012**

**Board consideration of Technical Review Panel recommendations:
May 2012**

Applicants considering a [multi-country application](#) in Round 11 should refer to the separate materials available

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Sources of further guidance

- Read the Global Fund's [Round 11 FAQs](#) (Frequently Asked Questions)
- Read the Global Fund's [Round 11 Information Notes](#)
- Contact existing in-country partners, and/or look up [partner contact details](#) on the Global Fund's website

Purpose of the Guidelines

These guidelines give detailed directions on how to complete a Round 11 application.

They are intended to be read by everyone who will be involved in the implementation of Global Fund grants and we strongly recommend they are read from start to finish before completing the application.

It is very important to carefully read each section of the guidelines when completing the corresponding section of the proposal form and other mandatory documents in order to submit a complete application.

The Global Fund will not accept incomplete applications.

Application Materials

Which documents must be submitted for a complete application?

Mandatory documents:

1. **Proposal Form Sections 1-2:** must be submitted once per applicant
2. **Proposal Form Sections 3-8:** must be submitted for each disease component
3. **Logframe (Attachment D):** must be submitted for each disease component
4. **Performance Framework (Attachment A):** must be submitted for each disease component
5. **Preliminary List of Pharmaceutical and Health Products (Attachment B):** must be submitted for each disease component that requests funding for pharmaceutical and health products
6. The following financial information must be submitted for each disease component:
 - a. **Financial gap analysis and counterpart financing table**
 - b. **Detailed budget and work plan**
 - c. **Summary budget tables and incremental request table**

Applicants can submit the financial information in one of two ways:

1. Completing the Global Fund budget template (**Attachment E**); OR
 2. Completing another budget template AND completing **Attachment F**, which includes the financial gap analysis and counterpart financing table and the summary budget tables and incremental request table.
7. **Membership Details of CCM or Sub-CCM (Attachment C):** must be submitted once per CCM or Sub-CCM applicant [not required for a non-CCM applicant]
 8. **Eligibility documents:** must be submitted once per applicant according to the instructions in section 2

Please note that it is important to respect the page limits identified in each of the sections of the proposal form in order to ensure a proper review by the TRP.

Supplementary documents:

Summarize information from other documents (e.g., national strategies) in the proposal form when it is essential to the TRP's review. If the relevant information is too lengthy, an electronic copy of the relevant document may be submitted with the application as an annex. List the name and exact page reference of the relevant document in the proposal form annex checklist. However, **do not expect that the TRP will read all of the supplementary documents. All information essential to the proposal should be summarized and included in the proposal form.**

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Which languages are accepted?

The Global Fund will accept application documents in any of the six United Nations official languages (Arabic, Chinese, English, French, Russian and Spanish).

Do I need to translate my documents?

The working language of the TRP is English. Unless the applicant sends an identical English translation of the mandatory documents (see above) to the Global Fund by the Round 11 submission deadline of **15 December 2011**, the Secretariat will translate the mandatory documents. The Secretariat will not translate any supplementary documents.

Is additional guidance available?

For a list of the most common questions encountered during proposal development, refer to the Round 11 [Frequently Asked Questions](#) (FAQs).

For information and guidance from the Global Fund on the following areas, refer to the Round 11 [Information Notes](#).

New in Round 11



New targeted funding pool for HIV, tuberculosis and malaria

Applicants must choose whether to apply for the General Funding Pool, which overall will receive 90 percent of the available resources in Round 11, or the Targeted Funding Pool, which will receive the remaining 10 percent (or a maximum of US\$ 150 million for the first two years of the grant life).

Note that each pool has a different set of requirements and that different prioritization rules will apply to proposals in each pool in the event that there are insufficient resources to fund all TRP recommended proposals.

Proposals in the Targeted Funding Pool must comply with a funding upper ceiling of US\$ 5 million for the first two years and US\$ 12.5 million for a five-year proposal. There is no upper budget ceiling in the General Funding Pool. Please refer to the information note on [eligibility, counterpart financing and prioritization](#) for more information.



New eligibility and counterpart financing rules

At its Twenty-third meeting in May 2011, the Global Fund Board agreed on new eligibility and counterpart financing criteria, which (alongside minimum CCM requirements) determine whether countries are eligible to apply for Global Fund support, and under what conditions. The eligibility criteria takes into account the country income level, the national disease burden, the focus of proposals and - starting in Round 11 - the history of recent funding of the applicant.

Income level. The Global Fund makes the determination of income classification based on the World Bank (Atlas Method) Income Classifications. The Global Fund applies a one-year grace period where a country moves up from one income level to the next¹. For purposes of eligibility, countries that fall into the following income classifications are eligible for Global Fund funding, with some restrictions (refer to [the Global Fund Eligibility List for 2011 Funding Channels](#)).²

¹ The grace period does not apply for applicants who move to High Income.

² GF/B23/14.

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- (a) Low income countries
- (b) Lower middle income countries
- (c) Upper middle income countries

Disease burden. All low income and lower middle income countries, regardless of the magnitude of their disease burden, are eligible to apply. Under the new criteria, upper middle income countries must be able to demonstrate a severe or extreme disease burden to be eligible for funding under the General Pool, and a high disease burden to be eligible for funding under the Targeted Pool. Small island economies³ are also eligible for the Targeted Pool if they have moderate or low disease burdens. Those which have ‘Extreme’ or ‘Severe’ disease burden may apply to either the General Pool or the Targeted Pool.

Recent funding history. If an applicant has a Global Fund grant for a particular disease or for cross-cutting HSS that started implementation in the last 12 months (i.e. on or after 15 December 2010) or a recently approved proposal that has not yet been signed into a grant, that applicant is not eligible to submit a new proposal for that same disease (or HSS). This is known as the recent funding history rule. The 12 month implementation period begins from the program start date as set out in the grant agreement.

Where the recent funding history rule is applicable, **only proposals from applicants who have successfully gone through the special TRP process to request an exemption to this rule will be accepted.**

Focus of proposals. In the General Pool, proposals from low income countries do not have to meet any focus criteria. Proposals from lower middle income countries must focus at least 50 percent of the budget on underserved and most-at-risk populations⁴ and/or highest-impact interventions⁵ within a defined epidemiological context. Proposals from upper middle income countries must focus 100 percent of the budget on these populations and/or interventions.

In the Targeted Pool, all proposals regardless of the applicant’s country income level must focus 100 percent of their budgets on most-at-risk populations and/or highest-impact interventions.

Counterpart Financing. The new counterpart financing policy has three provisions: (a) a minimum threshold for government contributions; (b) increasing government contributions over time; and (c) improvements to expenditure data.

The governments of all applicant countries are required to make minimum contributions to the national disease program budget (or, in the case of cross-cutting HSS proposals, to all the relevant national disease programs). This will help ensure additionality of Global Fund support, and the financial sustainability and country ownership of programs.

The minimum government contributions to the national disease program (as a percentage of total government and Global Fund financing) are:

³ As found at the International Development Association website.

⁴ Underserved and most-at-risk populations are subpopulations within a defined and recognized epidemiological context that have significantly higher levels of risk, mortality and/or morbidity, and whose access to, or uptake of, relevant services is significantly lower than the rest of the population.

⁵ Highest-impact interventions within a defined epidemiological context are those that address emerging threats to disease control, lift barriers to the broader disease response and/or create conditions for improved service delivery; and/or enable the roll-out of new technologies that represent best practice; and are not adequately funded at present.

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- (a) Low income countries: 5 percent
- (b) Lower middle income countries:⁶
 - (i) 20 percent for ‘lower’ lower middle income countries (‘Lower LMIC’)
 - (ii) 40 percent for ‘upper’ lower middle income countries (‘Upper LMIC’)
- (c) Upper middle income countries: 60 percent

When submitting proposals, applicants must demonstrate that these minimum thresholds have been met. If a country is below the threshold, it must submit for TRP review a justification and an action plan for moving towards the threshold.

Countries also have to be able to demonstrate increasing government contributions to the national disease program(s). Finally, countries are required to report financial information for national disease programs to technical partners on a yearly basis, with data broken down by source of funding. Proposals may also include measures to improve expenditure tracking.

The table below gives an overview of the eligibility criteria for the two available pools of funding in Round 11:

Income Level	Disease Burden	Funding History	Focus of Proposal		Counterpart Financing (minimum threshold) ¹
			General Funding Pool	Targeted Funding Pool	
Low Income	No	No recent	No	or 100% focus on specific populations/interventions	
Lower Middle Income Countries	No Restriction	No recent funding ²	50% focus on specific populations/interventions	or 100% focus on specific populations/interventions	Lower LMIC = 20%
					Upper LMIC = 40%
Upper Middle Income Countries	Severe or Extreme	No recent funding ²	100% focus on specific populations/interventions	or 100% focus on specific populations/interventions	60%
	High ³	No recent funding ²	only		

¹ The minimum government contribution to the national disease program, as a share of total government and Global Fund financing for that disease. ² Exceptions may apply. ³ Small island economies are eligible if they have moderate or low burdens.

For more information on the eligibility and counterpart financing requirements, please see the [Information Note on the New Eligibility, Counterpart Financing and Prioritization Policy](#). Please also refer to the list of eligible countries and economies in Round 11.

⁶ For the purpose of counterpart financing, Lower middle income countries (LMICs) are split into two income groups using as a cut-off the midpoint of the range of GNI per capita for LMICs as reported by the World Bank. Countries at the midpoint or below the midpoint shall, for the purposes of the GF Policy, be described as Lower LMICs and those above the midpoint as Upper LMICs. All LMICs must comply with requirements regarding the focus of proposals (see Paragraph 17 GF/B23/14).

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New CCM guidelines

At its Twenty-third meeting, the Global Fund Board approved the new CCM Guidelines that strengthen some of the six minimum CCM eligibility requirements. For more information on this see “Section 2: CCM Requirements for Eligibility.”



Mandatory consolidation in Round 11

Starting in Round 11, all applicants will have to write a consolidated proposal, which takes into account all existing same disease grants in the country. For more information, see the section of the guidelines entitled “Consolidated disease proposals and the new grant architecture.”



New tools in Round 11: Applicant Disease Profile and Partner Country Profiles

To assist applicants that have existing Global Fund grants in completing their Round 11 consolidated proposal(s), applicants can download an Applicant Disease Profile (ADP) together with the proposal form and guidelines from the Global Fund website. This profile contains financial and programmatic information for each disease for which an applicant has existing grants, with separate profiles for each disease.

Applicants will also receive partner reports by disease, which contain epidemiological statistics and other relevant information about the disease profile in the country. These reports serve as useful inputs for applicants when assessing their existing programmatic strengths and weaknesses. Applicants should also refer to these reports when completing the epidemiological tables in the country context section of the proposal form (see the guidelines on Section 3 for more details).

Note that both the Applicant Disease Profile and the partner country profiles will be provided to the TRP during their review of Round 11 applications. As these documents reflect programs that are in progress, the data in these reports will change between the time of the launch of Round 11 and the TRP review.



Other new elements in Round 11

- **Elements that make a strong proposal:** As part of the effort to streamline the proposal form, all questions related to specific policy issues have been removed, with the understanding that these topics should be addressed throughout the proposal. For more information see the section of the guidelines entitled “Elements that make a strong proposal”;
- **Round 11 Priority Interventions:** This table, brought back from the Round 9 proposal form, should be used to highlight priority interventions that this proposal will support and to enumerate the populations that will be addressed through these interventions. For more information, see the guidance around question 3.5 in the “Country Context” section. This section is mandatory for malaria proposals. It is optional but recommended for HIV and tuberculosis proposals.
- **Proposal Logframe:** All applicants are required to submit a new mandatory document, the proposal logframe, which is a tool for summarizing the proposal strategy, numbering the interventions, and clearly linking performance indicators with proposed interventions. For more information see the guidance around question 4.3 in the “Interventions” section.
- **PR sign off and endorsement:** PRs must now sign off on the application confirming that they understand all of the core components of the proposal (interventions, performance framework, budget and work plan) and they are ready to implement if the proposal is approved. For more information see “Section 8: Management strategies”.

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Steps to developing a strong proposal

The proposal development processes used by the CCM (or Sub-CCM) to evaluate all submissions received as input into the application is an essential part of the Global Fund's assessment of applicant eligibility. Proposal development processes should ensure the broad and inclusive participation of stakeholders from many different sectors (public, private, civil society, etc.).

→ Refer to section 2 of the guidelines for additional information

Step 1	Start early: This is to allow all sectors and constituencies, including non-members of a CCM or Sub-CCM, enough time to participate in the process of determining the needs, gaps and priorities.
Step 2	Consult broadly and inclusively: Both government and non-government stakeholders should come to a consensus on the needs, gaps and priorities of addressing the disease(s). Distribute information at the national, subnational and community levels to increase demand and improve universal access to services. Key populations excluded from existing programs and people living with or affected by the disease(s) should be included in this process.
Step 3	Select Principle Recipient(s) Early: Do this as early as possible. The CCM should select the PR or PRs in an independent and transparent manner. Once selected, the PR(s) should be involved in the development of the proposal. In particular, the PRs should be aware of the content of the activities assigned to them, the performance framework that they will be assessed against, and the corresponding budget and work plan that will support those activities. PRs should be aware of the financial management and reporting requirements of the Global Fund.
Step 4	Identify barriers and develop solutions: Define the barriers in the disease program, health and community systems in responding to the needs established in Step 2. Involve national, sub-national and community level stakeholders from government and non-government sectors in the identification of systematic barriers and the development of solutions to address them.
Step 5	Share potential priorities: Ensure early and broad agreement throughout the country on the direction of Round 11. It is also important at this stage to share priorities with key populations excluded (socially or geographically) from existing programs and/or at a higher risk of exposure as well as people living with the disease.
Step 6	Invite contributions: Formalize participation of key populations in the development of the application and consider their inclusion as implementers (e.g., Principal Recipient or sub-recipient). Through an open and transparent process, select contributions that will help achieve results and impact to include in the final proposal.
Step 7	Finalize the Application: Confirm the priorities for Round 11. Consider a peer-review during proposal development to strengthen overall technical soundness.
Step 8	Review the application: Check the overall soundness and coherence of the entire application.

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Overview of the Proposals Process

The Global Fund Secretariat screens each proposal it receives for completeness and eligibility. The Secretariat may contact the applicant for clarifications during this process.

After the initial Secretariat screening, eligible proposals go to the TRP for a technical review. The TRP is an independent body of international experts in HIV, tuberculosis, and malaria. It also includes cross-cutting experts. It reviews proposals based on the criteria set out in Annex 1 of these guidelines. The TRP only reviews the technical content of the proposal and does not take into consideration the overall availability of funds.

If an applicant submits a proposal for more than one disease or cross-cutting HSS request, the TRP will review each component separately.

Since Round 10, the TRP has had greater flexibility to recommend an otherwise strong proposal for funding conditional upon the removal of a limited set of weaker elements, resulting in the reduction of the proposal budget. This practice is called “upfront budget removals”.

More information on the TRP is available at the Global Fund’s website, <http://www.theglobalfund.org/en/trp/>

Applicants are strongly encouraged to read the document entitled “Report of the Technical Review Panel and the Secretariat on Round 10 Proposals” for lessons learned before completing their application. This report is available at: <http://www.theglobalfund.org/en/trp/reports/>

Board decision on funding and other processes

The Board makes funding decisions based on TRP recommendations and these decisions are subject to the availability of funds.

The Board approves a proposal for the whole of the proposal term (maximum of five years). However, funding is only initially committed for a period of up to three years⁷, with the possibility of renewal for the remainder of the proposal term up to the maximum requested budget, depending on performance review at grant renewal and the availability of funds.

Board approval is conditional upon the applicant’s satisfactory completion of TRP clarifications. While this clarification process is underway, the Secretariat will initiate assessments of the nominated Principal Recipient(s) through the Local Fund Agent, and start grant negotiations. Following Board approval, successful applicants have 12 months to sign their grants before funding expires.

In the event that resources are limited, the Board will apply a prioritization method to determine which components amongst those recommended by the TRP will be approved. The prioritization criteria are:

- For the General Funding Pool, the prioritization criteria are based on a three-part composite index that assigns scores for country income level, country disease burden and the recommendation category given by the TRP. The table below shows the scoring system to be used:

⁷ For applicants who have transitioned to single stream(s) of funding and established Implementation Periods, funding would be committed only up to the end of the current implementation period (based on the proposed start date of new funding).

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INCOME LEVEL		DISEASE BURDEN		TRP RECOMMENDATION	
Low income	4	Extreme	8	Category 1 or 2	4
Lower LMIC	3	Severe	6	Category 2B	3
Upper LMIC	2	High	4		
Upper middle income	1	Moderate	2		
		Low	1		

For example, a low income country with an extreme disease burden and a Category 1 recommendation will receive 16 points (the maximum), and will be prioritized over an upper-middle income country with a high disease burden and a Category 2B recommendation (which scores 8 points). For cross-cutting HSS applications, an average burden score will be calculated for the diseases benefiting from the HSS proposal.

- For the Targeted Funding Pool, the TRP will also assign a recommendation category. In the event of insufficient funding being available for the recommended proposals, an additional score will be assigned based on an agreed methodology.

Appeal Mechanism for Round 11

If an applicant applies for funding for the same disease component in two consecutive Rounds (for example, Round 10 and Round 11 HIV), and is unsuccessful both times, they are eligible to appeal. The only basis for an appeal is if an applicant believes the TRP has made a material error in their review. **Note that the elements removed in the practice of “upfront budget removals” described above are not eligible for appeal.** Find more information on the criteria and process for [internal appeals](#) on the Global Fund website.

Consolidated disease proposals and the new grant architecture

Introduction

At its Twentieth meeting in 2009, the Global Fund Board approved a new grant architecture, to simplify the Global Fund’s support to current and future implementers of national disease-fighting and health systems strengthening programs.

Starting with Round 11, all proposals submitted to the Global Fund will require the applicant to present a **consolidated request for funding** which incorporates financial and programmatic information on any current Global Fund support to the country for the disease.

Consolidated disease proposal

A consolidated disease proposal is a **complete programmatic picture of the funding requested from the Global Fund for a disease program for the duration of the proposal term** (i.e., up to five years). Consolidated proposals build upon existing Global Fund grants in a country for one of the three diseases. The purpose is to ensure that funding requests to the Global Fund are more program-based and holistic; building upon lessons learned from years of program implementation and making adjustments to program strategies and planned program activities, when warranted.

A consolidated disease proposal must include information on all of the applicant’s existing same-disease grants in the request for funding. Applicants are strongly encouraged to evaluate the programmatic successes and shortcomings of their existing same-disease grants, and to ensure that they still fit with the disease epidemiology and reflect the most recent national and international disease control policies and guidelines. Applicants should adjust their proposed program going forward to reflect any changes in country context and lessons learned from implementation to ensure that the grant money received from the Global Fund is achieving optimum value for money.

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In addition to reflecting on programmatic successes and failures, applicants should examine the current management arrangements and determine whether they are optimal for achieving the proposed strategy going forward. The consolidated disease proposal may or may not re-nominate all existing Principal Recipients, may choose to nominate new PR(s), and may also reallocate responsibilities amongst PRs to strengthen program implementation.

If approved, the single stream(s) of funding resulting from the consolidated disease proposal will replace any ongoing grants for each Principle Recipient in the disease program.

The difference between writing a consolidated disease proposal and transitioning to single stream(s) of funding during grant negotiation

Submitting a consolidated disease proposal is not the same as transitioning to single stream funding, which happens during grant negotiation. The consolidated disease proposal lays the framework for the program that will be implemented, including suggesting which PR(s) will manage which parts of the proposed program. If the consolidated disease proposal is approved, a single stream of funding agreement will be signed for each Principal Recipient implementing in the disease program.

It is important to note that **single streams of funding are created per Principal Recipient per disease or cross-cutting health system strengthening program**, so in cases where an applicant nominates multiple Principal Recipients to manage Global Fund funding for the applicant's disease program, a single stream of funding will be created for each Principal Recipient.

In cases where applicants have existing single streams of funding, these agreements will be amended to reflect any new funds received through the Round 11 proposal.

How to develop a consolidated disease proposal: identify needs, gaps, objectives and activities

Applicants are strongly encouraged to assess the programmatic and managerial performance of their existing grants and to explore opportunities for reprogramming and modifying the scope of their proposed program going forward to incorporate any lessons learned, in addition to changes based on the most relevant epidemiological information or country context. Goals, objectives, SDAs and activities should be developed to fit with the current epidemiological and programmatic needs in the country/region. Once the objectives of the Round 11 proposal are agreed upon, the applicant must be able to articulate any changes in the implementation arrangements or targeted populations of the existing grants and the new proposal.

In the interventions question (section 4) applicants will be asked to make links between the goals, objectives, SDAs and key activities in the proposal and those from grants that are currently being implemented, noting where activities are increased or decreased in scale, continued without change or discontinued. For activities proposed to be continued, applicants should make reference to those in their logframe (4.3(a)) and in the narrative description of programmatic activities (4.3(b)). For activities from previous grants that are proposed to be discontinued, applicants should make reference to those in the discontinued activities table (4.3(c)) noting the reason for discontinuation.

Once applicants have assessed their needs and gaps, and have laid out their objectives and key activities, the corresponding performance framework and detailed budget should be prepared to reflect the priorities put forward in the new proposal.

How to deal with funds brought over from existing grants

The total Round 11 funding request will include funding from existing grants that have been included in the consolidated disease proposal, in addition to some new funding that is requested through the proposal (known as the "incremental funding" amount). Applicants are asked to determine the "incremental funding" requested from the consolidated disease proposal in the question 7.6(d) of the Funding Request Section.

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The amount of funding to be brought over from existing grants into the consolidated disease proposal will depend on several factors, including the proposed start date of the consolidated disease proposal and when the existing grants are “cut off” in order to become part of the single stream of funding. **Applicants should carefully follow the budget template to show how they have calculated their incremental funding amount.**

Recognizing the complexities in calculating the correct amount of both existing funding and incremental funding in order to arrive at the total upper ceiling funding request for TRP recommendation and Board approval, applicants are encouraged to ensure they have the most recent programmatic and financial picture of their existing grants. Some of this information can be found in the Applicant Disease Profile that will be downloaded at the time of application, with additional detail on current performance frameworks and detailed budgets available through the current Principal Recipients. Following the submission of the proposal, there will be an iterative Secretariat screening process with the applicant to ensure accuracy in the incremental funding amounts requested through the proposal.

What to expect if your proposal is approved

From Round 11 all applicants will have to submit a consolidated proposal that, if approved, will be signed into a stream of funding per PR per disease at grant negotiation. This new “single stream of funding” (SSF) will go through a life cycle that is slightly different from the past model, notably at the stage of Periodic Review.

The TRP recommends proposals for funding to the Global Fund Board, who make a decision to fund the proposals based on the TRP recommendations and the availability of new funding. Following Board approval of proposals, there is a stage of TRP clarifications, which can result in adjustments to the original proposal, and can lead to a reduction of the Board-approved upper ceilings. Along with the TRP clarifications process, the LFA conducts an assessment of the nominated PR(s) and the Secretariat begins grant negotiations, which are finalized through the single stream of funding agreement. If at any time during the TRP clarifications or the grant negotiations process, the TRP or Secretariat determine that the Board-approved grant no longer represent a good use of Global Fund funding, a recommendation to not fund the approved proposal can be given to the Global Fund Board.

A key difference between an existing grant agreement and a single stream of funding agreement has to do with how funding is committed over time. Whereas existing grants each have funding commitments of 2+3 years (or 3+3 years in the case of Rolling Continuation Channel grants) single streams of funding will have fixed regular implementation periods of up to three years, which remain unchanged by the introduction of new funds.

A key change in the grant life cycle as a result of the new grant architecture is the new Periodic Review, which replaces the Phase 2 grant renewals process. Whereas previously grant recipients underwent Phase 2 reviews approximately 18 months after implementation began, the date of Periodic Review is fixed depending on the review cycle timeline decided by the country at time of transitioning to single stream of funding. Like the Phase 2 process, each Periodic Review will be an in-depth evaluation of programmatic performance, progress towards proposal goals and impact achieved and efficient and correct use of funds. The outcome of the evaluation will then determine funding levels for the next implementation period.

However, unlike the current model, which requires a Principal Recipient to have a separate performance review for each of its grants (e.g., one for its Round 5 HIV grant and a separate one for its Round 7 HIV grant), under the new system each Principal Recipient will have only one periodic review per disease or health system strengthening program every cycle. This periodic review will determine the funding commitment for the next implementation period of up to three years.

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In cases where there are multiple Principal Recipients managing funds for a disease or health system strengthening program, all PRs will go through their periodic reviews simultaneously. This is intended to provide a more holistic evaluation of how Global Fund resources are impacting disease programs, allowing grant renewals decisions to be based on a systematic analysis of progress towards impact and outcome. For this purpose, at Periodic Review CCMs are expected to include in their assessment an analysis of progress towards the goals and objectives of the proposal, supported by a program evaluation or joint program review.

The comprehensive assessment conducted at the time of Periodic Reviews results in additional financial commitment recommendations to the Board for each PR, including: (1) a performance rating; (2) a recommendation category; and (3) a recommended additional commitment amount.

What to expect if you have existing SSFs

Applicants with existing single streams of funding in the same disease as the proposal will already have set their periodic review and financial commitment cycles, and should make sure to reflect on the timing of the Periodic Review when determining the proposed start date. As agreed with the CCM and PRs during grant signing, these cycles will apply to all PRs implementing in the same disease or health system strengthening program going forward in order to ensure a holistic and robust Periodic Review process.

If applicants with existing SSFs in the disease program are recommended for funding, the incremental funding request that will go forward to the Board for approval will only cover the period through the end of the current implementation period. During grant negotiation, any existing SSF agreements will be amended to reflect the newly approved funding. A new PR nominated as part of the Round 11 proposal, if approved, will sign a single stream of funding agreement, and align their financial commitment and Periodic Review cycles with existing Principal Recipients implementing in the disease program.

What if you don't have any existing grants in this disease area - does the consolidated disease proposal apply?

Applicants without any existing grants in the disease to which they are applying will not have any existing grants to make reference to in their proposal summary (section 4) or in their funding request (section 7). Therefore, there is no need to fill out the question on discontinued activities (4.3(c)). However, all other questions in the proposal form are applicable to all applicants, regardless of whether they have existing Global Fund grants in the disease for which they are applying.

For regional applicants, the same principle applies: those with existing Global Fund grants in the disease must fill out the full form, new regional applicants can skip the question on discontinued activities (4.3(c)). All regional applicants should make reference to the disease programs in the countries represented in their application and ensure they describe how the proposal builds upon, but does not duplicate ongoing disease programs in those countries.

Sources of further guidance

For more detailed information on the new grant architecture, transitioning to a single stream of funding, or submitting a consolidated disease proposal, the applicant is encouraged to access the following sources of guidance:

<http://www.theglobalfund.org/en/activities/grantarchitecture/>

http://www.theglobalfund.org/documents/rounds/11/R11_Consolidation_InfoNote_en/

<http://www.theglobalfund.org/en/activities/renewals/>

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Elements that make a strong proposal

There are certain elements that the Global Fund values and looks for in proposals. These include equity and human rights (including gender equality and sexual orientation and gender identity issues), aid effectiveness, the roles of both the private sector and communities in strengthening implementation, and whether the proposal makes a compelling case for investment by demonstrating good value for money.

These elements are in line with Global Fund principles and contribute to making a proposal technically sound. They are also important elements that the Global Fund will track throughout grant implementation, including at the time of grant renewals, as part of the basis for decisions on continuing funding.

The Global Fund recognizes that how applicants integrate these elements will depend on the local context, disease burden, type of epidemic and key affected populations in each country. Applicants are strongly encouraged to:

- Assess needs in these areas prior to starting the proposal development process and understand current weaknesses and gaps
- Develop interventions appropriately through a broad and inclusive process that includes members of affected and infected populations
- Link these interventions directly to key drivers of the disease to ensure universal access to comprehensive prevention and treatment, care and support services
- **Carefully review the TRP Review Criteria (Annex 1) to understand how the TRP will assess applications against these dimensions.**

These elements need to translate practically into interventions, and should therefore be clearly reflected in the proposal strategy, the logframe, performance framework, and budget and work plan.

EQUITY AND HUMAN RIGHTS

The Global Fund promotes equity and human rights as core principles of its funding. Attention to equity and human rights is essential to ensure that Global Fund financing is making an effective contribution and helping to promote universal access to key services for all populations in need. **The incorporation of equity into the proposal is a key criteria for TRP review.**

The burden of disease caused by HIV, TB and malaria is distributed differentially across regions and population groups, which has implications for program planning and design. Yet access to services is inequitable in many countries and not aligned to need. There continue to be large gaps in access to essential health interventions as a result of poverty or social inequalities. Discriminatory laws and policies and stigma continue to be an obstacle to an effective response to the three diseases, and in particular HIV. Achieving health equity means that those in need are able to access the services they require in relation to age, sex, sexual orientation or gender identity, socio-economic status, geographical location or other factors. It means that services are delivered to the right people in the right places and that most affected populations are involved in the planning and delivery of these services.

Depending on the disease and the country context, the Global Fund recognizes that certain **population groups** may require explicit attention. These may include women and girls; men who have sex with men; transgender persons; injecting drug users; sex workers and their clients; prisoners; refugees, migrants or internally displaced populations; people living with HIV; adolescents, and young people; vulnerable children and orphans; ethnic minorities; or other group(s) specific to the country context.

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In 2008-09, the Global Fund adopted two complementary strategies to promote *Gender Equality* (with a focus on women and girls) and equity in relation to *sexual orientation and gender identities or SOGI* (with a focus on men who have sex with men, transgender populations, and male, female and transgender sex workers). These strategies outline concrete actions for the Global Fund to promote equity through its policies and procedures; partnerships; communications and advocacy; and leadership. The proposals process is a key moment for developing equitable proposal strategies which will lay the foundation for the incorporation of equity throughout the grant lifecycle.

Approaches to promote equity rest on the principle of “know your epidemic; know your response” which should cut across the entire proposal. The main steps in incorporating an equity and human-rights approach in the proposal are as follows:

1. “Know your epidemic; know your response”: Collect and analyze disaggregated epidemiological and behavioral data (for example, through an equity assessment) to understand the burden of disease among different population groups. Analyze current levels of access to key services for these population groups and gaps in relation to need. Attempt to understand the main constraints or barriers in reaching these groups, including the legal, policy and social environment and human rights-related barriers to care; the extent to which services are affordable, accessible, acceptable, of good quality and meet the needs of key affected populations; and the extent to which specific human rights programs are included in national disease responses especially for marginalized or vulnerable groups.

2. Develop appropriate interventions: Incorporate the results of this analysis into the proposal strategy. This should be apparent in the description of the current response to the epidemic, its gaps and weaknesses, and the epidemiological profile of the target population (section 3). The proposed interventions (section 4) should seek to address these barriers and describe clearly how they aim to promote equity and human rights. Interventions to promote equity and human rights can include health interventions but also health systems strengthening (such as building surveillance and M&E capacity), community systems strengthening or other activities to address structural barriers (including referral systems for legal or welfare services).

3. Monitor progress: Proposed interventions to promote equity and human rights should have indicators for measurement and monitoring (section 5) and should be supported by a robust budget (section 7). Key outcome and impact indicators should be disaggregated by sex, age, geographical setting, socioeconomic status or other factors as relevant (considering UNGASS, the national M&E system and the context of the epidemic/disease in the country). Progress in achieving equity will be assessed at the time of the Global Fund Periodic Review.

Please consult the [Round 11 information notes](#) on Gender, SOGI, Equity, HIV and Human Rights and Tuberculosis and Human Rights.

COMMUNITY SYSTEMS STRENGTHENING

Community systems are community-led structures and mechanisms used by community members and community based organizations to interact, coordinate and deliver their responses to the challenges and needs affecting their communities. In the context of health, community systems strengthening (CSS) is an approach that promotes the development and sustainability of communities and community organizations, and enables them to contribute to the long-term sustainability of health and other interventions at community level.

CSS involves a broad range of community actors and includes an enabling and responsive environment in which their contributions can be effective. The goal of CSS is to achieve improved health outcomes by developing the role of key affected populations and communities and community-based organizations in the design, delivery, and monitoring and evaluation of services and activities related to prevention, treatment, care and support of people affected by HIV, tuberculosis, malaria and other major health challenges.

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Applicants will need to work closely with community organizations and actors to identify which community system strengthening interventions to fund, based on analysis of existing resources and the gaps and weaknesses in the systems. It is also important to show clearly how interventions will strengthen systems, to ensure that CSS funding is appropriately targeted.

Some examples of CSS interventions include:

- Advocacy and access to legal services;
- Implementation and monitoring of policies that affect access to health and welfare services or watchdog capacity;
- Strategic planning, monitoring and evaluation, including support for operational research and generation of research-based and experiential evidence for results-based programming;
- Support both for core funding for community based organizations and networks, including organizational overheads and staff salaries and stipends, as well as targeted funding for implementation of programs and interventions;
- Physical infrastructure development, including obtaining and retaining office space and equipment, improving communications technology, and providing and maintaining transport.

For a guide on how to develop CSS indicators and SDAs, including monitoring and evaluation, applicants are strongly encouraged to consult the CSS framework when developing their proposals: <http://www.theglobalfund.org/en/application/otherguidance/>.

Please consult the [CSS information note](#) for more information.

AID EFFECTIVENESS

In this approach, countries define their development priorities (ownership principle), and development partners support those priorities with their aid. Countries improve the capacity of their national systems, while development partners increasingly use national systems (alignment principle), and donors coordinate their efforts to reduce transaction costs (harmonization principle). Programs are managed for results and aid is delivered in a context of mutual accountability.

Proposal development lays the foundation for effective implementation arrangements. Applicants are encouraged to consider the following macro-level opportunities for aid effectiveness:

- Has the CCM actively discussed the vision of grant implementation within the disease program?
- How can implementation arrangements be chosen so that they are consistent with existing systems, policies, and processes?
- Have civil society PRs been included in the process and are their activities aligned and integrated into national policies and reporting?
- Have formal communication channels been established between the CCM, the PR(s), government ministries (e.g. Ministry of Finance), development partners, and the Global Fund Secretariat?

Suggested actions to improve the aid effectiveness of proposals and grants include:

- Align the proposal strategy with the disease program, national health and/or disease strategy, and its implementation plan and budget;
- Align grant start dates with country planning and fiscal cycles;
- Transparently report grants for government PRs in the national budget as approved by Parliament, and record grant disbursements for government PRs in the national accounting system of the Ministry of Finance;

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- Ensure that civil society PRs participate in national strategy development and implementation and ensure their activities are aligned and reported as part of the strategy, where feasible;
- Where appropriate capacity exists, use the government’s budget execution procedures, the government financial reporting procedures, the government audit, and the government procurement and supply management (PSM) systems available within the national pharmaceutical sector;
- Include activities in the proposal to strengthen national systems (e.g., national M&E system, systems within the national pharmaceutical sector);
- Use existing national M&E systems for grant data collection and reporting, including the use of national indicators, targets, and forms, and strengthen national disease program reviews, where they occur;
- Show evidence of harmonization of proposed salaries with existing compensation policies.

For further information, see the [Improving Aid Effectiveness information note](#).

PRIVATE SECTOR

The Global Fund is supportive of proposals that focus on the creation, development and expansion of government/private/non-government organization (NGO) partnerships, also known as Public-Private-Partnerships (PPPs). The Global Fund defines ‘private sector’ as for-profit firms, social enterprises, business federations and coalitions, employer associations, industry lobby groups and philanthropic foundations that are part of corporate endowments. Private sector areas of collaboration are often called co-investment, but may also involve product or service donations or a role as a supportive partner. All three types contribute to the planned outcomes of the proposal.

Co-investment: Private sector know-how in the implementation adds value through capacity building, scale-up and logistical support. For example, the Global Fund works with many companies using corporate health infrastructure to expand workplace health care services beyond workers to the surrounding communities. Private sector organizations may be particularly well suited to act as recipients, and in some cases they may be the best source for delivery of services in remote locations where other options are not available.

Other models may exist depending on the local context as long as they meet the following criteria:

- In all cases, the beneficiaries of a co-investment partnership extend beyond the employees of the companies and their direct dependents.
- The co-investment partner must provide an additional contribution to the funding requested from the Global Fund, whether this contribution is non-financial (e.g., access to facilities or staff) or cash.

The private sector can also provide on-going capacity development to applicants as a supporting partner through providing financial, management or other technical support.

For more information and key documents on the private sector, please visit:

<http://www.theglobalfund.org/en/civilsociety/>

MATERNAL AND NEWBORN CHILD HEALTH (MNCH)

HIV, tuberculosis and malaria place heavy burdens on the health of women and children. There are many opportunities to impact maternal, newborn and child health outcomes, in applications for the three diseases or health systems strengthening, using the flexibilities of funding within the current Global Fund mandate.

Identifying opportunities for integration requires a comprehensive understanding of the country context related to disease burdens, maternal and child mortality and health systems constraints. The process for establishing country priorities optimally requires the involvement of all

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stakeholders with a particular emphasis of joint involvement with those with expertise in MNCH, those communities affected, and relevant sectoral participation.

It is useful to consider interventions across the lifecycle continuum, which starts at pre-pregnancy and extends through pregnancy and delivery to post-partum care and maternal health as well as to postnatal care, infancy and childhood. Interventions will be specific to the country gap analysis and should be evidence based, represent value for money with a strong focus on equity and gender equality.

For more information, please consult the information note on MNCH and the MNCH practical guidance tool.

QUALITY OF SERVICES

The purpose of the Global Fund's investments is to achieve positive health impact. While scaling-up is an important determining factor of impact, it is as important to ensure that healthcare services are provided at appropriate quality level. The quality of services indeed affects the outcomes/impact of health programs. Even with high coverage, activities and services that are of poor quality and not delivered according to recognized standards will have suboptimal, or even adverse, results. In addition to the public health risks, this also poses a risk of ineffective and inefficient use of the available resources, thus providing poor value for money.

There are many definitions of quality of services with many different nuances to the focus and intent. In addition, there are other related terms, including 'quality of service' and 'quality of care'. The Global Fund adopted the term 'quality of services', which is the 'degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge'.⁸

Interventions should be built on sound national guidelines; they require a clear design of services, leadership buy-in, local capacity to use systems improvement methods and reliable data systems.⁹ Applicants are strongly encouraged to consider during proposal development quality improvement mechanisms that ensure that programs deliver high quality services.

A number of documents are available that provide guidance to decision-makers and managers at country level on the design and implementation of effective interventions to promote quality in health systems. The WHO publication 'Quality of Care. A process for making strategic choices in health systems'¹⁰ addresses quality improvement of the health system in general.

Other documents refer more specifically to quality improvement interventions for HIV, TB and malaria programs. The WHO, for example, is developing a number of guidance documents which can be consulted for improving quality of HIV prevention, testing and counselling and treatment^{11,12}, or that propose quality standards that can be set for HIV prevention and care for people who inject drugs.¹³ This guidance can be used at any level of the health care system to implement a process to address problems identified by providers of, for example, HIV testing and

⁸ Institute of Medicine Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academies Press, 2001.

⁹ Youngleson MS, Nkurunziza P, Jennings K, Arendse J, Mate KS, Barker P. Improving a mother to child HIV transmission programme through health system redesign: quality improvement, protocol adjustment and resource addition. PLoS One. 2010 Nov 9;5(11):e13891.

¹⁰ WHO. Quality of Care. A process for making strategic choices in health systems (2006). Accessed on 24 May 2011 at http://www.who.int/management/quality/assurance/QualityCare_B_Def.pdf

¹¹ WHO. Operations manual for delivery of HIV prevention, care and treatment at primary health centres in high-prevalence, resource-constrained settings. Edition 1 for field testing and country adaptation, Accessed on 23 May 2011 at http://www.who.int/hiv/pub/imai/om_11_quality_improvement.pdf

¹² WHO. Guide for monitoring and evaluating national HIV testing and counselling (HTC) programmes: field-test version (2011). Accessed on 23 May 2011 at http://whqlibdoc.who.int/publications/2011/9789241501347_eng.pdf

¹³ WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (2009). Accessed on 23 May 2011 at http://www.who.int/hiv/pub/idu/idu_target_setting_guide.pdf

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counselling services.^{14,15} For additional references on guidelines related to global recommendations on the prevention and treatment of HIV, the WHO website should be consulted.¹⁶ For TB programs, the ‘International Standards for Tuberculosis Care (ISTC)’¹⁷ describe a widely endorsed level of care that all practitioners should seek to achieve in managing individuals who have, or are suspected of having, tuberculosis. For malaria, the JHPGE publication on scaling up malaria in pregnancy describes the application of performance criteria¹⁸ while the WHO ‘guidelines for the treatment of malaria’ provide global, evidence-based recommendations on the case management of malaria¹⁹, thus providing a framework for standard setting at national level.

VALUE FOR MONEY

The Global Fund assesses value for money as a key criterion in recommending a proposal for funding. Applicants should consider value for money throughout the proposal development process, ensuring that the submitted application demonstrates how the program will maximize the sustainable health impact that can be achieved with the requested funding.

There are three elements of value for money to consider:

- 1. Effectiveness** judges whether the proposed activities are technically well-designed to achieve the objectives of the strategy and the goals of the proposal in terms of improvement to outcomes, impact, and sustainability. In order to demonstrate effectiveness, the applicant must explain (i) the health problems that will be addressed, and identify where in the national health strategy or plan this is designated a priority, (ii) the reasons for choosing the particular activities described in the proposal to address these problems, and (iii) the evidence (or the reasoning if evidence is so far inadequate) for why these particular activities represent the most effective approach (i.e., why the applicant believes this is the best way to achieve the desired outcomes, impact, and sustainability in the context). After the applicant has demonstrated the most effective approach to each health problem addressed through the proposal, it is important to show that the activities will be carried out efficiently.
- 2. Efficiency** means that the desired outputs will be obtained at the least cost possible in terms of inputs. The applicant must demonstrate that cost has been minimized by showing: (i) that the requested procurement of all inputs is budgeted at the least possible cost, and (ii) that well-designed and well-functioning systems exist for delivery of health services given the country context (including the structure and management of health systems, materials stockage and distribution, and health personnel policies). Situations may exist where the selected inputs are not at the least-cost; this is acceptable if the applicant can justify why the choice is required under the given circumstances. Improvements in systems and health personnel capacity required to ensure efficiency in the delivery of health services should also be described and costed.
- 3. Additionality** describes whether the requested funding will represent additional resources, beyond what is available from other sources, to address the health problem(s) targeted through the proposal. There is little value, from the Global Fund’s perspective, in providing funds when this results in other resources being withdrawn. The applicant must demonstrate that if the Global Fund approves the proposal, there will be no reduction in other funding, and that government contribution to both the health sector and the disease program will increase over the lifetime of

¹⁴ WHO. Improving HIV testing and counselling services (2010). Technical brief WHO/HIV/11.01.

http://whqlibdoc.who.int/hq/2011/WHO_HIV_11.01_eng.pdf

¹⁵ WHO. Handbook for improving HIV testing and counselling services. Field-test version (2010). Accessed on 23 May 2011 at http://whqlibdoc.who.int/publications/2010/9789241500463_eng.pdf

¹⁶ <http://www.who.int/hiv/pub/guidelines/en/> (Assessed on 23 May 2011)

¹⁷ Tuberculosis Coalition for Technical Assistance. *International Standards for Tuberculosis Care (ISTC)*. The Hague: Tuberculosis Coalition for Technical Assistance, 2006. Accessed on 24 May 2011 at http://www.who.int/tb/publications/2006/istc_report.pdf

¹⁸ jhpiego. Scaling Up Malaria in Pregnancy Programs. What it takes (2008). Accessed on 24 May 2011 at http://www.k4health.org/system/files/malaria%20in%20pregnancy_jhpiego.pdf

¹⁹ WHO. Guidelines for the treatment of malaria (2010). Accessed on 24 May 2011 at http://whqlibdoc.who.int/publications/2010/9789241547925_eng.pdf

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the grant. The applicant must also show that every effort will be made to maintain or increase other funding, for example from other international donors and the private sector.

In summary, effectiveness is what provides value, efficiency is achieving that value for the least amount of money, and additionality is ensuring that Global Fund financing is not displacing other resources. It is only when there is strong evidence of all three of these elements that a proposal demonstrates good value for money.

For further information, see the [Value for Money information note](#).

Other considerations: Humanitarian Situations

During conflict and natural disasters, both the directly affected and the surrounding population's vulnerability and risks increase, while equity and protection of human rights are challenged. Women, children, elderly and the disabled are more at risk of violence, rape, trafficking and abuse. Poor housing and overcrowding may result in more exposure and infections and limited access to health services compromises access to prevention and treatment.

Where appropriate, the Global Fund supports the inclusion of populations affected by humanitarian situations in proposals for the three diseases from countries that are in conflict or experiencing natural disasters.

Key steps in addressing people affected by humanitarian emergencies include, the identification of currently affected populations, partners involved in delivering care and services, risk evaluation of displacement, and potential mechanisms for immediate response to population influx or displacement (including transport and stockpiling).

Services for the emergency response include:

- Establishing safe and rational blood transfusion and universal precautions;
- Availability of free condoms;
- Establishing a protection system especially for women and girls;
- Support to the implementation of clinical management of rape;
- Identification of people requiring continuation of HIV and TB treatment and provision of therapy;
- Distribution of LLINs;
- Availability of malaria rapid tests and treatments;
- Data collection and analysis to plan for integrating services into the primary health care system as soon as possible.

Part 2: Completing the Proposal Form

Only complete one version of Section 1-2, even if more than one disease component is included in the application

Sections 3 through 8 of the proposal form are individual sections that must be completed for each disease component. For applicants submitting a cross-cutting health systems strengthening component, please refer to the [common HSS proposal form and guidelines](#) jointly developed by the Global Fund and the GAVI Alliance that are available on the Global Fund website.

SECTION 1: APPLICANT INFORMATION AND FUNDING SUMMARY

1.1 Applicant name and country/economy eligibility information

In the first part of this section, indicate the applicant's name, the country and whether the country is also included in a multi-country proposal by selecting the relevant component.

To complete the country eligibility information part of this section, refer to the [Global Fund eligibility list](#). Then complete the country eligibility table with the following information based on the Global Fund eligibility list:

- (a) Country's income level: low-income (LI), lower-lower-middle income (LLMI), upper-lower-middle-income (ULMI) or Upper-Middle Income (UMI)
- (b) Country's disease burden: low, moderate, high, severe or extreme (for each disease component; this does not apply to Cross-Cutting Health Systems Strengthening)
- (c) Indicate whether the applicant has received a Board-approved grant that has completed less than twelve months of implementation (starting from the program start date or implementation period start date as set out in the grant agreement) for each component. If the applicant has grants for a disease or cross-cutting HSS component that have less than a year of implementation, the applicant is in principle not eligible to apply for funding for that component.
- (d) This question should be answered only by applicants with grants that have completed less than 12 months of implementation (starting from the program start date or implementation period start date as set out in the grant agreement). If the applicant has submitted a Proposal Concept to request an exemption to the funding history eligibility rule, indicate whether the full proposal was deemed receivable. Note that if this is not the case, or if the applicant has not submitted a Proposal Concept, the proposal will not be eligible and will not be reviewed by the TRP.

1.2 Component/s and choice of funding pool

Select the component/s for which funding is requested in Round 11. For each component, also indicate the choice of funding pool.

Remember that each pool has its own set of requirements and prioritization criteria and that the incremental funding request for proposals submitted in the Targeted Pool are capped at US\$ 5 million for the initial two years and US\$ 12.5 million for a five-year proposal.

In particular, Upper-Middle Income countries with a high disease burden for a particular disease (according the Global Fund eligibility list) can only submit a proposal for that particular disease through the Targeted Funding Pool. It is not possible to submit a stand-alone HSS request in the Targeted Pool. However, it is possible to include cross-cutting or disease-specific HSS interventions within a disease proposal submitted to the Targeted Pool.

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For more information on the eligibility and prioritization criteria for each of the funding pools, please refer to pages 4-6 of the Guidelines and to the [Information Note on the New Eligibility, Counterpart Financing and Prioritization Policy](#).

1.3 Funding summary

The funding summary table should be completed as **a final step** before submission of the application.

For each component, identify the annual incremental funding request for the duration of the proposal based on the calculation of the incremental amount in Table 7.6(d). The yearly and total amounts entered for each disease and cross-cutting HSS proposal in Table 1.3 must be equivalent to the yearly and total amounts in table 7.6(d).

Remember that the **incremental funding request** for proposals submitted in the Targeted Pool are capped at US\$ 5 million for the initial two years and US\$ 12.5 million for a five-year proposal.

1.4 Contact details

List the complete contact details of two persons that will be available to answer technical or administrative questions, or ensure other stakeholders can respond, during the screening process that occurs immediately after the submission deadline. For Round 11, this process will happen as of 15 December 2011 and continue through February 2012. **It is important that the person(s) identified in this section are available to respond to queries at the start of the screening process in late December and early January.**

1.5 List of abbreviations and acronyms used by the applicant

To facilitate the review of the proposal by the [Technical Review Panel](#) (TRP), include a list of uncommon or country-specific abbreviations and acronyms used in throughout the application.

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SECTION 2: CCM REQUIREMENTS FOR ELIGIBILITY

CCM applicants:	Complete questions 2.1 to 2.7
Sub-CCM applicants:	Complete questions 2.1 to 2.10
Non-CCM applicants:	Only complete question 2.11 to 2.15

CCM and Sub-CCM applicants

To support the most effective responses possible, the Global Fund requires CCMs²⁰ to **meet six requirements to be eligible for Global Fund financing**.

Please read the Global Fund's policy and practical guidance on the [six requirements for CCM eligibility](#).

In this section, the applicant must indicate how they are adhering to these six requirements.

A number of documents supporting the information provided in this section are requested (e.g., CCM governance documents and CCM meeting minutes). The documents provided must show evidence of the processes used by the CCM. This documentation must be submitted with the proposal as supplementary attachments. Applicants are strongly encouraged to use the checklist at the end of section 2 of the proposal form to crosscheck the documents required and to clearly name and number all attachments.

2.1 Requirement 1: Proposal development process

In this section, the applicant is required to document the following items:

- (a) the transparent process used to coordinate the development of the proposal that engages a broad range of stakeholders - including CCM members and non-members - in both the solicitation and review of activities for possible integration into the proposal;
- (b) the efforts used to engage key population groups²¹ in the development of the proposal, including most-at-risk populations;
- (c) Attach a signed and dated version of the minutes of the meeting(s) at which the CCM decided what to include in each disease proposal.

Supporting documentation may include the following, depending on the processes used by the applicant to meet this requirement:

- Public announcements using print media, television, radio, internet and/or email announcements (with distribution list) inviting stakeholders to participate
- Criteria used to review proposals
- Minutes of meetings which record decisions taken on what to include in the application, stakeholder input and participation
- Minutes or reports from proposal development related workshops, technical working groups or panels

²⁰ The requirements outlined in this section apply to CCMs and sub-national CCMs (sub-CCMs).

²¹ Key population groups include: women and girls, men who have sex with men, transgender persons, people who inject drugs, male and female and transgender sex workers and their clients, prisoners, refugees and migrants, people living with HIV, adolescents and young people, vulnerable children and orphans, and populations of humanitarian concern

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2.2 Requirement 2: Process to select Principal Recipient(s)

The Global Fund requires all CCMs to:

- (a) Nominate one or more PR(s) at the time of submission of their application for funding²²;
- (b) Document a transparent process for the nomination of all new and continuing PRs based on clearly defined and objective criteria; and
- (c) Document the management of any potential conflicts of interest that may affect the PR nomination process.

CCM applicants must demonstrate that PR nomination occurred through a transparent process for each PR. Documents provided must show evidence of the process used and must demonstrate how potential conflict of interest was managed. Supporting documentation may include the following:

- CCM terms of reference outlining processes for PR nomination
- Copies of any advertisements or invitations made for potential PR candidates
- The criteria used for PR nomination
- The list of PR candidates considered and a description of how they meet the agreed criteria
- Minutes of CCM meetings where PR nomination is planned, discussed and confirmed. Minutes should include a summary of discussions, a list of participants, decision points and a record of who and which constituency took part in the decision making process
- CCM conflict of interest policy and documentation illustrating how it was applied to PR nomination

The Global Fund recommends the applicant to consider the following when selecting a Principal Recipient(s) for each disease proposal:

- (a) **Financial and legal responsibility for grant funds:** The nominated Principal Recipient(s) should be assessed by the applicant as capable of leading implementation and being responsible to the Global Fund for finances and program implementation under a grant agreement.

➔ *Refer to the information at section 8.1 of these Guidelines on Principal Recipient implementation capacities*

Details on Grant Recipients' accountability are outlined in the following documents and available on the Global Fund's website:

- Fiduciary Arrangements for Grant Recipients;
 - Guidelines for Performance Based Funding; and
 - Guidelines for Annual Audits of Program Financial Statements.
- (b) **Legal-capacity to enter into grant agreements with the Global Fund:** In addition to government entities or ministries, the full range of potential Principal Recipients includes non-governmental or faith-based organizations, a private sector firm or private foundation, an incorporated network for people living with the diseases, a community-based organization that has legal status in the country; or another incorporated body.
 - (c) **Reinforcing and building local ownership and accountability:** It is expected that local institutions, rather than United Nations agencies or other multilateral or bilateral development partners will be nominated as Principal Recipient(s)²³. In exceptional circumstances (e.g. civil war or post-conflict reconstruction) when no local stakeholders in the government or non-government sectors are able to act as Principal Recipient(s), other

²² In exceptional cases, the Global Fund will directly select PRs for the CCM under the Additional Safeguard Policy.

²³ Neither UNAIDS nor WHO may be nominated as a Principal Recipient.

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entities may be nominated. In these instances, plans to increase the capacity of in-country organizations to become the Principal Recipient (or joint Principal Recipient) over the program term should be considered. Where appropriate, these plans should be integrated into the proposal (in section 4.3 and section 4.5, and included in the budget and work plan).

International non-governmental organizations with an established local presence are considered local stakeholders in this context. If so, the extent of affiliation of the local body with the international organization should be clearly explained.

- (d) **Building on government and non-government sector implementation capacity:** The Global Fund recommends that the applicant routinely include dual track financing (DTF) (see below), meaning a Principal Recipient from both the government and non-government sectors are nominated for implementation in each disease proposal.
- (e) Taking into consideration the principles set out in section 2.2 above, applicants should list, by disease, the Principal Recipient(s) that are nominated in the Round 11 proposal. Detailed information on the implementation capacity of these implementers is requested in section 8.1.

Principles supporting dual track financing

National programs that are designed to be implemented through a multi-sector approach may bring more opportunities to:

- Raise awareness of accessibility of, and therefore demand for services, including primary prevention services at the community and sub-national level and services aimed at creating an enabling environment for improved health outcomes;
- Scale-up existing service delivery to a broader range of population groups or geographic regions;
- Move more quickly towards the provision of access to prevention, treatment, and care and support to all persons in need including key populations and people who may not already be included in national disease programming; and
- Contribute to sustainability of programmatic interventions over the longer term, through the increased capacity, reach, and relevance that comes from a broader range of inter-working implementing partners having complementary skills including management and oversight capacities.

For more information, refer to the information note on [dual track financing](#).

2.3 Non-implementation of dual track financing

In this section, and only if applicable, the applicant is requested to summarize the reason(s) for deciding not to implement dual track financing.

Information should be country-specific, describing the process of having considered Principal Recipients from both government and non-government sectors. As relevant, the applicant may comment on alternative ways in which the Round 11 proposal moves towards this principle.

The Global Fund's recommendation on dual track financing applies separately for each disease.

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2.4 Requirement 3: Processes to oversee program implementation

In this section, the applicant is requested to describe the process that will be used to oversee program implementation, and in particular:

- (a) How the CCM will engage program stakeholders and CCM members in oversight; and
- (b) How the CCM will engage non-CCM members, non-government constituencies, and people living with and/or affected by the diseases in program oversight.

The oversight plan as well as any other document supporting the information provided in this question must be submitted with the proposal as a supplementary document. Supporting documentation may include the following:

- Minutes of CCM meeting documenting CCM endorsement of the oversight plan
- CCM documents which outline the CCM oversight plan
- CCM documents which describe how the CCM oversight plan will be implemented. This may include a work plan outlining specific activities, timeline and budget
- Terms of reference for an oversight committee and the list of members

2.5 Requirements 4 and 5: Broad and inclusive membership

In this section, the applicant is requested to:

- (a) indicate whether there is continuing and active membership of people living with and/or affected by HIV and of people affected by TB or malaria (where funding is requested or has previously been approved for the respective diseases).
- (b) describe how members representing non-government constituencies were selected to sit on the CCM by their own constituency, based on a documented, transparent process, developed within each of these constituencies. This requirement applies to all non-government members including those members representing people living with or affected by the three diseases, but not to multilateral and bilateral partners.

Supporting documentation may include the following:

- Meeting minutes from a constituency documenting how they selected their representative. The minutes should include a description of the candidates considered, the criteria used for selection, the individuals who took part in the selection process and the organizations they represent.
- Copies of advertisements or correspondence inviting representatives from the non-government constituency to take part in a member selection process or to nominate or select an organization.

For the Global Fund, non-government constituencies include but are not limited to the following:

- NGOs and community-based organizations;
- People living with the diseases;
- People representing key populations at a higher risk of exposure;
- Faith based organizations;
- Private sector²⁴; and
- Non-government academic institutions.

²⁴ For a definition of 'Private Sector', refer to section the "Elements that make a good proposal" section of these Guidelines.

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Supporting documentation may include the following:

- CCM membership list with details of member's name, organization and constituency, clearly identifying the individual as representing people affected by the disease
- Minutes of CCM meetings indicating participation of people living with and or affected by the disease
- In cases where an individual wishes to remain anonymous with respect to their disease status, the CCM can share certification that among its membership there is a person who is affected by HIV and of people affected by TB or malaria. This certification can come from the CCM Chair or Vice Chair, the entire CCM or a multilateral or bilateral partner, for example.

2.6 Requirement 6: Managing conflicts of interest

To ensure adequate management of conflict of interest, the Global Fund requires all CCMs to:

- (a) Develop and publish a policy to manage conflict of interest that applies to all CCM members, across all CCM functions. The policy must state that CCM members will periodically declare conflicts of interest affecting themselves or other CCM members. The policy must state, and CCMs must document, that members will not take part in decisions where there is an obvious conflict of interest, including decisions related to oversight and selection or financing PRs or SRs.
- (b) Apply their conflict of interest policy throughout the life of Global Fund grants, and present documented evidence of its application to the Global Fund on request.

The CCM's conflict of interest policy should be attached to the proposal submitted to the Global Fund. CCM applicants must demonstrate that their conflict of interest policy outlines a plan to manage actual and potential conflict of interest. The CCM should:

Describe which sections within the conflict of interest policy state that:

- the policy applies to all CCM members across all CCM functions
- CCM members will periodically declare conflicts of interest affecting themselves or other CCM members
- CCMs must document that members will not take part in decisions where there is an obvious conflict of interest, including decisions related to oversight and selection or financing of PRs or SRs.

Describe what systems the CCM has in place to ensure that the conflict of interest policy is applied throughout the life of Global Fund grants.

Supporting documentation may include:

- CCM governance documents which outline the conflict of interest policy
- Minutes of CCM meeting documenting CCM endorsement of the conflict of interest policy
- CCM governance documents which describe how the conflict of interest policy will be implemented
- Terms of reference and membership of a sub-committee responsible for overseeing the application of the conflict of interest policy
- Documentation of CCM member self- declaration of potential conflict of interest that may affect themselves or other CCM members
- A description of how conflict of interest declarations and related documents are filed by the CCM

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2.7 Proposal endorsement by CCM members

The membership details form must be signed by all CCM members. It should be sent to the Global Fund as an original paper document after being scanned and sent with the electronic version of the completed application. Note that this form has a number of drop-down boxes that have been pre-filled to assist with the completion of the document.

A CCM applicant may request a pre-filled copy of the most recent Membership Details form provided to the Global Fund by sending a request to proposals@theglobalfund.org. The applicant can review the pre-filled version and update membership details accordingly before submitting the finalized and endorsed document with a Round 11 application.

The Global Fund requires all members to sign the form unless:

- The CCM's own constitution sets out an alternative, documented procedure for signature of proposals that requires less than the full membership to sign the submission and the rules, and the minutes from the meeting in which these rules were accepted by the whole CCM are included with the proposal;
or
- A member is unable or unwilling to endorse the proposal. That member must inform the Global Fund in writing (proposals@theglobalfund.org or by mail) of the reason for not endorsing the proposal, to ensure that the Global Fund understands that member's position.
or
- The proposal is being submitted as a Non-CCM proposal.

➔ *Go to the checklist instructions for sections 1 and 2 in these Guidelines*

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Sub-CCM applicants only

Questions 2.8, 2.9 and 2.10 below, in addition to all questions above (2.1 through 2.7) are to be completed by Sub-CCM applicants.

2.8 Status of Sub-CCM

In certain circumstances, such as in very large countries, a sub-national Country Coordinating Mechanism (Sub-CCM) may evolve, typically under the guidance of a CCM. In such situations, the Sub-CCM fulfills the roles and responsibilities of a CCM for the sub-national region. As appropriate, a Sub-CCM forms at a state level, province and/or administrative division, or by a grouping of several states, provinces and/or administrative divisions.

The applicant should check whether they are applying as a mechanism that is part of an overall CCM approach, or as an independently operating mechanism. Then, complete the answers as directed.

2.9 CCM endorsement

Where the Sub-CCM was convened by, or is part of the overall disease coordination approach of the CCM, the membership of the CCM (at a meeting or through another documented process) must agree to endorse a Sub-CCM proposal.

Two documents are required to demonstrate endorsement by the CCM members. Sub-CCMs should identify the annex numbers for these documents in the space provided in the proposal form by typing over the italics.

2.10 Justification of independence of Sub-CCM

The types of supplementary documents to be submitted in support of a statement that the Sub-CCM should be assessed independently of a CCM include:

- statutes or other legal documents confirming the independent authority of the Sub-CCM;
- international agreements or conventions that recognize the independent nature of the Sub-CCM's territory; or
- proof of the CCM's acceptance of the Sub-CCM's independence.

→ Go to the checklist instructions for sections 1 and 2 in these guidelines

→ Sub-CCM applicants do not complete the sections 2.11 through 2.13 of the proposal form

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Non-CCM applicants only

In limited situations, the Global Fund approves proposals submitted by applicants who apply outside of the CCM.

Non-CCM applicants considering the submission of a proposal are required to contact the CCM in their country before completing the proposal form. The CCM should be asked to consider including the ideas from the non-CCM applicant in the national proposal - and ask what the CCM's process is to consider all proposals submitted (e.g. whether there is a public tender process, or an expression of interest process etc, and how proposals will be considered).

The Global Fund's [website for Round 11 lists the key contacts for national CCMs](#).

2.11 Sector of work

A Non-CCM applicant should tick only one box that is most descriptive of their sector. If the 'Other' box is selected, then the corresponding sector must be specified.

2.12 Status of Non-CCM applicant

(a) Main justification for Non-CCM proposal

The applicant should tick only one box that represents the main reason for the Non-CCM proposal and attach supplementary documents to support this.

There are three types of circumstances where a country may apply as a Non-CCM:

- (i) countries without a legitimate government;
- (ii) Countries in conflict, facing natural disasters, or in complex emergency situations (identified by the Global Fund through reference to international declarations such as those of the United Nations Office for the Coordination of Humanitarian Affairs);
or
- (iii) Countries that suppress or have not established partnerships with civil society and non-governmental organizations. These circumstances include a CCM's failure or refusal to consider a civil society or non-governmental organization proposal, particularly those targeting highly marginalized and/or criminalized groups, for inclusion into the national composite CCM proposal.

→ *Proposals not endorsed by CCMs for documented technical weaknesses communicated to the Non-CCM applicant are unlikely to be accepted as Non-CCM applications*

(b) Attempts to have the activities included in the CCM's proposal

Relevant applicants should provide a clear timeline to demonstrate all efforts to participate in the CCM's process to develop a proposal, setting out what submissions were made to the CCM, what reply was received, and what the non-CCM applicant did to work with and/or participate in CCM meetings or proposal development sessions and all applicable dates.

→ *When Non-CCM proposals are received, the Global Fund contacts the CCM to obtain their input on the topics raised, and the Global Fund's decision on eligibility will be final*

Also, provide an explanation of the practical feasibility of working in the country without a working relationship with the CCM.

2.13 Principal Recipients

Non-CCM applicants should list, by disease, the Principal Recipient(s) that are nominated in the Round 11 proposal. Detailed information on the implementation capacity of these implementers is requested in section 8.1.

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2.14 Non-implementation of dual track financing

→ *Refer to the guidance on these requirements at section 2.3 of these Guidelines*

2.15 Signature by authorized representative of Non-CCM applicant

Documents submitted in support of this section must show that the individuals signing the proposal on behalf of the Non-CCM applicant have authority to do so.

Checklist Instructions - Sections 1 and 2

Complete the checklist to:

- ensure that the Membership Details form (if applicable) have been included; and
- provide additional documents as clearly named and numbered annexes, and list these in the checklist table for ease of reference.

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SECTION 3: COUNTRY CONTEXT

3.1 Disease Program

Summarize the country's current strategies to respond to the disease on a comprehensive basis, addressing the national prevention, treatment, and care and support services. If the response to the disease is planned through a program-based approach at the health sector level, then this summary should include relevant information to enable the TRP to consider the overall framework in which the Round 11 request for additional support is made. Also include whether strategies have changed over recent years due to changing incidence or prevalence.

It is important to ensure that the information provided explains the following:

- Summary of the epidemiological situation of the disease;
- What kind of prevention, treatment, and care and support strategies are being implemented and for which people (e.g., age, sex, key populations, regions);
- What strategies are being implemented to ensure a fully enabling social, economic, and legal and policy environment;
- How the strategies are consistent with the pattern and burden of disease;
- In the case of HIV, how interventions can effectively reach key criminalized populations, including men who have sex with men, sex workers, and people who inject drugs; and
- Outcomes expected from proposed strategies (e.g. coverage, efficiency, equity of access by target populations).

Refer to supplementary documents that have been included with the proposal submission and are directly relevant to understanding the focus of the Round 11 proposal.

3.2 Major Constraints and Gaps

The extent to which national, sub-national and community system constraints can limit/impact the demand for, and access to, comprehensive HIV, tuberculosis and/or malaria prevention, treatment and care and support services should be carefully assessed prior to developing a Global Fund proposal.

For this question, consider the following:

- Any key affected populations that may have disproportionately low access to prevention, treatment, and care and support services;
- Gender norms and practices, legal barriers, and stigma and discrimination that may cause inequity in access to services for key affected populations;
- Government, non-government and community level weaknesses and gaps and how these sectors may support and expand services to these populations. This can include any weaknesses and gaps in the quality of services being delivered.

In these sections, the applicant describes the weaknesses and gaps within the **health system**, the related **disease program** and within the **community systems**.

A comprehensive description of **weaknesses and gaps** should comment on:

- A description of the structural arrangements between government, private sector and civil society in order to ensure equitable access to health services;
- The ability of the current health and community systems to achieve and sustain scaled up interventions to appropriately respond to the threat of the disease(s);
- The ways in which the national health system facilitates or hinders effective and efficient quality service delivery by each sector;

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- The ability of the national disease program to equitably reach women and men (and boys and girls) according to their different needs, as well as other key affected populations and sexual minorities;
- Whether certain groups, such as women and girls, adolescents, and high risk groups, may face barriers to access or barriers arising from geographic, urban/rural or other location issues.

Where there is an existing analysis of strengths, weaknesses, opportunities and threats in, for example, the National Health Development Plan, applicants should include this in their proposal either as a summary within this section, or as a clearly named and numbered annex.

Also describe the efforts currently underway to resolve weaknesses and gaps in the health system, the disease program and community systems. In your description, address the efforts undertaken by national and other international sources, including government and non-government support. The description should not include any information on how the Round 11 proposal contributes to these efforts, which will be described in the proposal strategy section.

3.3 Epidemiological Profile of Target Populations

Provide detailed information on the population size data and epidemiological profile of target populations in the proposal. **Applicants will receive epidemiological reports from partners at the time of downloading the application, which can be referenced when completing this section.**

- Activity targets:** 'Check' the relevant box(es) and attach a map of the target population. For malaria components especially, it is important to provide a clear map of the geographical distribution of the malaria disease burden and corresponding control measures already approved and in use.
- Size of target population(s):** Refer to the partner epidemiological report and use this space to provide data not listed there (updates or sizes of population groups not provided in the profile but targeted to the proposal).
- Disease epidemiology of target population(s):** Refer to the partner epidemiological report and use this space to provide data not listed there (updates or data on specific sub-populations targeted by the proposal **For both (b) and (c):** The table in Annex 3 provides a non-exhaustive list of target population groups by disease. Applicants are encouraged to segment population groups into relevant gender and age segmentations, as they exist within national monitoring and evaluation frameworks or other relevant data sources.
- Narrative description of the epidemiological profile of target population(s):** Provide a narrative description of the current epidemiological profile of the target populations, and how this profile is changing with respect to the disease. This description should give specific reference to the ways that the epidemic affects certain population groups, including key populations, as well as the current profile of the epidemic amongst these groups. Also use this space to describe reasons for differences between the partner epidemiological profile and the data provided in (b) and (c).

→ If a proposal targets a particular group, but there is no available data, include the population group in table 3.3 (b) and explain that data is not available in the column entitled 'Source of Data'.

→ Where key disaggregated data is not available, the proposal should incorporate a plan to acquire this data prior to the Periodic Review.

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3.4 Reporting Cycles

Read the section entitled “Consolidated disease proposal and the new grant architecture” in the earlier part of the Round 11 Guidelines to understand the background to the transition to a single stream of funding and what this means for alignment to in-country cycles.

Specifically, under the new grant architecture, the applicant will have more flexibility to set the start dates and review timelines of their grant(s) to correspond with national cycles and systems. This includes the ability to have implementation cycles of up to three years, with a corresponding Periodic Review²⁵ that will be able to correspond with in country review processes that are already scheduled (e.g., annual surveillance reports, periodic Demographic and Health Surveys, etc.).

The date of the Periodic Review is something that will be established at the time of grant negotiation. In order to better inform that discussion, applicants are asked to ensure that they include the following information in their response to section 3.5 of the Proposal Form:

- (a) national fiscal cycle: the twelve-month period used by the government as its fiscal accounting period. For non-CCM applicants, please enter a shared fiscal cycle or leave this question blank.
- (b) programmatic reporting cycle, including the time when annual data are compiled for review.

3.5 Round 11 Priority Interventions

Note to applicants: this table is mandatory for all malaria proposals and optional, but recommended, for HIV and TB proposals, in particular those which are based on a national strategy.

Use the tables in this question to provide information on how the interventions prioritized in this proposal will address identified gaps in coverage for specific population groups. If this proposal is based on a national strategy, then these priority areas should be a prioritized subset of the interventions contained in the national disease response.

In the tables below, list three to six interventions (inserting one intervention per table) that have been prioritized to receive funding from the Global Fund through this proposal. These interventions should be:

- i. Consistent with the current disease epidemiology;
- ii. Suited to address the weaknesses and gaps identified in questions 3.1 through 3.3; and
- iii. Consistent with the national strategy/national disease control program (where applicable).

When completing this section, applicants should only mention the top priority interventions and not all the interventions planned through this proposal.

All numbers in this table should relate to the size of the population groups targeted by the priority interventions, not the financial need for the interventions.

The table has four lines related to **population coverage for the priority interventions** as follows:

- (A) Identify the planned targets;
- (B) Identify the level of coverage for these targets already expected via other (non-Global Fund financed) grants and programs;
- (C) Identify the difference between the targets and the planned results;

²⁵ The Periodic Review will replace the Phase 2 Review under the new grant architecture.

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- (D) Identify the additional coverage requested through this proposal. This may be the full gap identified in (C) or a portion of it, depending on factors related to country priorities and absorptive capacity assessments. This line should include coverage that is planned from ongoing grants that will be consolidated through this proposal, in addition to the scale-up of any coverage that is being requested.

The information requested is for the years 2010, 2011 and 2012, and for the years 2013 through 2017 (based on, current information, forward-looking plans, national budgeting processes, and estimates).

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SECTION 4: PROPOSAL SUMMARY

Important reminder to applicants

When completing Section 4, applicants must bear in mind the new focus of proposals eligibility requirements and make sure to adequately highlight this in the proposal summary (Section 4.2) and the interventions section (Section 4.3).

For proposals deemed receivable after having successfully gone through the process for requesting an exemption to the recent funding history rule, applicants must make sure that the proposal is fully consistent with the proposal concept that was the basis for granting the exemption. This must also be emphasized when responding to Sections 4.2 and 4.3.

4.1 Duration of Proposal

The maximum duration of a proposal is five years from the planned start date; however, it is possible to submit a proposal for less than five years. The duration of the proposal must be consistent throughout the proposal form and all attached documents. Where possible, it is preferable to align the proposal start date to existing in country cycles.

Consider the following points when determining the planned start date:

- Take the expected timing of the start of Phase 2 for ongoing grants into account and where possible align this with the planned start date of the new proposal; and
- The Global Fund Board will consider the Round 11 TRP recommendations at the 25th Board meeting in May 2012. The target is to complete grant negotiations and sign grants within six months of Board approval (Global Fund policy gives a maximum of 12 calendar months from time of Board approval to complete grant signing).

4.2 Executive Summary of Round 11 Proposal

Provide a brief summary of the proposed interventions (these interventions will be described in more detail in the next section.) Your summary should include an overview of the goals, objectives service delivery areas (SDAs), activities and planned outcomes of the proposal. It should explain how the proposed interventions will contribute to improved outcomes for the disease. Where relevant, describe how this proposal builds on the experience and lessons learned from existing Global Fund grants. Explain how this proposal adds to, and does not duplicate, existing programs funded by the Global Fund or other donors. Your summary should explain how the proposed interventions respond to the gaps that you identified in Section 3.2.

In addition, explain the rationale for selecting the priority interventions that you are focusing on in this proposal and that you identified in Section 3.5. Finally, if you have included in your proposal activities to strengthen community and health systems, describe how these activities will contribute to the disease response.

4.3 Interventions

(a) Logframe for proposal

The purpose of the logframe is to provide a programmatic description of the proposal and an overview of the goals, objectives, SDAs and key activities in the proposal, including key indicators, especially in relation to grants that are already being implemented in the country. It should only include key activities (the most important activities) in the proposal and not go to the level of detail of listing all activities.

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By key activities, we refer to those activities whose frequency of occurrence, or cost of implementation, are significantly higher than other activities. Examples of key activities may include: “Developing an adherence support program for people taking antiretroviral therapy”, “Procuring drugs for the treatment of tuberculosis”, or “Distributing long-lasting insecticide treated bed nets.”

Applicants with existing grants should start a new numbering system for this proposal (even where ongoing interventions are being incorporated) and ensure it is carried throughout the proposal. Each objective, SDA and activity should have a unique identifying number. Since the logframe only includes key activities, fill in these activities, then develop the budget and work plan which has numbers for all activities and then add in all the key activities in the logframe that mirrors the numbering in the budget and work plan.

Below is a series of instructions for each section of the logframe.

Program Level:

Program goals - Goal(s) are broad and overarching statements of a desired, medium to long-term outcome of the program and should be consistent with the national disease control strategic plan. Examples: 1) Reduce malaria related mortality and morbidity in children under 5 and pregnant women, 2) Reduce HIV related mortality in the country, 3) Reduce tuberculosis incidence and mortality in the country. Insert all program goals under the “Description” column. Insert all goals in the same box.

All goals included in the logframe should also be included in the performance framework.

Objectives - Each goal should have a set of related, more specific objectives that will permit the program to reach the stated goal(s). These objectives should be consistent with the objectives of the national disease control or health sector strategic plan. Insert all proposed objectives under “Description”. Only insert one objective per row.

All objectives included in the logframe should also be included in the performance framework.

SDA - To achieve each objective, the key services to be delivered are defined under respective Service Delivery Areas (SDAs). A list of standard SDAs can be found in the [M&E Toolkit](#) available on the Global Fund website. Insert proposed SDAs in the “Narrative Summary” column. Only insert one SDA per row.

Information in this section should appear in the SDA column in the performance framework.

Activities - In this section, include a brief description of the key activities, to be conducted under each SDA. Only include key programmatic activities and not all activities. Examples of key activities include “Developing an adherence support program for people taking antiretroviral therapy”, “Procuring drugs for the treatment of tuberculosis”, “Developing a distribution mechanism for long-lasting insecticide treated bed nets”, or “Distributing long-lasting insecticide treated bed nets.” Insert all proposed activities under “Description”. Only insert one activity per row.

This information does not need to be included in the performance framework.

Description of Goal(s), Objectives, SDAs and activities: For each goal, objective, SDA and key activity provide a short written description. Provide a brief one-two sentence summary here as there will be additional room to describe the interventions in 4.3 (b).

Indicate if from existing grant(s) and associated Round(s) or new: If these interventions are from existing grants, write the grant number. If this is a new goal, objective, SDA, or key activity, indicate “new” in this column.

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If from existing grant, indicate: continuation without change; increase in scale; decrease in scale: For goals, objectives, SDAs and activities from existing grants, indicate if each one will continue without change, increase in scale or decrease in scale. For proposed increases and decreases in scale, briefly describe what the proposed change entails. Do not describe discontinued interventions here, they will be captured in a separate table in 4.3 (c). For new goals, objectives, SDAs and key activities, applicants can leave these cell blank or insert “N/A”.

Implementation responsibility: identify PR or SR responsible for implementation: Explain who will be responsible for implementing each goal, objective, SDA and key activity.

Target population/Target area (national, province, district, etc.): Identify as relevant which target population and/or target geographical area the intervention will focus on. Clearly indicate if the coverage of an intervention is nationwide or more focused (in specific population groups or selected regions, districts, etc.).

Indicator(s): For each line in the logframe related to goal(s), objective(s) and SDA(s), indicate which indicator(s) will be used to monitor the achievement of that line. **Limit the indicators in the logframe to impact, outcome, and output indicators**, and if relevant some key process indicators. At the goal, objective and SDA levels, you may insert more than one indicator per row.

Indicators should be included for all goals, objectives and SDAs. Indicators are not needed for each activity line. At the goal level, impact indicators should be included. At the objective level, outcome indicators should be included, and at the SDA level, output indicators should be included. At each of these levels, applicants may insert more than one indicator per row. It is also relevant to note that multiple objectives may have the same outcome indicators.

Specific examples of indicators can be found in detail in the M&E Toolkit available at: <http://www.theglobalfund.org/en/me/documents/>. Applicants are also strongly encouraged to consult the “Indicator Selection” section of the [Information Note on TRP Commonly Identified Weaknesses](#).

(b) Narrative description of programmatic activities

Write a thorough narrative description of the goals, objectives, service delivery areas (SDAs), and activities of the consolidated disease proposal and make sure to refer to elements of existing grants that are being integrated. Give special attention to **any changes in epidemiology, treatment protocols, lessons learned from ongoing implementation and other factors that would justify changes in the implementation strategy of existing grants**. Be sure to reference the numbering system developed in 4.3(a) in the narrative description.

Within this description, provide a detailed explanation of:

- (1) How the proposed activities address the targeted population(s) referred to in 3.3 and what changes have occurred in the targeted population and how the proposed interventions address those changes;
- (2) How the proposed activities link to, and build upon lessons learned, from any similar activities in ongoing grants;
- (3) Any links between the proposed activities and existing Global Fund grants for other diseases or HSS; and
- (4) Who will implement each area of activity - the applicant must indicate whether the activity will be implemented by a Principal Recipient, a sub-recipient, sub-sub recipient or any other implementer.

Use evidence-based evaluations of existing programs when considering the proposed goals, objectives, SDAs and activities for the consolidated disease proposal. You may include changes to activities from existing grants that are included in this consolidated proposal if changes in the epidemiology or other new developments justify such changes. Where there are changes proposed, provide clear and evidence-based justifications for these changes in the narrative description.

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(c) Discontinued activities

Use this table to show the interventions from previous grants which will be discontinued under the consolidated Round 11 proposal, making reference to the SDA or activity number from the previously approved proposal.

Make sure to briefly explain the reason why the intervention is being discontinued, using a clear and evidence-based justification for the proposed change.

4.4 Links to non-Global Fund External Resources

The current proposal must show links with any programs financed from non-Global Fund sources for the disease. For example, if the proposal plans to provide bed nets and other funding is supporting indoor residual spraying as a strategy for the prevention of malaria in the country, clearly show how the Round 11 request compliments but does not duplicate these existing activities.

4.5 Strengthening Implementation Capacity

Applicants are encouraged to include a funding request for management and/or technical assistance (TA) to achieve strengthened capacity and high quality services. This may include efforts to strengthen program-level management and implementation capacity, in addition to support for the Principal Recipient and/or sub-recipients nominated in the proposal. TA should also address long-term local capacity building and known gaps and program weaknesses, and contribute to high quality services. Requests for technical and management assistance are assessed by the TRP within the overall context of the proposal strategy and budget. They should be appropriate for the assistance that is requested and cost-effective.

The Global Fund recommends that between three and five percent of the total costs of the proposal be allocated to TA. Where you should fit within that range will depend on circumstances in your country. You may allocate less than 3 percent or more than 5 percent; however, if you do so, you need to explain why.

The funding request should be supported by a TA plan, which should be developed with extensive consultation and endorsed by key partners. In this section of the proposal form, you are required to provide a summary of the TA included in your program. If your proposal is approved, you will be asked to prepare a formal TA Plan prior to the signing of the grant agreement (or, if circumstances warrant, within a year after signing). The formal TA Plan does not have to be included in your proposal. However, if it is ready, you may attach it as a supplementary document.

The TA funding request approved in the upper ceiling of the proposal will be subject to TRP clarifications as applicable, and cannot be reprogrammed or used for any other purposes.

→ For more information, Refer to the [Strengthening Implementation Capacity information note](#), before completing this section in the Proposal Form.

4.6 Addressing Weaknesses from a Previous Category 3 Proposal

Applicants who are resubmitting a proposal which received a Category 3 recommendation from the TRP in Round 10 must describe how they have responded to the weaknesses identified in the original TRP review form. Organize the description in the same order as the weaknesses listed in the TRP Review Form.

4.7 Addressing Links with a Cross-Cutting HSS Funding Request

Applicants who are submitting a cross-cutting funding request for HSS using the common proposal form jointly developed by the Global Fund and GAVI must show the linkages between the two proposals. Clearly demonstrate that the interventions in the two proposals are complementary and not duplicative.

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4.8 Enhancing TB/HIV Collaborative Activities (*For HIV and TB proposals only*)

Describe how this proposal contributes to strengthening TB/HIV collaborative activities, including the scope and status of ongoing TB/HIV collaborative activities through other funding sources. Consider the following options in the response to this section:

Establish the mechanisms for collaboration

- Coordinating body for TB/HIV activities effective at all levels
- Surveillance of HIV prevalence among TB patients
- Joint TB/HIV planning
- Monitoring and evaluation (M&E)

Decrease the burden of TB in people living with HIV- the Three I's

- Intensified TB case-finding in people living with HIV
- Isoniazid prevention therapy (IPT)
- TB Infection control in health care and congregate settings

Decrease the burden of HIV in TB patients

- HIV testing and counseling
- HIV prevention methods
- Co-trimoxazole preventive therapy (CPT)
- HIV care and support
- Antiretroviral therapy (ART)

In addition, describe the collaboration between the respective national tuberculosis and HIV programs. In particular, highlight how the tuberculosis and/or HIV proposal has been developed jointly between the two national programs; and if there is a common work plan between the two national programs.

→ Refer to the [Collaborative TB/HIV activities](#), for more information

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SECTION 5: MONITORING AND EVALUATION

Applicants should consider the recommended inclusion of between 5 to 10% of the proposal budget (depending on in-country circumstances) to support the strengthening of existing M&E systems.

5.1 Performance Framework

After completing the logframe in 4.3, complete the performance framework. Ensure the inclusion of all impact, outcome and select priority output indicators in the performance framework. Indicators should be disaggregated to monitor progress in achieving equity and in achieving progress in program implementation with the target populations. For further detailed guidance, refer to the instructions tab of the performance framework template.

→ *When preparing the performance framework, applicants may find it helpful to consult the M&E Toolkit. For Round 11, please refer to the revised set of indicators in the February 2009 Third Edition of the [Toolkit](#).*

5.2 (a) Impact and Outcome Measurement

Describe the planning for data collection of impact and outcome level information related to this proposal. Methods of data collection/data sources to collect impact and outcome level information should include, but not be limited to large-scale surveys, demographic surveillance, vital registration systems and routine program data. All major impact and outcome level data sources related to this proposal should be reflected in the table, regardless of whether the Global Fund is contributing towards the total cost of the data collection and reporting.

Planning for collection of impact and outcome data may not be available for the entire five-year period but at least provide information covering the first implementation period and tentative information for the second implementation period, when possible. Where data on the funding of the surveys does not exist, try to estimate the total cost of the survey for the year in which it will be conducted, and indicate if any of the costs of that survey have been included in the proposal.

How to complete this table:

Add additional sets of rows as needed for each separate impact/outcome indicator to be measured. These indicators should be in line with those in the performance framework, the national disease strategy and the national M&E plan and should follow international standard definitions. Standard indicators and definitions are available in the Monitoring and Evaluation Toolkit.

For each indicator, the applicant should describe:

- The last year the data on this indicator was collected;
- The method of data collection/data source for the indicator;
- The funding required in order to facilitate the collection of this data. The funding should be broken down into the following lines (and placed into the year in which the survey will be done):
 - The total cost of the planned survey;
 - The total amount of secured funding and the funding source(s). This should represent the amount of funds secured and available to fund data collection for each year. Funds that have been requested but have not yet been secured should *not* be listed in this row;
 - The total funds for data collection requested through this Round 11 proposal. Specify the total amount of funds requested to fill the funding gap.

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5.2 (b) Program Evaluations (preparing for the Global Fund Periodic Review)

One of the goals of the new grant architecture is to place greater emphasis on outcome and impact evaluations. In this spirit, starting from Round 11 countries are required to plan for a program evaluation/review assessing outcomes and impact as part of their proposal. The process, methodology and findings of the evaluation/review will be summarized in a written report available to key stakeholders and to the Global Fund. Applicants should budget this evaluation/review within their proposals to the Global Fund either in full or partially (e.g. to strengthen existing national reviews).

In this section provide details in relation to the program evaluation/review for this disease proposal, considering the following aspects:

Scope of the review/evaluation: Some countries have processes in place for undertaking comprehensive assessments of their national disease programs (e.g., Joint Health Sector reviews, National Program Reviews). The scope of such national reviews, as well as their rigor, inclusivity and frequency is highly variable across regions and countries. Applicants are encouraged to strengthen and use existing review processes as much as possible. If you decide to plan for an ad-hoc, Global Fund specific evaluation exercise, a strong justification should be provided.

Key methodological issues:

- a) As proposal goals typically refer to reductions in the burden of the diseases in a country, the program evaluation/review should focus on the national disease program. While there is no intent to directly attribute outcome or impact results to the underlying SSFs, the program evaluation/review should establish whether the national disease program supported by the Global Fund is progressing towards its stated goals, drawing conclusions regarding how the Global Fund portfolio, together with other stakeholders, has contributed to the observed progress.
- b) The program review/evaluation must provide a comprehensive and systematic account of progress towards proposal goals. As such, it should focus on impact and outcomes, rather than output indicators. Key questions that the review should address include:
 - Is the program progressing towards proposal goals and having an impact on the disease?
 - What were the key drivers of the trends in disease burden?
 - Is the program reaching equitable outcomes for populations most in need?
 - What were the critical contextual factors and/or strengths/weaknesses in program implementation influencing the performance of the disease response in the country (either positively or negatively)?
 - What was the contribution of the interventions financed by the Global Fund to the observed progress?
 - Based on the outcomes of the assessment, what are the key recommendations for future program implementation?
- c) The review is an opportunity to validate and analyze results obtained through routine program data, surveys and surveillance. Appropriate outcome and impact indicators, collection methods and tools for the analysis should be selected in accordance with technical guidance available for each disease.

Timeline: In planning the program evaluation/review, timelines for data collection of key indicators should be taken into account, to ensure that updated data will be available. Additionally, consider that the results of the review/evaluation are expected to be available for the submission of the request for additional financial commitment at Periodic Review (typically 24 months after the start of the implementation period).

Roles and Responsibilities: Describe the roles and responsibilities of CCM, PRs, SRs and other in-country stakeholders, including donors and technical partners. In doing so, consider the need to

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ensure a balance between the principles of country-ownership, inclusiveness, technical rigor and objectivity.

5.3 Links with the National M&E System

Identify how existing national M&E systems will be used to collect and report on data needed during the implementation of the Round 11 proposal. In particular, clarify how national indicators, national data collection tools and reporting systems, including reporting channels and cycles will be used.

If some of the M&E arrangements planned for this proposal are not using the national M&E systems, indicate which SDAs and/or activities and explain why this is the case.

5.4 Strengthening Monitoring and Evaluation Systems

Describe the M&E system strengthening measures that will be implemented to strengthen the M&E systems in country (including those of the Principal Recipients and sub-recipients). Ensure these activities are captured in 4.3 and include the funding requested to support each of these activities in the proposal budget.

Where there are identified gaps in essential epidemiological data (e.g., in key populations), you are encouraged to plan activities related to collecting this information in the Round 11 proposal.

Tools that exist to help diagnose M&E weaknesses and gaps include:

- the Global Fund's M&E Systems Strengthening Tool;
- the Health Metrics Network Assessment Tool;
- the UNAIDS 12 Components M&E System Assessment Tool (recommended for HIV programs).

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SECTION 6. PHARMACEUTICAL AND OTHER HEALTH PRODUCTS

This section should only be completed by applicants who seek funding for pharmaceutical and/or health products through their consolidated disease proposal.

For the purposes of this section, pharmaceutical and/or health products includes all pharmaceutical products, health products and other consumables (e.g., reagents, slides, gloves), and health equipment. For health equipment, include the total cost of ownership, which means all of the costs required to keep the equipment operational such as replacement parts and annual maintenance.

The Global Fund expects Principal Recipients and sub-recipients to procure products of assured quality at the lowest price possible, in accordance with national laws and applicable international obligations. Specific topics relevant to this section include:

- the existence of well-functioning transparent procurement and policy systems;
- quality assurance systems and quality control activities;
- intellectual property rights;
- supply management and coordination (storage and distribution); and
- ensuring appropriate use and patient safety including pharmacovigilance systems and drug resistance surveillance.

Functioning pharmacovigilance systems that will ‘detect, assess, understand and prevent adverse effects or any other possible drug-related problems’²⁶, are necessary for successful programs. Where possible, national pharmacovigilance systems should be used and strengthened as needed. Applicants are encouraged to develop a pharmacovigilance plan as part of their Procurement and Supply Management Plans and to seek funding from the Global Fund, as necessary, for the implementation of these pharmacovigilance plans.

The Global Fund has prepared the following guides to our policies on the management of pharmaceutical and health products:

- Guide to Global Fund Policies: <http://www.theglobalfund.org/en/procurement/guide/>
- Guide on Quality Assurance Policy: <http://www.theglobalfund.org/en/procurement/quality/>

Once a proposal has been approved for funding, the Principal Recipient(s) is responsible for submitting a Pharmaceutical and Health Products Management Plan. This plan describes the detailed arrangements for the management of pharmaceutical and health products over the proposal term. Prior to the disbursement of funds for the procurement of such products, the Global Fund (with assistance from the LFA) will assess this plan and the systems and capacity that it describes.

6.1 Management of Pharmaceutical and Health Product Activities

Provide an overview of the organizations which are planned to be involved in the management of pharmaceutical and health product activities through this proposal. In table 6.1, identify the organizations (government departments or non-governmental organizations) that will be responsible for each of the functions described in the left side of the column and provide a brief description of the organization’s management experience in that function. Include a reference to at least two reports prepared by all organizations identified, and include links to those reports, when available.

→ *Applicants are encouraged to attach, as a clearly named and numbered annex, a diagram of main organizations involved in procurement, indicating their interactions with other entities.*

²⁶ Pharmacovigilance is defined by the WHO as “the science and activities relating to the detection, assessment, understanding and prevention of adverse effects or any other possible drug-related problems.

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Describe how the proposal utilizes and/or builds upon existing in-country procurement and pharmaceutical management systems. Make sure to identify the main weaknesses and gaps in existing country systems and the proposed strategies for addressing these gaps. Where there is an expectation that capacity needs will increase significantly in order to implement activities in this proposal, explain what plans are in place to ensure increased capacity.

If the proposal includes a new or significantly altered management approach to pharmaceutical and health products, provide a clear rationale for this change.

→ *In instances where the strengthening of common management systems for pharmaceuticals and health products will benefit more than a single disease, the applicant may wish to include the request in a cross-cutting HSS funding proposal.*

→ *Activities to strengthen disease specific procurement and pharmaceutical systems should be included as part of the program description in question 4.3 (and included in the work plan and budget).*

6.2 Pharmaceutical and Health Products Required for Initial Three Years of Implementation

First, complete a Pharmaceutical and Health Products list (Attachment B) for all products that are to be funded in the first three years of this proposal. Once this is done, fill out this narrative section with a description of products included in this list that are not currently included in the national, institutional, or WHO Standard Treatment Guidelines (STGs) or Essential Medicines List (EMLs). Describe the STGs that are planned to be used and the rationale for their use.

Justify the estimated unit prices of all pharmaceutical and health products based on either the international price references provided in the [Round 11 Unit Price Guidance](#), or with another published international reference source. If the provided price is out of range, please justify.

Indicate if local legislation or other rules are preventing access to low cost prices through a local manufacturer and, if applicable, provide a plan for addressing these challenges over the life of the grant.

Applicants submitting a malaria proposal and requesting support for indoor residual spraying (IRS) are recommended to submit a plan on pesticide management that includes:

- a. procedures following the FAO/WHO “code of conduct” for pesticides (<http://www.fao.org/docrep/005/y4544e/y4544e00.htm>);
- b. a resistance management plan; and
- c. if DDT is going to be used, applicants should ensure appropriate reporting to the Stockholm convention.

6.3 Multi-drug Resistant Tuberculosis (for TB and HIV proposals only)

Indicate whether the proposal includes a request for funding multi-drug resistant tuberculosis (MDR-TB). If the “Yes” box is ticked, USD 50,000 per year over the full proposal term must be included in the detailed budget and the funds must be reserved for payment to the GLC during the proposal term. These funds cannot be used for any other implementation activities.

→ *To help limit resistance to second-line anti-tuberculosis pharmaceuticals, the Global Fund requires procurement of pharmaceuticals to treat MDR-TB to occur through the Green Light Committee (GLC) of the StopTB Working Group on drug resistant tuberculosis.*

→ *For further information on the Stop TB Partnership’s new global framework for support to scale-up effective MDR-TB management, and on changes regarding the Green Light Committee (GLC) and the Global Drug Facility (GDF), please see the Global Fund information note on [“Scaling up Effective Management of Drug-Resistant Tuberculosis”](#).*

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SECTION 7: FUNDING REQUEST

→ *If part or all of the funding for the proposal may be contributed through a common funding mechanism, the applicant is requested to contact the Global Fund's Secretariat for further guidance.*

This section of the Round 11 Proposal Form captures information regarding the funding requested through this proposal.

Under Sections 7.1 to 7.4 the applicant must show the Round 11 funding request within the broader context of the funding for the national disease program, and overall national health expenditure, and demonstrate compliance with the Global Fund's counterpart financing requirements. Under Section 7.5, the applicant is required to submit a detailed budget and work plan together with three mandatory summary tables. The applicant must also present the calculation of the incremental funding requested in Round 11. Additional questions on specific cost categories are also included under this section.

The information provided below must be read in conjunction with other available guidance, including:

- Guidelines for Budgeting in Global Fund Grants
- Guidance for Completing the Enhanced Financial Reporting Template
- Information notes relevant to this section:
 - Information note on Eligibility, Counterpart Financing and Prioritization
 - Unit costs for selected key health products
 - Value for money

7.1 Financial Gap Analysis and Counterpart Financing Calculation

(a) Completing the Financial Gap Analysis and Counterpart Financing Table

Applicants must use the 'Financial Gap Analysis and Counterpart Financing' table to provide financial information pertaining to the national program²⁷ that implements the national disease strategy. Detailed instructions on how to complete the Financial Gap Analysis and Counterpart Financing Table are provided as a separate tab in the Excel templates.

The financial gap analysis table identifies the:

- (i) Funding needed to address the overall response to the disease;
- (ii) Funding available from domestic and external sources, including existing Global Fund grants and other non-Global Fund resources; and
- (iii) Resulting financial gap between funding needed and funding available.

Applicants should also make available in the table data on government contribution to the overall health sector to provide contextual input to the TRP review. The data, along with other contextual information, will be assessed to ensure that in meeting additionality requirements for the disease programs, funding is not diverted away from other priority areas.

The table collects data on contribution of different funding sources to the national program for the:

- (i) Two years preceding the year of application;
- (ii) Year of application; and
- (iii) Proposal implementation period

²⁷ If there is no 'national program' relevant to the proposal, then the gap analysis should be prepared based on the program described in the applicant's proposal, ensuring that other contributions to the cost of the program are clearly explained.

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(b) To better contextualize and assess financial data provided in the proposal, applicants are required to:

1. Provide an overview of the composition of government contribution to the “national program” in terms of:
 - a. Ministries and departments covered;
 - b. Levels of government included (central, regional and local);
 - c. Whether government contribution pertains to direct programmatic costs alone or whether it includes other health system costs which have been apportioned to the disease program.
2. Indicate whether amounts contributed by each source for the years 2009, 2010 and 2011 pertain to:
 - a. Budget: Data from an annual financial plan, drawn up according to budgetary principles, that authorizes spending on disease program/health sector for each financial year;
 - b. Disbursement: Disbursement data represent the placement of financial resources at the disposal of entities within a recipient country for the disease program/health sector; or
 - c. Expenditure: Actual consumption of financial resources for provision of services.
3. Indicate whether amounts forecast from each source for the years 2012 to 2016 pertain to:
 - a. Estimation: Funds that are likely to be available based on historical trends, non-binding announcements, agreements being negotiated, and/or plans for tapping potential funding sources;
 - b. Commitment: A firm obligation expressed in writing and backed by availability of necessary funds for the disease program/health sector.

7.2 Estimation of Current and Anticipated Domestic and External Funding

Methodology for estimating disease and health spending, and acceptable sources of data

Applicants should provide actual expenditure data for the years prior to the year of application and budget data for the year of application.

To ensure standardized and validated data for funding decisions of the Global Fund as well as monitoring compliance with counterpart financing, countries are required to report on disease program and health spending in accordance with methodologies specified by technical partners. This includes methodologies underlying data reported by countries for:

- Tuberculosis: Financial data reported in the data collection form for the World Health Organization’s annual Report on Global Tuberculosis Control (See <http://www.who.int/tb/country/en/>)
- Malaria: Data on malaria financing reported in questionnaire for the annual World Malaria Report of the World Health Organization (See http://www.who.int/malaria/world_malaria_report_2010/en/index.html)
- HIV/AIDS: Data reported in the UNAIDS National AIDS Spending Matrix as part of the UNGASS Country Progress Report for Monitoring the Declaration of Commitment on HIV/AIDS. Details available at: <http://www.unaids.org/en/dataanalysis/tools/nasapublications/>
- Health Spending: National Health Accounts (NHA) data published by the World Health Organization annually, following an official consultation process. Details available at: <http://www.who.int/nha/en/>

Data should be drawn from official country documents, which can and will be verified. The documents from which the data has been sourced should be explicitly specified in the table. If the country has reported disease expenditure to technical partners in the specified methodology for any of the previous years in consideration, data from such country reports should be used to provide information requested in the table. If the applicant determines that the data reported to technical partners is not complete or if the country has not yet reported, other data sources can

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be used. For previous years and current year, data sources could include government budgets and spending plan; audited accounts of the government, unaudited accounts placed on the floor of the legislature, National Health Accounts (NHA) and disease sub-accounts, resource tracking surveys and spending assessments such as National AIDS Spending Assessment (NASA), Public Expenditure Reviews, Public Expenditure Tracking Surveys and donor reports. Data for forward-looking estimation of financial support to disease program and health sector can be drawn from health and disease strategy and planning documents, medium term expenditure frameworks for health, grant agreements and loan agreements.

7.3 Compliance with the Counterpart Financing Requirements

Minimum threshold for counterpart financing is based on the income category to which the applicant country belongs (to know your income level classification, please refer to [the Global Fund Eligibility List for 2011 Funding Channels](#)):

- Low Income- 5%
- Lower Middle Income- Lower Tier- 20%
- Lower Middle Income- Upper Tier- 40%
- Upper Middle Income- 60%

In addition to meeting the minimum counterpart financing threshold, applicants must also demonstrate:

- increasing counterpart contribution by the government to the GF supported national disease program over the proposal term; and
- increasing counterpart contribution by the government to the overall health sector over the proposal term.

Applicants are required to assess whether they meet the prescribed counterpart financing requirements. If the requirements are not met at the proposal stage, the TRP may reject the proposal unless a strong justification is provided.

The justification should be supported by specific actions planned for the implementation phase to reach the minimum requirements and request for continued funding, for example actions to improve domestic contributions and/or health spending assessment to provide better data.

7.4 Financial Gap and Counterpart Financing Data Sources

In this section:

- (a) provide a brief **assessment of completeness and reliability of financial data** reported in the ‘financial gap analysis and counterpart-financing table’.

Applicants are required to describe the sources used to complete the Financial Gap Analysis and Counterpart financing table. Reference details of the source documents for data used should be made explicit. The data provided will be verified against source documents during LFA assessment during grant negotiations for successful proposals.

Expenditure data provide the most accurate assessment of the financial status of a health system, and reflect the actual financial cost of providing services. In previous Rounds, expenditure data was requested to provide a context for proposed scaling up of services. However, from Round 11 there is greater emphasis on expenditure data especially of government, as it is a critical input for calculation of counterpart financing and its monitoring. Countries should be able to track disease and health expenditure on a routine basis by strengthening and building upon existing systems and processes. Most countries are already reporting data on disease and health spending to technical partners. However, there is considerable scope for further improving quality and reliability of the reported data. Applicants need to assess adequacy of existing systems and processes in generating valid government spending data in consultation with country focal points of technical partners (WHO and UNAIDS) to identify constraints as well as actions for improving data quality, if any.

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- (b) briefly discuss **all actions planned to improve data quality** consistent with guidelines for reporting of program financial data to technical partners and, if applicable, state if the proposal includes a request for Global Fund support for expenditure tracking study during the first implementation period.

Applicants are encouraged to include targeted investments in the disease proposal for identified actions to improve disease and health spending data consistent with methodologies and guidelines prescribed by technical partners. This may range from support to strengthen existing systems and processes to a disease spending assessment. Applicants may budget for up to USD 50,000 for a disease spending assessment during the first implementation period of the proposal to verify expenditure data.

All actions for improving quality of disease or health spending data for which funding is sought should be included under Section 4.3. Actions limited to spending assessments and/or data reporting improvements could be included under the “Program Management and Administrative Cost” Service Delivery Area (SDA). More systemic interventions could be included under “Health Systems Strengthening: Information System” SDA. Budgeting by cost categories should be according to guidelines for budgeting in Global Fund grants. Spending assessments are to be budgeted under “Monitoring & Evaluation” cost category or under “Technical Assistance” (only if the funding is for remunerating an external consultant).

7.5 Detailed Budget and Work Plan

Choosing a detailed budget template

Applicants are required to present their budget and workplan in the format described in the Global Fund Budgeting Guidelines. There are two tools available to applicants to prepare budgets in the required format, the **Global Fund detailed budget and work plan template** and the **WHO costing tool**.

Applicants who choose not to use one of these tools should ensure that their budgets and work plan are presented in the standard format (listing reference number, objective, SDA, activities, indicators, quantities and unit costs, and implementers, etc.) in order to facilitate the TRP review and grant signing process. Applicants using their own template must also complete the mandatory summary budget tables and incremental request table. A template Excel file has been developed for this purpose (Attachment F).

For more information on detailed budgets, including the required budget format and attributes consult the [Guidelines for Budgeting in Global Fund Grants](#).

Work Plan

Applicants must provide a detailed work plan showing the anticipated implementation start and end dates for all activities (including no cost activities) over the initial three years, broken down into quarters. The work plan must follow the same ‘by objective, SDA, indicator, activity and implementer’ structure as the detailed budget, logframe and performance framework. It can be submitted as a separate document or as part of the detailed budget.

Both the Global Fund detailed budget and work plan template and the WHO costing tool provide the standard information and present the work plan in the format accepted by the Global Fund.

Size of the funding request - General Pool

In the General Pool, there are no fixed upper limits on the size of a proposal, and the size of proposals may vary considerably based on country context, type of proposal and the amount of existing funds brought over from existing grants included in a consolidated proposal. However, demonstrated evidence of absorptive capacity is an important criterion for additional financial support from the Global Fund. The TRP may view negatively proposals that request large amounts

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where the ability to absorb such funding has not been demonstrated, through existing capacity or through planned capacity strengthening (including via the Round 11 proposal).

There are also no fixed lower limits on the size of a proposal. However, as the Global Fund promotes comprehensive programs and particularly those aimed at scaling-up proven interventions, the TRP may view negatively requests for small programs (of the order of several hundred thousand US Dollars or below). Smaller requests by individual partners and/or smaller non-governmental organizations should be combined into the overall single disease proposal.

Size of the funding request - Targeted Pool

Funding requests submitted through the Targeted Pool must comply with the fixed maximum upper ceiling incremental amounts of US\$ 5 million for the initial two years and US\$ 12.5 million over the five-year proposal term.

Note that for all proposals in the Targeted Pool, the totality of the incremental funding request must be focused on key populations and/or ‘highest impact interventions.’

Consolidated funding request and incremental amount calculation

With the mandatory implementation of the new Global Fund grant architecture starting in Round 11, applicants must develop a holistic program for the TRP to review based on identified needs, gaps, priorities and existing programming under existing same-disease grants. The resulting Round 11 funding request to support the programmatic elements will include some new funding (this is known as the “incremental” or additional amount) but it will also include some of the existing funding from the existing grants that have been included in the Round 11 consolidated disease proposal.

The amount of funding to be brought over from existing grants into the consolidated disease proposal will depend on several factors, including the proposed start date of the consolidated disease proposal and when the existing grants are “cut off” in order to become part of the single stream of funding.

Recognizing the complexities in calculating the correct amount of existing funding and incremental funding in order to arrive at the true upper ceiling funding request for TRP recommendation and Board approval, the Secretariat will work closely with applicants following submission, and during the Secretariat screening period, to ensure accuracy in these amounts. Note that, should the Round 11 proposal be approved for funding, the Board approved incremental amount may be adjusted depending on the actual program start date.

CCM (and Sub-CCM) support costs

Applications for this support are made through a separate form and are subject to review by the Secretariat. These are not financed through grant funds. Information on CCM (and Sub-CCM) support costs is available at: <http://www.theglobalfund.org/en/ccm/>

Budget checklist

Before submitting the detailed budget and work plan, applicants are encouraged to perform the following final checks:

Does the detailed budget take into account the changes due to the mandatory transition to the new grant architecture?

- Includes all of the applicant’s existing same-disease grants
- Costs are broken down quarterly for the first three years and yearly for the rest of the proposal term
- Includes a calculation of the incremental/new funding request
- Includes costs for preparing for the evaluation and reporting prior to the Periodic Review

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Is the funding request presented in such a way that it is fully consistent with the proposal narrative and the performance framework?

- The numbering system used in the detailed budget is fully consistent with the numbering used elsewhere in the application (i.e. logframe, proposal narrative)
- Funding request is consistent with the analysis of funding gaps and other sources of funding

Is the detailed budget verifiable and does it fulfill the requirements in terms of reasonableness, consistency, level of detail and formatting?

- Detailed budget is in Excel format (not PDF)
- Costs are expressed in one consistent currency that is either US Dollars or Euros
- Information on the exchange rate used for converting costs in local currency to US Dollars or Euros, and the assumptions used to account for exchange rate variations and inflation are provided
- Unit costs, detailed cost assumptions and other justifications have been provided and included in the submission
- Calculations are accurate and totals are consistent across the different budget sheets and summary tables
- Costs are consistent with current market prices with reasonable allowances for cost variations across time
- Reflects a realistic split of costs across years (i.e. taking into account startup, completion of activities and wind down) and a reasonable rate of utilization of funds
- Items are correctly classified under the Global Fund's cost categories
- Requisite justification and supporting documentation provided with relation to Human Resources, Procurement and Supply Management, Technical Assistance and other important costs

Applicants are also strongly encouraged to consult the “Budget” section of the [Information Note on TRP Commonly Identified Weaknesses](#).

7.6 Summary and Incremental Request Tables

If the applicant chooses to use GF budget and work plan, the summary budget tables (by SDA, cost category and PR) are automatically generated. If the applicant opts to use their own budget template, they must complete Attachment F, which includes all of the mandatory summary budget tables.

The yearly totals of all of the summary budget tables (by SDA, cost category and PR) should **match exactly**, and correspond with the totals in the detailed budget.

7.6 (a) Summary by objective and service delivery area

Provide a summary of the annual budget for each service delivery area (SDA) in respect of each year of the proposal. The objectives and SDA listed should correspond to those in the performance framework. This breakdown of the budget by SDAs should be prepared from the detailed budget.

7.6 (b) Summary by cost category

Summarize the annual totals from the detailed budget by disease into a table under the following cost categories:

- Human Resources
- Technical and Management Assistance
- Training
- Health Products & Health Equipment
- Pharmaceutical products (medicines)
- Procurement & Supply Management costs

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- Infrastructure and Other Equipment
- Communication materials
- Monitoring & Evaluation
- Living support to clients/target populations
- Planning and Administration
- Overheads
- Other

For further guidance on the costs that fall under each of the categories, please refer to the guidance provided in the [Guidelines for Budgeting in Global Fund Grants](#).

7.6 (c) Summary budget by PR (where more than one PR is being proposed)

If more than one PR is being proposed, the applicant must present a per PR breakdown of the funding request. If the nominated PRs are implementing existing grants that are included in the Round 11 proposal, the totals by PR represent the amount of overall funding for each of the Single Streams, including the new funds being requested in Round 11.

7.6 (d) Incremental amount (actual new funding requested for the proposal)

If there are funds from existing same-disease grants included in this proposal, the applicant must present a summary of the calculation of the new funding being requested per quarter for the proposal term. This corresponds to the difference between the total funding request (Line A) and the funding from existing same-disease grants included in the consolidation for the periods overlapping with the current proposal's duration (Line B for signed grant amounts and Line C for approved but not yet committed funds, including upper ceiling amounts for Phase 2 and unsigned grants).

When entering the amounts for existing funding, applicant must take into account the Board decisions related to efficiency savings and funding limitations. This information is summarized in the [Guidelines for Budgeting in Global Fund Grants](#). Further guidance on how to calculate the incremental amount is available in the Excel templates.

7.7 Human Resources

The Global Fund seeks to ensure that any proposed financing of salaries, per diems, other compensation, volunteer stipends and top-ups is consistent with current HR compensation in the health sector, specifically national salary or interagency frameworks. If they are not consistent, this could lead to diversion of staff from existing programs to new programs financed by the Global Fund, which is something the Global Fund wants to avoid.

In this section, explain how compensation issues in the health sector have been analyzed and what steps have been taken to ensure Global Fund supported salaries are consistent with national salary or interagency frameworks. If some or all of your salary costs are not consistent with existing compensation policies, provide a solid justification for this. Relevant documentation must be attached, even if the documentation is only in draft form. If no such documentation is available, provide a clear description of current practices as well as efforts to elaborate and document in-country compensation policies.

7.8 Overhead Costs

In the Guidance for Completing the Enhanced Financial Reporting Template the following are mentioned as examples of overheads: running costs such as rent, electricity, utilities, communication costs (mail, telephone, internet), insurance, fuel, security, cleaning. By nature such costs are often 'indirect' i.e. they cannot be directly attributed to the activities of the grant but are nevertheless required to be able to manage the grant.

The [Guidelines for Budgeting in Global Fund Grants](#) include a module on Budgeting for Planning and Administration and Overhead costs. Please read this module and ensure that this proposal complies

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with the relevant Global Fund policy. Use this section to describe the management and overhead fees associated with this proposal and analyze compliance with the Global Fund policy.

7.9 Compliance with the Focus of Proposal Requirement

In the General Pool, proposals from lower middle income countries (lower tier and upper tier) must focus at least 50 percent of the budget on underserved and most-at-risk populations and/or highest-impact interventions within a defined epidemiological context.

Proposals from upper middle income countries must focus 100 percent of the budget on these populations and/or interventions.

Every applicant that opts to apply for the Targeted Funding Pool - regardless of income level - must focus 100 percent of their budgets on most-at-risk populations and/or highest-impact interventions.

Highest-impact interventions are defined as evidence-based interventions that:

- 1) address emerging threats to the broader disease response; and/or
- 2) lift barriers to the broader disease response and/or create conditions for improved service delivery; and/or
- 3) enable roll-out of new technologies that represent global best practice; and
- 4) are not funded adequately.

In this section, the applicant must provide a narrative description of how compliance with the relevant focus of proposal requirements has been taken into account when budgeting for the proposal.

Please refer to the information note on the Eligibility, Counterpart Financing and Prioritization and to the Frequently Asked Questions for guidance on underserved and most-at-risk populations and highest impact interventions within a defined epidemiological context.

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SECTION 8. MANAGEMENT STRATEGIES

8.1 Principal Recipient(s)

How to complete this section:

In this section, explain why existing PRs are being reappointed to manage and oversee implementation of grants.

If the applicant is nominating new PRs in addition to or instead of existing ones, indicate and explain here why they are a suitable choice. Provide contact details for all PRs in this space.

The nomination of Principal Recipients in proposals is subject to final approval by the Global Fund as part of the capacity assessment and grant negotiations process.

Principal Recipients are responsible for financial and program management for all funding contributed to the program through this proposal. Responsibilities include:

- Receiving and managing funds, and accounting for funds;
- Implementing and overseeing program implementation;
- Making efficient arrangements for disbursement of funds to sub-recipients, including overseeing the financial arrangements for sub-recipients, and preparing a plan for the annual audit of sub-recipient activities under the grant;
- Reporting on program performance to the Global Fund and the CCM or its equivalent according to the performance framework; and
- Requesting additional disbursement of funds based on performance.

If the Board approves a proposal, an independent Local Fund Agent (LFA) appointed by the Global Fund will work with the Global Fund to assess these minimum capacities. If a Principal Recipient outsources a key role, the Global Fund will also assess both the entity handling the outsourced function(s) as well as the nominated Principal Recipient. For example, if the Principal Recipient is the Ministry of Finance but entrusts program implementation to the Ministry of Health, then both the Ministry of Finance and the Ministry of Health will be assessed.

→ *Information on the grant oversight role of Principal Recipients is available at:* http://www.theglobalfund.org/documents/core/grants/Core_Fiduciary_Arrangements_en/

→ *The required minimum capacities and the assessment tools used by the LFA are available at:* <http://www.theglobalfund.org/en/lfa/documents/>

8.2 Sub-recipients

Describes the sub-recipients²⁸ nominated to carry out the planned activities. List any identified sub-recipients, describe the work planned for them, their past implementation experience, challenges with existing implementation and intended strategies to address these challenges.

If sub-recipients are not yet identified, explain why not and describe the transparent and time-bound process that will be used by the Principal Recipient(s) to select the sub-recipients.

In order to assess the feasibility of the proposal, it is important for the TRP to understand how sub-recipients will be involved in implementation. Therefore, applicants are expected to identify all or most of the sub-recipients before proposal submission. This is particularly important if a sub-

²⁸ **Potential sub-recipients include:** non-governmental and community-based organizations ('CBOs'); networks of people living with the diseases; the private sector; faith-based organizations ('FBOs'); academic/educational institutions; government (including ministries of health as well as other ministries involved in a multi-sectoral response to the diseases, such as education, agriculture, youth, women's affairs, information, etc.); and, where no national recipient is available, multi-/bilateral development partners.

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recipient has a major role in service delivery of the Round 11 interventions (e.g. SDAs and activities) described in question 4.3.

8.3 Coordination Between and Among Implementers (PRs and SRs)

If there is more than one nominated Principal Recipient for this proposal, describe how multiple principal recipients will coordinate with each other. Also describe how the nominated PRs will coordinate with their respective sub-recipients.

8.4 Principal Recipients' Sign-Off

A representative of each PR must sign off on the proposal, confirming that they endorse it and are ready to implement as described in the narrative section of the proposal form, performance framework and detailed budget/work plan. Where two or more PRs are being proposed, PRs should also refer to the summary budget breakdown per PR in the detailed budget to ensure that they are aware of the proposed distribution of the budget per implementing entity. PRs must also be aware that grants must be signed no later than 12 months after their Board approval, but that the current target to complete grant negotiations is six months.

ANNEX 1: TRP REVIEW CRITERIA

ANNEX 2: EXAMPLES OF KEY POPULATIONS AND EPIDEMIOLOGICAL DATA FOR TARGET POPULATIONS

ANNEX 3: LIST OF ABBREVIATIONS AND ACRONYMS

ANNEX 4: GLOSSARY OF TERMS

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ANNEX 1: TRP REVIEW CRITERIA

The TRP uses the set of criteria below to evaluate proposals and decide whether they are suitable for funding. The table below maps the TRP review criteria to specific questions in the proposal form so that applicants are able to see where compliance with the criteria should be demonstrated.

TRP CRITERIA	RELEVANT QUESTIONS IN THE PROPOSAL FORM
SOUNDNESS OF APPROACH	
Provides a clear and up to date situational analysis of the epidemiology and strategic approaches to addressing the diseases, which includes an epidemiological and programmatic review describing key affected populations and underserved/marginalized or otherwise vulnerable groups;	Disease Program (3.1), Major Constraints and Gaps (3.2), Epidemiological Profile of Target Populations (3.3) , Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Performance Framework (5.1), Detailed Budget and Work Plan (7.5)
Proposed interventions are consistent with situation analysis and epidemiological profile and address needs of most affected populations;	Major Constraints and Gaps (3.2), Epidemiological Profile of Target Populations (3.3), Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Performance Framework (5.1), Detailed Budget and Work Plan (7.5)
Proposed interventions are consistent with international best practices in the disease area or for health systems (from WHO, The International Union against TB and Lung Disease, UNAIDS, Roll Back Malaria) and are at a scale that will produce an impact;	Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Enhancing TB/HIV Collaborative Activities (4.8)
If proposal puts forth innovative approaches that are not consistent with international best practices, a clear plan for pilot testing and evaluating the new approach(es) prior to scale-up is included;	Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Performance Framework (5.1), Detailed Budget and Work Plan (7.5)
Any proposed scale-up is based on demonstrated local effectiveness of the proposed approach;	Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Performance Framework (5.1)
Shows active engagement of people living with the disease and affected communities in the planning, implementation and monitoring and evaluation of relevant proposal elements;	Proposal Development Process (2.1), Process to Oversee program Implementation (2.4), Broad and Inclusive Membership (2.5), Proposal Endorsed by Members (2.7), Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Performance Framework (5.1), Detailed Budget and Work plan (7.5)
Actively engages appropriate stakeholders in implementation, including government, civil society, affected communities and the private sector;	Proposal Development Process (2.1), Non Implementation of Dual Track Financing (2.3), Process to Oversee program Implementation (2.4), Broad and Inclusive Membership (2.5), Proposal Endorsed by Members (2.7), Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Detailed Budget and Work Plan (7.5)

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ANNEX 1: TRP REVIEW CRITERIA

TRP CRITERIA	RELEVANT QUESTIONS IN THE PROPOSAL FORM
<p>Addresses human rights and equity issues around gender, sexual orientation and gender identity, including stigma and discrimination and legal barriers to prevention, treatment, and care for the three diseases. Also addresses the specific needs of women and girls with respect to the three diseases and the barriers affecting their access to prevention and care. This is demonstrated through the following:</p> <ul style="list-style-type: none"> • A clear situational assessment has been conducted of the issues needing to be addressed, including the legal, policy and social environment and human rights-related barriers to care; the extent to which services are affordable, accessible, acceptable, of good quality and meet the needs of key affected populations; and the extent to which specific human rights programs are included in national disease responses; • Relevant data (epidemiology, current programmatic efforts, etc.) are presented in a disaggregated fashion; • Proposed interventions address the issues identified, and needs of key populations highlighted, in the situational assessment and demonstrates a human rights-based approach in program implementation; • Proposal actively engages women, girls and sexual minorities in planning, implementation and monitoring and evaluation. 	<p>Major Constraints and Gaps (3.2), Epidemiological Profile of Target Population (3.3), Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Performance Framework (5.1), Detailed Budget and Work Plan (7.5)</p>
FEASIBILITY	
<p>Proposal demonstrates technical and operational feasibility and involves the parties necessary to ensure effective implementation, including supporting decentralized interventions and/or participatory approaches to disease prevention and control (including those involving the public, private and non-government sectors, and communities affected by the disease), where appropriate;</p>	<p>Non Implementation of Dual Track Financing (2.3), Epidemiological Profile of Target Populations (3.3), Strengthening Implementation Capacity (4.5), Principle Recipients (8.1), Sub-Recipients (8.2), Coordination Between or Among Implementers (8.3), Principle Recipients’ Sign Off (8.4)</p>
<p>Proposal is aligned to and complements existing programs and supports national policies, strategies and plans;</p>	<p>Disease Program (3.1), Round 11 Priority Interventions (3.5), Links to non-Global Fund External Resources (4.4), Addressing Links with a Cross-Cutting HSS Funding Request (4.7), Financial Gap Analysis (7.1)</p>
<p>Demonstrates successful implementation of large scale programs funded by international donors (including the Global Fund) or major national sources, and efficient disbursement and use of funds. (For this purpose, the TRP will make use of Grant Score Cards, Grant Performance Reports, and other documents related to previous grant(s) in respect of Global Fund supported programs and other development partner funded programs);</p>	<p>Executive Summary of Round 11 proposal (4.2), Interventions (4.3), Links to non-Global Fund External Resources (4.5), Principle Recipients (8.1), Sub-Recipients (8.2), Coordination between or among implementers (8.3), Applicant Disease Profile, existing grant documentation</p>

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ANNEX 1: TRP REVIEW CRITERIA

TRP CRITERIA	RELEVANT QUESTIONS IN THE PROPOSAL FORM
Capacity to implement the proposal is demonstrated or technical assistance/capacity building activities are included as a major intervention;	Disease Program (3.1), Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Strengthening Implementation Capacity (4.5), Addressing Weaknesses from a Previous Category 3 Proposal (4.6), Principle Recipients (8.1), Sub-Recipients (8.2), Coordination Between or Among Implementers (PRs and SRs) (8.3)
Proposal includes specific impact and outcome (quantitative and qualitative) indicators for proposed interventions and will allow for a time-bound assessment of progress toward goals and objectives;	Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Logframe (4.3(a)), Performance Framework (5.1)
Targets for impact and outcome indicators are set realistically, are linked to baseline data and situation analysis, and rationale for choosing these levels is explained;	Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Performance Framework (5.1)
Proposal has a clear and well-defined logical framework for its implementation and performance framework for its impact that draw on and feed into national M&E systems and processes, where appropriate;	Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Logframe (4.3(a)), Performance Framework (5.1), Impact and Outcome Measurement Systems (5.2), Links with National M&E System (5.3), Strengthening M&E Systems (5.4)
If resubmitted, proposal adequately addresses all weaknesses and comments previously noted by the TRP.	Addressing Weaknesses from a Previous Category 3 Proposal (4.6)
POTENTIAL FOR SUSTAINABILITY AND IMPACT	
Proposal includes evidence that the proposed activities and coverage levels will have measurable impacts on disease prevalence, incidence, morbidity and/or mortality;	Epidemiological Profile of Target Population (3.3), Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Performance Framework (5.1)
Proposal reflects strong high-level, political support and is realistic in light of the current policy and legal environment;	Proposal Development Process (2.1), Process to Oversee Program Implementation (2.4), Broad and Inclusive Membership (2.5), Executive Summary of Round 11 Proposal (4.2), Interventions (4.3)
Proposal clearly specifies how it will contribute to health and community systems strengthening;	Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Addressing Links with a Cross-Cutting HSS Funding Request (4.7), Strengthening Monitoring and Evaluation Systems (5.4)
For any cross-cutting HSS request, proposal clearly demonstrates why and how it will strengthen health outcomes related to HIV, TB and malaria;	Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Addressing Links with a Cross-Cutting HSS Funding Request (4.7),
Proposal demonstrates the potential for long-term sustainability of the approach outlined, including building sustainable capacity to absorb increased resources and demonstrating the ability to transition recurrent expenditures to a sustainable funding source over a reasonable timeframe;	R11 Priorities (3.5), Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Financial Gap Analysis (7.1), Estimation of Current and Anticipated Domestic and External Funding (7.2), Compliance with the Counterpart Financing Requirements (7.3), Financial Gap and Counterpart Financing Data Sources (7.4)

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ANNEX 1: TRP REVIEW CRITERIA

TRP CRITERIA	RELEVANT QUESTIONS IN THE PROPOSAL FORM
Proposal explains clearly how it will strengthen the ability of affected communities to participate in interventions and will document increased community engagement over time; and	Proposal Development Process (2.1), Non Implementation of Dual Track Financing (2.3), Process to Oversee Program Implementation (2.4), Broad and Inclusive Measurement (2.5), Major Constraints and Gaps (3.2), Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Performance Framework (5.1), Detailed Budget and Work Plan (7.5), Principle Recipients (8.1), Sub-Recipients (8.2)
Proposal harmonizes with existing initiatives and other partnerships in the disease area or health sector (such as the WHO/UNAIDS “Universal Access” initiative, the Stop TB Partnership, the Roll Back Malaria Partnership, the “Three Ones” principles, the IHP+, and UNICEF’s “Unite for Children, Unite against AIDS” campaign).	Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Links to non-Global Fund External Resources (4.4), Financial Gap Analysis (7.1)
VALUE FOR MONEY	
Proposed interventions are among the most effective and cost-efficient for achieving the desired outcome in a given context;	Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Performance Framework (5.1), Detailed Budget and Work Plan (7.5)
Budget is set at a level necessary to achieve desired impacts;	Executive Summary of Round 11 Proposal (4.2), Interventions (4.3), Detailed Budget and Work Plan (7.5)
Uses lowest cost quality products available while respecting international agreements and property rights; ²⁹ and	Pharmaceutical and Health Products Required for Initial Three Years of Implementation (6.2), Detailed Budget and Work Plan (7.5)
Requested Global Fund support is additional to existing efforts and will not substitute for other resources (national, private sector, or international).	R11 Priority Interventions (3.5), Links to non-Global Fund Resources External Resources (4.4), Financial Gap Analysis (7.1), Estimation of Current and Anticipated Domestic and External Funding (7.2), Compliance with the Counterpart Financing Requirements (7.3), Detailed Budget and Work Plan (7.5)

²⁹ Including the World Trade Organization’s Agreement on Trade-Related Aspects of Intellectual Property Rights (the TRIPS Agreement) and the Doha Ministerial Declaration on the TRIPS Agreement and Public Health.

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ANNEX 2: EXAMPLES OF KEY POPULATIONS AND EPIDEMIOLOGICAL DATA FOR TARGET POPULATIONS

HIV	Tuberculosis	Malaria
Non-exhaustive list of other key populations targeted by the proposal		
Number of orphans	Number of prisoners	Number of migrants (or migrant workers)
Number of injecting (or other) drug users (female, male) and their partners	Number of migrants (or migrant workers)	Number of people living in poverty
Number of sex workers (female, male, and transgender) and their long-term partners	Number of infants	Number of bed nets in use by population
Number of men who have sex with men and, where relevant, their female partners	Number of people living in poverty (or conflict/post conflict)	
Number of transgender persons		
Non-exhaustive list of potential epidemiological data for populations targeted by proposal		
Average number of new cases of HIV reported annually	Estimated number of people with all forms of incident tuberculosis	Reported malaria episodes per year
Number of males and females separately > 14 years completing HIC Counseling and Testing	Estimated number of women > 15 years with all forms of incident tuberculosis	Malaria deaths per year (all ages)
Estimated number of incident TB cases in people living with HIV	Estimated tuberculosis related deaths per year	Estimated malaria episodes per year
Number of people in need of ARVs,	People notified for new smear positive tuberculosis	No hospitalization for severe malaria
Number of women and men separately > 14 years in need of ARVs	Case detection rate of new smear positive cases disaggregated by sex	Proportion of children receiving appropriate malaria treatment within 24 hours disaggregated by sex
Number of women and men separately > 14 years receiving ARVs	Treatment success rate disaggregated by sex	Proportion of pregnant women receiving appropriate malaria treatment within 24 hours disaggregated by age
Number of children 0 - 14 receiving ARVs disaggregated by sex	Estimated MDR TB or XDR TB cases	Malaria fatality rate disaggregated by sex and age
Number of male and female injecting (or other) drug users receiving ARVs disaggregated by age		
Number of women and men in need of treatment for opportunistic infections disaggregated by age		
AIDS related deaths per year by sex and age		
Percentage and age of births assisted by skilled birth assistants per year		
Estimated annual number of women 15-49 with unmet need		

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ANNEX 2: EXAMPLES OF KEY POPULATIONS AND EPIDEMIOLOGICAL DATA FOR TARGET POPULATIONS

HIV	Tuberculosis	Malaria
for contraception		
Estimated percentage of adolescents and young people by sex, newly infected annually (disaggregated by 10-14, 15-18, and 19-24 if possible)		
Non-exhaustive list of knowledge/behavior data for key populations targeted by proposal		
Percentage of young men/women (10-24 years) with correct knowledge of HIV	Percentage of population with correct knowledge about TB disaggregated by sex and age	Percentage of people/target groups who knew the cause, symptoms, treatment or prevention measures for malaria.
Percentage of key populations with “key populations” correct knowledge on HIV disaggregated	Percentage of women and men in a selected community expressing accepting attitudes towards TB patients	Percentage of pregnant women, girls and boys who slept under an ITN the previous night
Age of first sexual intercourse disaggregated by sex.		
Percentage of women and men age 15-49 who have had sexual intercourse with more than one partner in the last 12 months, among respondents aged 15-49, who were sexually active in the last 12 months. (Disaggregate by age 15-18, 19-24, and above if possible)		
Percentage of female and male and transgender sex workers reporting use of a condom with last client		
Percentage of MSM reporting use of a condom at last anal intercourse, disaggregated by age		
Percentage of female and male IDUs who reported using sterile injecting equipment the last time they injected		
Percentage of male and female IDUs who report the use of condom at last sexual intercourse		

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ANNEX 3: LIST OF ABBREVIATIONS AND ACRONYMS

ACT	Artemisinin-based combination therapy
ADP	Applicant disease profile
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal Care
ARV	Antiretroviral
BCC	Behavioral change communication
BSS	Behavior Surveillance Survey
CBO	Community-based organization
CCM	Country Coordinating Mechanism
CRIS	Country response information system
CSS	Community systems strengthening
DHS	Demographic and Health Surveys
DOTS	Directly observed treatment Short Term
DRS	Drug resistance surveillance
DST	Drug susceptibility testing
FBO	Faith-based organization
GLC	Green Light Committee
GOV	Government
HAART	Highly active antiretroviral therapy
HCW	Health care worker
HIS	Health Information System
HIMS	Health Information Measurement Systems
HIV	Human immunodeficiency virus
HSS	Health systems strengthening
IMS	Impact Measurement Systems
IPT	Intermittent preventive treatment
IRS	Indoor residual spraying
ITN	Insecticide-treated net
KAP	Knowledge, Attitudes and Practices survey
LFA	Local Fund Agent
LLIN	Long-lasting insecticidal net
MDG	United Nations Millennium Development Goals
MDR	Multi-drug resistant
M&E	Monitoring and Evaluation
MERG	Monitoring and Evaluation Reference Group
MICS	Multi indicator cluster surveys
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NAC	National AIDS Committee
NGO	Non-governmental organization
NMCP	National malaria control program
NTP	National tuberculosis control program
OI	Opportunistic infection
PHC	Primary Health Care
PEP	Post-Exposure Prophylaxis
PICT	Provider Initiated Counseling & Testing
PMTCT	Prevention of Mother to Child Transmission
PPTCT	Prevention of Parent to Child Transmission
PR	Principal Recipient
PV	Pharmacovigilance
RBM	Roll Back Malaria
RDT	Rapid diagnostic test
SR	Sub-recipient
SSF	Single stream of funding
STI	Sexually transmitted infection
TB	Tuberculosis
TRP	Technical Review Panel

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ANNEX 3: LIST OF ABBREVIATIONS AND ACRONYMS

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session (on HIV/AIDS)
UNICEF	United Nations Children’s Fund
VCT	Voluntary counseling and testing
VfM	Value for Money
WHO	World Health Organization
WHOPES	WHO Pesticide Evaluation Scheme

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ANNEX 4: GLOSSARY OF TERMS

ADDITIONALITY To ensure that national resources already committed to a national program are not displaced or duplicated through funding from an approved proposal, it is necessary for applicants to demonstrate that funds requested from the Global Fund are *additional* to existing available resources.

ALIGNMENT Refers to setting the dates for the Component Implementation Period to be in line with the most relevant in-country cycle. For example, Global Fund reporting and reviews can be aligned with country systems for reporting and review, and Global Fund grant renewals can be aligned with national fiscal cycles.

APPROVED FUNDS Funds that have been approved by the Global Fund Board for the whole proposal (years 1-5), but not necessarily committed.

APPLICANT DISEASE PROFILE Contains financial and programmatic information for each disease for which an applicant has existing grants, with separate profiles for each disease.

(GLOBAL FUND) BOARD The Board is responsible for the overall governance of the organization, and determines policies, objectives and strategies of the Global Fund.

BUDGET AND WORKPLAN The budget and workplan outline program implementation and the activities of any sub-recipients along with the associated costs. These are mandatory attachments to any funding request.

CO-INVESTMENT Refers to the harmonized and coordinated joint investment of public and private resources with the common objective to improve equitable access to and provision of health services.

COMMITTED FUNDS Funds that have been committed by the Global Fund Board for the first implementation period (years 1-3) of the proposal. The Board can only commit funds it has or expects to receive within the next 12 months.

(STAND-ALONE) COMPONENT Component is defined as HIV/AIDS, tuberculosis, malaria or cross-cutting health systems strengthening.

COMMUNITY SYSTEMS Community systems are the community-led structures and mechanisms used by communities, through which community members, community organizations and other community actors interact, coordinate and deliver their responses to the challenges and needs affecting their communities.

IMPLEMENTATION PERIOD The cyclical period of up to three years to which all Principal Recipients for a disease or cross-cutting health system strengthening program in a given country will align their Single Stream of Funding and thus financial commitments. This period is aligned to an in-country cycle (e.g. national fiscal or national programmatic reporting). The alignment is decided by the Country Coordinating Mechanism together with the Principal Recipients implementing in the disease or cross-cutting health system strengthening program.

CONSOLIDATED PROPOSAL Starting with Round 11, applicants will be required to submit a consolidated proposal. Consolidated proposals provide a complete programmatic picture of the entire disease or cross-cutting health system strengthening program for which the applicant is requesting funding for the duration of the proposal term (i.e. up to five years). Consolidated proposals give applicants the opportunity to reflect on the progress made toward addressing the disease with their existing Global Fund grants and propose a revised strategy based on the most relevant epidemiological or programmatic country context. This strategy should also build on lessons learned and adjust for any weaknesses or gaps identified in the course of implementation. On approval the consolidated proposal will be signed -

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ANNEX 4: GLOSSARY OF TERMS

- if the country *has not* transitioned to the new grant architecture for a given disease or cross-cutting health system strengthening program - into a single stream of funding agreement per Principal Recipient, which will replace the existing grant(s); or
- if the country is receiving funding for the first time for a given disease or cross-cutting health system strengthening program - into a single stream of funding agreement per Principal Recipient; or
- if the country *has* transitioned to the new grant architecture for a given disease or cross-cutting health system strengthening program - as an amendment to an existing single stream of funding agreement for a Principal Recipient. A newly nominated Principal Recipient in this situation would sign a new single stream of funding agreement.

COUNTERPART FINANCING The contribution made by the government of an applicant country to the national disease program.

COUNTERPART FINANCING THRESHOLD The mandatory minimum level of the government's contribution to the national disease program, as a share of total government and Global Fund financing for that disease.

COUNTRY COORDINATING MECHANISM This is a country-level multi-stakeholder partnership that has overall ownership of and responsibility for proposal development and grant oversight.

DISEASE BURDEN Official data provided by the headquarters of the following key partners per disease: HIV and AIDS: UNAIDS and WHO; tuberculosis: WHO; malaria: WHO. For prioritization purposes, disease burden is measured as low, moderate, high, severe or extreme.

DUAL-TRACK FINANCING The recommended inclusion of both government and non-government PRs in proposals for Global Fund financing.

ELIGIBILITY CRITERIA Determines which countries can apply for funding, the focus of the proposal and the components for which funds can be requested. Determination takes into account: disease burden; political commitment; the involvement of an inclusive CCM; and the poverty situation of the country in which activities will be implemented.

FUNDING, DOMESTIC In the context of the 'Financial Gap Analysis and Counterpart Financing Table', this refers to all current and anticipated domestic resources to meet the funding needs of the full national disease program. This includes: loans and debt relief, government funding resources, national private sector resource.

FUNDING, EXTERNAL In the context of the 'Financial Gap Analysis and Counterpart Financing Table', this refers to all current and anticipated external resources to meet the funding needs of the full national disease program. This can include: grants from international donors/organizations, contributions from the private sector outside the applicant country, etc. Global Fund resources are calculated separately.

GLOBAL FUND FINANCING In the content of counterpart financing, this is the annual average of financing requested and other existing Global Fund grants for that disease, for the first implementation period of the new proposal.

GOVERNMENT CONTRIBUTION In the content of counterpart financing, this is the annual average of that government's spending in the past two years and current government budget for the relevant disease program. Government expenditure is ideally measured as all government spending on the disease program, excluding external assistance other than loans.

GRANT AGREEMENT A grant agreement is a legally binding document that sets out the obligations of the Global Fund and the Principal Recipients. Each grant agreement is based on an approved component in a proposal.

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ANNEX 4: GLOSSARY OF TERMS

GRANT CONSOLIDATION Refers to (i) merging an approved proposal with an existing grant(s) for that Principal Recipient for the same disease or cross-cutting health system strengthening program, or (ii) merging two or more existing grants for the same Principal Recipient and disease or cross-cutting health system strengthening program into a Single Stream of Funding agreement.

GRANT START DATE The grant start date is the first of the month following the date on which the grantee receives funds into its bank account.

HEALTH PRODUCTS These are pharmaceuticals, other health products (e.g. insecticide-treated nets, laboratory and radiology equipment, and supportive products such as painkillers) and single-use health products (such as condoms, rapid and nonrapid diagnostic tests, insecticides and injection syringes).

HIGHEST IMPACT INTERVENTIONS Within a defined epidemiological context, these are evidence-based interventions that: (i) address emerging threats to the broader disease response; and/or (ii) lift barriers to the broader disease response and/or create conditions for improved service delivery; and/or (iii) enable roll-out of new technologies that represent global best practice; and (iv) are not funded adequately.

IMPACT The effect of (or the contribution of) an intervention toward the reduction or elimination of morbidity and mortality.

IN-COUNTRY STAKEHOLDERS These include the Principal Recipients, Country Coordinating Mechanisms, Sub-recipients, in-country development partners, civil society organizations, the private sector, and other entities engaged in the fight against AIDS, TB and/or malaria.

INCREMENTAL FUNDING AMOUNT The new funding being requested in a consolidated proposal (as opposed to the amount of existing and anticipated Global Fund funding from already approved proposals). Applicants must use the incremental request table provided in the budget template to show how they have calculated their incremental funding amount.

KEY POPULATIONS Key population groups include: women and girls, men who have sex with men, transgender persons, people who inject drugs, male and female and transgender sex workers and their clients, prisoners, refugees and migrants, people living with HIV, adolescents and young people, vulnerable children and orphans, and populations of humanitarian concern. Please refer to Annex 2 of the Round 11 Guidelines for examples of key populations per disease.

LOCAL FUND AGENT (LFA) Local Fund Agents are entities contracted by the Global Fund in countries with active grants to provide independent information, advice and recommendations to the Global Fund.

LOGFRAME A new tool for summarizing the proposal strategy, numbering the interventions, and clearly linking performance indicators with proposed interventions. All applicants are required to submit a logframe for each proposal, using the template provided.

MACROS Macros are elements of code within a document that provide easy-answer multiple-choice questions through the use of radio buttons, tick-boxes and drop-down menus. In order for this function to work, a user must enable macros on their computer. Many of the Round 11 application materials use macros.

MONITORING AND EVALUATION PLAN The Country Coordinating Mechanism submits a monitoring and evaluation plan as part of a proposal and it should present objectives, service delivery areas, indicators, and targets. The Principal Recipient is responsible for finalizing it at the grant negotiation and signing stage.

NONHEALTH PRODUCTS These are all products other than “health products” as described above. They include vehicles, computers, construction materials and services, such as technical assistance.

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OBJECTIVES Objectives describe the intention of the proposal and provide a framework through which services are delivered in order to achieve the goals of the program. An example is: “to improve survival rates in people with advanced HIV infection in four provinces.”

OVERHEAD COSTS Necessary (usually indirect) costs incurred for the effective management of a grant. These include: running costs such as rent, electricity, utilities, communication costs (mail, telephone, internet), insurance, fuel, security, cleaning.

PARTNERS Partners can be drawn upon throughout the grant process to help develop proposals, implement programs and evaluate program performance. Partners include multilateral and bilateral agencies, nongovernmental organizations, civil society organizations, private sector entities, and other development organizations that address HIV/AIDS, TB and malaria.

PERFORMANCE-BASED FUNDING This is a mechanism that links funding to the achievement of clear and measurable results. It promotes accountability and transparency, and provides incentives for recipients to use funds efficiently and effectively.

PERFORMANCE FRAMEWORK This is the formal statement of the performance expected over the grant period, which contains key indicators and targets, and is used to measure program outputs, coverage, outcomes and impact. All applicants are required to submit a performance framework for each proposal, using the template provided.

PERIODIC REVIEW Looks at the entirety of Global Fund funding for a disease or cross-cutting health system strengthening program in a given country. All Principal Recipients implementing in the program will be reviewed at the same time. The Periodic Review replaces the Phase 2 review, and is an in-depth assessment of programmatic performance and public health impact of activities supported by the Global Fund. Prior to the end of each Implementation Period, a Periodic Review of the disease or cross-cutting health system strengthening program is required.

PHARMACOVIGILANCE This refers to the detection, assessment, understanding and prevention of adverse effects, particularly long-term and short-term side effects of medicines.

PHARMACEUTICAL SYSTEM A pharmaceutical system consists of functions and activities to select, quantify, procure, store, distribute, use and monitor quality assured health products, which together represent the pharmaceutical sector within the health system.

PRIORITIZATION The mechanism by which proposals are prioritized for funding in the event that sufficient resources are not immediately available to approve all TRP-recommended proposals by the Global Fund Board. The criteria applied for prioritization of applications is dependent on whether a particular application is to the general funding pool or the targeted funding pool.

PRIORITY INTERVENTIONS Interventions (in the proposal) that are consistent with the priorities of the national strategy/national disease control program. Such priorities should be consistent with the current disease epidemiology and identified weaknesses and gaps in the proposal.

PRINCIPAL RECIPIENT A Principal Recipient is a legal entity that is responsible for the implementation of a grant, including oversight of Sub-recipients, grant funds, and communications with the Local Fund Agent, Fund Portfolio Manager and Country Coordinating Mechanism on grant progress.

PROPOSAL A proposal is made up of a proposal form, mandatory attachments and supporting documents. It is submitted to the Global Fund by Country Coordinating Mechanisms or other eligible entities in response to the Global Fund Board’s call for proposals. Proposals request funding for prevention, care and treatment of people and communities living with, affected by, or at risk from HIV/AIDS, TB and/or malaria.

ROUND 11 – GUIDELINES

ANNEX 4: GLOSSARY OF TERMS

RECENT FUNDING HISTORY In the context of the new policy on eligibility, applicants that have received funding for the same disease or cross-cutting HSS component which has been implemented for less than 12 months cannot submit a proposal for the same component. The 12-month period calculated from the implementation start date to the closing date for submission of proposals.

REPORTING CYCLES The period of implementation that is reported on for purposes of the Periodic Review. Under the new grant architecture, the applicant has more flexibility to set the start dates and review timelines of their grant(s) to correspond with national cycles and systems.

REPROGRAMMING (AT THE TIME OF A FUNDING APPLICATION) Applicants are strongly encouraged to assess the programmatic and managerial performance of their existing grants and to explore opportunities for reprogramming and modifying the scope of their proposed program going forward to incorporate any lessons learned.

(GLOBAL FUND) SECRETARIAT The Secretariat is responsible for carrying out the day-to-day operations of the Global Fund, under the guidance of the Global Fund Board.

SERVICE DELIVERY AREA This refers to a collection of key services to be delivered in order to achieve a specific objective. There may be one or more service delivery area per objective. For example, antiretroviral treatment and monitoring are separate service delivery areas aimed at achieving an improvement in survival rates among people with advanced HIV infection in a number of provinces.

SINGLE STREAM OF FUNDING (SSF) A core feature of the new grant architecture is the single stream of funding per Principal Recipient per disease or cross-cutting health system strengthening program. Each Principal Recipient will have one grant agreement only per disease and/or cross-cutting health system strengthening program, which will be amended each time additional funding is approved and at the time of Periodic Review. *Also see “Alignment” and “Grant consolidation”.*

SUB-RECIPIENT These are entities (government or non-government, big or small) receiving Global Fund financing through a Principal Recipient for the implementation of program activities. They are usually selected among stakeholders involved in the fight against HIV/AIDS, TB and malaria.

TECHNICAL REVIEW PANEL An independent, impartial team of disease-specific and cross-cutting health and development experts, appointed by the Global Fund Board to guarantee the integrity and consistency of an open and transparent proposal review process.

UNDERSPENDING Funds that have been disbursed to the PR, but have not been spent because the planned program activities are behind schedule.

UNDISBURSED AMOUNT The amount that has been committed, but has not yet been disbursed to the PR.

UNDERSERVED AND MOST-AT-RISK POPULATIONS Sub-populations, within a defined and recognized epidemiological context: (i) that have significantly higher levels of risk, mortality and/or morbidity; (ii) whose access to or uptake of relevant services is significantly lower than the rest of the population.