Report on the Involvement of Faith-Based Organizations in the Global Fund

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To Fight AIDS, Tuberculosis and Malaria

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Background and Summary

Introduction

Recognizing their important role as partners and implementers, since its creation in 2002 the Global Fund has been working closely with faith-based organizations (FBO). FBOs serve as members of Country Coordinating Mechanisms (CCM) and as beneficiaries of Global Fund grants, both as Principal Recipients (PR) and Sub-recipients (SR).

Data for the report has been drawn from an extensive review of the Global Fund's CCM database; an analysis of the Global Fund's grant portfolio, including results from a 2006 survey sent to Principal Recipients; and additional interviews with Global Fund Portfolio Managers and selected Principal Recipients. The report also includes a description of activities the Global Fund is taking to enhance the involvement of FBOs in CCMs.

The analysis showed that FBOs administer grants in many countries and are an essential part of the governance of the Global Fund programs in most countries through their involvement in CCMs. In 2006 alone, 9 faith-based organizations received funds as PRs and an additional 488 FBOs were SRs. The findings further revealed that 94 out of 120 CCMs (78.3%) with active Global Fund grants had at least one faith-based representative. In addition to funding, resources allocated to FBOs in the form of drugs, commodities, and other supplies and equipment are quite significant.

Additionally, the Global Fund has engaged in a number of activities to encourage the full participation of all members of civil society, including FBOs on CCMs. This includes developing and implementing requirements to diversify the composition of CCMs and numerous workshops and materials to educate FBOs and other members of civil society on how to best engage with the Global Fund. The Global Fund is also implementing a dual-track financing system to encourage the nomination of civil society organizations, including NGOs, FBOs, community-based organization and academic institutions as Principal Recipients.

Faith-Based Organizations as Principal Recipients and Sub-Recipients[1]

Overview

The Global Fund to Fight AIDS, Tuberculosis and Malaria was created to dramatically increase resources to fight three of the world's most devastating diseases, and to direct those resources to areas of greatest need. As a partnership between government, civil society, the private sector and affected communities, the Global Fund represents an innovative approach to international health financing. The Global Fund's work in all its structures is guided by seven general principles. These are to:

- operate as a financial instrument, not an implementing entity;
- make available and leverage additional financial resources;
- support programs that reflect national ownership;
- operate in a balanced manner in terms of different regions, diseases and interventions;
- pursue an integrated and balanced approach to prevention and treatment;
- evaluate proposals through independent review processes;
- establish a simplified, rapid and innovative grant-making process; and
- operate with transparency and accountability.

Principal Recipients (PR)

For each grant, the CCM nominates one or more public or private organizations to serve as the PR. The PR is legally responsible for local implementation of the grant, including oversight of SRs and grant funds and communications with the CCM on grant progress. The PR also works with the Global Fund Secretariat to develop a two-year grant agreement that sets program targets to be achieved over time. Over the course of the grant agreement, the PR requests additional disbursements based on demonstrated progress towards these intended results. This performance-based system of grant-making is key to the Global Fund's commitment to achieving concrete results.

Sub- Recipients (SR)

PRs work with Sub-recipients (SR) to implement the grant. It is the responsibility of the PR to ensure that its SRs have the capacity to implement the program activities assigned to them. Article 14 of the grant agreement outlines the PRs responsibilities with respect to SRs, including the PRs responsibilities in assessing and evaluating SRs.

Sub-Recipients

> *From time to time, the Principal Recipient may, under the Global Fund is Agreement, provide Grant funds to other entities or make direct payments on behalf of such entities to carry out Program activities ("Sub-recipients"), provided that the Principal Recipient:*
>
> *(a) assesses the capacity of each Sub-recipient to implement Program activities and report thereon, makes such assessments available to the Global Fund upon request, and selects each Sub-recipient based on a positive assessment of that Sub-recipient's capacity to carry out the Program activities that are being assigned to it and in a transparent documented manner;*
>
> *(b) enters into a grant agreement with each Sub-recipient creating obligations of the Sub-recipient to the Principal Recipient that are generally equivalent to those of the Principal Recipient under this Agreement, and which are designed to facilitate the*

[1] Data on Sub-recipients was collected from the 2006 Principal Recipient Survey and through additional follow-up with Fund Portfolio Managers and PRs on a case-by-case basis. At the time of the survey, disbursements had not yet been made to Albania, Bosnia and Herzegovina, Brazil, Iraq, Maldives, Syria, Tunisia, and the Multi-Country Africa West Africa Corridor Program, hence data is not available for these countries in the Sub-Recipient analysis sections.

compliance of the Principal Recipient with the terms of this Agreement. Such obligations shall include, but not be limited to, a requirement that the Sub-recipient employ all Grant funds solely for Program purposes, and use reasonable efforts to ensure that Grant funds are not employed to support or promote violence, to aid terrorists or terrorist related activity, to conduct money-laundering activities or to fund organizations known to support terrorism or that are involved in money-laundering activities;

(c) makes a copy of each Sub-recipient grant agreement available to the Global Fund upon request; and

(d) maintains and complies with a system to monitor the performance of sub-Recipients and assure regular reporting from them in accordance with this Agreement.

The Principal Recipient acknowledges and agrees that providing Grant funds to Sub-recipients or making payments on behalf of Sub-recipients to implement Program activities does not relieve the Principal Recipient of its obligations and liabilities under this Agreement. The Principal Recipient is responsible for the acts and omissions of its Sub-recipients in relation to the Program as if they were the acts and omissions of the Principal Recipient.

Dual-Track Financing

As a part of the Global Fund's commitment to strengthening the role of civil society including FBOs at its 15th meeting the Global Fund Board decided to establish a dual track financing system whereby proposals would routinely include both government and non-government PRs, which could include an FBO, for Global Fund grants. While this option was previously available and working in countries like Zambia, the goal is to increase the representation of civil society organizations across the entire Global Fund portfolio. The Board recommended the submission of proposals with both government and non-government PRs. If a proposal does not include both, a rationale would need to be included. The possible benefits to be achieved through dual-track financing include increased absorptive capacity from taking advantage of all sectors, accelerated implementation and grant performance and the strengthening of weaker sectors in the community.

Faith-Based Organizations (FBOs) as PRs and SRs

Faith-Based Organizations (FBOs) are the critical providers of rural health care and orphan care in many parts of the developing world and could play an expanded role for reaching the hard-to-reach and poorest population groups. Recognizing the unique advantages of FBOs, the Global Fund encourages FBO participation in all grants, both as PRs and SRs. As part of the civil society sector, NGOs, FBOs, Communities and the private sector are implementing about 40 percent of Global Fund grants.

A large number of FBOs are implementing programs as PRs and SRs with financial support from the Global Fund. Since its creation, 11 different FBOs have served as PRs of Global Fund grants, and the number is increasing with each new funding round. Based on the 2006 Principal Recipient Survey, 9 FBOs received funds as PRs and an additional 488 FBOs were SRs. In addition, in many countries like Zambia, FBO SRs further sub-grant to other faith-based organizations as sub-sub-recipients. A good example is the Churches Health Association of Zambia (CHAZ). Described further below, CHAZ disburses money to 411 local FBOs to fight AIDS, 73 local FBOs to fight TB and 75 local FBOs to fight malaria.

The analysis showed that there is a strong presence of FBOs in certain regions of the world. For example, in West and Central Africa, the percentage of monetary resources channeled to FBOs is the highest at 11.8%. This is because FBOs are a major provider of healthcare services and actively engaged in the Global Fund. Latin America and the Caribbean is also high with 11% of Global Fund monetary resources going to FBOs as PRs or SRs. Additionally, the presence of FBOs as PRs and SRs is notable in the Middle East and North Africa region, largely due to the work of FBOs in fragile states such as Somalia and the Sudan. FBOs receive approximately 7.3% of funding in the Middle East and North Africa region.

These figures indicate that wherever FBOs are playing a major role in healthcare delivery, they stand to access a large amount of money once they successfully engage with the Global Fund. For example,

the high percentage in Latin America and the Caribbean is strongly related to the presence of World Vision as a PR in both Guatemala and Suriname as well as a SR of a large portion of the Multi-Country Meso Region grant.

Results from the 2006 Principal Recipient Survey and additional country-level follow-up with Fund Portfolio Managers and Principal Recipients reveal that the regions with the smallest percentage of FBO SRs are Eastern Africa, East Asia and the Pacific, South and West Asia, and Eastern Europe, with 2.4%, 2%, 1.7% and 1% respectively. One reason for these lower percentages is a large number of FBOs receiving small grants. For example in Eastern Africa 61 faith-based SRs are receiving small grants. Ethiopia also heavily skews the results for the region. A predominantly Christian country, Ethiopia received nearly 10% of all Global Fund resources disbursed worldwide in 2006. However, the country chooses to implement the grants almost exclusively through its government systems which is the case in many countries.

Examples of FBOs as PRs and SRs

World Vision: An International FBO serving in Different Capacities within the Global Fund model

World Vision International (WVI), an international FBO with a global presence, has national offices in close to 100 countries. More than 20 of them are actively engaged with the Global Fund from advocacy with their governments to increase funding to the Global Fund to representing civil society on their CCMs. WVI has been actively engaged with the Global Fund, beginning with the first meetings to establish this new entity and continuing at different levels, including:

- *Principal Recipients:* Armenia (TB), Guatemala (HIV, Malaria and TB), Somalia (TB) and Thailand (TB)
- *Sub-recipients:* Cambodia (two AIDS sub-grants), Democratic Republic of the Congo (TB), Haiti (HIV), Honduras (HIV), Indonesia (Malaria), Kenya (Malaria), Lesotho (HIV), Malawi (HIV), Mongolia (TB), PNG (TB), Philippines (two TB sub-grants), Somalia (two sub-grants – HIV and Malaria), Sudan (two sub-grants - Malaria and TB), Tanzania (Malaria), Thailand (two sub-grants - TB and HIV), Timor Leste (Malaria), Uganda (HIV)
- *CCM Members*: Armenia, Cambodia, Democratic Republic of Congo, Dominican Republic, Honduras, Guatemala, Lesotho, Philippines, Senegal, Sierra Leone, Somalia.

WVI provides technical support for writing grants, which has resulted in several successful proposals. National offices provide project data, fund consultants and support the proposal process. WVI delegates have attended both Partnership Forum and occasionally, Board meetings. In several major conferences, WVI has shared lessons learned on its Global Fund engagement, notably at the International AIDS Conferences in Bangkok (2004) and Toronto (2006).

Currently, WVI has a total Global Fund portfolio (as a PR and SR) of more than $130 million, including all three diseases. Where WVI's National Office is the PR, an Implementation Unit has been established to provide the necessary management, financial and technical support for implementation. At the global level, relationships with the Global Fund are maintained through regular meetings with Portfolio Managers within the Global Fund Secretariat.

Lessons learned from WVI's experience include:

- Front-end investments by FBOs are required to make their engagement with the Global Fund meaningful. This could include staff time, travel or even match funding for approved proposals. Based on the WVI experience, a combination of a good track record, technical staff and financial systems are necessary. The Global Fund process is rigorous and competitive, and specialized technical inputs are needed for an FBO to compete.
- An important component for success is a strong presence and understanding of the political process in-country. The FBO must be active in relevant networks, and recognized for quality programming while successfully making its case for a proposal.

- Previous experience with external donors is critical. This experience gives an FBO familiarity with the procedures in applying for grants for global health. FBOs that have not had much exposure to external funding mechanisms will be at a major disadvantage.
- The Global Fund process is highly transparent, and many groups track its performance. As a result, Global Fund grant recipients and decision-makers often receive more scrutiny.

Catholic Relief Services Madagascar – A Global Fund Principal Recipient

Catholic Relief Services (CRS) was founded in 1943 by the Catholic Bishops of the United States. It serves as the official international relief and development agency of the U.S. Catholic community. CRS works through local offices and an extensive network of partners on five continents and in 98 countries. CRS has a long history of working in the HIV/AIDS sector in Eastern and Southern Africa. Since its first HIV/AIDS project in 1989 in Uganda, CRS has supported 180 AIDS projects in 40 countries. With its background and close ties to local Catholic structures and community-based organizations, CRS believed that it was uniquely qualified to serve as a Principal Recipient for the Global Fund Round 2 HIV/AIDS grant in Madagascar. CRS has an extensive portfolio of innovative and successful HIV/AIDS programs in the region, a long tradition of working with communities and community-based organizations in HIV/AIDS prevention, demonstrated past performance of good organizational and management practices, as well as an ability to strengthen local organizations implementing HIV/AIDS projects. In short, CRS was well poised to deliver high quality sexually transmitted infections (STIs) diagnosis and treatment and HIV/AIDS education.

In 2003, CRS received $1.5 million dollars in Global Fund financing to treat well-known STI and prevent AIDS. The project involves implementing programs to manage STIs, voluntary counseling and testing and the creation of youth centers for counseling on reproduction. They use a variety different strategies including providing both blood testing and STI services to make sure that anyone who needed treatment for an STI was reached. To date, nearly 2,800 people have been treated through these programs.

CRS has also involved other parties such as Youth for Christ as sub-recipients, and they have done a great job developing STI educational campaigns. The messages focus on abstinence, fidelity, voluntary counseling and testing, and treatment of STIs. Community workers go from door- to-door, with preachers, evangelists and others to educate people about STIs. The fruits of their labor is clearly seen in rural areas where campaigns targeting traditional healers have motivated them to send their patients to hospitals and clinics to receive treatment for STIs.

CRS also sits on Madagascar's CCM and will continue to help develop proposals, so that the faith-based perspective on prevention and treatment of HIV/AIDS and other infectious diseases is reflected in future proposals.

The Churches Health Association of Zambia- A Global Fund Principal Recipient

The Churches Health Association of Zambia (CHAZ) was established in 1970 to serve as an umbrella organization of church health institutions and community-based organizations. Today, CHAZ is comprised of 129 members, which together account for 59 percent of health care coverage in the rural areas of Zambia and 30 percent of the health care in the country as a whole. The extensive CHAZ network includes 32 hospitals, 68 health care clinics and 26 community based organizations.

Due to its extensive network and experience, CHAZ was selected to serve as one of four Global Fund PRs in Zambia. In this capacity, CHAZ oversees five grants and will receive $50 million in direct Global Fund financing through 2008, at which time additional Phase 2 funding may be added. This portfolio includes two HIV/AIDS grants, two malaria grants and one TB grant.

CHAZ has effectively used resources from the Global Fund and other partners to substantially scale-up its work. In addition, CHAZ also receives a smaller amount of funding from bilateral donors, including PEPFAR through Catholic Relief Services as well as from the Centers for Disease Control and Prevention.

CHAZ channels money to a large number of FBOs, including 411 local FBOs to fight AIDS, 73 local FBOs to fight TB and 75 local FBOs to fight malaria. CHAZ works to provide communities with health services, disaster relief, training, medicine, support and community-wide programming. This work includes a heavy emphasis on supporting AIDS orphans to ensure that they can still get an education and at least one decent meal a day. CHAZ has also been working to establish and refurbish centers for the prevention of mother-to-child HIV transmission (PMTCT). Global Fund financing has allowed CHAZ to make a significant impact in the fight against malaria as well as distributing bed nets and the most effective malaria treatments.

Istiqama: A local Mosque-A Global Fund Partner in Zanzibar

Malaria kills almost one million people every year, most of them women and children. In Zanzibar, significant efforts have been taken to roll back malaria through the use of various malaria control interventions, including anti-malarial drugs and bed nets. To date, over 300,000 bed nets treated with insecticide have been distributed to pregnant women and children. This has led to a significant decrease in the number of people falling sick, and an increase in family savings, among other benefits.

Zanzibar has been able to achieve this success with the help of Global Fund financing. Serving as the Principal Recipient, in 2004, the Ministry of Health and Social Welfare of Zanzibar received a malaria grant for $8 million dollars to further Zanzibar’s malaria control efforts through the expansion of Artemisinin-Based Combination Therapy (ACT) and Insecticide Treated Nets (ITNs) coverage. They have partnered with local mosques such as Istiqama which helps them educate communities on the proper use of bed nets and malaria prevention. “We regard them as partners because they help us create awareness in mosques, which produces good results,” says Dr. Abdullah Ali, a program manager with the Ministry of Health.

Specifically, Istiqama educates followers in mosques during Friday prayers. Religious leaders train the faithful by demonstrating how best to handle bed nets. They reach entire families by first talking to husbands who then pass the information onto their wives, who often are the ones who receive and use bed nets. Istiqama’s efforts have greatly contributed to malaria control awareness within the community.

Istiqama became involved in malaria control and prevention when the Ministry of Health sent out a request inviting all local NGOs to develop proposals on what they wanted to do in relation to malaria control. The Ministry of Health then reviewed the proposals and selected the best ones based on technical merit. Despite it being a very competitive process, Istiqama’s proposal stood out from the other proposals and impressed the Ministry of Health. They appeared to have the organizational capacity including internet access and program managers knowledgeable about Global Fund malaria control programs to give the Ministry of Health confidence that they would be an effective implementing partner in the fight against malaria.

Kwai River Christian Hospital in Thailand- A Global Fund Sub-Recipient

The Kwai River Christian Hospital (KRCH) is a 25-bed public health and community service center serving the mountainous rural area along Thailand’s border with Myanmar. Within Kanchanaburi Province in the east, KRCH is about 100 miles from Bangkok. Since 1960, it has been providing vital medical care to thousands of people who would otherwise have none. Each week, two new TB patients begin receiving treatment at the hospital. It also serves as an important research facility for influenza and other diseases for the United States Armed Forces Research Institute of Medical Science (AFRIMS).

KRCH is affiliated with the Church of Christ in Bangkok. It began receiving financial assistance as a sub-recipient of a Global Fund grant to fight Tuberculosis in Thailand, which had earlier been awarded to the Department of Disease Control, Ministry of Public Health, which serves as a PR, in May 2003. KRCH was alerted to the possibility of receiving a Global Fund grant for TB through a brochure sent by the local health department. A doctor on staff, who subsequently led the TB program, wrote the budget proposal. After presentations to the health department in Kanchanaburi and a trip to Bangkok, the department accepted the proposal and immediately began funding the program.

Global Fund financing has helped KRCH tremendously. Before funding, most of the patients in the community could not afford to travel to the hospital. They did not have money for food, much less TB medication. Now, through the TB grant, patients receive free medication and are recovering rapidly. Moreover, KRCH is able to provide patients with money for food and transport. The grant also provides funding for community visits and for the treatment of family members. To date, KRCH has treated about 100 TB patients with Global Fund financing.

Norwegian Church Aid - A Global Fund Sub-Recipient

The Interfaith Network on HIV/AIDS in Thailand (INAT) consists of sixty Buddhist, Muslim, Catholic and Protestant places of worship offering them free food, medicine, counseling and other health services. This network uses trained religious leaders and volunteers as well as people living with AIDS from temples, churches and mosques across Thailand to organize home-based care activities for people living with AIDS in remote areas.

In partnership with Norwegian Church Aid (NCA) sixty “caring, sharing and healing centers” for people living with AIDS have been developed including 30 centers at Buddhist temples, 14 centers run by Muslim mosques, 16 centers by Catholic and Protestant churches. In addition to home-based care the interfaith network supports small income generating opportunities for people living with AIDS. Through the use of Global Fund financing people are trained in product development and marketing mainly for income generation.

This process did not occur over night. Initially, NCA struggled to secure Global Fund financing. The proposal process was challenging due to their lack of experience with proposal development and program management. To compete with other NGOs applying for funding they had to build their organizational capacity as well as increase their national visibility. After an unsuccessful Round 4 proposal NCA approached the CCM and the technical review team with their proposal. After responding to some critical feedback, NCA’s proposal was accepted for Phase 2 funding of a Round 1 HIV/AIDS grant focused on improving service delivery of essential medicines and services. They received $1.6 million from the Department of Disease Control of the Ministry of Public Health of Thailand the Principal Recipient of the grant. Presently, a member of the interfaith network sits on Thailand’s CCM as the FBO representative.

Non-Cash Distribution

Global Fund disbursements to FBOs extend far beyond actual cash received. In addition to monetary resources, predominantly in Sub-Saharan Africa faith-based health facilities also receive additional commodities purchased in bulk by countries through Global Fund financing. For example, according to Global Fund expenditure targets for Rounds 4 to 6[2], 48% of expenditures are set aside for consumable items such as drugs, commodities, and products.

Typically, government PRs such as the Ministries of Health in many countries will purchase these commodities and distribute them to local health clinics and non-governmental organizations, including FBOs. For example in Kenya, the General Secretary of the Christian Health Association of Kenya (CHAK) confirmed via personal communication that faith-based health facilities in Kenya have received ARVs, HIV test kits, anti-malaria drugs, and bed-nets from the Ministry of Health. However, the monetary value of these commodities is extremely difficult to quantify. Additionally, because the Kenyan Ministry of Health is receiving support from the Global Fund, PEPFAR, UNICEF, and WHO, as well as other donors, it is difficult for CHAK to distinguish which commodities are purchased with funds from specific donors. This information may reside with the individual PR which purchased the items in bulk to reduce overall costs.

In October 2007, Global Fund staff conducted a field visit to Tanzania to track the distribution of Global Fund resources in the country. The purpose of the visit was to explore the hypothesis that most Global Fund-supported programs do not include the dollar value of drugs and commodities to the different implementing entities in their budgets and work plans. As a result, *allocations to civil society and FBOs could be far greater than what is captured in monetary disbursements to SRs*.

[2] http://www.theglobalfund.org/en/funds_raised/distribution/

The field visit confirmed that civil society organizations, in particular faith-based health care providers, are involved in implementation to an extent far greater than is shown in the budgets submitted to the Global Fund Secretariat. The specific breakdown of commodities to the different sectors within Tanzanian society is represented in Tables 1 and 2.

Table 1: Distribution of Commodities, including ARV Sites, Supplies for VCT Sites, Motor Vehicles, and Supplies for Orphan Care in Mainland Tanzania

Entity	ARV Sites	VCT Sites	Motor Vehicles	Orphan Care
Government	109 (54%)	439 (87%)	59 (65%)	0
Faith-Based	65 (33%)	22 (4%)	12 (13%)	6 (46%)
Private	26 (13%)	0	0	0
NGO	0	10 (34%)	20 (22%)	7 (54%)

Table 2: Disbursements of ACTs in Tanzania from Global Fund Resources

	Type	Total	Percent
District Hospitals	Government	976,085	60.7%
Regional Hospitals	Government	96,005	6.0%
Consultant Hospitals	Government	42,485	2.6%
VA Hospitals and DDH	Faith-Based	493,030	30.7%
Total		**1,607,605**	100%

VA = Voluntary Agency; DDH = Designated District Hospital

Tracking Funding to PRs and SRs – Enhanced Financial Reporting

In an effort to better track the amount of money as well as commodities and other information on PRs and SRs, the Global Fund is currently implementing its new Enhanced Financial Reporting system. Through this system the Global Fund will be able to better capture the amount of resources going to FBOs and other recipients. The Enhanced Financial Reporting system will entail requesting once a year from PRs a minimum set of budget and expenditure information, including cost category, program activity and implementing entity.

Enhanced Financial Reporting was developed in 2007 by the Global Fund and 16 participating countries wherein a pilot-test was implemented. The results of the pilot test showed that the majority of grant recipients found the system useful for their own grant management and that the information requested was not overly difficult to provide. The system is an important tool in improving accountability and transparency at the Global Fund. First reported results are anticipated in April 2008 and information for the entire portfolio will be available early 2009.

Summary of Findings

Data from the 2006 Principal Recipient Survey was analyzed and are presented in the section on Appendix 2 focusing on the following information by country:

- **Table 3** lists total funding approved and disbursed to all faith-based PRs since the Global Fund's inception. (See Appendix 2)
- **Tables 4-11** include data obtained from the 2006 Principal Recipient survey. This is presented by country and region as total number of FBOs receiving funding as PRs and SRs and total amount disbursed to FBOs.
- **Table 12** is a global analysis reflecting the disbursement of funds to FBOs as Principal and Sub-Recipients.
- **Table 13** lists by country all FBO Principal and Sub-recipients that received funding in 2006 and the total amount they received.

Faith-Based Organizations in Country Coordinating Mechanisms

Country Coordinating Mechanisms (CCMs) are central to the Global Fund's commitment to local ownership and participatory decision-making. CCMs include representatives from both the public and private sectors, including governments, multilateral or bilateral agencies, non-governmental organizations, academic institutions, private businesses and people living with the diseases. The purpose of these country-level partnerships is to develop and submit grant proposals to the Global Fund based on priority needs at the national level. After grant approval, CCMs oversee progress during grant implementation. For each grant, the CCM nominates one or several public or private organizations to serve as a PR. According to the Global Fund's *Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility* (2005, page 4):

> *The Global Fund recognizes the importance of national contexts, customs and traditions, and therefore does not intend to prescribe specific CCM compositions. However, in accordance with its guiding principles, the Global Fund expects CCMs to be broadly representative of all national stakeholders in the fight against the three diseases. In particular, the Global Fund encourages CCMs to aim at a gender balanced composition. The CCM should therefore be as inclusive as possible and seek representation at the highest possible level of various sectors.*

To this end, the Global Fund recommends that all countries strive to include the following actors in their CCMs:

- Academic/Educational Sector;
- Government;
- NGOs/Community-Based Organizations;
- People living with HIV/AIDS, TB and/or Malaria;
- Private Sector;
- Religious/Faith-Based Organizations;
- Multilateral and Bilateral Development Partners in-country.

The Global Fund guidelines strongly recommend that all CCMs have at least 40% of its membership as civil society members, which would include FBOs. As a part of the grant approval process, the Global Fund assesses the composition of each CCM that submits a proposal to ensure that the CCM is complying with the established composition guidelines. If for any reason the CCM does not meet the composition guidelines, it must provide an explanation or risk having its proposal being rejected.

In most instances, CCMs operate at the national level. In regions with a high composition of small nations or territories, such as in the Caribbean and the Western Pacific region, regional CCMs exist in place of national structures. Regional CCMs also exist to monitor and implement regional grants, such as the Meso CCM in Central America, the Andean CCM in South America and the Medical Research Council CCM in southern Africa. In a few countries, especially where the political climate has created divisiveness, sub-CCMs exist. Examples include southern Sudan, Kosovo (Serbia) and Zanzibar (Tanzania).

Of the 120 CCMs included in this research, 94 have at least one faith-based representative, or 78.3% of all CCMs. Many countries have more than one faith-based representative serving on the CCM. Faith-based representatives comprised 6% of total CCM membership worldwide. Faith-based representation is highest in sub-Saharan African countries with Eastern and West & Central Africa boasting the highest number of faith-based representatives with percentages of 8.6% and 8.5% respectively. Faith-based representation is lowest in Eastern Europe at 3.2%. These trends are also reflective of the general involvement of FBOs in healthcare delivery in different regions of the world. Countries where there are no faith-based representatives on the CCM are predominantly seen in certain Eastern European countries which have historically not had a significant portion of healthcare services provided by FBOs. Additionally, CCMs with a membership of less than 10 people and in

countries where governmental policies inhibit the participation of religious groups in civil society typically did not have faith-based representatives.

It is important to note that faith-based issues on CCMs were sometimes represented by individuals not affiliated with an FBO. Ten countries have a representative of a governmental ministry of religious affairs, which is counted as a governmental representative. For example, in Turkey a member of the executive board of the governmental Department of Religious Affairs is a member of the CCM. This individual represents the governmental sector on the CCM, however his designation on the CCM is "informing Muftis (provincial religious authority) and Imams (religion officers), who act as civil society leaders having direct contact with community on HIV/AIDS and STI."[3] Additionally, 28 CCMs have a representative from a civil society network that includes FBOs and it is possible that faith-based interests are represented through this channel as well.

Examples of FBOs on CCMs

In Nigeria, along with other civil society groups FBO representatives often hold meetings throughout the year with their constituents in order to actively involve them in CCM decision making processes. It is recognized and appreciated that the FBOs provide a voice for and aspirations of the poor and the marginalized in Nigerian society. The CCM in Nigeria praised the fact that the FBOs draw their legitimacy from "the people", and that they use this "people power" to mobilize, sensitize, and create awareness among their constituents about the three diseases and how they can participate in the national response. In addition, in Tanzania, the CCM includes one seat for Christians and one for Muslims. Christian churches which provide approximately 40% of the hospital care in that country are represented through the Christian Social Services Commission (CSSC). This is an umbrella organization coordinating the healthcare work of all major churches in Tanzania. CSSC is also a key Sub-Recipient of the Global Fund grants in Tanzania and as CCM Vice Chair, is one of the cases where FBOs are in a CCM leadership position.

[3] http://www.theglobalfund.org/programs/CCMMembers.aspx?CountryId=TUR&lang=en

Actions Taken by the Global Fund to Enhance Faith-Based Involvement in CCMs

Since its inception, the Global Fund has worked to ensure that faith-based organizations were engaged at multiple levels of its model. This includes developing requirements around the diverse composition of CCMs, a dual track financing system to encourage the nomination of non-governmental Principal Recipients and numerous workshops and materials to educate FBOs and other members of civil society on how to best engage with the Global Fund.

Through its innovative model promoting public-private partnerships and country ownership the Global Fund provides faith-based organizations a seat at a table from which they have been traditionally been excluded. The CCM guidelines developed by the Global Fund requires the CCM to be representative of all national stakeholders, specifically people living with the disease(s) as well as government and civil society representatives including FBOs. Through the CCM, FBOs are able to participate in developing proposals, nominating Principal Recipients and monitoring grants.

The Revised CCM guidelines[4], newly produced in connection with Round 8, explicitly mentions the importance of FBO representation by recommending that Religious/Faith-Based organizations are represented among the 40% of non-government sector (see Part 5: Composition). Moreover, Annex 1 to the Revised CCM Guidelines include FBOs as one of the types of civil society **valuable to CCMs** (full list in Appendix**)**, and encourages CCMs to pursue such representation, according to the following rationale:

> ***"vi. Religious and Faith-Based Groups:*** In many settings religious and faith based organizations play a vital role in reaching communities infected and affected by the three diseases. Not only do these organizations and groups provide crucial services but some are instrumental in convincing political leaders at the national, regional and local level prioritize the needs of affected populations. They are increasingly becoming involved in implementation of interventions and provide a valuable role in the development of effective proposals. […]"

Additionally, the Global Fund has hosted several workshops and events to specifically engage with FBOs, enabling them to be an active partner of the Global Fund. Most recently:

- In March 2007, the Global Fund facilitated the launch of the publication *"Scaling up Effective Partnerships: A Guide to Working with Faith-Based Organizations in the response to HIV and AIDS*[5]*,* co-produced by Church World Service, Ecumenical Advocacy Alliance, Norwegian Church Aid, UNAIDS, and World Conference of Religions for Peace. The guide is intended to provide background information and case studies, counteract myths and give practical guidance to people who want to collaborate with faith-based organizations on joint projects related to HIV and AIDS. The launch took place in Oslo in connection with the first Meeting of the Global Fund Second Replenishment (March 6-7, 2007). The Global Fund Secretariat further supported the wide distribution of this publication, through its Fund Portfolio Managers to country partners.

- In May 2007, the Executive Director of the Global Fund met with representatives of FBOs in Washington, D.C. for the launch of a manual entitled, *"Engaging with the Global Fund to Fight AIDS, Tuberculosis and Malaria: A Primer for Faith-Based Organizations"*, a 49-page document designed to help FBOs better engage with the Global Fund to enhance participation at multiple levels of the model. The manual was published as a joint effort between Christian

[4] http://www.theglobalfund.org/pdf/5_pp_guidelines_ccm_4_en.pdf
[5] The publication may be downloaded at http://www.e-alliance.ch/media/media-6695.pdf

Connections for International Health, World Vision International, and Friends of the Global Fight (USA).[6]

- In April 2008, the Global Fund convened a meeting in Dar Es Salaam, Tanzania with faith-based organization representatives from sub-Saharan Africa. The meeting was attended by 120 FBOs, making it the largest meeting ever co-organized by the Global Fund to address the specific needs of the faith-based community and corgranised with the World Council of Churches, and the Churches Health Association of Kenya. Partners including UNAIDS, the World Health Organisation and Pepfar provided technical support. The meeting gave a platform for Sub-Saharan faith based organizations working in malaria, TB and HIV/AIDS to share their experiences of engaging with the Global Fund and discuss strategies for scaling up their involvement as well as their demand for resources for implementation of programs. Specifically, the meeting reviewed:

    - Contributions made so far by FBOs, either as Principal Recipients or Sub-recipients;
    - Increasing recipient demand and highlighting new avenues for increasing the role of FBOs as PRs and in scaling up Global Fund resourced programs;
    - Better engagement of FBOs in CCMs;
    - Engaging the proposal development processes at country level
    - Global Fund's minimum requirements for assessments of principal recipients and monitoring and evaluation of community-based groups.

- The Global Fund also provided support to the Council of Anglican Provinces of Africa during its annual meeting in June 2008 in Nairobi through a skills building workshop. Representatives from 13 countries received an orientation on the Global Fund's architecture. This included in-depth group discussions on how representatives could engage with the Global Fund in their countries.

[6] A press release about the launch may be found at http://www.ccih.org/Global_Fund/Press_Release_FBO_Global_Fund_Manual.htm and the manual may be downloaded at: http://www.ccih.org/Global_Fund/FBO.Manual.pdf

Appendices

Appendix 1: Methodology on Data Gathering for the Report

Data on monetary allocations to PRs and SRs was derived from the findings of the 2006 Principal Recipient Survey conducted by the Global Fund Secretariat. The 2006 survey was the most comprehensive undertaking to date by the Global Fund to track country-level allocations of all grants disbursed. The survey included questions about the number of disbursements, the amount of those disbursements and the activities funded. It achieved an 85% response rate from all PRs.

The data presented in this report are the most accurate figures obtained to date on FBOs as SRs. The results of the survey have established a baseline for future research in this regard. Similar data will be available in subsequent years for comparative purposes. The Global Fund Secretariat repeated the annual Principal Recipient survey in 2007, and those results are currently being compiled.

In addition, quantitative data was derived from a database of all CCM members updated with Round 7 proposal applications and cross-referenced with the CCM membership data available publicly on the Global Fund website. The list of PRs for Round 7 is not available yet, as the grant signing process is currently underway.

The following definition of faith-based organization was used:

- religious and religion-based organizations and networks;
- communities belonging to places of worship;
- specialized religious institutions and religious social service agencies; and,
- non-profit institutions that have a religious character or mission.

The Global Fund database containing the most current information and contact details for members of all CCMs with active grants, including Round 7 member lists, was extensively reviewed. The database was cross-referenced with individual country pages on the Global Fund website for additional information about members' designation on the CCM. The faith-based representatives identified met at least one of the following criteria:

1. self-identified as Religious/Faith-Based Organization in lists supplied by individual CCMs;
2. member of clergy or religious order; or
3. representing an organization that meets the definition of 'faith-based organization' as described above. CCM data analyzed below includes only CCMs with active grants and excludes new applicants for Round 7.

In order to obtain data on specific allocations to SRs in 2006, the results from the 2006 Principal Recipient survey were extensively reviewed. When more information was needed, the individual countries' Fund Portfolio Managers (FPM) were contacted. Additionally, all country pages on the Global Fund website were assessed to obtain the most up-to-date information on the total funding that has been requested, approved, and disbursed to PRs since the Global Fund's inception. Faith-based PRs and SRs identified met at least one of the following criteria:

1. self-identified as Religious/Faith-Based Organization in lists supplied by individual PRs; or
2. an organization that meets the definition of 'faith-based organization' as described above.

Lastly, qualitative research was conducted in the form of informal telephone interviews with faith-based CCM members in India, Kenya, and Uganda and the World Vision International focal point for the Global Fund. The purpose of these telephone interviews was to verify country-level information from the 2006 Principal Recipient Survey, discuss the experience of FBOs in their respective countries, and to learn more about the organizations' future plans for collaboration with the Global Fund.

Appendix 2: Summary of Findings on FBOs Access to Global Fund Resources

Table 3: Total Amount Approved and Disbursed to Faith-Based Principal Recipients between 2002 and 1 October 2007

Country	Organization	Amount Approved	Amount Disbursed
Armenia	World Vision International – Armenia	$7,249,891	$6,475,787
Global	Lutheran World Federation	$700,000	$700,000
Guatemala	Fundación Visión Mundial Guatemala	$58,400,397	$24,804,504
Madagascar	Catholic Relief Services – Madagascar	$1,503,624	$1,503,624
Nigeria	Christian Health Association of Nigeria	$25,570,061	$11,101,254
Somalia	World Vision – Somalia	$13,825,351	$7,777,694
Sri Lanka	Lanka Jatika Sarvodaya Shramadana Sangamaya	$7,406,225	$4,287,322
Suriname	Medische Zending (Medical Mission) – Primary Health Care Suriname	$4,603,345	$3,181,216
Thailand	World Vision Foundation of Thailand	$7,726,767	$2,401,020
Zambia	The Churches Health Association of Zambia	$50,903,608	$46,602,655
Zimbabwe	Zimbabwe Association of Church Related Hospitals	$12,418,550	$4,703,030
Total		$185,704,474	$110,356,890

Table 4: East Asia and the Pacific: 2006 Disbursements to FBO Principal Recipients and Sub-Recipients as Derived from 2006 Principal Recipient Survey[7]

Country	Number of FBO Recipients	Amount Disbursed to FBOs
Cambodia	2 SR	$1,347,845.50
East Timor	2 SR	$103,800.73

[7] Data obtained from 2006 Principal Recipient Survey and additional follow up with Fund Portfolio Managers

Indonesia	6 SR	$566,137
Mongolia	1 SR	$51,773.70
Papua New Guinea	3 SR	$473,981
Philippines	1 SR	$438,814
Thailand	6 SR	$1,195,695.65
Total	**21 SR**	**$3,704,066.58**

Table 5: Eastern Africa: 2006 Disbursements to FBO Principal Recipients and Sub-Recipients as Derived from 2006 Principal Recipient Survey

Country	Number of FBO Recipients	Amount Disbursed to FBOs
Comoros	1 SR	$2,000
Democratic Republic of the Congo	9 SR	$1,619,225
Ethiopia	7 SR	$208,618.19
Kenya	17 SR	$1,729,353.89
Madagascar	1 PR 4 SR	$918,146.59
Tanzania	5 SR	$3,968,086.96
Uganda	17 SR	$5,158,206.95
Zanzibar (Tanzania)	1 SR	$87,574.90
Total	**1 PR 61 SR**	**$13,691,212.48**

Table 6: Eastern Europe: 2006 Disbursements to FBO Principal Recipients and Sub-Recipients as Derived from 2006 Principal Recipient Survey

Country	Number of FBO Recipients	Amount Disbursed to FBOs
Armenia	1 PR	$1,347,316
Bulgaria	2 SR	$37,712.35
Kyrgyzstan	1 SR	$8,192
Russian Federation	1 SR	$38,319
Total	**1 PR 4 SR**	**$1,431,539.35**

Table 7: Latin America & Caribbean: 2006 Disbursements to FBO Principal Recipients and Sub-Recipients as Derived from 2006 Principal Recipient Survey

Country	Number of FBO Recipients	Amount Disbursed to FBOs
Bolivia	1 SR	$11,572
Colombia	2 SR	$197,470
Dominican Republic	2 SR	$180,715
Ecuador	1 SR	$80,082.61
Guatemala	1 PR; 2 SR	$11,015,792
Haiti	1 SR	$95,259.62
Honduras	2 SR	$129,534.96
Jamaica	4 SR	$176,210
Multi-Country Americas (Meso)	1 SR	$625,850
Nicaragua	1 SR	$56,585
Peru	1 SR	$228,357
Suriname	1 PR 1 SR	$2,376,345.33
Total	**2 PR 19 SR**	**$15,211,363.85**

Table 8: Middle East and North Africa: 2006 Disbursements to FBO Principal Recipients and Sub-Recipients as Derived from 2006 Principal Recipient Survey

Country	Number of FBO Recipients	Amount Disbursed to FBOs
Algeria	1 SR	$16,082
Chad	2 SR[8]	$223,143
Mauritania	1 SR	$354,542
Niger	2 SR	$22,074
Somalia	1 PR; 1 SR	$3,337,989.76
Sudan	8 SR	$2,506,908
Total	**1 PR; 15 SR**	**$6,460,738.76**

Table 9: South and West Asia: 2006 Disbursements to FBO Principal Recipients and Sub-Recipients as Derived from 2006 Principal Recipient Survey

Country	Number of FBO Recipients	Amount Disbursed to FBOs
Bangladesh	6 SR	$463,145
India	1 SR	$32,778
Sri Lanka	1 PR	$1,230,490
Total	**1 PR; 7 SR**	**$1,726,413**

Table 10: Southern Africa: 2006 Disbursements to FBO Principal Recipients and Sub-Recipients as Derived from 2006 Principal Recipient Survey

Country	Number of FBO Recipients	Amount Disbursed to FBOs
Angola	2 SR	$2,570,440
Botswana	1 SR	$37,508
Lesotho	4 SR	$595,794
Malawi	31 SR	$2,044,819[9]
Namibia	3 SR	$1,652,988.73
South Africa	7 SR	$745,633
Swaziland	16 SR	$801,917
Zambia	1 PR 231 SR	$15,146,573.61
Zimbabwe	1 SR	$1,983,525
Total	**1 PR 306 SR**	**$25,579,198.34**

Table 11: West and Central Africa: Disbursements to FBO Principal Recipients and Sub-Recipients as Derived from 2006 Principal Recipient Survey

Country	Number of FBO Recipients	Amount Disbursed to FBOs
Benin	1 SR	$79,266.18
Cameroon	17 SR	$298,380.60
Central African Republic	11 SR	$796,079
Gambia	4 SR	$1,764,593
Ghana	4 SR	$6,539,330.84
Guinea-Bissau	2 SR	$65,904.32
Liberia	1 SR	$149,425
Nigeria	1 PR 1 SR	$13,285,872

[8] Chad's funding to FBOs is divided amongst numerous small organizations. In their response to the 2006 PR survey, they indicate this as 'divers FBOs,' and the precise number of FBOs funded as SR is not available.

[9] Figure is a conservative estimate, based on estimated costs of ARVs, health products, essential medicines, HIV test kits, medical equipment, and ambulances. These items were purchased in bulk by the PR in Malawi and items were distributed to 23 faith-based health facilities in addition to other sub-recipients. In addition to these in kind goods, 8 faith-based organizations received monetary disbursements totaling $221,449.

Senegal	3 SR	$78,651
Sierra Leone	14 SR	$589,714
Togo	1 SR	$30,300
Total	**1 PR 55 SR**	**$23,677,515.94**

Table 12: Global and Regional Analysis of 2006 Disbursements to FBO Principal Recipients and Sub-Recipients as Derived from 2006 Principal Recipient Survey[10]

Country	Total Amount Received	Number of FBO Recipients	Amount Disbursed to FBOs	% of Total Funding to FBOs
East Asia & the Pacific	$205,660,448.48	21 SR	$4,178,047.58	2%
Eastern Africa	$571,440,734.09	1 PR; 61 SR	$13,691,212.48	2.4%
Eastern Europe	$148,826,658.80	1 PR; 4 SR	$1,431,539.35	1%
Global (LWF)	$115,000	1 PR	$115,000	100%
Latin America & Caribbean	$139,021,578	2 PR; 19 SR	$15,211,363.85	10.9%
Middle East & North Africa	$88,725,105.60	1 PR; 15 SR	$6,460,738.76	7.3%
South & West Asia	$102,726,553.29	1 PR; 7 SR	$1,726,413	1.7%
Southern Africa	$250,864,500.49	1 PR; 306 SR	$25,579,198.34	10.2%
West & Central Africa	$199,991,899.56	1 PR; 55 SR	$23,677,515.94	11.8%

Table 13: Faith-Based Organizations Receiving Funding as Principal Recipients and Sub-Recipients in 2006

Country	Organization	Principal Recipient Amount	Sub-Recipient Amount
Algeria	Algerian Muslim Scouts		$16,082
Angola	Unspecified FBO		$500,000
Angola	CUAMM (Italian FBO)		$2,070,440
Armenia	World Vision International – Armenia	$1,347,316	
Bangladesh	RDRS		$108,474
Bangladesh	LAMB		$32,354
Bangladesh	HEED		$204,814
Bangladesh	Danish-Bangladesh Leprosy Mission		$57,465
Bangladesh	The Leprosy Mission Bangladesh		$46,270
Bangladesh	PIME Sisters		$13,768
Benin	Catholic Relief Services		$79,266.18
Bolivia	Cuerpo de Cristo		$11,572
Botswana	BOCAIP		$37,508
Bulgaria	YMCA Russe		$21,149.62
Bulgaria	Samariani Foundation		$16.562.73
Cambodia	Sihanouk Hospital Center for Hope (SHCH)		$1,204,613.83

[6] The following countries reported no disbursements to FBO PRs or SRs in 2006 including China, Lao PDR, Multi Country Western Pacific, Vietnam, Burundi, Eritrea, Rwanda, Azerbaijan, Belarus, Croatia, Estonia, Georgia, Kazakhstan, Kosovo (Serbia), Kyrgyzstan, Macedonia, Moldova, Montenegro, Romanian, Tajikistan, Turkey, Uzbekistan, Argentina, Belize, Chile, Costa Rica, Cuba, El Salvador, Guyana, Panama, Paraguay, Nepal, Afghanistan, Bhutan, Iran, Pakistan, Djibouti, Egypt, Jordan, Mali, Morocco, Yemen, Mozambique, Burkina Faso, Congo, Cote d'Ivoire, Equatorial Guinea, Gabon, Guinea, Sao Tome and Principe.

Cambodia	National Pediatric Hospital/World Vision International		$143,231.67
Cameroon	Association Schilo		$4,950
Cameroon	Jape Ebamina		$5,000
Cameroon	CLS-CPS		$28,280
Cameroon	CDLS (Yokadouma)		$31,774.20
Cameroon	Hopital Protestant Garoua Boulai		$4,996
Cameroon	UVRES Sainte Marthe		$5,497.20
Cameroon	Action Chrétienne pour le Dév.		$8,320
Cameroon	Fondation BETHLEEM de Mouda		$3,770
Cameroon	OSEELC Meiganga		$5,000
Cameroon	C/S Mission Plein Evangile		$9,058
Cameroon	Conseil des Eglises Protestantes du Cameroun		$5,000
Cameroon	One Love Association (P+ Association)/St. Theresa Catholic Medical Centre Mambu-Bafut		$5,000
Cameroon	Muslim Students Association Bamenda – Cameroon		$45,466
Cameroon	Catholic Relief Services Cameroon and Diocese of Kumbo Department of Family Life Office		$13,146
Cameroon	World Health Missionary Service		$36,000
Cameroon	CBC – Cameroon Baptist Convention		$43,400
Cameroon	Centre Chrétien de Developpement		$43,723.20
Central African Republic	Association Mama Theresa (AMT)		$59,470
Central African Republic	CARITAS Bangui		$404,336
Central African Republic	CARITAS Bambari		$48,350
Central African Republic	CARITAS Bria		$47,650
Central African Republic	CARITAS Bosangoa		$50,069
Central African Republic	CARITAS Bouar		$54,230
Central African Republic	CARITAS Berberatie		$42,522
Central African Republic	Sociéte Saint Vincent de Paul (Nola)		$44,617
Central African Republic	Comité Islamique pour la Lutte contre le Sida (CILS/Mobaye)		$24,618
Central African Republic	Groupe des Chrétiens pour les Œuvres Sociales (GCOS/Bria)		$24,635
Central African Republic	Action Chrétienne pour la Compassion (ACC)		$39,102
Chad	UNAD		$212,755
Chad	Divers FBOs		$10,388

Colombia	Parroquia de San Andres de Tumaco		$57,477
Colombia	Fe y Alegria Cali		$139,993
Comoros	MOUFTORAT		$2,000
Democratic Republic of the Congo	Armée du Salut		$51,276
Democratic Republic of the Congo	ECC MERU		$7,945
Democratic Republic of the Congo	Diocese De Kisantu		$127,394
Democratic Republic of the Congo	ECC IMA		$233,751
Democratic Republic of the Congo	CORDAID		$690,275
Democratic Republic of the Congo	Armée du Salut		$116,124
Democratic Republic of the Congo	CORDAID		$53,338
Democratic Republic of the Congo	Catholic Relief Services		$126,207
Democratic Republic of the Congo	ECC-IMA		$212,915
Dominican Republic	Pastoral Juvenil		$135,780
Dominican Republic	Esperanza Internacional		$44,935
East Timor	Christian Children's Fund		$43,351.40
East Timor	World Vision International		$60,449.33
Ecuador	Catholic Relief Services		$80,082.61
Ethiopia	Ethiopian Orthodox Church		$76,105.51
Ethiopia	Ethiopian Muslims Development Agency		$38,994.60
Ethiopia	Christian Relief and Development Association		$6,139.59
Ethiopia	Afar region sub-recipients – faith-based organizations		$35,919.81
Ethiopia	Oromia region sub-recipients – faith-based organizations		$17,816.24
Ethiopia	SNNP region sub-recipients – faith-based organizations		$28,252.56
Ethiopia	Tigray region sub-recipients – faith-based organizations		$5,389.88
Gambia	Christian Children's Fund		$253,500
Gambia	Catholic Relief Services		$1,054,697
Gambia	Christian Children's Fund		$95,321
Gambia	Hands on Care		$361,075
Ghana	Various FBOs		$1,148,948.34
Ghana	Women in Lord's Vineyard		$40,000
Ghana	Strong Tower		$40,000
Ghana	Various FBOs		$5,310,382.50
Global	Lutheran World Federation	$115,000	
Guatemala	Fundación Visión Mundial Guatemala	$11,015,792	
Guatemala	Associación CRS		$74,657

Guatemala	Associación CRS Hospicio San José		$50,889
Guinea-Bissau	Sant'Egidio		$45,000
Guinea-Bissau	Ceu e Terra		$20,904.32
Haiti	CARITAS		$95,259.62
Honduras	Penitentiary Pastoral		$19,024.97
Honduras	Samaritan's Purse		$110,509.99
India	St. Joseph's Leprosy Hospital and HIV/AIDS Centre		$32,778
Indonesia	Church World Service		$27,462
Indonesia	World Vision International		$259,179
Indonesia	Persatuan Dharma Karya Kesehatan Indonesia (PERDHAKI)		$31,810
Indonesia	HOPE Worldwide Indonesia		$27,222
Indonesia	Muhammadiyah		$156,964
Indonesia	PBNU		$63,500
Jamaica	Hope Worldwide Jamaica		$103,732
Jamaica	Whole Life Ministries		$20,653
Jamaica	Bethel Baptist Church		$43,311
Jamaica	Campus Crusade for Life		$8,514
Kenya	Christian Health Association of Kenya (CHAK) (HIV – Round 2)		$894,084
Kenya	National Council of Churches in Kenya (HIV-Round 2)		$113,279.72
Kenya	Christian Women Partners (HIV – Round 2)		$31,289.75
Kenya	Christian Children Fund (Malaria – Round 2)		$15,408.57
Kenya	World Vision Kenya (Malaria – Round 2)		$11,070.99
Kenya	NAHWO (Malaria – Round 2)		$18,081.56
Kenya	NAHWO (TB – Round 5)		$6,327.67
Kenya	Apostles of Jesus AIDS Ministries (HIV – Round 2)		$27,270 as SR of KANCO SR
Kenya	Christian Children Fund (HIV – Round 2)		$6,685.60 as SR of KANCO SR
Kenya	Presbyterian Church of East Africa (HIV – Round 2)		$25,348.55 as SR of KANCO SR
Kenya	St. Margarita Development Centre (HIV – Round 2)		$24,909.98 as SR of KANCO SR
Kenya	Young Men Christian Association (HIV – Round 2)		$27,284.23 as SR of KANCO SR
Kenya	Christian Health Association of Kenya (CHAK) (Malaria – Round 4)		$270,340.42
Kenya	Christian Community Services (Malaria – Round 4)		$1,321.66

Kenya	NAHWO (Malaria – Round 4)		$23,316.03
Kenya	Christian Children Fund (Malaria – Round 4)		$43,994.31
Kenya	World Vision Kenya (Malaria – Round 4)		$50,879.31
Kyrgyzstan	Unspecified FBO		$8,192
Lesotho	Christian Council of Lesotho; Catholic Relief Services; Christian Association of Lesotho; Scripture Union		$595,794
Liberia	Christian Health Association of Liberia		$149,425
Madagascar	Catholic Relief Services - Madagascar	$378,952.59	
Madagascar	FTK		$11,665.69
Madagascar	SALFA		$340,982
Madagascar	SAF/FJKM, SALFA		$31,500
Madagascar	SALFA		$166,712
Malawi	Lifeline Malawi; Partners in Hope; Christian Health Association of Malawi (CHAM); Katete AIDS Project; Bowe Home Based Care; Shuluti CBO; Mdabwi CBO; Mother Mary; 23 additional faith-based health facilities		$221,449 + 23 faith-based health facilities were provided with ARVs; other health products including drugs for opportunistic infections; HIV test kits and medical equipment; and 5 ambulances.
Mauritania	POOLS/ONG/SENLS		$354,542
Mongolia	World Vision – Mongolia		$51,773.70
Multi-Country Americas (Meso)	Visión Mundial w/ ICAS & PASMO		$625,850
Namibia	Catholic AIDS Action		$648,934.60
Namibia	Phillipi Trust		$618,989
Namibia	Council of Churches Namibia		$385,065.13
Nicaragua	Vicariato		$56,585
Niger	Fraternité Notre Dame		$13,980
Niger	Orphelinat Soeurs de Gethsemani		$8,094
Nigeria	Christian Health Association of Nigeria	$13,285,872	
Nigeria	GLRA		$616,160
Papua New Guinea	Catholic Health Services		$269,352
Papua New Guinea	Hope World Wide		$78,808
Papua New Guinea	Anglicare Stop AIDS		$125,821
Peru	Centro Parroquial Ecumenico Rosa Blanca		$228,357
Philippines	World Vision Development Foundation		$438,814
Russian Federation	Kaliningrad Religious Organization, Catholic Charitable Center Karitas – Zapad		$38,819

Senegal	ONG Alliance Des Religieux		$26,217
Senegal	ONG CCF-CAMA		$26,217
Senegal	ONG World Vision		$26,217
Sierra Leone	Council of Churches in Sierra Leone		$47,415
Sierra Leone	World Vision – SL		$84,925
Sierra Leone	Adventist Development Relief Agency		$38,449
Sierra Leone	Christian Health Association – SL		$25,510
Sierra Leone	United Methodist Church		$26,702
Sierra Leone	The Shepherd Hospice		$34,176
Sierra Leone	Young Women Christian Association		$13,018
Sierra Leone	Council of Churches – SL		$26,858
Sierra Leone	Methodist Church – SL		$29,671
Sierra Leone	Christian Children Fund		$73,799
Sierra Leone	Catholic Relief Service		$48,860
Sierra Leone	Sierra Leone Red Cross Society, Action for Development, Christian Children's Fund and World Vision		$140,331
Somalia	World Vision International	$3,158,422.93	$179,566.83
South Africa	YMCA		$63,317
South Africa	Youth for Christ – Knysna		$26,158
South Africa	Youth fro Christ – George		$72,002
South Africa	Nazareth House		$20,907
South Africa	Living Hope Care Centre		$232,059
South Africa	CMSR Bethesda Care Centre		$267,179
South Africa	Themba Care Centre		$64,011
Sri Lanka	Lanka Jatika Sarvodaya Shramadana Sangamaya	$1,230,490	
Sudan	World Vision International		$640,270
Sudan	World Vision Equatoria		$333,678
Sudan	ADRA		$485,297
Sudan	Diocese of Rumbek		$39,234
Sudan	World Relief		$381,585
Sudan	Diocese of Rumbek		$482,126
Sudan	World Vision International		$86,707
Sudan	World Relief		$58,011
Suriname	Medische Zending (Medical Mission) – Primary Health Care Suriname	$2,376,345.33	$37,590.33
Swaziland	Hope House; Nazarene Task Force; RFM; Scripture Union; Africa Evangelical; Anglican United Against HIV/AIDS; Church Forum; Parish Nursing; Faith Bible School; Evangelical Church; World Teach; Salvation Army; The		$801,917

	Voice of the Church; Shiloh Counseling; Mpolonjeni – Salvation Army; Shewula Nazarene		
Tanzania	World Vision (Training & Promotion)		$310,760.69
Tanzania	CSSC		$2,186,969
Tanzania	World Vision Tanzania		$573,553.59
Tanzania	Kanisa Katoliki Na Ukumwi (KAKAU)		$127,524.68
Tanzania	Christian Social Services Commission		$769,279
Thailand	NCA		$524,373
Thailand	World Vision Thailand – Ranong		$42,004
Thailand	Kwai River Christian Hospital		$28,741
Thailand	World Vision Thailand – Phangnga		$33,793.50
Thailand	Thai Catholic Commission for Seafarers		$70,213.82
Thailand	World Vision Foundation		$496,570.33
Togo	Unspecified FBO		$30,300
Uganda	All Saints Cathedral		$10,726.38
Uganda	Bishop Masereka		$40,281.28
Uganda	Christian Children's Fund		$462,090.88
Uganda	Catholic Relief Services		$410,377.95
Uganda	Deliverance Church Uganda		$8,825.09
Uganda	Golgotha Mission		$10,771.32
Uganda	Inter-Religious Council		$494,709.74
Uganda	Islamic Medical Association		$61,647.59
Uganda	Lutheran World Federation		$60,112.61
Uganda	Mild May International		$2,632,588.25
Uganda	Teso Gospel Foundation		$19,898.16
Uganda	Uganda Muslim Tabliq		$25,171.10
Uganda	Uganda Catholic Secretariat		$102,229.32
Uganda	Uganda Muslim Rural Development Association (UMURDA)		$36,026.92
Uganda	Uganda Protestant Medical Bureau		$21,617.58
Uganda	Watoto Child Care Ministires – KPC		$611,229.45
Uganda	World Vision		$149,903.33
Zambia	Churches Health Association of Zambia	$4,764,261.89	$1,463,717.06
Zambia	Diocese of Ndola		$464,195.24
Zambia	Kabwe Adventist Family Health Institute		$369,894.36
Zambia	Mindolo Ecumenical Foundation		$254,382.33
Zambia	Diocese of Mansa		$251,665.04
Zambia	Diocese of Monze		$195,967.95

Zambia	Evangelical Fellowship of Zambia		$183,705.11
Zambia	Diocese of Mongu		$138,122.77
Zambia	Expanded Church Response		$131,224.99
Zambia	Council of Churches in Zambia		$118,766.54
Zambia	Diocese of Chipata		$115,264.25
Zambia	Monze Mission Hospital		$102,964.71
Zambia	Zambia Inter-Faith Networking Group		$93,743.19
Zambia	Henwood Foundation		$86,118.33
Zambia	YWCA		$67,218.86
Zambia	Youth Alive Zambia		$50,221.65
Zambia	UCZ Presbytery		$43,578.35
Zambia	Mbereshi Mission Hospital		$36,402.21
Zambia	Envirogreen Association of Zambia		$25,565.81
Zambia	Lubwe Mission Hospital		$32,354.54
Zambia	Mambilima Mission Hospital		$31,058.11
Zambia	Mpongwe Mission Hospital		$26,328.84
Zambia	Mtendere Mission Hospital		$22,731.75
Zambia	Chibula Mission Hospital		$22,502.04
Zambia	Loloma Mission Hospital		$22,500.08
Zambia	Neelam		$21,202.55
Zambia	Mphunde RHC		$19,418.21
Zambia	Diocese of Solwezi		$19,410.72
Zambia	Katondwe Mission Hospital		$18,783.94
Zambia	Nyamphande RHC		$21,097.99
Zambia	Mukinge Mission Hospital		$17,754.33
Zambia	St. Paul’s Kashikishi Mission Hospital		$17,638.18
Zambia	Zimba Mission Hospital		$17,555.53
Zambia	St. Luke’s Mission Hospital		$17,204.77
Zambia	Macha Mission Hospital		$15,350.30
Zambia	Ibenga Community HBC		$13,299.32
Zambia	St. Anthony RHC		$13,132.79
Zambia	Nangoma Mission Hospital		$12,651.57
Zambia	Chipembi RHC		$12,592.53
Zambia	St. Mary’s RHC		$12,512.86
Zambia	Prisons Fellowship of Zambia		$11,613.47
Zambia	Coptic Hospital		$11,072.65
Zambia	ICOZ		$10,930.32
Zambia	Nyanje Mission Hospital		$10,916.67
Zambia	Fiwale RHC		$10,085.87
Zambia	Minga Mission Hospital		$10,020.79
Zambia	Chishere Homes		$8,539.21
Zambia	Mwami Mission Hospital		$7,278.85
Zambia	Kwenuwa Women Association		$6,6649.28

Zambia	St. Francis Hospital		$6,109.84
Zambia	Mulungushi RHC		$5,783.96
Zambia	Dawn Trust Community Care		$5,681.65
Zambia	Simwatachela RHC		$5,106.89
Zambia	Kayami RHC		$4,986.96
Zambia	Kafulafuta RHC		$4,923.46
Zambia	Luawu RHC		$4,611.23
Zambia	Isubilo Community Centre		$4,554.30
Zambia	Mulanga RHC		$4,371.43
Zambia	Chilubula Mission Hospital		$3,712.93
Zambia	Chinika House		$2,846.44
Zambia	Zamani Isipo Support		$2,664.98
Zambia	Njase RHC		$2,052.71
Zambia	Incommunity Care for Orphans		$1,934.40
Zambia	Mupapa RHC		$1,878.06
Zambia	Sachibondu RHC		$1,878.06
Zambia	Kalene Mission Hospital		$1,845.24
Zambia	St. Luke's Mission Hospital		$1,728.55
Zambia	Kaparu RHC		$683.15
Zambia	Churches Health Association of Zambia	$916,617.33	$574,300.68
Zambia	Kalene		$27,640.62
Zambia	Mtendere MH		$26,881.47
Zambia	Chikuni MH		$23,941.28
Zambia	Lumezhi Mission Hospital		$23,630.37
Zambia	Chilubula MH		$19,188.03
Zambia	Mupapa Bendet Project		$18,670.84
Zambia	Kayambi Mission RHC		$16,056.20
Zambia	Lukolwe MH		$15,519.94
Zambia	Mpunde RHC		$15,519.94
Zambia	St. Luke's MH		$14,929.66
Zambia	Mulanga RHC		$14,920.56
Zambia	Mulungushi RHC		$14,020.23
Zambia	Monze Mission Hospital		$12,283.70
Zambia	Chingombe Mission Hospital		$12,146.59
Zambia	Chivuna Mission Rural Health Centre		$6,481.62
Zambia	Sikalongo Mission Health Centre		$6,455.84
Zambia	Minga Mission		$6,232.19
Zambia	Katondwe Mission Hospital		$4,196.29
Zambia	Nyanje Mission Hospital		$3,961.54
Zambia	Chabbobboma Mission RHC		$3,668.09
Zambia	Jagaimo Mission RHC		$3,668.09
Zambia	Kalichero (Muzeyi) Mission Rural Health Centre		$3,668.09
Zambia	Lubwe Mission Hospital		$3,668.09
Zambia	Mangango Mission Hospital		$3,668.09
Zambia	Masuku Mission Rural		$3,668.09

	Health Centre		
Zambia	Mbereshi Mission Hospital		$3,668.09
Zambia	Mumbezhi Mission RHC		$3,668.09
Zambia	Mwandi Hospital TB Global		$3,668.09
Zambia	Namwianga RHC Malaria		$3,668.09
Zambia	Siamwatachela RHC		$3,668.09
Zambia	Sichili Mission Hospital		$3,668.09
Zambia	Yuka Mission Adventist Hospital		$3,668.09
Zambia	Kasaba Mission Hospital (St. Margrets)		$3,521.37
Zambia	Mambwe Mission RHC		$3,081.20
Zambia	Kanyanga Mission Health Centre		$2,878.75
Zambia	St. Joseph RHC		$2,564.10
Zambia	Churches Health Association of Zambia	$3,036,406.40	$2,132,124.92
Zambia	Anglican Diocese of Mansa		$27,397.44
Zambia	Mpongwe Mission Hospital		$22,066.95
Zambia	Prisons Fellowship		$21,954.42
Zambia	St. Paul Hospital		$21,878.92
Zambia	Mishikishi RHC		$21,821.94
Zambia	Namwianga RHC		$21,608.26
Zambia	Simwatachela RHC		$21,578.06
Zambia	Nangoma RHC		$21,280.63
Zambia	Mtendere Mission Hospital		$20,965.81
Zambia	Mbereshi Hospital		$19,771.79
Zambia	St. Margaret's Mission Hospital		$19,149.29
Zambia	Lukolwe Mission RHC		$18,535.33
Zambia	St. Theresa Mission Hospital		$18,049.86
Zambia	Mankunka RHC		$17,860.40
Zambia	Chipili RHC		$16,864.74
Zambia	Lubwe Mission Hospital		$16,686.32
Zambia	Kafulafuta Mission RHC		$16,049.86
Zambia	Mpunde RHC		$15,810.54
Zambia	Chipembi RHC		$15,611.11
Zambia	Mupapa Bendet Project		$15,609.40
Zambia	Zimba Mission		$15,392.88
Zambia	Mangango Mission Hospital		$15,125.36
Zambia	Sikalongo RHC		$14,928.49
Zambia	Kaparu RHC		$14,237.61
Zambia	Sachibondu RHC		$14,165.31
Zambia	St. Anthony Mission		$13,844.73
Zambia	St. Joseph Mission Hospital		$13,844.73
Zambia	Mumbezhi RHC		$13,639.32
Zambia	Katondwe Mission Hospital		$13,593.73
Zambia	Santa Maria Mission Hospital		$13,562.68

Zambia	Njase RHC		$13,503.99
Zambia	Luampa Mission Hospital		$13,415.95
Zambia	Mulungushi RHC		$12,968.66
Zambia	Chilubula Hospital		$12,858.69
Zambia	St. Luke Hospital Mphanshya		$12,780.70
Zambia	Mungwi RHC		$12,535.61
Zambia	St. Mary RHC		$12,420.23
Zambia	Nyampande RHC		$11,995.73
Zambia	Chikankata Hospital		$11,318.02
Zambia	Fiwale RHC		$11,109.69
Zambia	Chabbobboma RHC		$10,769.23
Zambia	Mwami Hospital		$10,547.36
Zambia	Catholic Diocese of Chipata		$10,400.28
Zambia	Kafue Mission RHC		$10,354.70
Zambia	Sichili Mission Hospital		$10,314.81
Zambia	Chivuna RHC		$9,972.93
Zambia	Masuku Mission RHC		$9,824.50
Zambia	Mwandi Hospital		$9,712.25
Zambia	Siachitema RHC		$9,686.61
Zambia	Loloma Mission		$9,685.19
Zambia	Mambilima Mission Hospital		$9,538.46
Zambia	Ipafu RHC		$9,401.71
Zambia	Nyanje Hospital		$9,355.84
Zambia	Foundation of Community Action		$9,097.22
Zambia	Monze Mission Hospital		$8,988.60
Zambia	Kutemwa Ndikusamala Ministries		$8,339.03
Zambia	Chinyingi Mission RHC		$7,727.64
Zambia	Jacaimo RHC		$7,434.18
Zambia	National Baptist		$7,407.41
Zambia	St. Francis Hospital		$5,938.82
Zambia	Chikuni Mission RHC		$5,585.47
Zambia	Kalichero RHC TB		$5,585.47
Zambia	Good Shepherd Prison Ministries		$5,135.33
Zambia	Lwawu Mission Hospital		$4,823.72
Zambia	Kamoto Hospital		$4,592.59
Zambia	Community Based TB Programme		$4,586.89
Zambia	Sitoti RHC		$4,558.40
Zambia	Kalene RHC		$4,548.43
Zambia	Illondola RHC		$4,501.42
Zambia	Chinika House (Sacred Heart Sisters)		$3,595.44
Zambia	Macha Hospital		$3,418.80
Zambia	Sioma Mission Hospital		$3,133.90
Zambia	Chilonga Mission Hospital		$1,760.68
Zambia	Mambwe Mission RHC		$1,555.27
Zambia	Minga Hospital		$1,424.50
Zambia	Muzeyi RHC		$1,424.50
Zambia	Lumezi Mission Hospital		$880.34
Zambia	Yuka Mission Hospital		$880.34
Zambia	Churches Health Association of Zambia	$3,668,853	$1,692,408.17

Zambia	Chilanga Hospice Lusaka		$108,221.37
Zambia	Chipembi Hospital		$20,945.09
Zambia	Coptic Hospital Lusaka		$127,673.49
Zambia	Loloma Mission Hospital		$126,853.06
Zambia	Lubwe Mission Hospital		$103,492.95
Zambia	Mbereshi Mission Hospital		$111,702.27
Zambia	Monze Mission Hospital		$199,498.88
Zambia	Mpongwe Mission Hospital		$150,010.27
Zambia	Mwami Mission		$183,216.94
Zambia	Nangoma Mission		$136,403.56
Zambia	Nyanje Mission Hospital		$133,753,35
Zambia	St. Fidelis Chilubula		$161,589.67
Zambia	St. Luke's Mission Hospital		$107,225.51
Zambia	St. Paul's Kashikishi Mission Hospital		$181,223.95
Zambia	Zimba Mission		$124,643.48
Zambia	Churches Health Association of Zambia		$426,456.24
Zambia	Churches Health Association of Zambia	$2,333,978.75	$1,656,645.19
Zambia	Fiwale RHC		$15,253.41
Zambia	St. Theresa		$14,476.70
Zambia	Mpongwe MH		$13,305.52
Zambia	St. Anthony		$12,806.80
Zambia	Kafue RHC		$12,728.89
Zambia	Ipafu RHC		$11,202.01
Zambia	Zimba MH		$9,662.70
Zambia	Kanyanga RHC		$8,906.55
Zambia	Mtendere MH		$7,707.72
Zambia	Mulanga RHC		$7,692.08
Zambia	Mwami Adventist Hospital		$5,803.26
Zambia	Nangoma MH		$4,590.84
Zambia	Lukolwe RHC		$4,173.99
Zambia	St. Paul's Mulungushi		$4,042.27
Zambia	Macha MH		$3,619.89
Zambia	Loloma MH		$3,532.47
Zambia	Kaparu RHC		$3,310.21
Zambia	Mpunde RHC		$3,133.02
Zambia	Mpanshya MH		$3,034.13
Zambia	St. Joseph		$2,901.63
Zambia	Kafulufuta RHC		$2,801.57
Zambia	Luampa MH		$2,601.46
Zambia	Mishikishi RHC		$2,401.35
Zambia	St. Kalemba		$1,262.84
Zambia	Chipembi RHC		$708.75
Zambia	Chinyingi Mission Hospital		$332.23
Zambia	St. Kalemba MH		$332.23
Zambia	St. Paul's Mulungushi		$310.08
Zambia	Chingombe RHC		$155.04
Zanzibar (Tanzania)	Unspecified FBO		$87,574.90
Zimbabwe	Zimbabwe Association of Church Related Hospitals		$1,783,525

Appendix 3: Decision Point on Dual-Track Financing: Global Fund 15th Board Meeting

Strengthening the Role of Civil Society and the Private Sector in the Global Fund's Work

Decision Point GF/B15/DP14:
The Board believes that civil society and the private sector can, and should, play a critical role at all levels of the architecture and within every step of the processes of the Global Fund, at both the institutional and country levels. This includes their critical roles in the development of policy and strategy and in resource mobilization at the Global Fund Board level, and in the development of proposals and the implementation and oversight of grants at the country level. The Board further expresses its desire for strengthened and scaled-up civil-society and private-sector involvement at both the country and Board levels, while recognizing the respective strengths and roles of the two sectors.

With this goal in mind – and also reaffirming the importance of effective Country Coordinating Mechanisms (CCMs)[11] in ensuring strong country-level development of proposals and oversight of grants – the Board recognizes the need to further enable civil society and the private sector to play their critical roles, facilitated by the following:

- The routine inclusion, in proposals for Global Fund financing, of both government and non-government Principal Recipients (PRs) for Global Fund grants ("dual-track financing"). The Board recommends the submission of proposals with both government and non-government PRs. If a proposal does not include both government and non-government PRs, it should contain an explanation of the reason for this;

- The routine inclusion, in proposals for Global Fund financing, of requests for funding of relevant measures to strengthen the community systems necessary for the effective implementation of Global Fund grants;

- The effective representation and meaningful participation of vulnerable groups (as defined in the context of each particular country) on CCMs; and

- Simplified CCM access to funding to support their effective administrative functioning, for the life of a grant that the CCM is overseeing when needed, and increased transparency by CCMs about how they plan to ensure access by civil society to such funding.

The Board requests the Secretariat to take the necessary actions and collaborate with partners to achieve the above outcomes, working with the relevant Board committee(s), where necessary.

In particular, the Board requests the Policy and Strategy Committee to agree on a suitable definition of the term "civil society", by building on existing work to that effect.

In addition, the Board requests the Portfolio Committee (PC) to do the following:

- Modify future proposal forms and guidelines (starting with those for Round 8) to encourage the use of dual-track financing and the inclusion of funding requests for strengthening community systems in proposals;

[11] All references to a CCM include – in addition to a Country Coordinating Mechanism – a Sub-National CCM and a Regional Coordinating Mechanism, and in the case of a non-CCM proposal (where relevant) a grant applicant.

- Propose means to increase the representation of vulnerable groups on CCMs, such as by revising the relevant, current recommendation on the composition of CCMs;
- Propose guidance to CCMs regarding types of civil-society and private-sector representatives that could be most relevant to the work of CCMs;
- Propose appropriate modifications to the policy or guidance on the funding for CCM activities;
- Propose guidance on increasing the capacity of the Technical Review Panel in the area of civil society and the private sector; and
- Report on progress at the Sixteenth Board Meeting.

Regarding dual-track financing, the Board notes the following:

- The possible benefits achieved through dual-track financing include increased absorption capacity (from taking full advantage of the implementation capacity of all domestic sectors, both governmental and non-governmental), accelerated implementation and performance of grants, and the strengthening of weaker sectors; and
- CCMs, PRs and the Secretariat should implement dual-track financing according to the following principles:
  - The implementation should be consistent with alignment and harmonization of efforts to fight the three diseases;
  - It should be consistent with national strategies to fight the three diseases, or there should be a justification stated when this is not the case;
  - It should seek to minimize transaction costs and demands on CCMs, PRs and the Secretariat;
  - It should apply equally the same expectations of accountability, transparency and responsibility to government and non-government PRs; and
  - It should seek to be consistent with national plans for human resources for health.

The Board requests the Secretariat to consult with the Finance and Audit Committee to further analyze and refine the estimates of budgetary implications, including possible costs and savings, of this decision and report its findings to the Sixteenth Board Meeting.

Appendix 4: Annex 1 to CCM Guidelines

Guidelines on Types of Civil Society and Private Sector Representation Most Relevant to the Work of CCMs

For each CCM, it is necessary to consider the types of civil society and private sector representatives who would be valuable to the CCM at present and in the future, as the role and importance of partnership among these sectors increases, particularly in proposal development and grant oversight. These guidelines are intended to provide guidance for CCMs wishing to strengthen and/or improve the representation of civil society and private sector representatives.

Civil Society Representatives

The kinds of civil society representatives who would be integral to these processes would ideally include, but would not be limited to, individuals or organizations representing:

i. ***Vulnerable groups/key populations:*** these organizations represent those persons who are most knowledgeable about what it means to be living with/affected by one or more of the three diseases and represent the needs of disparate key affected groups; vulnerable groups may also have a better understanding of how to increase access to services for reach hard-to-reach populations.

ii. ***Womens organizations:*** women and young girls are often most affected by the three diseases and are particularly vulnerable due to physiological and socio-economic factors. It is important that women's organizations, as well as other organizations, representing the concerns of women, are well-represented on CCMs to ensure that programmatic issues relating to gender are reflected in proposals to the Global Fund.

iii. ***Children and Young People:*** Children and *young* people should be represented on the CCM, through youth groups, organizations, national and international NGOs working with children and young people infected and affected by the three diseases.

iv. ***International NGOs working in the three diseases:*** International non-governmental organizations (INGOs) are valuable to CCMs as they generally have strong connections with community level stakeholders and vulnerable populations; they have experience in implementation and are well-placed to contribute valuable insight into proposal development and the determination of programmatic activities; and INGOs also may have strong relationships with other sectors, including governments, multi/bilateral organizations which are valuable to partnership building. Some INGOs are also well-placed to further support the participation of vulnerable and marginalized groups on CCMs, through capacity building or support towards the attendance of hard-to-reach groups.

v. ***Experienced national NGOs working in the three diseases:*** National non-governmental organizations working in the three diseases know in particular the needs of communities outside of large urban areas and understand the disparate needs of key populations. They are often involved in the delivery of services as well as in prevention and education programs; they have strong community networks and are often aware of additional initiatives being conducted in a given setting.

vi. ***Religious and Faith-Based Groups:*** In many settings religious and faith based organizations play vital role in reaching communities infected and affected by the three diseases. Not only do these organizations and groups provide crucial services but some are instrumental in convincing political leaders at the national, regional and local level prioritize the needs of affected populations. They are increasingly becoming involved in implementation of interventions and provide a valuable role in the development of effective proposals.

vii. ***Academia:*** members from academic institutions bring a range of knowledge of the epidemic, as well as social, political and cultural determinants involved in fighting the three diseases, including knowledge of key affected groups as well as insight into demographical factors and potential challenges to scaling up activities.

Private Sector Representatives

Given the breath of expertise and resources that the private sector can provide, the GGM can benefit greatly from including companies and organizations that represent the most relevant facets of the private sector, which include, but are not limited to, the following kinds of companies and organizations:

i. ***Large for-profit companies with a proven commitment to fight the three diseases****:* a wide range of large national or multinational companies have pioneered company-specific responses to fight against HIV/AIDS, TB and malaria. Representative from these companies can not only provide leadership and expertise to GeMs and grant implementers, but also draw on the significant resources of their respective companies in supporting the scale-up of national programs.

ii. ***Organizations representing small & mid-sized enterprises (SMEs) and the informal sector:*** In most developing countries, the majority of private enterprises are subsistence micro-enterprises, most of which are concentrated in low value added sectors and operate in the informal sector. The SME and informal sector accounts for an average of over 50% of all economic activity and thus can give a voice to the majority of people who are economically active in most countries. Representatives from these sectors can support the design and implementation of programs which are relevant to a very large share of the economy and workforce.

iii. ***Business associations to fight HIVIAIDS, TB and malaria:*** In many affected countries, as well as internationally, socially responsible companies have formed associations and networks to combat the three diseases. Their goal is often to promote and support the implementation of health programs in the workplace (and the community more broadly) and to draw on the collective expertise and resources of member companies in supporting local, national and international efforts to combat the three diseases. These associations can provide insight into using private sector expertise and infrastructure to reach severely affected communities, and draw on their networks of companies to support and participate in the more efficient and effective design and implementation of programs.

iv. ***Representatives from exposed industries:*** Certain industries are more affected by the three diseases, including transportation, agriculture, oil & gas and mining. For-profit companies, business coalitions and/or employers associations who represent the exposed industries can offer insight and support for sector-specific interventions that can reach higher risk groups of workers and communities.

v. ***Private practitioners and for profit clinics:*** In many affected countries, the private health care sector provides services to large parts of the population and thus play vital role in the scale-up of national interventions. Representatives from this sector can provide valuable insight into the design of programs which can best leverage private health care services to complement the public health system as well as identify appropriate practitioners and clinics to involve in grant implementation.

vi. ***Charitable foundations established by corporations:*** Many large private philanthropic foundations or foundations established by companies have extensive experience in supporting HIV and AIDS, TB and malaria programs in different country contexts. These organizations can be an invaluable source of international expertise, as well as provide resources to support GGMs and program implementation.

Appendix 5: Further Reading

A number of case studies and articles have been written, highlighting the successful relationship between the Global Fund and faith-based organizations. Links to further reading in this regard may be found at:

Thailand: Faiths unite to help people living with AIDS generate income

http://www.theglobalfund.org/en/in_action/thailand/hiv3/
This article reflects on Norwegian Church Aid as a sub-recipient. Currently 2500 people living with HIV in Prao District in Chiang Mai province are supported through free food, medicine, counseling, other health services, and income generating projects at 60 Buddhist, Muslim, Catholic and Protestant places of worship

Thailand: Monks supporting prevention and care programs

http://www.theglobalfund.org/en/in_action/thailand/hiv2/
Buddhist monks have educated over 300,000 people on HIV prevention through Global Fund-supported projects to the Ministry of Health and Raks Thai Foundation

Uganda: Uniting different faiths to fight AIDS

http://www.theglobalfund.org/en/in_action/uganda/hiv2/
The first-ever Award for Commitment against AIDS by the Friends of the Global Fund Africa was given to Rev. Canon Gideon Byamugisha of Uganda. In 1992, Rev. Byamugisha became the first African religious leader to openly disclose his HIV+ status. He later went on to found the International Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (INERELA+), which is comprised of Buddhist, Christian, Hindu, and Muslim religious leaders in over 20 countries.