Guidance paper on Global Fund to fight AIDS, Tuberculosis and Malaria related activities in WHO

World Health Organisation
HIV/AIDS, TB and Malaria Cluster
Department of Country Focus
ACRONYMS

ACT Artemisinin-based combination therapies
AMR Anti-Microbial Resistance
ARV Anti-RetroViral
CCM Country Coordinating Mechanism
GDF Global TB Drug Facility
GFATM Global Fund to fight AIDS, Tuberculosis and Malaria
GLC Green Light Committee
HTM HIV/AIDS, TB and Malaria
ITNs Insecticide Treated Nets
LFA Local Fund Agent
MDR Multi-drug Resistance
M&E Monitoring and Evaluation
MoU Memorandum of Understanding
PSC Programme Support Costs
PR Principal Recipient
RO Regional Office
SR Sub-Recipients
TRP Technical Review Panel
UNICEF United Nations Children's Fund
UNDP United Nations Development Programme
UNDG United Nations Development Group
UNOPS United Nations Office for Project Services
UNTG United Nations Theme Group
WR/LO WHO Representative/Liaison Officer
GUIDANCE PAPER ON GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA-RELATED ACTIVITIES WITHIN WHO

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Part 1
Background

Purpose of this document

The purpose of this paper is to outline a strategy to guide WHO’s interactions with the Global Fund to fight AIDS, TB and malaria (GFATM) and its processes and related entities in countries. This is only a summary and further information is available in a variety of sources, some of which are listed in the Annexes, which also contain a list of Frequently Asked Questions. The document is an update of the WHO guidance released in 2003.

Origins and purpose of the Global Fund

- The GFATM was established in 2002 as a public-private partnership. Its aim is to mobilize rapidly significant additional resources for the fight against HIV/AIDS, TB and Malaria in developing countries, and by doing so support poverty reduction efforts and the achievement of the Millennium Development Goals.

- The GFATM and its Board are committed to remaining a financing mechanism and to not becoming an operational agency. In practice, its work is leading to the creation of new processes and structures at country level. However, as the GFATM does not have a permanent country presence, its success depends on the efforts of countries and the active collaboration of technical and development partners, including WHO.

- WHO has played a central role in the creation and development of the GFATM since it was first proposed at the 2000 G8 meeting in Okinawa. A close working relationship has been developed at many levels:
  - WHO (as well as UNAIDS and the World Bank) is a non-voting member of the GFATM Board, and WHO is currently an active member of three of the four Board Committees (currently under review);¹
  - WHO has been contracted to provide administrative services to the GFATM, through an Administrative Services Agreement.
  - At country level, WHO is active in over 80% of CCMs;²
  - Regional Offices and HQ are providing direct support to countries, and all are participating in Regional Meetings organized by the GFATM;
  - There are strong, ongoing links between WHO-HQ and the GFATM secretariat across a range of policy and technical issues.
  - WHO’s primary responsibility is to support countries in accessing and effectively using GFATM resources, while at the same time strengthening the health sector as a whole. This strategy therefore focuses on issues, approaches and actions relevant to WHO engagement with GFATM processes at country level.

Part 2

WHO collaboration with the GFATM

Principles

WHO’s primary responsibility is to Member States. WHO’s status as a specialized health agency should be used in order to help Member States access and utilize external finances - from sources including, but not limited to the GFATM - in ways that address priority health needs.

The GFATM is one important source of development finance among others. WHO therefore cannot be outside of the process; WHO should participate and ensure that GFATM grants complement domestic health financing and harmonize with support from other donors, in line with national priorities. An important premise of the GFATM is that its resources are additional, and should not replace existing domestic and external commitments. WHO fully supports the operationalization of the “Three Ones Principles” for HIV/AIDS, which should also guide GFATM-related programmes and structures.

WHO is committed to supporting national development processes: such as poverty reduction strategies, Sector Wide Approaches and national health policies and disease-specific programmes. Where sound national health strategies and plans exist, they should be reflected in GFATM proposals and implementation plans. In other cases, WHO support should strengthen national strategies using WHO technical standards and norms. Technical cooperation from WHO should not be restricted to specific projects, but should address all of the work of the government in that area. New threats and challenges (such as MDR-TB) may necessitate innovative approaches, linked to existing development plans.

Support for effective health systems. While the focus of the GFATM is on HIV/AIDS, TB and malaria, there is a need to strengthen the health system to deliver these interventions. GFATM support does not come at the expense of other health programmes. The GFATM now encourages applicants to address health system issues that strengthen the HIV, TB and malaria response in their proposals, including access to health services, surveillance, and human resource constraints. WHO should prioritize effective health systems, including access to medication, improving human resource capacity and institutional development in general.

Coordination with partners. The GFATM is generating huge technical cooperation needs at country level, which WHO cannot respond to alone. Responsibilities vis-à-vis the GFATM must be shared with other development partners in health. Coordination with UNAIDS and with the Roll Back Malaria and StopTB partnerships is particularly important. Coordination with the World Bank, Regional Development Banks, and bilateral agencies should also be pursued.

Providing technical support requires well-resourced institutions. As GFATM-related work expands, WHO and others are requested to provide increasing levels of technical support. WHO will endeavour to ensure sufficient resources are available to provide such support in a manner that does not reduce the effectiveness of expected results in other areas and partnerships. All technical support must be based on WHO policies, norms and standards.

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3 http://www.unaids.org/en/about+unaids/what+is+unaids/unaids+at+country+level/the+three+ones.asp.
4 This is a recent change agreed for the 5th round (details can be found in the proposal guidance).
Guidance on WHO’s role in working with the GFATM

Overarching

Given past experience, WHO has developed core guidance for country offices, which must be sensitive to variations across countries, and to what Member States may ask:

- WHO welcomes additional funding provided by the GFATM to countries in line with country plans and priorities, and driven by country proposals;
- WHO advocates that such funding be additional to existing national and international funding for the health sector;
- WHO supports the GFATM in building health systems to deliver HIV/AIDS, TB and malaria services;
- WHO will serve to support national authorities in enhancing donor coordination, including GFATM resources;
- WHO will be active in all aspects of CCM work as long as the integrity of the WHO mandate and role are not compromised. WR/LOs will work to ensure that WHO technical guidance is adhered to in country proposals;
- WHO supports the premise that CCMs be inclusive of all partners at country level.
- WHO country offices should not accept the role of Principal Recipient, except under very exceptional circumstances, and only after discussion with Region and HQ.
- WHO can be a sub-recipient and contractor, but this must be within the broader WHO country and regional office expected results. WHO does not submit to tenders organized by the CCM or PR, but can enter into agreements with countries;
- WHO should assist countries to monitor and evaluate their GFATM-related grants, but should not be held responsible for guaranteeing the accuracy of the data generated, unless this has specifically been agreed;

Country Coordinating Mechanisms (CCMs)

The GFATM describes the CCM as a “national consensus group”. It “facilitates the proposal development process, including the translation of national strategies into concrete implementation plans with clear responsibilities, timing of activities, budgets and expected outcomes; approves and endorses the final version of a single coordinated country proposal; and plays a major role in monitoring and follow up on the implementation of proposed activities”. CCMs involve a range of partners, including civil society, the private sector, Ministry of Health and other government ministries. In some countries they are formed around existing coordination mechanisms, such as the UNTG on HIV/AIDS. For regional GFATM grants, regional CCMs may be established.

WHO membership of the CCM is a country-led decision, but WR/LOs and technical staff are encouraged to participate fully. They can help promote public-private partnerships, and play a key ‘brokering’ or ‘facilitating’ role bringing stakeholders together, achieve consensus, mobilize timely and appropriate support, advocate national health needs and priorities, and lead technical working groups. Where WHO is not a member of the CCM it should seek to be recognized by the CCM as a principal source of technical advice and support on health-related matters.

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6. A complete list of CCMs can be found at: http://www.globalfundatm.org/proposals.html.

7. For instance, the Pacific Islands have been submitted a successful application to the GFATM and are now operating through a Technical Working Group which covers several countries in the region.
Box A

**Issues and challenges associated with WHO's role in CCMs**

- **Inactive or ineffective CCMs:** In some countries, CCMs meet infrequently and/or have little real debate. CCM members are then asked to endorse proposals which they have played little or no role in developing. In other countries, CCMs are reported to be unmanageably large, resulting in ineffective working methods and logistical difficulties (such as time-consuming collection of signatures). The GFATM is actively monitoring the effectiveness of CCMs, and has requested examples of good and bad practice from CCM members and partners. The Governance and Partnerships Committee has developed a series of new recommendations to strengthen CCMs.

- **Conflict of interest:** There have been instances where some CCM members have perceived a conflict of interest between WHO's involvement with proposal development, and possible financing received by WHO during implementation. Given that a similar conflict would apply to other CCM members with a role in proposal implementation, neither WHO nor the GFATM see this as a reason for not participating in CCMs.

- **Managing a divergence of views within CCMs:** In one country, WHO was pressured by a donor group to join it in pushing the government to include a particular health programme in the GFATM proposal, as a prerequisite for endorsing the proposal. The WR resisted this pressure as s/he felt this was inappropriate in the context of the needs of the country. The size and nature of CCMs means that managing a divergence of views and approaches may sometimes create difficult and delicate situations in many countries. WR/LOs should not hesitate to seek support from regional colleagues in these instances.

- **Linkages between CCMs and other relevant committees:** In many countries the links between the CCM and other coordinating mechanisms, including the UN Country Team, the UN Theme Group on HIV/AIDS etc. are not optimal. This creates concern about duplication, and about the marginalization of existing mechanisms. WHO Country Teams should facilitate information exchange and coordination between the different mechanisms of which they are members.

- **Regional CCMs:** Additional information and experience is needed on how country offices should be involved in regional CCMs.

Box B

**WHO role in development of proposals to the GFATM**

1. At the request of the government or CCM, WHO will provide technical assistance in the development and revision of proposals to the GFATM. In order to ensure timely development and submission of proposals to the GFATM, the HTM cluster will coordinate provision of technical assistance with regional and country offices jointly with clusters/units responsible for health systems.

2. The WR/LO is responsible for coordinating WHO input into the proposal development process at the country level. If the country office does not have sufficient capacity in the technical area concerned, staff or consultants from the regional office and/or HQ will be made available to provide such assistance.

3. The role of WHO should ideally be made clear in the proposal so that there is a consensus in the CCM at the time of submission. WHO collaboration, for example in CCMs, should be documented, as well as agreement on the use of WHO technical standards and norms; WHO support to specific projects should be clarified and budgeted for.

4. WHO Country Offices should encourage countries to form a technical working group (or groups) to support development of proposals, and should assist in facilitating or leading such groups. WHO Country Offices should also work closely with the UN Country Theme Group and coordinate with the UNAIDS Country Coordinator to ensure optimum collaboration among UN partners and to best utilize specific UN agency expertise.

5. Prior to submission by the CCM to the GFATM, WHO should reach a judgement on whether the submission is consistent with WHO technical policies and guidelines. This is the responsibility of the WR/LO who must ensure that the proposal conforms to WHO policies and before signing the proposal as a member of the CCM. WHO HQ and regions will make available the relevant technical policies and guidelines, and the WR/LO can ask for the proposals to be reviewed by appropriate technical staff at the regional office and/or HQ.

6. This should be an iterative process, and allow for WHO concerns to be made known in time for modifications to proposals to be made, if the country or CCM wishes to do so. To facilitate this, those working with the GFATM across WHO will track proposals known to be in development.

7. The above also applies in cases where WHO has not been involved directly in proposal development. (The above is an updated version of a memo sent by the DG to all Regional & Country Offices)
Box C

Issues/procedures for WHO involvement in 2nd Phase renewal of grants

- WHO country offices should keep track of the implementation of GFATM grants - with the purpose of identifying constraints and taking remedial action. WHO WR/LO should keep ROs and HQ apprised of issues that arise at country level particularly as they threaten the potential success of a grant or fundamental development relationships.

- The GFATM is in the process of establishing an “Early Warning System” for identifying grants that are facing significant difficulties with implementation and are not meeting intended targets. Such grants are subsequently designated as ‘poor performing’ and face the risk of discontinuation after 1st Phase, unless performance improves.

- For grants that are designated as ‘poor performing’ the country office needs to initiate a process to review factors associated with the poor performance and recommending remedial action. The regional office and HQ will be available to assist the Country Office in both the review and in addressing identified constraints.

- In the event that a TRP or secretariat recommends “no go” for 2nd Phase, the Country Office might need to gather information and prepare a dossier that outlines why the grant should or should not be given the chance to proceed to inform dialogue among GFATM Board Members and the CCM. Advocating for proceeding should only be done where the WR/LO determines that there exists a reasonable possibility that implementation will improve or where it is felt that the assessment was not satisfactory. Ideally, WR/LOs will have been proactive in addressing the situation before such a “no-go” situation is announced.

Box D

Issues/ procedure for WHO involvement in grant negotiations

- Once a proposal is approved, WHO liaises closely with the CCM and with the regional office and HQ to identify issues for clarification raised by the TRP and provide support to respond to those clarifications as quickly as possible.

- After clarifications have been made and accepted by the Fund, WHO may work with the Principal Recipient to draw up a plan for developing an implementation plan, M&E plan, procurement and supply management plan and programme management plan in preparation for grant negotiations.

- The country office should identify as early as possible during the proposal development technical assistance needs required throughout the entire cycle. This should document WHO’s potential contribution and resource needs.

- WHO may be requested to assist Sub-Recipients to develop implementation plans and define management arrangements - in readiness for SR assessments.

- Country offices should participate in grant negotiations between PR and Portfolio Managers, where appropriate - to provide clarifications, identify issues to be addressed, and provide contextual information.

- After the grant agreement is signed between the PR and GFATM it is useful to review the implementation, PSM, M&E plans and begin discussions with PRs and SRs on the type and timing of technical assistance to be provided by WHO (and others) during implementation. Ideally this will have been outlined in the proposal itself, but supported through separate financing; however, in some situations it may have to be budgeted in the proposal.

Principal Recipients

Principal Recipients (PRs) are the entities to which GFATM grant funds are disbursed. They are responsible for implementation, accountable for the grant to the GFATM, and are legally liable for the grant and its activities. They should be legally constituted entities which can enter into a Grant Agreement with the GFATM. The PR also manages allocation of resources to sub-recipients.

Principal Recipients are expected to be national institutions or local stakeholders – from government, civil or the private sector. Where local capacity is weak, the PR may be a multilateral institution – but the GFATM has indicated that this is an arrangement “of last resort”. In such cases,
UNDP is the GFATM’s preferred UN agency to take on the PR role and a global arrangement between the GFATM and UNDP has been established.

Many countries have requested that WHO take on the role of PR. However, this issue has raised a number of concerns. WHO country offices may lack sufficient capacity to function as PR, and assuming the PR function may place WHO in a supervisory position over the Ministry of Health, possibly compromising the relationship and technical advisory role with MoH. Also, the PRs are subject to financial and capacity assessment by an “LFA” (see section below), which may conflict with WHO rules and regulations. The GFATM is also concerned about perceived conflict of interest; WHO is a member of the GFATM Board and advises on the selection of the Technical Review Panel. UNDP has no such links with the GFATM Board or Secretariat. WHO should carefully delineate its responsibilities with UNDP given WHO’s responsibilities and mandate.

Country offices, therefore, should not accept the role of PR. If neither national institutions nor the local UNDP office are able to assume the responsibility, and WHO is suggested as an alternative, the matter should be first taken up with HQ and the Regional Office, where it might be considered in exceptional circumstances. Experience is growing however of WHO as a sub-recipient; for example TB grants as agreed in Indonesia and Myanmar, and under discussion in Tajikistan and Romania, and HIV/TB in the South Pacific Islands regional grant.

The preferred role for WHO is working with the PR to support building capacity within national authorities and working with other CCM members to support implementation. While WHO’s principal obligation is to Ministries of Health, country offices may provide technical support to other kinds of PRs, including UNDP and NGOs, if capacity is available. WHO can also play an important facilitation role in mobilizing support for PRs among other development partners.

In ‘poor performing countries’, WHO’s role is to understand the technical reasons for the delay, and negotiate with the PR, CCM and the GFATM on remedial action. WR/LOs are encouraged to communicate any problems early on to RO and HQ GFATM focal points to assist in tracking such issues and assist in problem solving.

Local Fund Agent

The GFATM describes the LFA as its “eyes and ears at country level”. Its main responsibilities include assessing PR capacity prior to the first disbursement of funds, periodic verifications of results achieved, and ensuring financial accountability throughout implementation of the grant. The initial assessment is in four areas: Financial Management and Systems; Institutional and Programmatic; Procurement and Supply Management; and Monitoring and Evaluation. After this assessment, PRs are asked to write a 12-month workplan which the LFA then reviews. Disbursement of the first tranche of funding is provisional on the approval of this workplan. The LFA does not manage or implement proposals.

To date, the GFATM has contracted six agencies to work as LFAs at global level: Price Waterhouse Coopers, KPMG, UNOPs, UK Crown Agents, Deloitte-Touche, and the Swiss Tropical Institute. Some GFATM Board Members have expressed concerns that the contracted LFAs do not have adequate country-specific knowledge or technical expertise in health.

There are unlikely to be circumstances in which WHO will be asked to assume the LFA role. In some countries, LFAs have asked WHO to assist their technical assessment of the PR, for example by asking WHO to recommend procurement experts. In one case, the LFA wanted to subcontract the entire technical assessment of the PR to WHO. While WHO should be engaged with LFA processes and facilitate the provision of expertise and support where possible, WHO should not be directly involved in the implementation of the LFA assessment, as this may compromise relations with Ministries of Health and other partners at country level.

9. See contact information on UNDP in Annex X.
**Monitoring and Evaluation**

If the GFATM is to continue to attract international support, it must demonstrate that its funds are used appropriately and produce the desired results. The GFATM is a performance-based aid instrument, and requires that financial disbursements be based on reported results. After two years, the GFATM carries out an assessment of ‘achievements so far’ which determines whether funding is continued, known as the ‘Phase Two’ process. This begins at the 16th month of a grant, when the CCM is invited to submit its results for the grant. The CCM then has two months to submit the report, and another two months are allowed for a decision to be reached to continue the grant, modify it, or terminate it.

The ability to carry out M&E is an important component of the PR assessment and grant negotiation processes. WHO has been called on to a) provide the consensus toolkits for HIV, TB and malaria, b) assist countries develop their M&E plans, c) assist in implementing aspects of a GFATM funded M&E system for a grant, and d) review data generated by the national M&E system.

Countries should be encouraged to seek technical assistance from local institutions or from WHO to develop and improve M&E systems. WHO country offices as well as the regional and HQ level need to enhance their capacity to provide this support to countries. Other international agencies such as UN system, bilateral agencies, NGOs and academic institutions could be called upon for support. Areas in which support might be required include improving national health information systems, disease surveillance systems, operational research, survey methods and data analysis.

**Procurement**

A significant proportion of GFATM resources will be used by countries to procure essential medical drugs and supplies. In the first four Rounds, roughly 50% budgeted for the first two years of approved proposals is earmarked for drugs and commodities. WHO has an important role to play in providing related guidance. Key points include:

- **WHO encourages the use and improvement of existing national public procurement mechanisms.** Where existing systems are not optimal (for example, high prices are paid for medicines or there are losses or delays in distribution) they may need to be strengthened and WHO should provide or facilitate the necessary support. In this context the existing procurement system should be assessed and a plan for strengthening it established.

- **WHO should only become involved in procurement if the LFA has assessed the PR and found it to have inadequate capacity to procure, resulting in the PR requesting support from WHO.** This should only be accepted where WHO has sufficient capacity, which varies from country to country, and agreed back-up from region & HQ.

- **WHO should encourage CCMs to seek expert advice on procurement during the development of proposals and (if proposals are successful) workplans.** Regional offices and HQ can facilitate this process by making expertise available on issues relating to procurement, including: generic medicines; the WHO pre-qualification project; sources and prices of medicines and commodities; treatment guidelines; and WHO principles on Good Pharmaceutical Procurement.

- The Fund asks PRs to seek the lowest possible price in its procurement of medicines, and to this end will be publishing prices paid on a public website. WHO should work with countries to help achieve low prices, for example through information sharing on current medicine prices offered by suppliers and through bulk purchasing. Where pooling mechanisms already exist (e.g. the Global Drug Facility for TB drugs and diagnostics) these should be used, if countries agree.

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11. Further information on WHO Essential Drugs and Medicines (EDM): http://www.who.int/medicines/.

WHO and UNAIDS, together with other agencies such as UNICEF and the Clinton Foundation, have created processes for groups of countries to negotiate with the pharmaceutical industry for lower prices on HIV/AIDS drugs. Countries are encouraged to make use of these provisions.

Countries requesting second-line TB drugs are required by the GFATM to apply to the Green Light Committee (GLC) for approval and technical assistance. The agreement made between the GLC and the GFATM is a good example of a formal acknowledgement and use of existing procurement mechanisms.

WHO through the work of the Pesticide Evaluation Scheme (WHOPES) provides information on appropriate specifications for insecticide treated nets (ITNs) and insecticides used in malaria control programmes. Also through its cooperation with UNICEF, WHO is working to assist countries to access conventional or long-lasting treated nets at the lowest price by taking advantage of the economies of scale afforded by forecasting net requirements. GFATM grantees are encouraged to use these mechanisms.

In response to the increasing drug-resistance in malaria, countries are advised to adopt combination drugs for treatment, preferably ACTs. WHO and other collaborating partners will assist countries in the procurement of these drugs. For the procurement of one ACT (artemether-lumefantrin), WHO has an agreement with manufacturers at a preferential price.

WHO should encourage and provide necessary PR assistance, when required, for quality assurance in commodity management. This involves an assessment of quality assurance mechanisms in the country, and facilitation of planning to strengthen such mechanisms. WHO has a list of pharmaceutical companies meeting the quality criteria, which could be a valuable technical resource to recipient countries.

WHO recommends that countries intending to increase access to treatment for HIV, TB and malaria also concurrently introduce or strengthen systems for antimicrobial resistance (AMR) surveillance and containment. The GFATM also strongly recommends that some portion of funds received is obligated to monitor and by extension contain AMR in HIV, TB and malaria.

Since some medicines and commodities purchased through GFATM will be distributed for free, it is possible that the demand will outstrip the supply, and sustainability of the programme will not be maintained. WHO should play an active role in providing advice on how to ensure that GFATM interventions reach those most in need, compliment existing programmes, and become sustainable in the long term.

Management and governance

WHO is able to support the GFATM process in countries managerially as well on governance matters. For example, assistance on regional representation to the Board, or on levels of discretion on policy issues. In any country, issues of governance arise, such as what NGO should be represented and how academics can be involved.

Part 3

Communicating with the GFATM

Formal communications between countries and the GFATM are made via the CCM or the PR. WHO's country, regional and global network can facilitate this process: in some countries, WRs/LOs have served as the focal point for communication among CCM members, MOH and the GFATM. In other countries, WHO has served as the chair of the Technical Working Group(s) under the auspices of the CCM.

One issue that has arisen is that certain CCM members have wanted to communicate concerns directly to the GFATM (for example, about the functioning of the CCM and/or the proposal submitted). GFATM CCM guidance now states clearly that CCM members can communicate directly with the GFATM secretariat if there are any problems or concerns about GFATM related processes (see focal points in Annex 1).

On issues related directly to WHO's collaboration with the GFATM, good communication links have been established between the GFATM secretariat and WHO-HQ, and with all regional and some country offices. For formal communications (for example relating to participation in Board Meetings), HQ (HTM/ADGO) remains the primary point of contact together with disease-specific focal points. However informal communications between the GFATM Secretariat and regional offices are well established. WPRO and AMRO have dedicated GFATM focal points covering all three diseases and communicating directly with the GFATM Secretariat. Other regions have assigned similar responsibilities to one of their Communicable Disease Directors, or HIV, TB and/or malaria officers. In EURO, the Director of the Division of Country Support is the regional focal point for GFATM related issues and works with relevant technical units. These arrangements ensure that queries from country offices are answered fast and that information from the GFATM is passed quickly to country level.
Part 4

Resource implications for WHO

Programme Support Costs

There are two options for WHO’s work:

- **remittance by GFATM to UNDP for remittance to WHO:** This is covered by the UNDG Guidance Note on Joint Programming.\(^{17}\) WHO would be receiving funds through UNDP (which would charge a 1% administration agent fee) under the ‘pass-through’ option and would charge normal PSC (using the options below) for funds recorded under the Voluntary Fund for Health Promotion (VFHP).

- **remittance by GFATM to country (PR) for remittance to WHO:** The provisions as per the ‘Operational Guide to PSC’\(^ {18}\) apply, as described below:
  - emergency procurement to Member States and NGOs: 0% PSC
  - non-emergency procurement to Member States and NGOs: 3% PSC
  - all other procurement (other than above): 6% PSC
  - activities other than procurement: 13% PSC (if overall budget comprises more than 80% for procurement of items, e.g. bulk purchases, the PSC rate would be 6% applied to the overall budget).
  - funds received by WHO for emergency situations are charged 6% PSC only when the two following conditions are met: - (a) a UN-CAP (UN Consolidated Appeal), a Flash Appeal or a WHO Appeal and, (b) HAC/HQ having cleared and/or co-managed the appeal for funds.
  - for “3x5 HIV” work, 6% PSC would be applied.

Subcontracting WHO services

Some PRs have requested that part of their GFATM grant be used to subcontract technical support and advice from WHO. PRs are free to use resources however they chose, providing that this is agreed within the CCM. In some cases, this technical support has been budgeted in the proposal submitted to the GFATM. This is not the preferred route for WHO to obtain financing, but if it is necessary, activities should be agreed before completion of the proposal, to avoid unnecessary bidding processes. WHO inputs may take two forms: technical assistance to be supplied by WHO, and subcontracting for specific activities such as M&E or Training. Examples where this has happened include South Pacific Grant (HIV/TB), Indonesia and Myanmar (TB), Angola (Malaria) and Zimbabwe (ARVs, with UNICEF).

Collateral Funding (i.e. funding from sources other than GFATM grants)

WHO’s view is that whenever possible non-GFATM grant funding should be sought for GFATM-related activities at WHO. Such fundraising activities should ideally be coordinated by designated focal points in HQ and regional offices. WHO is also working with the GFATM secretariat to raise awareness of the resource implications of GFATM-related activities. WHO will look to their support for efforts to raise additional resources. To make a strong case for this collateral funding, WHO departments in HQ, regional and country offices should track financial costs and human resource requirements to WHO of supporting GFATM-related activities at country level.

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18. Also see Resolution WHA34.17.
Part 5

Summary of WHO response to working with the GFATM

Country offices

The establishment of the GFATM is creating significant demands on WHO country offices. WR/LOs and technical staff have been called on to assist in the creation and functioning of CCMs, including facilitating coordination among major stakeholders; to provide technical support in the development of proposals and, where proposals have been successful, to help respond to TRP questions and assist in grant negotiations. As GFATM grants move progress with implementation, the level of demand on country offices is likely to increase dramatically.

It is critically important that the WR/LO and his/her staff remain up-to-date with the dialogue in the country related to GFATM proposals and their implementation, and share this communication with regional offices and HQ. This is particularly important when problems arise.

Country offices should continue to be proactive in initiating requests to the regional office and HQ for support. Technical expertise can also be mobilized from within the country, where possible in the context of the UNTG on HIV/AIDS and the UN Country Team. A key role for WHO will be ensuring that GFATM grants are consistent with national policies and international guidelines, and do not lead to implementation structures being built in parallel to national programmes.

WR/LOs might assign a staff member to be the focal point for GFATM-related issues. Adjustment of WHO biennial agreement and/or Country Cooperation Strategies or equivalent papers (e.g. Country Strategic Health Needs Report in EURO) may be needed as a result of a successful GFATM grant. On an occasional basis, HQ collates information on the time and cost implications of assisting countries for their GFATM grants. As such, it is helpful if country, regional and HQ offices/departments routinely track efforts and costs.

Regional offices

WHO ROs are assuming an increasingly proactive role in supporting countries vis-à-vis GFATM processes, and some now have dedicated focal points for GFATM activities. In addition, some ROs have established direct links with the GFATM Secretariat and are themselves important sources of technical advice for GFATM staff negotiating grant agreement with countries. Examples of RO initiatives on the GFATM include:

- Consultancy missions to countries to assist in the development of the proposals
- Establishing a peer review process for draft proposals to ensure consistency with WHO technical guidance
- Providing support for a group of countries to develop a regional proposal.
- Sharing up-to-date information/guidelines from the GFATM with country offices.
- Establishing regional working groups on the GFATM, and facilitating communication between the GFATM, PRs, LFAs through dedicated regional meetings, and through side events at regional level
- WR meetings. (For regional meetings initiated by the GFATM, it is recommended that WHO’s
role be that of host rather than convener, and that the GFATM be asked to cover costs and issue invitations)

• Documenting best practices vis-à-vis GFATM processes, in particular on proposal development and preparing a database of proposals which allows for an analysis of successful versus non-successful proposals

• Identifying partners for technical support and capacity building during implementation

• Hosting constituency meetings prior to GFATM Board Meetings which facilitates the selection of representatives to the Board and allows regional groups to come together and agree a joint position to be taken to the GFATM Board (if requested and agreed by the Member States).

• Regional procurement, as in AMRO/PAHO which undertakes procurement, with or without technical cooperation, through existing mechanisms for large purchases, gaining on negotiated prices.

**Headquarters**

The role of HQ in relation to the GFATM encompasses two main areas: within WHO, providing support and strategic guidance to regions and countries, and working directly with the GFATM. Key functions include:

*Within WHO:*

• Coordinating policy development within WHO in relation to GFATM processes

• Disseminating information on GFATM policies and activities to COs, ROs and relevant technical departments

• Strengthening networks within and outside WHO, in order to support the GFATM process at the country and regional levels

• Providing technical assistance to recipient countries through COs and ROs, as requested

• Coordinating efforts to mobilize additional resources to support country and regional offices

• Developing departmental plans on provision of support to countries and regions, making available the necessary information, tools and normative guidance for implementation, and coordinating across the three disease programmes

*With the GFATM:*

• Serving on the GFATM Board and Board committees and providing rapid feedback to regional and country offices

• Providing direct technical advice to GFATM secretariat as it develops policy in a broad range of areas, from monitoring and evaluation to portfolio management

• Working with the GFATM to ensure criteria for acceptance of proposals including adherence to WHO technical guidance

• Advocating for greater international support and resources for the GFATM.

• Liaison between GFATM portfolio/cluster managers and WHO RO/COs, GDF, GLC, etc.

**Learning from WHO work**

It is important that WHO learns from its interactions with the GFATM and its support to countries on GFATM processes. The impact of GFATM resources on national disease-control strategies, and
on efforts to strengthen related health systems, will be assessed. In addition, synthesis of the experience of country offices in participating in CCMs and working with LFAs and PRs, will be collated.

This learning will provide an important contribution to WHO’s “institutional knowledge bank” in general and to efforts to strengthen country offices in particular. In addition, it can be fed back to GFATM structures, for example through GFATM Board and Committee meetings, and thus help to improve GFATM policy and practice. Issues relevant to the second objective include: functioning of CCMs (including the role of UN Theme Groups) and LFAs; problems with using the proposal form and guidelines; implementation issues and problems; and additionality of resources.

On additionality, country offices are encouraged to work with others involved in this, such as the World Bank and IMF, to strengthen monitoring of financial data which will show whether GFATM monies are truly additional. One of the key principles of the GFATM is that its resources are additional to regular sources of funding, and it has stated that it will withdraw from a country if it sees that GFATM monies are being used to replace funding from existing budgets. In this regard, it is important to examine both activities at the country level and changes in regular donor contributions.

Efforts to learn from WHO work with the Fund should be continuous, but may need to be brought together systematically and periodically, for example in regional meetings or information gathering exercises. Mechanisms for more effective collaboration within and across all levels of the Organization (COs, ROs, HQ and various respective technical units) will be explored. WHO HQ will continue to work with ROs and COs to monitor GFATM-related implementation and identification of bottlenecks.

The process of gathering input from regional and country offices on this guidance has been an important first step in learning lessons on WHO’s work with the Global Fund. Further feedback will be sought for each new update.
List of contacts and information sources

<table>
<thead>
<tr>
<th>Topic</th>
<th>Name</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO: some contact persons for more information on working with GFATM HQ focal points for GFATM</td>
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</tr>
</tbody>
</table>

Web-sites and key documents online

Global Fund Observer http://www.aidspan.org/gfo
Frequently Asked Questions

Q1: What type of contract should be used for WHO dealings with the CCM and GFATM Principal Recipients?

A1: WHO is a member of the CCM, and no formal contract is required. For the PR, a standard WHO donor agreement can be used signed by WR, and approved by RD (as is the case, for example, for TB in Indonesia and Myanmar). Also, a Letter of Exchange (related to an MoU) has been entered into between WPRO and the Secretariat of the Pacific Community – in this case, WHO is a sub-recipient.

Q2: Since Health Systems are extremely important for the success of GFATM grants, and this is now recognized, how can they be strengthened through GFATM grants?

A2: It has now been agreed that Round 5 proposals can cover health system components directly linked to the delivery of services for the three diseases; however it up to the country/CCM to provide the evidence for this link in the proposal, which has been difficult in the past. The health systems groups and HIV, TB and Malaria groups in Regions and HQ can provide assistance for this aspect.

Q3: What are the pros and cons of WHO staff serving on the Technical Review Panel? Is there any experience of this happening?

A3: WHO’s main role in dealing with the Technical Review Panel is to respond to queries, update the TRP on relevant matters, observe and learn from the process, and encourage feedback. Some WHO staff are serving on the TRP in their own capacity, mainly because they had links with the GFATM before coming to WHO. All TRP members are acting in a personal capacity.

Q4: When there are negotiations underway between Principal Recipient and Portfolio Managers, in what capacity can WHO be involved? What is our mandate?

A4: There is often a lack of transparency, with obvious bottlenecks not being discussed openly. There is no formal system to guide WHO engagement, or to provide a clear mandate. WHO should aim to facilitate relations, where possible, and engage on resolving bottlenecks, using WHO’s privileged relations to provide access to key people. WHO should always be willing to help.

Q5: For ‘high level’ engagements, such as the ‘early warning and response system’, shouldn’t joint WHO-GFATM working groups be established, with HQ, Regional Offices and GFATM? Why are we waiting for GFATM to establish such systems – should not WHO be doing this?

A5: WHO needs its own ‘early warning system’, with WHO at country level alerting the rest of the organization when problems arise. In parallel to this, WHO will work with the GFATM ‘early warning system’, but will not be dependent on it. More information on this will be made available later from HTM, Geneva.

Q6: As more work is required on GFATM related issues, where are the extra funds for technical assistance going to come from? How can WHO be reimbursed for its work on GFATM proposals or for unexpected extra work not covered by proposals?

A6: WHO’s first aim is to ensure that there are sufficient resources available to provide the necessary support for implementation of proposals. WHO prefers to obtain financial support from sources other than the GFATM grant, such as country or regional donors, or as part of global donor agreements. Using GFATM grants as a source has not been promoted, as this may compromise WHO’s normative role, and affect support to areas not supported by GFATM grants. However, experience of WHO receiving resources through GFATM proposals is growing.

Q7: When the PR has been assessed by the LFA as “non-capable” to undertake its own procurement, and WHO is asked to take this on, how can it deal with local procurement?

A7: Many country offices have limited procurement capacity, and WHO should not normally take on this responsibility. Even for international procurement, this should ideally only be done when there are robust mechanisms in place to provide back-up, such as with the Global TB Drug Facility. However, in some countries the situation may allow WHO local procurement, but we should be very cautious about this.

Q8: What are the main causes of delays for ARV procurement? What can the PR or WHO country office do to speed up the process?

A8: There are numerous constraints to ARV procurement, as this is more complicated than for most other drugs, and WHO has very limited experience in doing this. If a WHO country office has been asked to take on this role, it should do its ‘homework’ to fully realize what it is getting itself into (various therapeutic protocols, registration and patent issues, etc.), and should be cautious about raising false expectations of fast deliveries.

Q9: What is the relation between Global Fund and sector-wide approaches in health at country level?

A9: The GFATM is trying to achieve greater harmonization of Global Fund financing with other donors and existing systems at country level. According to Richard Feachem’s speech in a recent Board meeting, they want to become a mechanism that seamlessly funnels resources into the scaling up of existing responses to the diseases, rather than establishing parallel activities. To date, GFATM grants are part of SWAs or Common Funds in Ghana, Mozambique and Zambia, and this is underway in the Malawi SWAp; this will expand if there is demand by the country and the SWAp is operational. The GFATM will be adjusting operational guidelines to allow a more systematic approach for aligning with SWAs. (see Tanzania, Arusha, 9th Board meeting 18-19 November 2004).
Example of GFATM-related monitoring of Technical Assistance (WPRO)

TENTATIVE PLAN OF WHO TECHNICAL ASSISTANCE NEEDED FOR GFATM-FUNDED PROJECTS THROUGHOUT 2005

### EXTERNAL CONSULTANTS

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<tr>
<th>Country Component</th>
<th>Area of Technical Assistance (TA)</th>
<th>Type of professional needed</th>
<th>Level of staff needed</th>
<th>Time needed</th>
<th>Type of contract</th>
<th>Overall estimated cost (salary + PD + travel)</th>
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<td>International</td>
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### WHO STAFF ESTIMATED TIME FOR GFATM-FUNDED PROJECT (2005)

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<th>Country Component</th>
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<th>Type of professional needed</th>
<th>Level of staff needed</th>
<th>Time needed</th>
<th>Staff from CO/RO or HQ?</th>
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