Summary to assist Group work

Best Practices

Country Dialogue

- Team work and leadership by the CCM
- Created a platform for **multi-stakeholder engagement** (national programmes, bilateral, KAP, civil society, etc) during country dialogue - identifying priorities, gap analysis and resource allocation.
- TB and HIV programmes working together for joint programming and **priority settings**
- **Joint writing team** convened by a CCM nominated chair facilitated process
- Specific efforts to engage TB stakeholders
- Involvement of all stakeholders in the process promotes **ownership** of the CN
- Intensified and expansion of existing collaborative TB/HIV activities
- Dialogue was good based on country data of service provision;
- Country dialogues involving variety of stakeholders
- Consensus on disease split decision through wide consultations (e.g. TB benefitted in Malawi)

Concept note process:

- Use TB/HIV module team (Kenya) or Use of one task force (Tanzania) for the CN writing process.
- Joint programme areas identified for Harmonization of key interventions
- High partner support
- CN based on national strategic plans and robust epidemiological analysis (evidence based)
- Both programs have a costed NSP which forms the basis for the grant application
- Peer review organized by WHO and partners very useful in finalization of CN
- Continuous engagement of the Global Fund country team to clarify issues
- Encouragement of GF of country ownership as countries need to provide counter funding

Implementation:

- Kenya’s experience where both the heads of TB and HIV program managers report to the same director – Facilitated easy working together.
- Provided opportunity for establishing/including one stop centers for implementation of activities
Bottlenecks/Challenges

Country level
• Historically vertical nature of the programmes making integration of planning and services difficult
  – separate funding lines
  – different Policies and management structures
  – different HR cadres
  – HIV and TB programme strategies have different timeline in countries
• Low baseline coverage of intervention in the country e.g. ART
• Ambitious targets not possible due to large funding gap (100% ART, PITC, PMTC, pediatric HIV)
• Unclear commitment from partners for country to come up with the clear programmatic and financial gap analysis
• Lack of up to date programme data
• Difficult to agree on the priority between HIV care (ART!) and prevention
• Fear of one programme overshadowing other
• Affects ongoing programme activities as same people are involved
• Differences in geographic distribution of diseases make it difficult to decide on resource allocation
• Country dialogue:
  – Suboptimal engagements among other non-technical stakeholders and suboptimal ownership of the process
  – Time consuming, lengthy and highly technical especially for the non technical stakeholders
  – Most disease specific CBOs do not have adequate capacity for other disease (more appropriate for HIV CBOs as larger in no)

Global Fund process:
• New process lack of prior experience in CN writing
• Changing or unclear guidelines with different interpretations of the CN development process and incomplete guidance by country team
• Long time consuming exercise
• Complexity in template and terminology used in the CN writing
• Complexity/challenges in Single CN very heavy on the HIV side >TB
• Difficulty using CN templates especially the budget templates not user friendly
• Extended repetitive discussions and justifications during each part of grant application to approval process
• Existing management structures for grant implementation necessitates two separate grants in some countries, but there is risk of business as usual
• Limited support from Global Fund country teams or comments are received late in the processes
• GF push for inclusion/deletion of specific interventions in some instances, overriding country decisions in some instances
• Costed NSP not considered during the grant negotiations by GFATM (different teams, different opinions)
• Non-engagement of technical stakeholders in grant making and decision only done by financial officers
**Opportunities**

- The two programmes to leveraging on each others respective knowledge, skills and strengths
- Joint programme implementation in terms of supervision, monitoring and supervision
- Harmonized roles of health care workers
- Harmonized/joint training curriculum
- Opportunity to expand HIV interventions to TB programme (TB has wider coverage)
- Opportunity to engage community involved in both HIV and TB programming
- Opportunity for resource allocation according country needs (TB allocation for GeneXpert, IPT scale up,)
- Allocation of resources for health system/evidence base research
- Provide avenue for task shifting in some interventions (HTC, CPT, ART in TB and HIV clinics)
- CN development process brought TB and HIV programmes together- opportunity for having single directorate (e.g. Malawi)
- Collaboration with other programmes e.g. RMNCAH, NCD
- Learning to be taken for Joint health planning for SDGs
- Provided opportunities to revise programme documents (NSP, M&E tools, guidelines, etc)
- Gave opportunity for establishing multi-partner task force to write the CN

**Bottlenecks/Challenges**

**Partners**

- Lack of coordination and clarity in providing technical assistance
- Consultants were not very clear and familiar to the single concept note development process