CDC ENGAGEMENT WITH THE GLOBAL FUND: CURRENT APPROACHES AND OPPORTUNITIES FOR ENHANCED COLLABORATION

Zara Ahmed

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Approved by:

Sandra B. Greene

Edward L. Baker, Jr.

Bruce Fried

Jim Herrington

Clint Liveoak

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ABSTRACT

Zara Ahmed: CDC Engagement with the Global Fund: Current Approaches and Opportunities for Enhanced Collaboration
(Under the direction of Sandra Greene)

The U.S. Centers for Disease Control and Prevention (CDC) is one of the U.S. government's (USG) largest public health agencies and leading implementers of global health programs. Primarily a domestic agency, CDC has expanded its global health work dramatically over the last 15 years via the President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative (PMI), and global tuberculosis control efforts, as well as through the Global Health Security Agenda and international Ebola response. To maximize the use of these resources and leverage funding from other partners, CDC has sought to increase collaboration with the Global Fund to Fight AIDS, TB, and Malaria (GF). Created in 2002, GF is a multilateral partnership that raises money from governments, the private sector, and civil society to combat these three major infectious diseases. Together, the USG (including CDC) and GF control 27% of all global health funds, over $9 billion annually, and jointly work in 63 countries. Given the significant funding being invested by both entities, maximizing programmatic and financial synergy is imperative for sustaining the public health gains supported by these organizations. However, little is currently understood about how CDC staff engage with GF and opportunities for improvement.

The primary, overarching research question of this study was how can CDC improve collaboration with GF at headquarters and country levels in order to increase the impact of health investments by both entities. This analysis utilized both quantitative and qualitative data collected from CDC staff in two stages to broadly assess current CDC engagement with GF at various levels. The study found that there is a high degree of interest among CDC staff in GF and that engagement with GF is

considered very important to their work, but that they were not necessarily maximally effective in their collaboration. CDC staff face multiple challenges regarding GF, including low levels of self-reported knowledge, lack of training, unclear support and communication systems, and deficiency in dedicated staff or time for engagement. There is a desire for more strategic direction, training, and prioritization of GF collaboration, particularly among country-based staff.

For my mentors, past and present, who always believed

and

For the strong, smart, brave, funny women who make this world better

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To the members of Cohort 11, this was a team effort. Across time zones, organizations, and interests, you have been an inspiration and endless source of encouragement. We are certainly a handful but also hilarious, dynamic, creative, and passionate. How lucky I am to have had this experience with you all.

To my family and friends, who have put up with me over these last three years (and decades before that). Apologies for my crankiness, long periods of anti-social behavior, and boring you with tales of the Global Fund.

To the staff of CDC, the Global Fund, and other global health organizations, thank you for the work you do everyday and your commitment to health access and equity. The processes may be tedious and the payoffs distal, but your efforts will put an end to the epidemics of HIV, TB, and malaria, creating a healthier world for generations to come.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CGH	Center for Global Health
CN	Concept Note
COM	Chief of Mission
COP	Country Operational Plan
DGHP	Division of Global Health Protection
DGHT	Division of Global HIV/AIDS and TB
DOS	Department of State
DPDM	Division of Parasitic Diseases and Malaria
DTBE	Division of Tuberculosis Elimination
FPMT	Fund Portfolio Management Team
GF	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GID	Global Immunization Division
HHS	Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HQ	Headquarters
HSS	Health Systems Strengthening
KNCV	Koninklijke Nederlandse Centrale Vereniging (Dutch Tuberculosis Foundation)
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOP	Malaria Operational Plan
NFM	New Funding Model
NGO	Non-government Organization

OD	Office of the Director
OGAC	Office of the Global AIDS Coordinator
OSAG	Overseas Advisory Group
PAHO	PanAmerican Health Organization
PEPFAR	President’s Emergency Plan for AIDS Relief
POC	Point of Contact
PR	Principal Recipient
PMI	President’s Malaria Initiative
QI	Quality Improvement
RA	Resident Advisor
RBM	Roll Back Malaria
SR	Sub-Recipient
TA	Technical Assistance
TRP	Technical Review Panel
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
UNICEF	United Nations Children's Emergency Fund
USG	United States Government
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

The U.S. Centers for Disease Control and Prevention (CDC) is one of the U.S. government's largest public health agencies and leading implementers of global health programs.[1] Primarily a domestic agency, CDC has expanded its global health work dramatically over the last 15 years. With the creation of the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI) in 2003 and 2005 respectively, and subsequent establishment of new CDC offices in dozens of countries, CDC has dramatically expanded its footprint and role in global public health. Along with the U.S. Agency for International Development (USAID), CDC is charged with the implementation of these initiatives, as well as U.S. Government (USG) global tuberculosis control efforts, known as TB Care 1.0 and 2.0. Further expansion of CDC's global reach has been achieved through the Global Health Security Agenda and the international Ebola response.

In order to maximize the use of these resources and leverage funding from other partners, CDC has sought to increase collaboration with major global health players, including UN agencies, foundations, other bilateral donors, and multilateral organizations. Chief among these has been the Global Fund to Fight AIDS, TB, and Malaria (GF). Created in 2002, GF is a multilateral partnership organization that raises money from governments, the private sector, and civil society to combat these three major infectious diseases.[2] GF is primarily a financing institution and does not implement programs on the ground in developing countries, but rather relies on local governments and non-governmental partners to do so. A Country Coordinating Mechanism (CCM) is constituted in-country to serve as a forum for reviewing and monitoring GF grants, with membership from various sectors and a diversity of actors

[1]U.S. Centers for Disease Control and Prevention, Global Health Strategy, 2012—2015. Accessed February 11, 2018. https://www.cdc.gov/globalhealth/strategy/pdf/CDC-GlobalHealthStrategy.pdf.
[2]The Global Fund, Overview. Accessed February 11, 2018. https://www.theglobalfund.org/en/overview/

(e.g., host government, other donors, civil society). Funding applications from the country, known as Concept Notes (CN), come through the CCM to GF headquarters (HQ) in Geneva, where they are reviewed by the Technical Review Panel (TRP), an independent committee of experts. GF allocates approximately 50% of global funding to HIV/AIDS, 32% to malaria, and 18% to TB; funding limits are set for countries based on disease burden, income status, and other factors.[3] Once the grant is made, it is overseen by the CCM, an external auditing firm in-country (known as the Local Fund Agent [LFA]), and a dedicated team from GF HQ (known as the Fund Portfolio Management Team [FPMT]). The overall operations and strategy of GF is set by its Board. The U.S. Government is represented on the GF Board by the U.S. Global AIDS Coordinator (for the U.S. Department of State) and the U.S. Assistant Secretary for Global Affairs (for the U.S. Department of Health and Human Services). The USG is also the largest contributor to GF, annually comprising up to one-third of all funding provided to the financing facility.[4] Table 1 summarizes funding by both entities for the three diseases.

Table 1: GF and USG Funding in Millions (2017)[5]

Source	HIV	TB	Malaria	Total
GF (Disbursement)	$1,524	$731	$1,335	$3,590
USG (Budget)	$5,210	$191	$723	$6,124
Total	**$6,734**	**$922**	**$2,058**	**$9,714**

[3]The Global Fund, Detailed Explanation of the Allocation Methodology 2017—2019. Accessed February 11, 2018. https://www.theglobalfund.org/media/5642/fundingmodel_allocations2017-2019detailedexplanation_report_en.pdf
[4]The Global Fund, Financials. Accessed February 11, 2018. https://www.theglobalfund.org/en/financials/.
[5]The Global Fund, Portfolio Overview. Accessed April 28, 2017. http://portfolio.theglobalfund.org/en/Home/Index
U.S. President's Emergency Plan for AIDS Relief, PEPFAR Funding. Accessed April 28, 2017. https://www.pepfar.gov/documents/organization/252516.pdf
U.S. Centers for Disease Control and Prevention, FY15 Operating Plan. Accessed 28, 2017. https://www.cdc.gov/budget/fy2015/operating-plans.html
The U.S. President's Malaria Initiative, About Us. Accessed April 28, 2017. http://www.pmi.gov/about

According to analysis by the Institute for Health Metrics and Evaluation, the USG is the second largest channel of all global health funding, after NGOs and foundations, and GF is the fourth largest; together, the USG and GF control 27% of all global health dollars (IHME, 2015), over $9 billion annually (Table 1).[6] The USG and GF both share a focus on three infectious diseases: HIV, TB, and malaria, with over 91% of USG and 98% of GF resources being directed towards those epidemics.

There is also significant overlap in geographic focus, with 63 countries around the world currently receiving support from both GF and USG, and 130 receiving support from either (Table 2).

Table 2: Number of Countries Receiving GF and/or USG Support[7]

Category	HIV	TB*	Malaria	Any Program
Both GF and USG	56	15	24	63
GF only	61	96	51	60
USG only	9	1	1	7
Total	**126**	**112**	**76**	**130**

**USG TB countries are defined as those listed for CDC support on the CDC Global TB website. Eight of these countries are also priority countries for TB Care 2.0.*

After initial rapid scale up, funding for both GF and USG global health work has remained relatively flat since 2010 (Figure 1). However, the number of people in need of treatment for HIV continues to increase (Figure 2), and continued efforts are needed to sustain gains made in the fight against TB (Figure 3) and malaria (Figure 4). Continuing to provide needed services in an environment

[6]Institute for Health Metrics and Evaluation, Financing Global Health. Accessed February 11, 2018. http://www.healthdata.org/data-visualization/financing-global-health.

[7]The Global Fund, Funding Allocation Model. Accessed April 28, 2017. http://www.theglobalfund.org/en/fundingmodel/allocationprocess/
U.S. President's Emergency Plan for AIDS Relief, Bilateral Countries. Accessed April 28, 2017. http://www.pepfar.gov/countries/bilateral/index.htm
U.S. Centers for Disease Control and Prevention, Global TB Program. Accessed 28, 2017. http://www.cdc.gov/tb/topic/globaltb/work.htm
The U.S. President's Malaria Initiative, Where We Work. Accessed April 28, 2017. http://www.pmi.gov/where-we-work

with stagnant funding will require increased attention to efficiency and cost control by all actors, including GF and CDC.

Figure 1: Global Fund and USG Global Health Resources, 2006—2017[8]

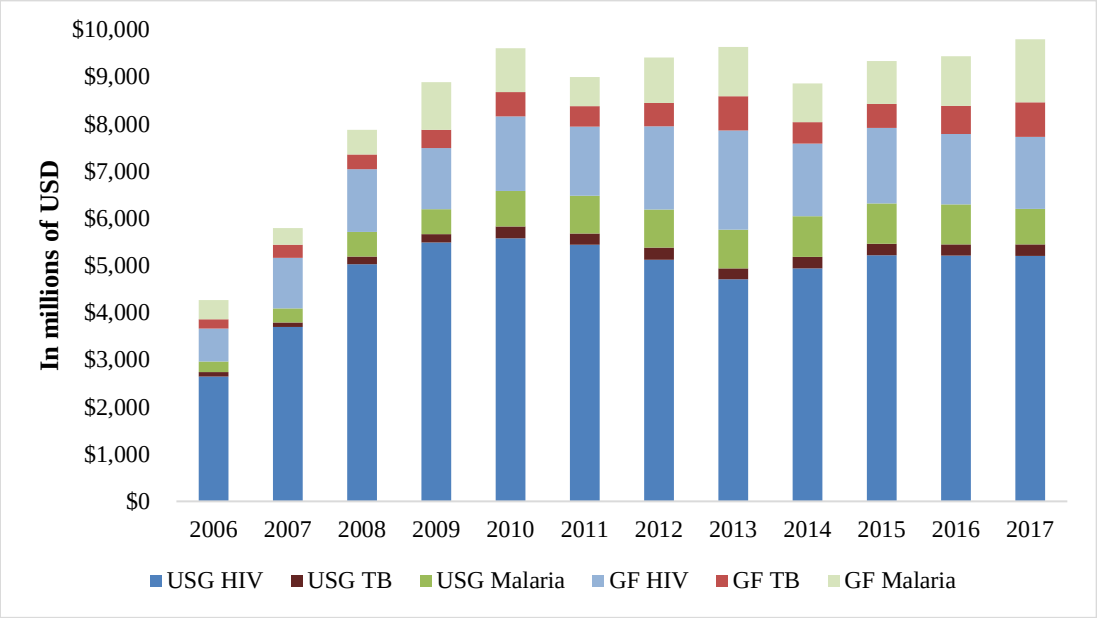
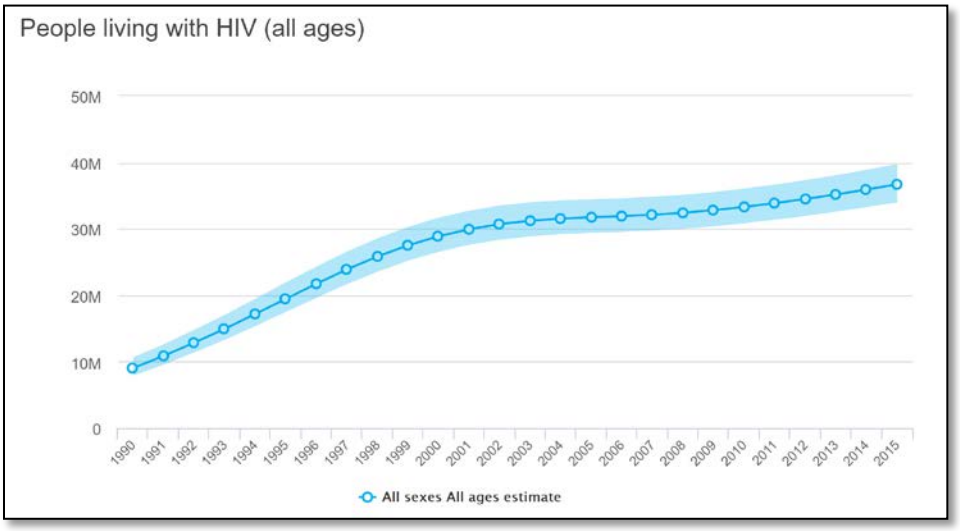


Figure 2: People Living with HIV Worldwide, 1990-2015[9]



[8]Kasier Family Foundation, U.S. Global Health Budget Tracker. Accessed February 11, 2018. https://www.kff.org/interactive/budget-tracker/landing/
The Global Fund, Financials. Accessed February 11, 2018. https://www.theglobalfund.org/en/financials/
[9] UNAIDS, AIDSInfo Tool. Accessed February 11, 2018. http://aidsinfo.unaids.org/

Figure 3: Global Trends in TB, 1990-2015[10]

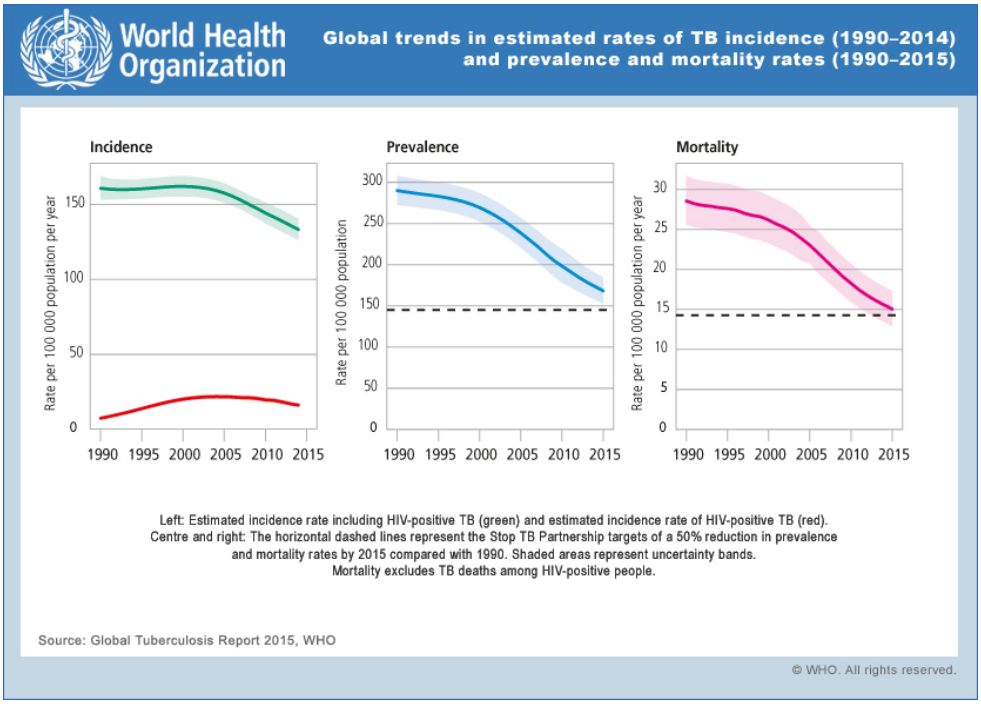
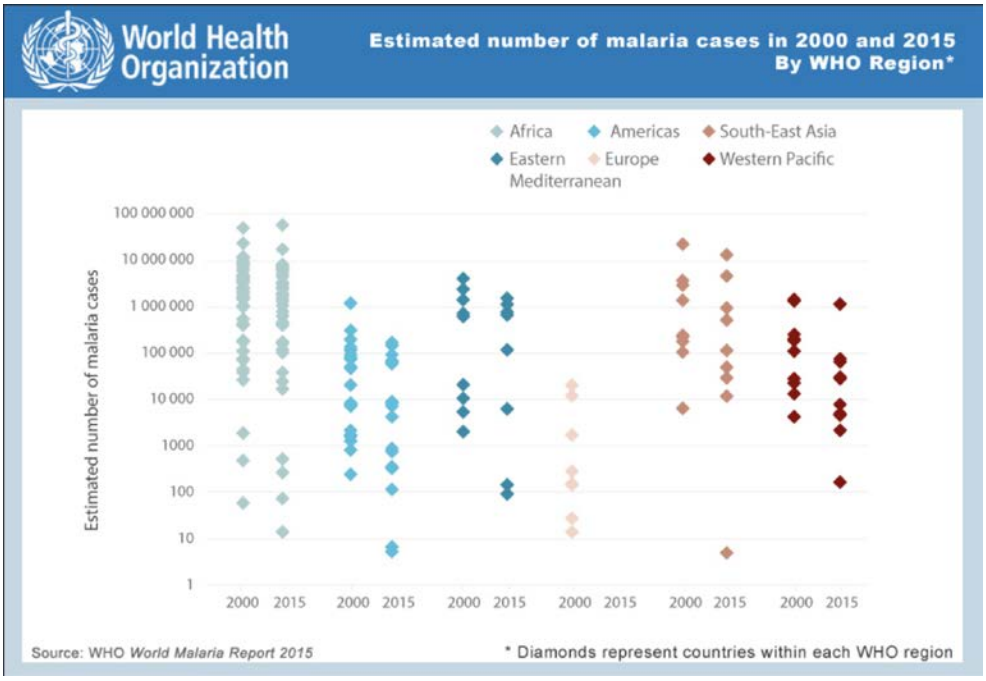


Figure 4: Global Trends in Malaria Cases, 2000-2015[11]



[10] World Health Organization, Global Trends in TB. Accessed February 11, 2018. http://www.who.int/gho/tb/epidemic/tb_001.jpg?ua=1

[11]World Health Organization, Malaria World Report. Accessed April 28, 2017. http://www.who.int/malaria/media/world-malaria-report-2015/en/

Given the significant funding being invested by both entities, as well as the epidemiologic demand, maximizing programmatic and financial synergy is imperative for sustaining the public health gains realized by these organizations. To this end, CDC has encouraged greater engagement by CDC HQ and field staff in GF processes and decision-making at various levels, with the hope of promoting more evidence-based and strategic choices. CDC staff routinely participate in various aspects of strategic and technical planning, budgeting, implementation, monitoring, and impact evaluation of activities supported by GF. Certain successes, challenges, and opportunities regarding CDC—Global Fund collaboration may be common across countries and disease areas, but have not been systematically documented and disseminated. This potentially hinders CDC encouragement of GF policy reform or improvements to technical approaches at the country level. Although efforts have been made to improve CDC contributions to GF processes over the past decade, CDC's engagement—at both the HQ and field levels—is often developed and implemented in an *ad hoc* manner, resulting in less than maximally effective strategic direction and impact of GF resources. CDC has an opportunity to improve coordination of its overall engagement with GF, as the CDC brings significant global health expertise and field experience in GF's three disease areas. The goal of this study is to examine current engagement by CDC with GF and to detail strategies for improvement. The overarching research question of this study is: How can CDC improve collaboration with the Global Fund at HQ and country levels in order to increase the impact of health investments by both entities?

DEFINITIONS

GF and CDC have unique systems, processes, and jargon, which can make understanding their relationship challenging. On the GF side, key terms include "New Funding Model" (NFM), which is the method employed for resource allocation by disease and country adopted for the 2014-2016 period. "Concept Note" (CN) is the grant application under the NFM, and "Country Coordinating Mechanism" (CCM) is the in-country oversight mechanism, usually comprised of representatives from government, other donors, civil society, implementing partners, and affected populations' representatives. "Fund

Portfolio Management Team" (FPMT) refers to the individuals from GF HQ in Geneva who oversee the portfolio and monitor performance.

On the USG side, CDC receives money from Congress through several multi-agency funding streams, including PEFPAR and PMI, as well as agency-specific appropriations for particular global health efforts. While CDC has some discretion over the distribution of funds between programs, many decisions are made by the Department of State. As such, CDC must work through the annual vertical planning processes for PEPFAR and PMI, known as the "Country Operational Plan" (COP) and "Malaria Operational Plan" (MOP) respectively, to shape the technical investments for a given country. There are a number of units within CDC involved in collaboration with GF, most notably the Center for Global Health (CGH) and its Division of Global HIV/AIDS and TB (DGHT) and Division of Parasitic Diseases and Malaria (DPDM).

CHAPTER 2: LITERATURE REVIEW

I conducted a literature review to answer the following research question:

What is the relationship between CDC and the Global Fund and how do the organizations engage with each other?

METHODS

I identified articles through iterative, systematic searches of major public health databases and scans of reference lists. The databases I reviewed included PubMed, PubMed Central, Scopus, Global Health, and Google Scholar. Reports from the Congressional Research Service were also searched. My search strategy employed the terms in the table below.

Figure 5: Literature Review Search Terms (Major and Replacement)

Major Terms	**Global Fund**	**AND**	**CDC**
Replacement Terms	GFATM GF Global Fund to Fight AIDS, TB, and Malaria		PEPFAR PMI TB Care US Government USG

Eligibility Criteria

Criteria for study inclusion were i) mention of GF and CDC (or one of the replacement terms above); ii) focus on, or discussion of, the relationship or interaction between the two; and iii) accurate initial description of GF and USG/CDC. Studies were excluded if they i) were about the technical work done by the organizations individually; ii) focused solely on their impact on civil society or other groups; iii) did not significantly discuss both organizations (i.e., only had passing mention of the other); or iv) did

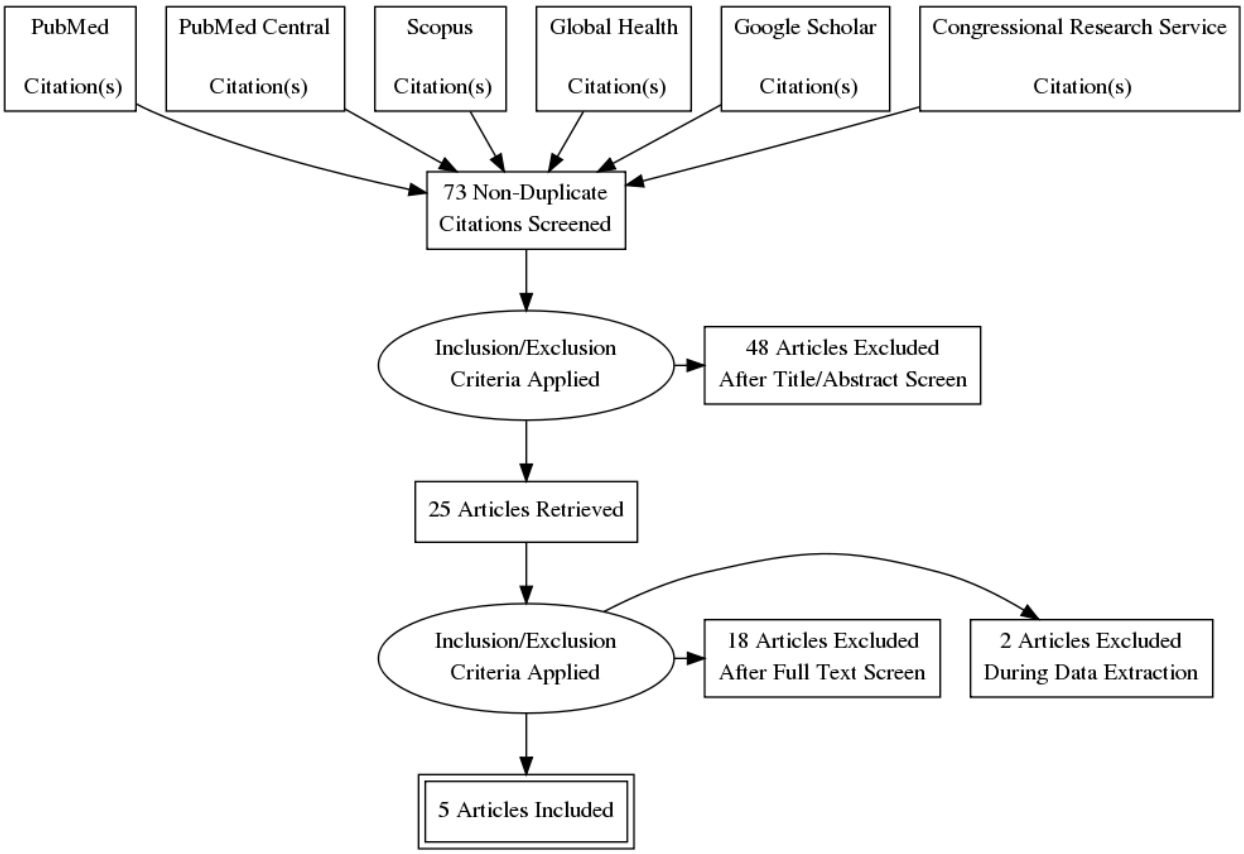
not discuss the interaction between the organizations. I considered including articles from outside the U.S. if they met the other criteria. Selected articles were English-language and either appeared in peer-reviewed publications or were prepared by well-established research organizations; blog posts, newspaper articles, and public fact sheets were excluded. The timeframe for this search was from 2002 to 2015, inclusive, given the establishment of GF in 2002.

RESULTS

Study Review and Selection

Once duplicate sources were removed, I reviewed titles and abstracts to assess potential relevance based on inclusion and exclusion criteria. In cases where it was unclear if the article fit the criteria, items were included and the full article retrieved. Of the 73 articles originally identified during the searches, 48 were excluded based on title and/or abstract (Figure 6). The remaining 25 articles were accessed and screened, 18 were excluded based upon the review of the full text, and two additional pieces excluded during the data review process. A scan of the bibliographies of the full text articles (snowballing) was done to identify any other potential items for inclusion but none were deemed relevant. A total of five articles were thus considered relevant and included in the review.

Figure 6: Results of Literature Search



Of the five articles identified, two were written by individuals directly engaged with PEPFAR (Ambassador Eric Goosby, US Global AIDS Ambassador and head of OGAC) and GF (Ms. Natasha Bilimoria, former President of the Friends of the Global Fight Against AIDS, Tuberculosis, and Malaria); two of the articles were written by academics, and one was written by a public policy researcher at the Congressional Research Service. While three of the articles reviewed global trends and impact, the other two (Hirsch et al, 2015; Bilimoria, 2012) focused on country case studies of Vietnam and Tanzania, respectively. Two of the articles (Bilimoria, 2012 and Goosby, 2012) focused solely, explicitly on the relationship between PEPFAR and GF; no articles were found that analyzed the relationship between CDC and GF specifically, or between PMI and/or TB Care and GF.

Table 3 below summarizes the characteristic of the articles included in this literature review.

Table 3: Articles Included in Review

Article	Authors	Affiliation(s)	Approach
The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS control	Biesma, et al. (2009)	UK universities	Systematic review
Lessons Learned from A Decade Of Partnership Between PEPFAR and the Global Fund: A Case Study from Tanzania	Bilimoria (2012)	Board of Directors, Friends of the GF	Case study (based on key informant interviews)
The Way Forward: Maximizing Our Impact Through Shared Responsibility and Smart Investments	Goosby (2012)	Global AIDS Ambassador (USG, OGAC)	Policy analysis and opinion
Caught in the Middle: The Contested Politics of HIV/AIDS and Health Policy in Vietnam	Hirsch, et al. (2015)	US and Vietnam universities	Case study and historical review
U.S. Global Health Assistance: Background and Issues for the 113th Congress	Salaam-Blyther (2013)	Congressional Research Service	Policy and financial analysis

After reviewing the selected articles several times for major themes and commonalities, it became clear that most or all of them covered three main elements: the nature of engagement beteween the entities, best practices for cooperation, and recommendations for improved coordination. This literature review captures key findings and analyses from the five articles in these areas.

NATURE OF ENGAGEMENT

Bilimoria provided the most detailed analysis of the day-to-day engagement between PEPFAR and GF, describing the frequency and types of communication (e.g., weekly phone calls, field visits), program coordination, and grant oversight between the two parties at the country level (largely in Tanzania, but also in Ethiopia and Zambia). Others, including Goosby (2012), posed questions and offered strategies (e.g., greater financial transparency and analysis, streamlining of operations) for enhancing partnerships but did not provide details on how such engagement currently occurs at the HQ or country levels. Similarly, Salaam-Blyther (2013) described the pros and cons of investment in GF and other multilaterals, compared to solely bilateral (i.e., PEPFAR, PMI, and TB Care) funding. The Biesma, et al (2009) systematic review highlighted the lack of harmonization in planning and funding between GF and other partners across countries, as well as challenges in divergent policies related to supply chain and support for civil society and health systems strengthening. Similar issues related to differences in the types of host country government engagement and technical priorities were also highlighted by Hirsch and colleagues (2015).

BEST PRACTICES

Only Bilimoria (2012) and Biesma (2009) identified best practices in USG and GF collaboration generally. These included greater stakeholder collaboration through planning and oversight processes (i.e., the CCM), and coordinated timing of disbursements to prevent gaps in funding of essential services. In Tanzania, joint planning and procurement helped avoid stock-outs of essential commodities (e.g., antiretroviral drugs, HIV test kits) and reduced drug theft and expiry. According to Biesma (2009), multiple countries benefited from enhanced communication and sharing of plans, as it produced greater transparency, accountability, and ability to anticipate future needs. In addition, Bilimoria (2012) cited USG participation in the CCM and grant application processes, as well as jointly funded projects, as successes in Tanzania as they improved program operations and oversight.

RECOMMENDATIONS

Based on the Tanzania case study, Bilimoria (2012) offered several technical recommendations for enhanced engagement, including sustained communication, allocating increased resources to oversight structures in-country, and greater alignment between national strategies. Hirsch and colleagues' (2015) recommendations largely revolved around the timing and approach to policy intervention by donors (i.e., joint agreement on program priorities, geographic areas of focus), including USG and GF, but do not discuss how they should coordinate efforts.

DISCUSSION AND LIMITATIONS

My review indicates a dearth of analysis on collaboration between USG and GF, with the exception of a few articles regarding work on HIV/AIDS. Overall, the articles included in this literature review did not examine, in detail, the ways in which the USG (and CDC in particular) and GF engage across countries and HQ, and could only provide examples from a few countries to support their general claims. While much of the focus has been on prior types of engagement, very little has been done to consider future, alternative means of collaboration, especially as USG and GF reform their own approaches to global health and set new priorities.

From my review of the existing literature, it is clear that there has been no systematic, holistic documentation and analysis of the dynamic between CDC and GF. My research sought to fill that gap and more fully describe the relationship between these two global players. The goal of this study was to examine current engagement by CDC with GF and detail strategies for improvement. More specifically, the primary, overarching research question of this study was: *How can CDC improve collaboration with the Global Fund at HQ and country levels in order to increase the impact of health investments by both entities?*

The aims of this study were:

- To describe the current nature of CDC engagement in Global Fund processes and structures at HQ and country levels.

- To characterize levels of knowledge of the Global Fund among CDC staff and determine areas for enhanced understanding.
- To detail the current mode and frequency of communication between CDC and the Global Fund, as well as other stakeholders.
- To identify best practices and lessons learned to date among CDC staff regarding Global Fund collaboration.

From my experience as a policy advisor in three CDC overseas offices and now as the Associate Director for Policy for a CDC global health division, I have a deep interest and experience with this subject. Having been a part of the development of several CNs and a member of CCM subcommittees, I have witnessed many of the challenges and opportunities associated with GF, as well as with CDC's approach to supporting the institution. Many colleagues in the field and at CDC HQ have had similar experiences and insights, and I feel invested in documenting their knowledge and recommendations in order to improve GF collaboration for all CDC staff and to increase the impact of our shared public health efforts.

CHAPTER 3: METHODOLOGY

DISSERTATION AIMS AND RESEARCH QUESTIONS

The primary, overarching research question of this study was:

- How can CDC improve collaboration with the Global Fund at HQ and country levels in order to increase the impact of health investments by both entities?

Following are the aims and associated data and methods of my study:

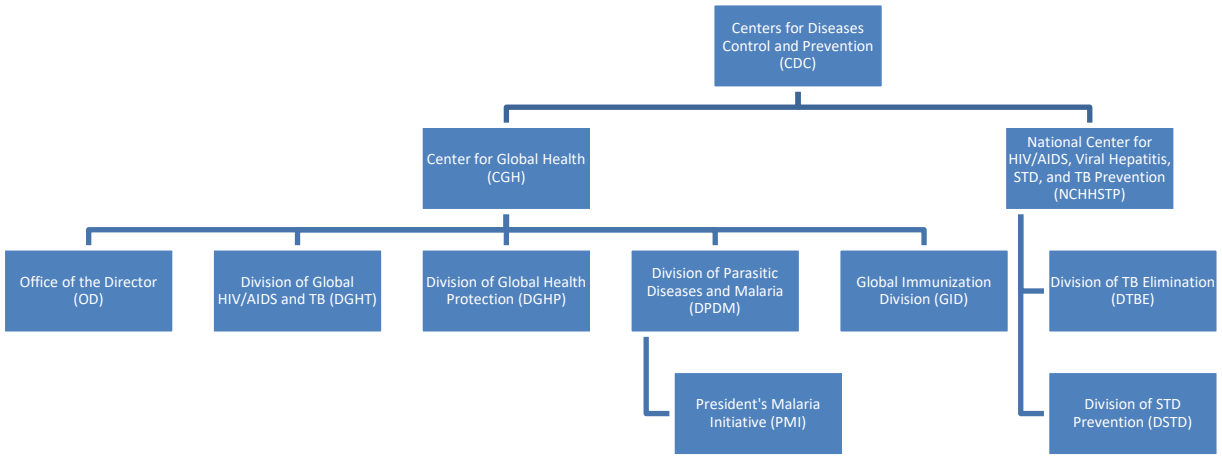
1. To describe the current nature of CDC engagement in Global Fund processes and structures at HQ and country levels.
    a. Methods: secondary analysis of a quantitative survey; key informant interviews
2. To characterize levels of knowledge of the Global Fund among CDC staff and determine areas for enhanced understanding.
    a. Method: secondary analysis of a quantitative survey
3. To detail the current mode and frequency of communication between CDC and the Global Fund, as well as other stakeholders.
    a. Method: secondary analysis of a quantitative survey; key informant interviews
4. To identify best practices and lessons learned to date among CDC staff regarding Global Fund collaboration
    a. Method: secondary analysis of a quantitative survey; key informant interviews to develop a plan for change

I utilized quantitative and qualitative data collected from CDC staff in two stages to broadly assess current CDC engagement with GF at various levels. This methodology and associated materials were approved the UNC Institutional Review Board and the CDC Center for Global Health Science Office. In the first stage, I analyzed largely quantitative secondary data which I collected through a

targeted online, 51-question survey (via SurveyMonkey) from May to July 2015. This survey was distributed by the CDC Center for Global Health Director at that time, Dr. Thomas Kenyon, to all staff in that Center (which included almost all country office staff) and individuals in other Centers working on global health.

Figure 7 below presents the current [2018] CDC operating sections in which respondents to the quantitative survey primarily work. CDC staff seconded to the World Health Organization (WHO), Joint United Nations Program on HIV/AIDS (UNAIDS), and other institutions are not represented in this figure but may have been included in the survey or interviews.

Figure 7: Current CDC Operating Units of Most Survey Respondents



Note: A few of the survey respondents were from other units within CDC or seconded to other organizations. The distribution of respondents is detailed in Chapter 4.

I analyzed data from the online survey using Excel and presented in tables, charts, and map formats (see Chapter 4).

In the second stage, I collected additional qualitative data through nine key informant interviews (KIIs; see Appendix C for sample questions) with CDC staff heavily engaged with GF at the policy and technical levels, including those seconded to GF. I analyzed data from the nine key informant interviews using thematic coding and integrated results into the overall description of findings and recommendations. This mixed methods approach harnessed CDC insights and inputs for both CDC and GF policy

development, as well as informed ways to strengthen collaboration and ensure continuous reform. I conducted this research sequentially to establish a baseline understanding of current engagement and inform the content and approach of the KIIs.

I used snowball sampling to identify interviewees. I selected the first three interviewees based on personal knowledge of their high level of experience with GF; two were in CDC country offices, and one was at CDC HQ. After the sessions with the three initial interviewees I asked each of them to recommend two to three other people who may be interested in participating or have unique perspectives on the GF partnership. I contacted all interviewees via email, with a standardized introduction describing the purpose of the research, expectations for the interview, and mechanisms for ensuring confidentiality of responses, as well as providing the written consent form. The email explained that they are not obligated to participate and that declining would have no effect on their professional relationships. A second email followed one week after the first if no response was received. If no contact was established, an alternate interview was identified through the network of those who have already participated. A few of the individuals contacted referred the email to a colleague who they believed would be better suited to the interview; these new referrals were then contacted per the protocol above.

When participants agreed to be interviewed, I scheduled a convenient appointment time. I conducted the interview by phone for all participants. With participant permission, I recorded all sessions and obtained written consent from the interviewee at the time of the phone interview. I reviewed the consent form orally and invited the participant to ask questions about the study. I obtained consent and interviewed all study participants in English. I described all of my study procedures in detail so that the participant was fully informed as to their options for participating in this study.

During this consent process, I reminded subjects they were free to choose to take part in the research study or not, and that their decision would not affect their employment at CDC. The potential participants were able to agree or decline to participate in the study at that time; all those contacted via phone agreed to participate. Those who consented to participate in the study were interviewed. During the consent process, I informed participants that information they provide through interviews was

confidential (i.e., not shared with anyone outside of the research team) and voluntary (i.e., they were not obligated to answer any question). Interviewees were told that they were free to take breaks and/or terminate the interview at any time. The interviews lasted from 20 to 75 minutes and were comprised of a series of open-ended questions about their experience working with GF and suggestions for enhanced collaboration.

To maintain confidentiality, I gave each subject a random numeric identifier so their specific comments could not be linked to the data. Given the small sample size, there were instances where the respondents' identities could be known, based on their examples or perspectives. In these situations, I made every effort to convey the information without revealing identifying details of the respondents (e.g., stating that the respondent works in a sub-Saharan African country rather than naming the specific country). Immediately after each interview, the digitally recorded files were uploaded and saved on a password-protected and encrypted computer continuously in my possession. I transcribed interview files and did not transfer the recordings to anyone else. I transcribed interviews verbatim and verified them against the audio recording to ensure that all thoughts and opinions were accurately reflected in the analysis. Once verification of the transcripts was complete, I conducted a content analysis, which involved identifying themes and categories prior to coding the data. Coding was done by reviewing transcripts of all the interviews in Word and color-coding them based on the pre-identified themes. A fellow doctoral student, not involved in the study, verified the coding by reviewing a sample of three coded interviews and provided feedback on the approach. This feedback was incorporated by adjusting the initial coding for the sample interviews and applied to all further coding. Following the coding of all interviews, I generated coding reports for each of the codes in order to systematically analyze and report on the information received during the key informant interviews.

Once the data were analyzed and the study completed, all recordings were destroyed to ensure that no responses would be linked to an individual. The results were presented in the aggregate and the names of the individuals kept confidential. General descriptors of key informants were included, but in order to maintain confidentiality of the respondents, the participants' names were not included. No hard

copies of any materials were collected from the interviewees or the survey participants. All interview data was stored in a password protected and encrypted computer in the continuous possession of the principal investigator.

While it would have been preferable to include GF individuals among the key informants, after consultation with several individuals at CDC, USAID, and the Department of State, it was determined not to be feasible or appropriate to officially interview GF staff for this project. However, unofficial consultation with a few GF staff or secondees was done after the analysis was completed to confirm the appropriateness of recommendations.

SURVEY DATA

Table 4 shows the categories of the quantitative survey respondents. The key informant interview subjects were drawn from these groups, based on analysis of the survey data and identified gaps or areas for further exploration.

Table 4: Targeted CDC Respondents to Online Survey, May—July 2015

Category	HIV	TB	Malaria
HQ Leadership	DGHT Director, Branch Chiefs	DGHT and DTBE Directors, Branch Chiefs	DPDM Director, Branch Chiefs, PMI Lead
HQ Technical	DGHT Technical Staff, GF, UNAIDS and WHO Secondees	DTBE Technical Staff, GF and WHO Secondees	DPDM Technical Staff, GF and WHO Secondees
Field Leadership	Country, Program Directors	Country, Program Directors	Country Director
Field Technical	CDC/PEPFAR Team Leads, HIV Technical Advisors, GF Liaisons	CDC/PEPFAR Team Leads, TB Advisors, GF Liaisons	PMI Resident Advisors, GF Liaisons

ANALYSIS OF FINDINGS

Once the full quantitative analysis of the survey data and the qualitative thematic coding of the KIIs was complete, the results were reviewed together to identify common themes, patterns, and trends, as well as areas of divergence. Quotes from the KIIs were used to illuminate or expand on findings from the survey data, offer explanations for results, or provide different perspectives. The findings were presented jointly by theme, with the most critical results and recommendations shared first by domain.

DATA TABLES

The results of the survey were broken into several thematic categories. Based on the content of the 51-question survey, categories include: characteristics of the survey respondents, support for development of Concept Notes, engagement with the CCM, collaboration with other stakeholders, external and internal communication, staffing and knowledge, and future CDC technical assistance.

LIMITATIONS

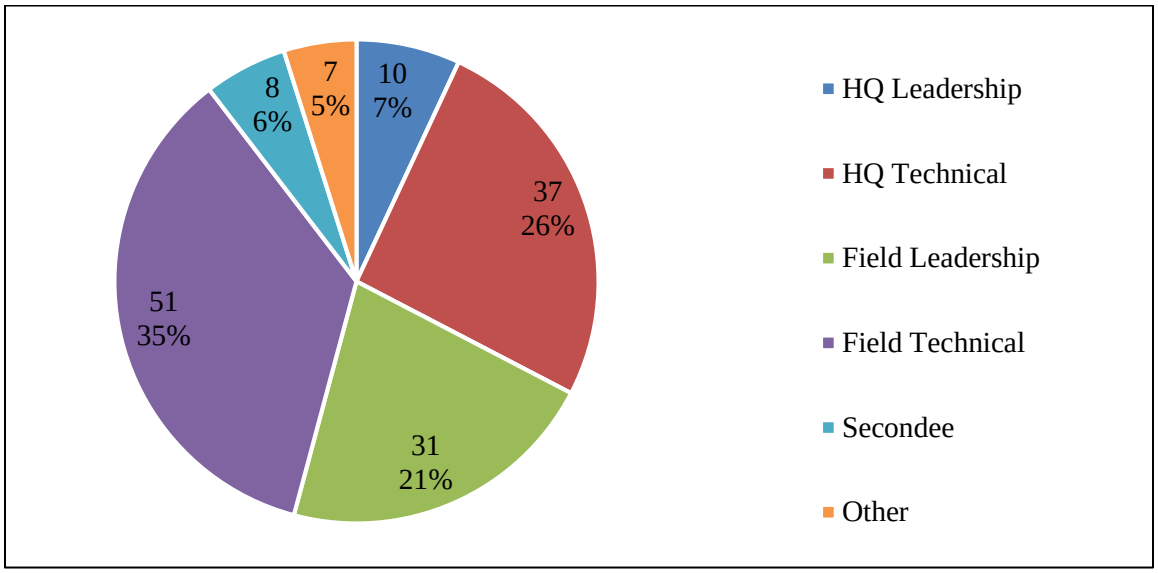
Although there are two parties in this relationship—CDC and GF—only one set of perspectives (those of CDC staff) were included in this analysis. Because GF staff could not be surveyed or interviewed officially for this study, it was not possible to obtain their views on how CDC engages with GF processes or how GF engages with CDC systems. In addition, this study utilized survey data collected in 2015, which may be dated by the time the recommendations can be enacted, particularly if major changes are made to GF policies or technical approaches. New CDC staff, developments in global health, and changes in country dynamics may also make these findings less relevant than if this study had been published immediately after the survey was conducted. Next, the limit of nine KIIs does not allow for the full range of perspectives to be presented and some viewpoints or recommendations may be inadvertently omitted. Finally, the researcher's own experiences may bias the results, even with every effort made to preserve objectivity.

CHAPTER 4: RESULTS

SURVEY AND INTERVIEW RESPONDENTS

Between May 26 and June 15, 2015, a total of 144 individuals completed some or all of the survey. Of the respondents, 82 (56%) were based in CDC country offices, 47 (33%) were based at CDC Headquarters, 8 (6%) were CDC staff placed in other institutions, and 7 (5%) reported "Other" locations/functions.[12] Forty-one (28%) of respondents were in leadership positions and 88 (61%) were in technical positions, with the remainder secondees or responding "Other". Figure 8 summarizes the respondents' current location and main function.

Figure 8: Respondents' Current Location and Main Function (N=144)

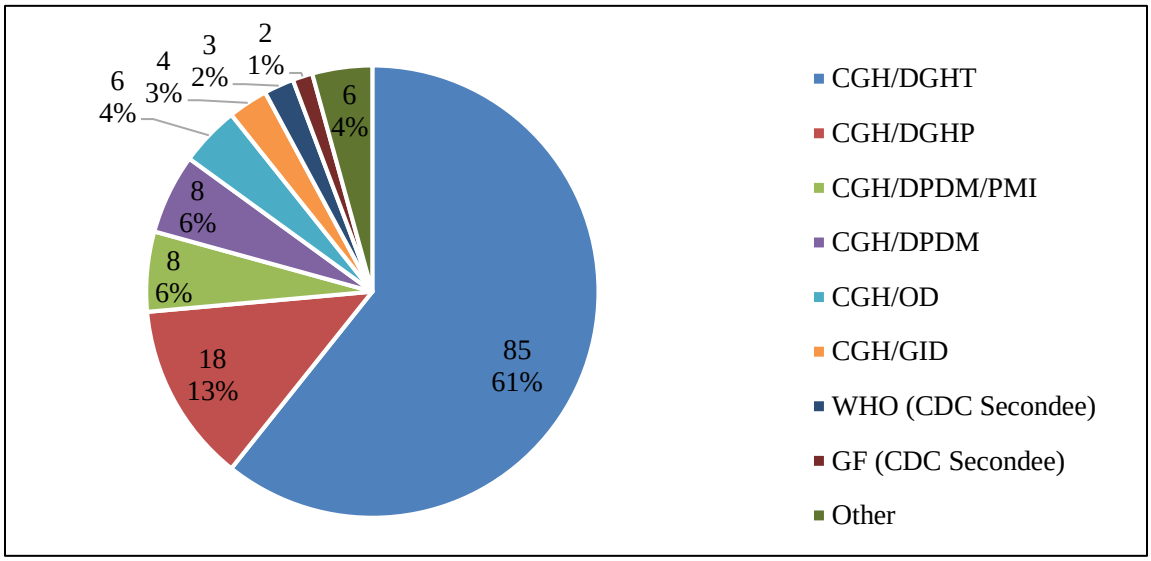


In terms of organization or office, the vast majority (123; 88%) of respondents came from CGH Divisions, with an additional six respondents (4%) coming from the CGH OD. DGHT accounted for 61%

[12]The seven individuals responding "Other" wrote in the following answers: CDC Country Office Technical Support; Overseas; CDC Secondee to the Global Fund Secretariat; CTS Contractor, PEPFAR Global Fund Liaison; CDC OD; Administrative Assistant; I am not involved in management. For ease of analysis, this group was merged with "CDC HQ & Secondees".

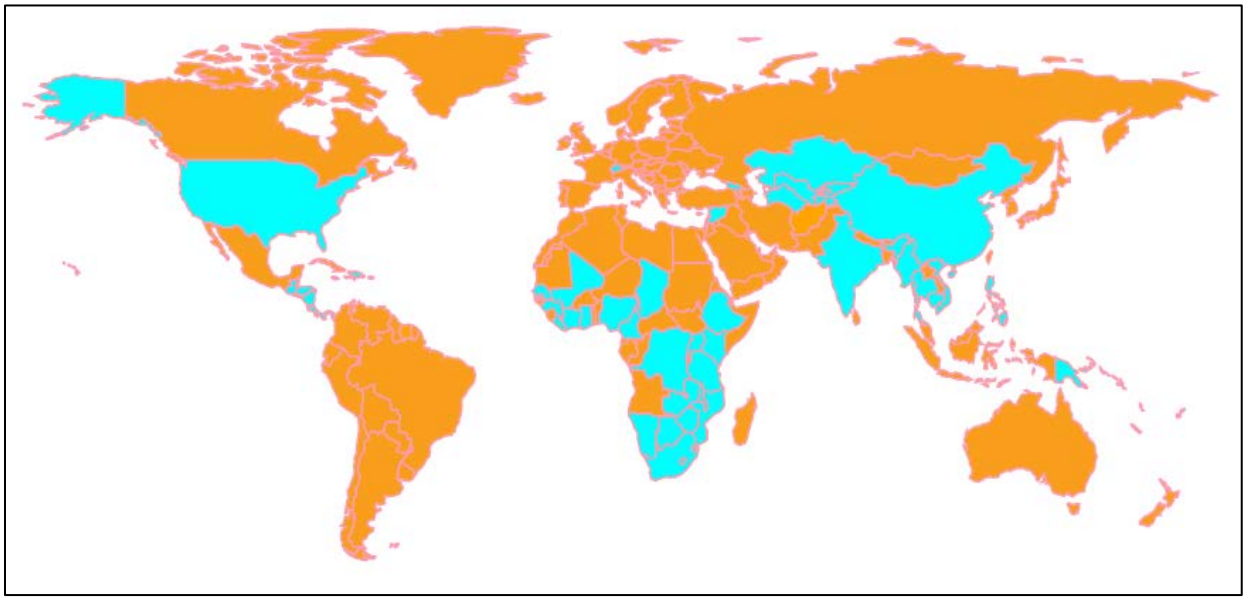
of all respondents, including 82% of field respondents, which was expected given the field presence of the division. In addition to respondents from WHO (3) and GF (2), participants also came from NCHHSTP/DSTD (2), DOS/PEPFAR Coordination Office (1), PEPFAR— GF Liaison (1), NCHHSTP/DTBE (1), DOD/DHAPP (1). Figure 9 summarizes the current organization or office of the respondents.

Figure 9: Respondents' Current CDC Organization/Office (N=140)



There was geographic diversity among the respondents, with 42 countries or regions represented. Figure 10 highlights in turquoise the stated work locations of the survey respondents.

Figure 10: Respondents' Current Work Location



Countries/regions stated: Barbados, Botswana, Burma, Cambodia, Cameroon, Central Asia Region, Chad, China, Cote d'Ivoire, Democratic Republic of Congo, Dominican Republic, Ethiopia, Georgia, Ghana, Guatemala, Guinea, Haiti, India, Kenya, Kyrgyz Republic, Lesotho, Liberia, Malawi, Mali, Mozambique, Namibia, Nigeria, Papua New Guinea, Philippines, Rwanda, Senegal, South Africa, Swaziland, Switzerland, Syria, Tanzania, Thailand, Uganda, U.S., Vietnam, Zambia, Zimbabwe

Similarly, interviewees had experience in a range of regions, including Southeast Asia, South Asia, and sub-Saharan Africa. Between them, they served in nine countries for CDC, with four also serving at CDC HQ. Three had experience working in Switzerland with GF and other multilaterals. Interviewees had worked for CDC as U.S. direct hires, contractors, and locally employed staff. HIV was the major component of all interviewees' work, but the majority reported covering TB and malaria as well.

KEY FINDINGS

Major findings of the survey are listed below, by domain. These findings were all confirmed and reinforced through the key informant interviews.

1. History with the Global Fund: CDC staff, particularly those in the field, consider GF very important to their work and have a high level of interest in GF activities.
    a. Over 80% of respondents reported that GF is "Very Important" (55%) or "Important" (25%) to their work; rates for field staff were 57% and 24%, respectively.

b. Almost 70% of respondents reported a “Very High” (38%) or “High” (31%) level of interest in GF; 74% of field staff reported such levels of interest (38% and 36%, respectively).

2. Support for Development of Concept Notes: CDC staff engage in all aspects of GF, especially the development of Concept Notes (CNs) but efforts are not necessarily maximally effective.
    a. CDC staff engage in key ways with GF, including “Technical assistance for development of Concept Notes” (60%), “Coordination with USG/CDC initiatives” (60%), “Technical assistance for development of National Strategic Plans” (56%), “Discussion with Country Coordinating Mechanisms [CCMs]” (52%), and “Support for implementation of Global Fund activities” (45%).
    b. Level of engagement is significant, as 44% of respondents considered their engagement with the development of Concept Notes “Very substantial” (14%) or “Substantial” (30%); rates for field staff were higher, at 19% and 38%, respectively.
    c. Overall, a low proportion (40%) of respondents considered themselves “Very effective (11%) or “Effective” (29%) at influencing the content of Concept Notes; rates among field staff were higher, at 15% and 35%, respectively, compared to 6% and 21% for HQ and secondee staff.
3. Engagement with the Country Coordinating Mechanism: Working with the CCM was named the most common way that CDC staff interacted with GF but CDC did not necessarily have a formal role or position on the CCM.
    a. CDC participated in the CCM in various ways, including as a voting member (39%), non-voting member (20%), and/or member of a CCM sub-committee (27%).
    b. However, the reported rate of CDC having a dedicated permanent (21%) or alternate (13%) seat was relatively low, with CDC most commonly (31%) rotating into a permanent seat with another USG agency.

4. Coordination with Other Stakeholders: Engagement by Ministries of Health in GF activities is particularly high, but not necessarily technically or strategically robust.
    a. Over 90% of respondents reported engagement by the Ministry of Health as “Very High” (77%) or “High” (13%).
    b. Only 45% of respondents reported the quality of technical or strategic contributions from the Ministry of Health as “Very Good” (20%) or “Good” (25%). Thirty-eight percent reported the quality as “Average”, 13% as “Poor”, and 4% as “Very Poor”.
5. External and Internal Communication: The exchange of information with GF teams and within CDC is largely irregular or infrequent, and highly dependent on proactive outreach or personal connections.
    a. In terms of external communication, phone calls with the FPMT seem to be largely ad hoc (52%) or never (29%). The case seems to be similar for in-person meetings, with 53% reporting only ad hoc meetings and 26% reporting never meeting with the FPMT.
    b. Over 65% of HQ staff and 51% of field staff reported being in contact on GF matters only once or twice a year, with an additional 8% of HQ staff and 25% of field staff stating that they are never in touch with each other on such issues.
    c. This situation may be due in part to a lack of official points of contact at HQ on GF issues or updates, as only 15% of field staff reporting having such a contact. Almost half (48%) reported not having such an official contact nor reaching out unofficially to any HQ staff on regarding GF.
6. Staffing and Knowledge: Despite substantial involvement, CDC does not have dedicated staff to engage with GF. In general, CDC staff have not received formal training on GF and generally rate their level of knowledge as relatively low. Field staff in particular are very interested in learning more about GF systems and processes.
    a. Over 93% of respondents reported that their offices do not have a CDC staff person dedicated full-time to GF activities.

b. Overall, 60% of staff reported never having received training from any source on GF, including 63% of field respondents.

c. On a scale of 1 to 5 (with 1 being "low" and 5 being "excellent"), on average CDC staff rated their knowledge various aspects of GF as 2.59, ranging from 2.40 for "Global Fund decision-making" to 2.82 for "Concept Note development". Among field staff the average rating was slightly higher, at 2.68, ranging from 2.40 for "Global Fund decision-making" to 3.13 for "Concept Note development".

d. In terms of interest in learning more about GF, on a scale of 1 to 5 (with 1 being "not interested" and 5 being "extremely interested"), on average CDC staff rated their interest as 3.82, with topical interest ranging from 3.62 in "Governance of The Global Fund" to 4.03 in "Global Fund monitoring and evaluation standards". Field staff rated their overall interest as 3.94; topical interest ranged from 3.70 in "Governance of The Global Fund" to 4.23 in "Global Fund monitoring and evaluation standards".

7. Future Technical Assistance: CDC staff think that if additional funds were made available, additional staff should be placed in-country to assist with GF on multiple technical and strategic elements.

    a. If additional funding were available for technical assistance to GF, CDC staff believe that the funding should support "CDC staff in country offices" (45%) or "CDC staff seconded to the Principal Recipient(s)" (41%).

    b. Major elements that CDC staff think the agency should provide technical assistance on include "Epidemiologic analysis and target-setting" (91%), "Laboratory systems planning" (84%), "Disease-specific program interventions" (79%), "Strategic planning" (75%), "Program M&E" (71%), and "Quality improvement systems" (70%).

These findings are described in more depth in the following sections.

HISTORY WITH THE GLOBAL FUND

Tables 5 and 6 present the reported years of work with CDC and engagement with GF. Overall, the survey respondents worked for CDC for a relatively long period, with 48% of field staff and 49% of HQ staff reporting ten or more years of work with the agency. However, both CDC field and HQ staff have been engaged with GF for a shorter period, with 47% and 45% reporting three or fewer years of engagement, respectively.

Table 5: Number of Years of Work with CDC

Response (N=141)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Less than one year	8 (10%)	0 (0%)	8 (6%)
1-3 years	18 (23%)	11 (18%)	29 (21%)
4-6 years	6 (8%)	12 (20%)	18 (13%)
7-9 years	10 (13%)	8 (13%)	18 (13%)
10-12 years	15 (19%)	8 (13%)	23 (16%)
13+ years	23 (29%)	22 (36%)	45 (32%)

Table 6: Number of Years of Involvement with Activities Related to the Global Fund

Response (N=141)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Less than one year	9 (11%)	12 (20%)	21 (15%)
1-3 years	29 (36%)	15 (25%)	44 (31%)
4-6 years	24 (30%)	14 (23%)	38 (27%)
7-9 years	12 (15%)	12 (20%)	24 (17%)
10-12 years	5 (6%)	3 (5%)	8 (6%)
13+ years	2 (2%)	4 (7%)	6 (4%)

CDC staff, both in the field and at HQ, consider GF very important to their work and have a high level of interest in GF activities, as captured in Tables 7 and 8. Approximately 80% of respondents reported that GF is "Very Important" (55%) or "Important" (25%) to their work; rates were slightly higher for field staff (81%) compared to HQ staff (77%). Similarly, almost 70% of respondents reported a "Very High" (38%) or "High" (31%) level of interest in GF; 74% of field staff reported such levels of interest compared to 63% of HQ staff.

Table 7: Importance of the Global Fund to Their Work

Response (N=142)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Very Important	47 (57%)	31 (52%)	78 (55%)
Important	20 (24%)	15 (25%)	35 (25%)
Somewhat Important	12 (15%)	7 (12%)	19 (14%)
Not Important	3 (4%)	7 (12%)	10 (7%)

Table 8: Level of Interest in the Global Fund

Response (N=141)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Very High	31 (38%)	23 (38%)	54 (38%)
High	29 (36%)	15 (25%)	44 (31%)
Moderate	16 (20%)	15 (25%)	31 (22%)
Low	4 (5%)	3 (5%)	7 (5%)
None	1 (1%)	4 (7%)	5 (4%)

Interviewees echoed these sentiments, stating that they considered GF a critical partner and extremely important to their work. Many cited the fact that USG is "the major investor in GF" as additional motivation to engage with GF. Others had previously worked for organizations implementing

GF grants or for the Local Fund Agent in country and wanted to maintain interaction with GF, even in their new role with CDC.

CDC staff support all types of GF grants (Table 9), even if their office may not receive funding for a particular disease program. Although 82% of respondents work for DGHT (with HIV/AIDS money), there was a high level of support for HIV/TB grants (57% for field staff), malaria grants (33%), and health systems strengthening grants (31%), indicating that country offices in particular are providing technical assistance on grants beyond their own funding stream(s). Several respondents documented this arrangement, stating that they contributed to the technical development of a Concept Note (CN) for program that did not receive USG funds in their country (e.g., a malaria CN when they only receive HIV and TB funding). Individuals serving as GF liaisons also reported that while their salaries were paid for by HIV funding, they covered all grants and disease areas.

Table 9: Types of Global Fund Grants on Which CDC Staff Engage

Response (N=85); multiple responses allowed	**CDC Field Staff n (%)**	**CDC HQ & Secondee Staff n (%)**	**All CDC Staff n (%)**
HIV only	22 (43%)	19 (56%)	41 (48%)
TB only	6 (12%)	8 (24%)	14 (16%)
HIV/TB	29 (57%)	13 (38%)	42 (49%)
Malaria	17 (33%)	9 (26%)	26 (31%)
Health Systems Strengthening	16 (31%)	6 (18%)	22 (26%)

In terms of types of collaboration with GF, the principal forms of engagement overall were "Coordination with USG/CDC Initiatives" (60%), "Technical Assistance for Development of Concept Notes" (60%), "Technical Assistance for Development of National Strategic Plans" (56%), "Discussions with Country Coordinating Mechanisms" (52%), and "Support for Implementation" (45%), as captured in

Table 10. Field staff reported higher levels of engagement in all areas, with the exception of “Site Visits to Global Fund Sites” (29% for field staff, 36% for HQ staff) and “Other”; responses for the latter category were focused on high level diplomatic conversation and resource mobilization. The finding on site visits is unexpected and may warrant further exploration.

Table 10: Engagement with Types of Global Fund Activities

Response (N=87; multiple responses allowed)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Coordination with USG/CDC initiatives	34 (67%)	13 (50%)	52 (60%)
Technical assistance for Concept Notes	32 (63%)	20 (56%)	52 (60%)
Technical assistance for National Strategic Plans	29 (57%)	20 (56%)	49 (56%)
Discussion with CCMs	32 (63%)	13 (36%)	45 (52%)
Support for implementation	30 (59%)	9 (25%)	39 (45%)
Site visits to GF sites	15 (29%)	13 (36%)	28 (32%)
Technical assistance for M&E of GF activities	15 (29%)	9 (25%)	24 (28%)
Implementation of surveys	20 (39%)	3 (8%)	23 (26%)
Member of the CCM	14 (27%)	2 (6%)	16 (18%)
Technical assistance to Technical Review Panel	9 (18%)	4 (11%)	13 (15%)
Resolution of Conditions Precedent/Management Actions	6 (12%)	1 (3%)	7 (8%)
Participation in mock TRP	4 (8%)	1 (3%)	5 (6%)
Other	5 (10%)	7 (19%)	12 (14%)

"Other" included: TA to MOH to implement GF activities; CCM reform; CCM oversight improvement; coordination with NGOs; member of oversight committee; HIV Impact Assessment; high level diplomatic coordinated host country engagement; resource mobilization with GF HQ

In the key informant interviews, the most common phrase used to describe CDC's role in all engagement with GF was "technical assistance." Because GF has no in-country presence, CDC staff describe CDC as the primary technical resource for all GF matters. One interviewee summed it up by saying:

> "There are numerous areas where CDC has a natural synergy with GF. I think the strongest role for CDC is in bringing to bear technical assistance in the monitoring and improvement of the implementation of GF grants, in addition to the design and consultation phase. For example, in my country, the CDC Care and Treatment Branch Chief and Deputy Director for Programs worked very closely in the design of the grant. Each Technical Working Group had CDC staff on them, looking at what PEPFAR is doing, what CDC is doing as part of PEPFAR, and helping formulate the proposal. Once the grants were implemented, our Strategic Information teams would weigh in to validate program data and the performance framework to help ensure that everything is tracking well and that we aren't duplicating efforts. On the program management side, the Cooperative Agreement Branch Chief and Strategic Information Branch Chief worked closely with GF staff in country to ensure that the disease packages made sense and grantees were doing the work."

Likewise, another interviewee said, "CDC has so much technical expertise in these countries and we leverage that expertise to help make sure that the funding goes to the right areas and the right places and the right programs." Another stated that "Our role is to provide continuous technical assistance to ensure that programs are up to standard and generating value for the money invested." CDC's technical acumen was seen as a point of pride and asset the USG, as it was in demand by the country. "The degree to which technical assistance is needed depends on the country. We didn't write the grant for my country but we were at the table. CDC has the analytic skills and scientific knowledge that are desired by the government," said another interviewee.

SUPPORT FOR DEVELOPMENT OF CONCEPT NOTES

Development of Concept Notes was reported was one of the two most frequent ways CDC staff engage on GF issues. Table 11 reflects the elements of the Concept Note to which CDC staff contribute, with "Programmatic Gap" (69%), "Country Context" (68%), and "Modular Template: Concept Note" (48%) being the most common. Levels of engagement were higher for CDC field staff compared to HQ staff in all area, with the exception of "Funding Landscape, Additionality, and Sustainability" (38% for

field staff, 50% for HQ staff). This may indicate a weakness in capacity of field staff to support this element and an area for increased focus.

Table 11: Input Provided to Sections of Concept Notes

Response (N=62; multiple responses allowed)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Programmatic Gap	28 (70%)	15 (68%)	43 (69%)
Country Context	28 (70%)	14 (63%)	42 (68%)
Modular Template: Concept Note	20 (50%)	10 (45%)	30 (48%)
Funding Landscape, Additionality, and Sustainability	15 (38%)	11 (50%)	26 (42%)
Modular Template: Targets	17 (43%)	7 (32%)	24 (39%)
Modular Template: Program Framework	14 (35%)	7 (32%)	21 (34%)
Implementation Arrangements and Risk Assessment	15 (38%)	6 (27%)	21 (34%)
Financial Gap Analysis	14 (35%)	5 (23%)	19 (31%)
Modular Template: Summary Budget	10 (25%)	3 (14%)	13 (21%)
Other	7 (18%)	3 (14%)	10 (16%)

The interviews with CDC staff revealed that they do a significant amount of background work in preparation for the CNs. Said one, “Before the CN writing begins, we do a PEPFAR portfolio analysis, look at where and what PEPFAR is doing, and where GF complementary support is needed so that we can ensure this is incorporated when the CN is written.” Another interview similarly highlighted engagement throughout the process, saying “Engagement is much higher during a CN year. Before starting the CN, we help develop the desk reviews of strengths and gaps. We then help develop the application, answer questions, prepare for defense, get set for implementation, and align the CN with our own COP.” CDC HQ was also critical to the preparation for CNs, with one interviewee explaining that, “This year we got support from CDC HQ on multiple levels. For the desk reviews, the TB one was done by a CDC HQ TDYer who came out to country, and the HIV one was supported remotely. They also provided support on the components of the CN and helped with the negotiation around procurement of commodities.”

CDC’s level of engagement in the development of Concept Notes (Table 12) was significant, as 54% of respondents considered their engagement with the development of Concept Notes “Very Substantial” (14%) or “Substantial” (30%); rates for field staff were higher, at 19% and 38%, respectively. However, per Table 13, overall only 40% of respondents considered themselves “Very Effective (11%) or “Effective” (29%) at influencing the content of Concept Notes; rates among field staff were slightly higher, at 15% and 35%, respectively. Even for field staff, a self-described effectiveness rate of 50% indicates room for improvement, especially given that only 15% consider themselves very effective.

Table 12: Level of Engagement in Concept Note Development

Response (N=81)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Very Substantial	9 (19%)	2 (6%)	11 (14%)
Substantial	18 (38%)	6 (18%)	24 (30%)
Active but Not Substantial	9 (19%)	8 (24%)	17 (21%)
Limited	6 (13%)	11 (32%)	17 (21%)
None	5 (11%)	7 (21%)	12 (15%)

Table 13: Effectiveness at Influencing Concept Note Development

Response (N=79)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Very Effective	7 (15%)	2 (6%)	9 (11%)
Effective	16 (35%)	7 (21%)	23 (29%)
Somewhat Effective	16 (35%)	10 (30%)	26 (33%)
Not Effective	3 (7%)	7 (21%)	10 (13%)
Don't Know	4 (9%)	7 (21%)	11 (14%)

Interviewees also felt that there was room for growth in terms of impact and the effectiveness of CDC engagement. One staff member highlighted the gap between technical and strategic level impact and offered a potential explanation, saying:

> "Our effectiveness is a different story. CDC can be very effective it comes to certain specific technical aspects, like HIV self-testing. PEFPAR can really influence at the country, CCM, and technical levels to show them the data from our programs, what we have done in other countries and encourage them to include in their grants. At both the local and Geneva levels we have potential to have even more influence but whether we do depends on personalities—who among the CDC country and HQ staff engage with GF, how much they know about GF systems and processes and what's possible and what's not. CDC needs to do better in understanding how GF thinks as a financial

> mechanism and understanding how you influence that thinking; that's something that not all CDC staff naturally know."

Several other interviewees mentioned the different levels of knowledge and perspectives between GF and CDC, and the challenge of making change happen:

> "The challenge on CDC side is not understanding that GF is not highly technical across the institution, that it's not the core mentality of the institution. So when we engage with the Fund they are thinking about risk management and ease of financial implementation—that's a different argument structure. You can bring in technical information but need to sell them that this will improve execution of funds, anticipate their concerns, show them that they can have program impact and not risk financial mismanagement. That's something we can do better at in country and Geneva, learn to speak their language, not fall down the technical rabbit hole right away. It takes patience and time and getting used to it; we can't get frustrated. Especially for PEPFAR, which is looking at such a vast amount of data at such a granular level, compared to watching the Fund lumber through the very basic indicators of their performance framework and watching them fund things which may not be validated programmatically can be difficult for our CDC staff."

> "Technocrats in CDC, like myself, are quite noisy people who point out what needs to be done in terms of resource use efficiency and technical implementation; we make noise in TWGs, CCMs, and with PRs so that things get done in most impactful ways. At the end of the day things get done but it's quite a struggle. We work through this lobbying process and spend a lot of time doing the analysis so we can present a compelling case. We have had significant impact but perfection is difficult to achieve. In terms of our lobbying of GF, sometimes we're successful and sometimes we're not."

However, some interviewees felt that they were able to effectively influence GF. One said, "The process was very rewarding, as we were able to promote cost-effectiveness and appropriate attribution. We prevented co-location so everyone is not in the same place but is working from similar strategies. Working with GF and the government allows us to support CDC objectives and stop double counting." Another explained, "Our engagement was very effective. First we made sure the MOH was on board with our intended use of the GF money but once that was in place we were able to successfully advocate for the funding for the project. It was very positive in our experience."

The effectiveness of CDC staff may be affected by a variety of external challenges. The most commonly reported challenges were "Poor Ministry of Health Leadership" (45%), "Length of the Process" (42%), "Length of Meetings" (39%), "Lack of Transparency" (35%), "Unclear Communication Channels" (34%), and "Poor Quality of Consultants" (30%). One interviewee stated that "missteps and

failures regarding GF were ones that all donors shared equally in their engagement with the government," highlighting the importance of coordination and the complexity of arrangements. Numerous other challenges were listed by survey respondents; these are captured under Table 14.

Table 14: Challenges Faced in Influencing Technical/Strategic Content of Concept Notes

Response (N=74; multiple responses allowed)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Poor MOH leadership	24 (51%)	9 (33%)	33 (45%)
Length of process	22 (47%)	13 (48%)	31 (42%)
Length of meetings	18 (38%)	7 (26%)	29 (39%)
Lack of transparency	18 (38%)	8 (30%)	26 (35%)
Unclear communication channels	16 (34%)	9 (33%)	25 (34%)
Poor quality of consultants	13 (28%)	9 (33%)	22 (30%)
Document management	13 (28%)	7 (26%)	20 (27%)
Influence of consultants	13 (28%)	6 (22%)	19 (26%)
Influence of CCM leadership	8 (17%)	6 (22%)	14 (19%)
Influence of SRs	7 (15%)	2 (7%)	9 (12%)
Influence of PRs	6 (13%)	2 (7%)	8 (11%)
Influence of other donors	3 (6%)	3 (11%)	6 (8%)
Lack of local interest	2 (4%)	4 (15%)	6 (8%)
Influence of civil society	3 (6%)	1 (4%)	4 (5%)
Lack of FPMT	2 (4%)	2 (7%)	4 (5%)
Other	14 (30%)	8 (30%)	22 (30%)

"Other" included: Not knowing PEPFAR strategy and CDC budget in time; paucity of reliable and current program and financial data and reports; lack of one-stop center to provide necessary info; having PEPFAR Coordinators at the table instead of technical staff; lack of meaningful engagement with key populations; host government not wanting to share with partners, address over/under-funding; lack of commitment and follow-through by PR and CCM leadership; inability of the government to prioritize and drop PRs; weak CCM secretariat; lack of clarity from CDC leadership on how to engage, especially since don't have dedicated TA funding; not all external consultants interested/focused on integrated activities.

Although only 30% of respondents listed the quality of consultants as a challenge in terms of influencing Concept Notes, the respondents overall found the quality of the consultants brought in to the

process to be suboptimal (Table 15). Only 3% rated them as "Very Good" and 18% as "Good", with 45% rated them as "Average" and 13% rated them "Poor" or "Very Poor"; the distribution was similar between field and HQ staff.

Table 15: Quality of External Consultants Brought In to Develop Concept Notes

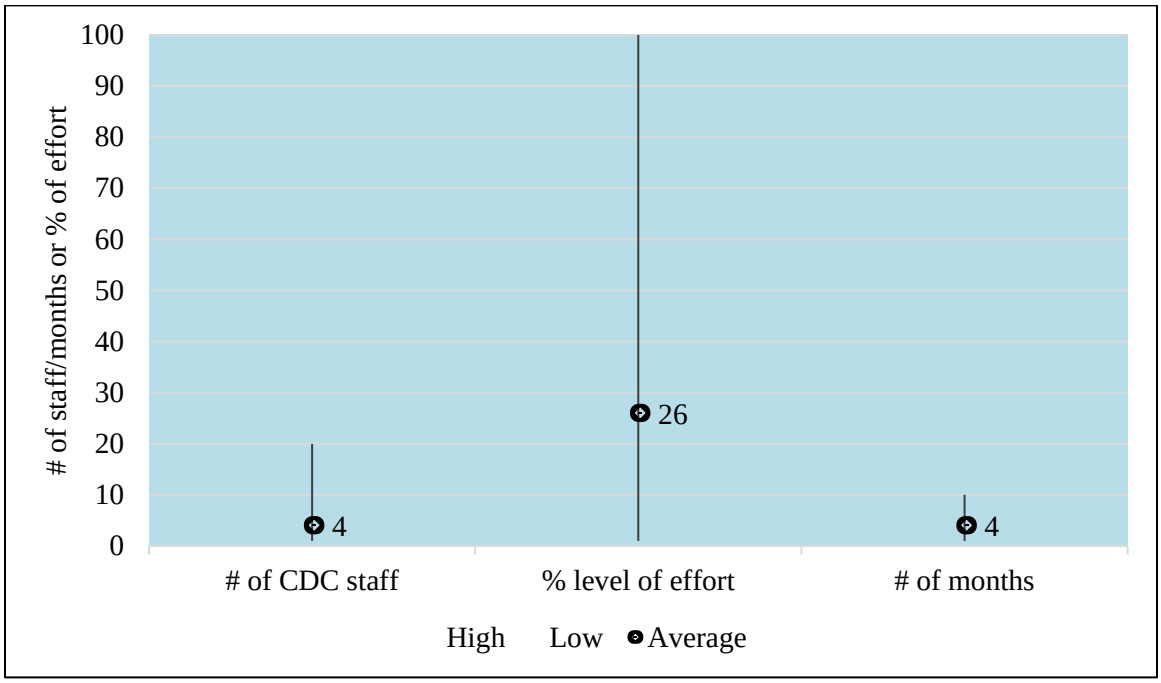
Response (N=77)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Very Good	1 (2%)	1 (4%)	2 (3%)
Good	10 (20%)	4 (14%)	14 (18%)
Average	23 (50%)	12 (43%)	35 (45%)
Poor	4 (8%)	3 (11%)	7 (9%)
Very Poor	2 (4%)	1 (4%)	3 (4%)
Don't Know	9 (18%)	7 (25%)	16 (21%)

When asked to estimate the level of effort directed towards the development of Concept Notes, on average respondents reported four CDC staff working at 26% level of effort for four months. The ranges were quite broad, with one to 20 staff reported engaged at up to 100% level of effort for up to 10 months, as captured in Figure 11. Interviewees described how their level of effort varied depending on the presence of a GF Liaison and the timing of the CN with the COP. One said:

> "We've had a number of challenges with the CN. For a while, we had a GF liaison in country, which was extremely useful. The timing has been hard since the CN process started while were doing COP17 and the government relied heavily on our team to pull this together. There was no dedicated support from GF or the MOH to pull this CN together but there were high expectations on us [CDC]."

Another echoed, saying "Had the CN not happened during COP we would have been even more involved. Usually I spent 5%-10% of my time on GF but during February and March, when we were doing the CN, it was much, much more."

Figure 11: CDC Level of Effort during Concept Note Development (N=38)



ENGAGEMENT WITH COUNTRY COORDINATING MECHANISM

Discussion with the Country Coordinating Mechanism was reported as one of the most common ways of engaging with GF, especially for field staff (63%). Per Figure 12, among field staff, CDC participated in the CCM in various ways, including as a voting member (39%), non-voting member (20%), and/or member of a CCM sub-committee (27%). However, the reported rate of CDC having a dedicated permanent (21%) or alternate (13%) seat was relatively low, with CDC most commonly (31%) rotating into a permanent seat with another USG agency (Figure 13).

Figure 12: CDC Role on the CCM (N=55)

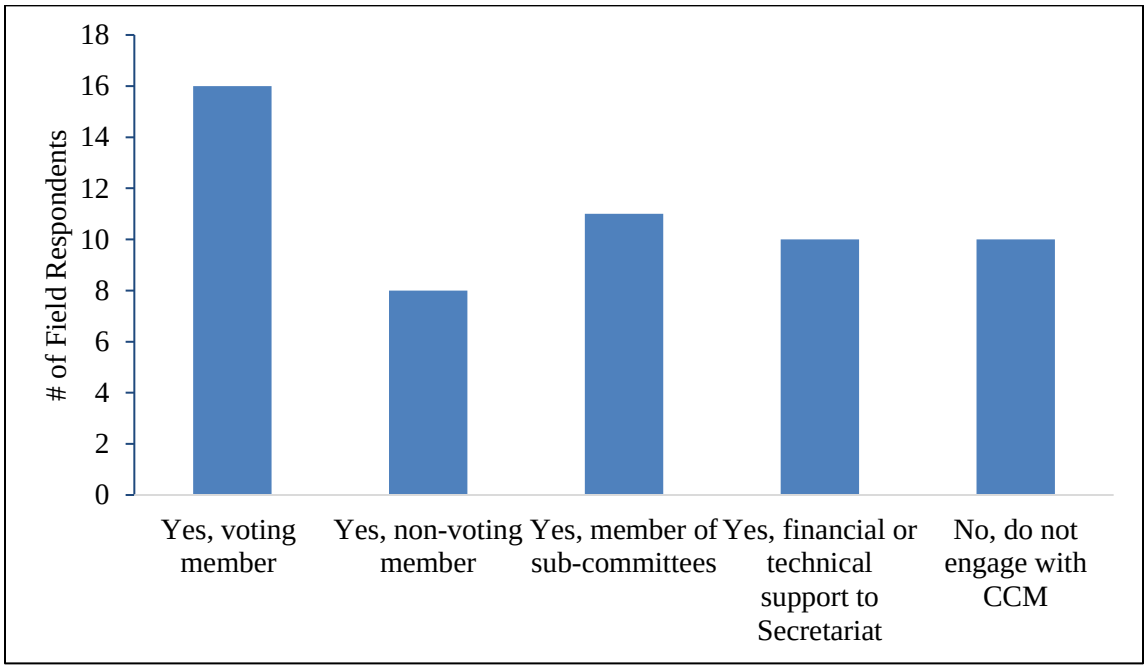
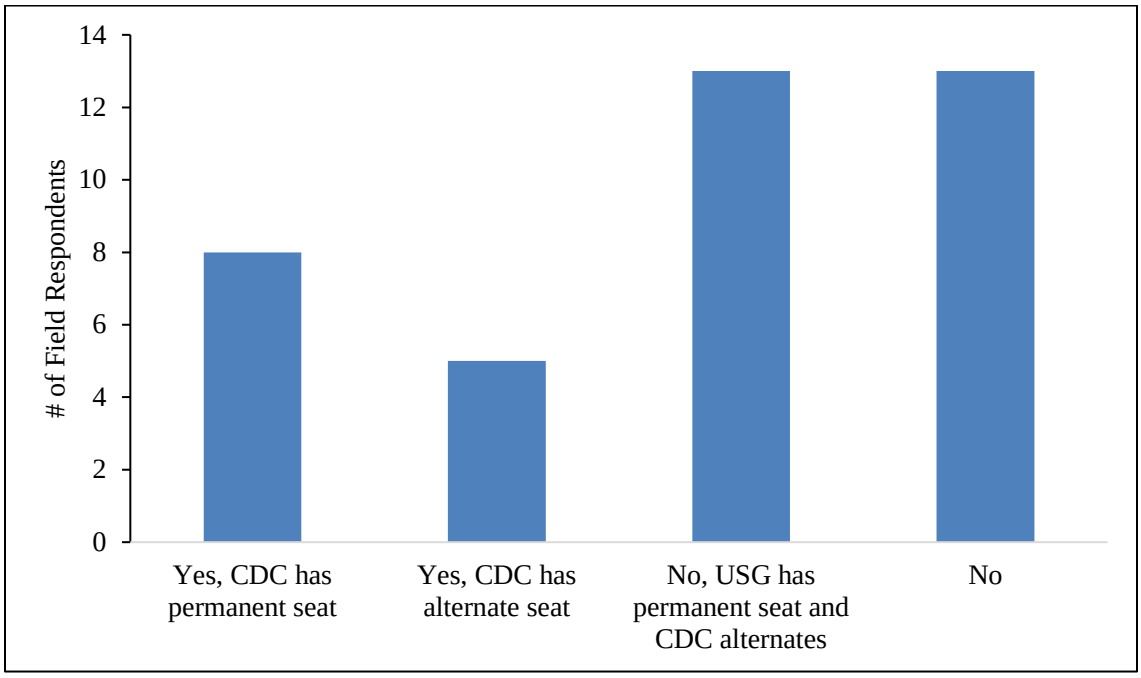


Figure 13: Type of CDC Seat on the CCM (N=39)

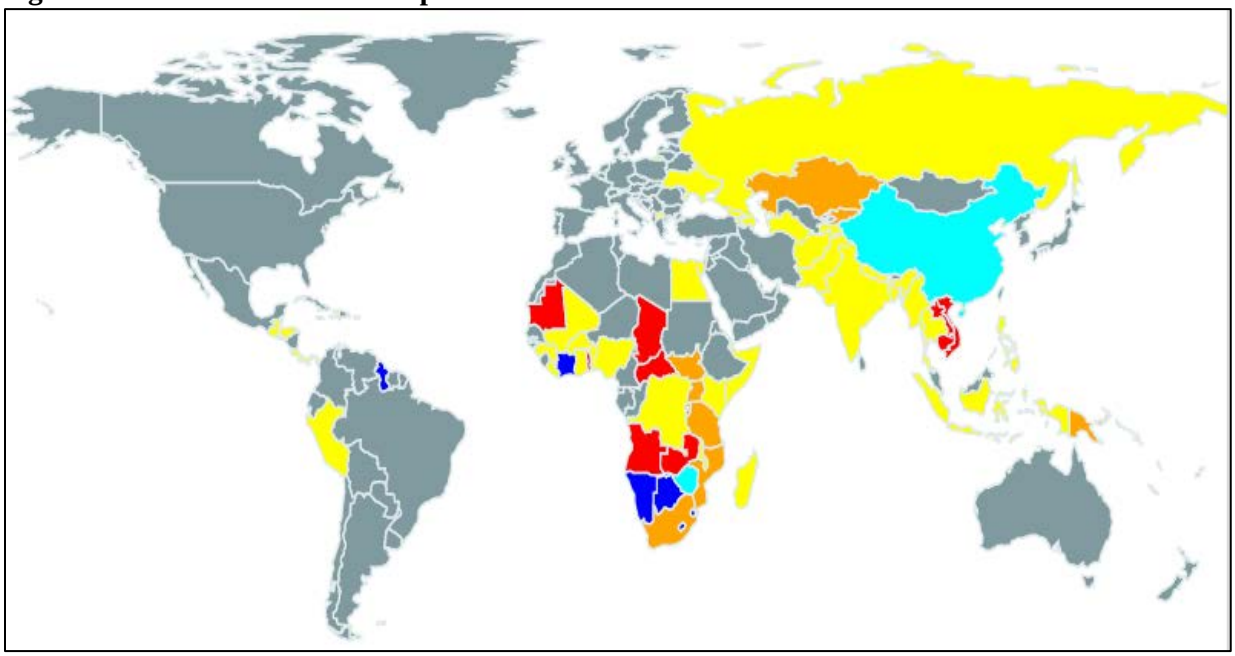


The official Global Fund 2014 CCM Composition Report[13] corroborates the relatively low number of dedicated CDC permanent CCM seats, with CDC listed as a member in eight CCMs, out of

[13]The Global Fund, CCM Data, Accessed April 22, 2017. http://www.theglobalfund.org/en/ccm/data/

148 total. While overall USG participation is much higher globally (Figure 14), USAID dominates membership, with additional seats held by U.S. Embassy (agency undefined) and the PEPFAR Coordination office.

Figure 14: Official USG CCM Representation



CDC only	USAID only	PEPFAR only	U.S. Embassy only	2+ USG agencies

Countries/regions with CDC representation on the CCM, per GF: China, Kazakhstan, Kyrgyzstan, Multicountry Americas, Rwanda, South Sudan, Tanzania, Zimbabwe

Interviewees confirmed that CDC participation on the CCM varied greatly among countries. "I think at the country level not all CDC country offices are involved in the CCM at all. In some countries they are very involved and focused on getting to know the CCM and if it is a strong body in country and who is driving the agenda there; that's important," said one. In contrast, others, even those highly involved in the development of CNs, were unsure of if and how CDC was participating on the CCM. Said an interviewee, "We haven't done well at engaging the CCM or local GF focal points. Mostly it's when the FPM comes to town. It could just be my level, at the technical level, but I'm not sure who sits on CCM. Maybe USAID, representing PEPFAR?" Interestingly, these individuals had worked in the same country for CDC, at different times, and were referring to the same CCM.

However, in some countries CDC had a formal role on the CCM and worked closely with other agencies. As one interviewee explained:

> "Both CDC and USAID made a concerted effort to be engaged in CCM. USAID had a big role in the CCM. PEPFAR had a seat on the CCM, USAID had a seat or alternate seat, CDC had an alternate role. At any time, all three had a full membership or alternate membership on CCM so we had to do a lot coordination. We got pulled into permanent committees and ad hoc working groups so all agencies had to be involved, when to pull back and let the technical staff step in."

Some individuals, particularly GF Liaisons, saw "capacitating the CCM" and "sharing information on USG programs with the CCM" as major elements of their jobs. "From the CDC side, we should be sharing information and our technical skills with the CCM, sharing key documents with in country actors and the FPM," said one. Similarly, another Liaison stated that "We need to provide complementary info on what we are doing with PEPFAR. I give updates technical committees of the CCM on what PEPFAR is doing and State does the same with the CCM."

COORDINATION WITH OTHER STAKEHOLDERS

When asked which U.S. Government agency serves as the primary focal point for GF activities in their context, only one respondent stated that CDC was designated for this purpose (Figure 15). In terms of other agencies, 19% reported USAID, 15% reported the Department of State, and 45% reported "Other"; most of the responses under "Other" refer to the PEPFAR Coordinator, which is generally under of the Department of State. With regard to the presence of full-time staff dedicated to GF activities, 60% of respondents reported that no such positions exist in other agencies' offices in their country, with another 24% unsure; only three respondents (7%) reported that the Department of State has such a position (Figure 16). Together, these results indicate that most commonly, the responsibility for serving as the GF main contact falls to the PEPFAR Coordinator/DOS, although the office is rarely staffed with a dedicated staff person for that purpose.

Figure 15: USG Agencies Serving as Primary Focal Point for the Global Fund (N=47)

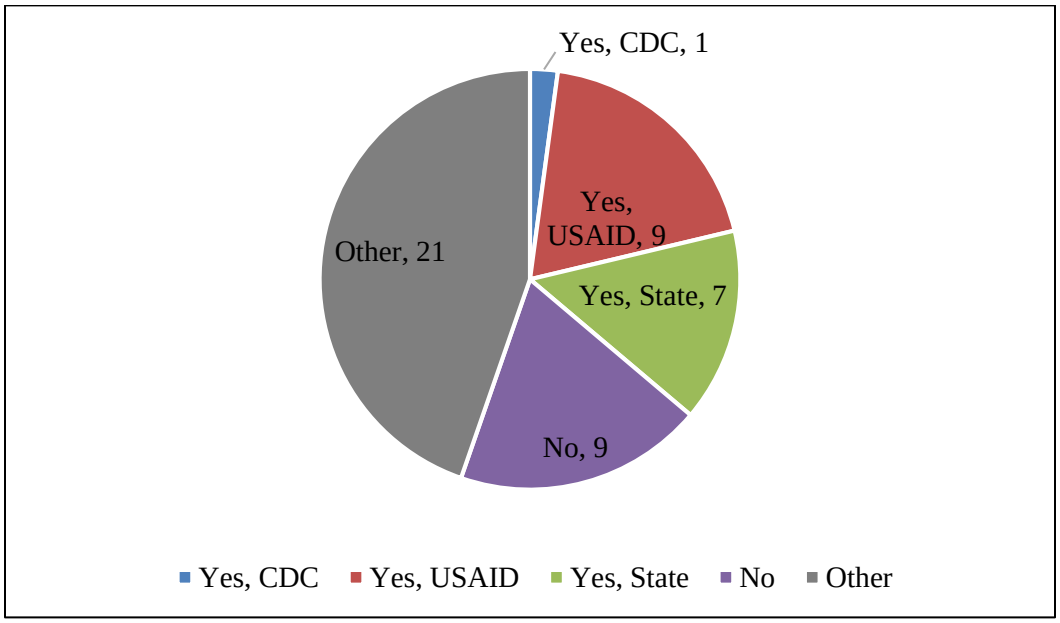
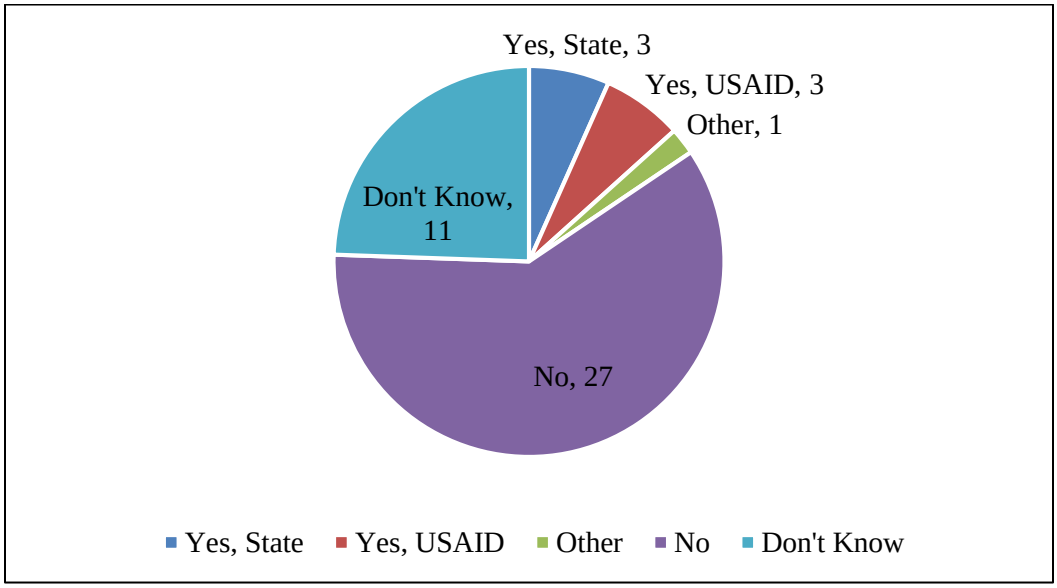


Figure 16: USG Agencies with Staff Dedicated Full Time to Global Fund Activities (N=45)



Beyond the USG, other stakeholders participate in GF activities to various degrees, as shown in Figure 17. With the exception of the U.S. Embassy Front Office and certain disease-specific institutions (i.e., Roll Back Malaria, KNCV), the level of engagement is extremely high. Unsurprisingly, engagement is highest for the Ministry of Health, with 90% rating it “Very High” (77%) or “High” (13%). However, as shown in Figure 18 the quality of technical contributions is much more varied, with 55% rating the

quality for Ministries of Health as "Neutral" (38%) or below (Figure 18). The lowest ratings were for UNICEF (65% at "Neutral" or below), other UN agencies (72% at "Neutral" or below), and other bilaterals (79% at "Neutral" or below).

Figure 17: Other Stakeholders' Level of Involvement in Global Fund Activities (N=61)

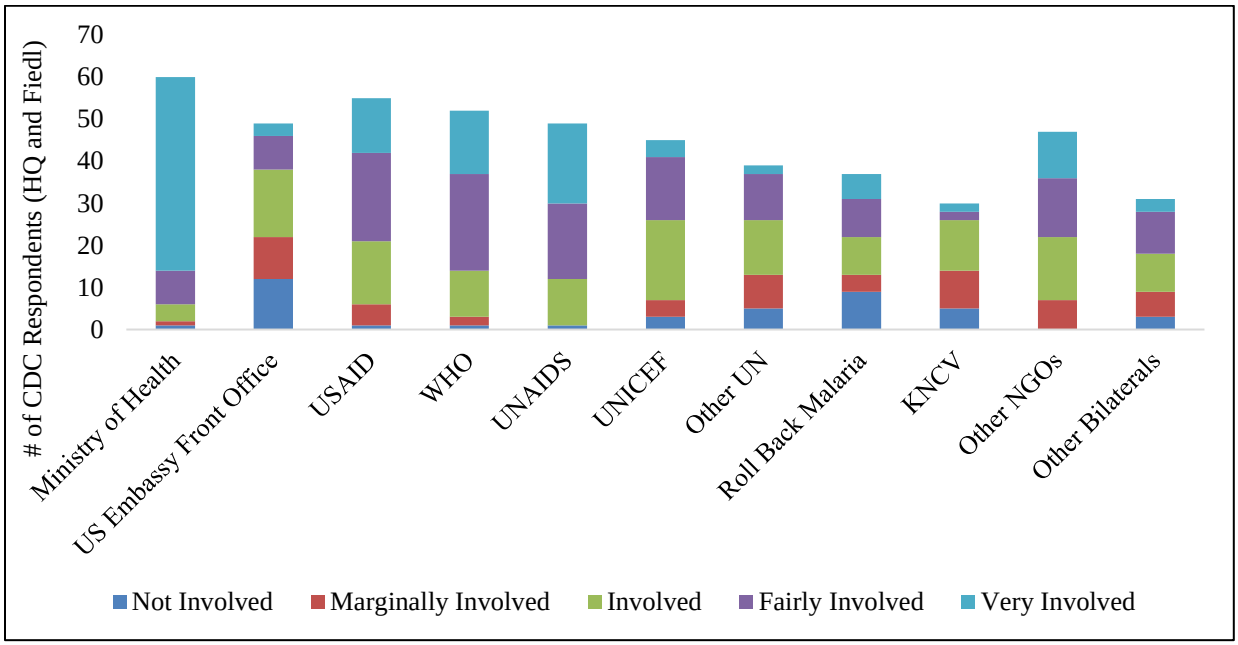
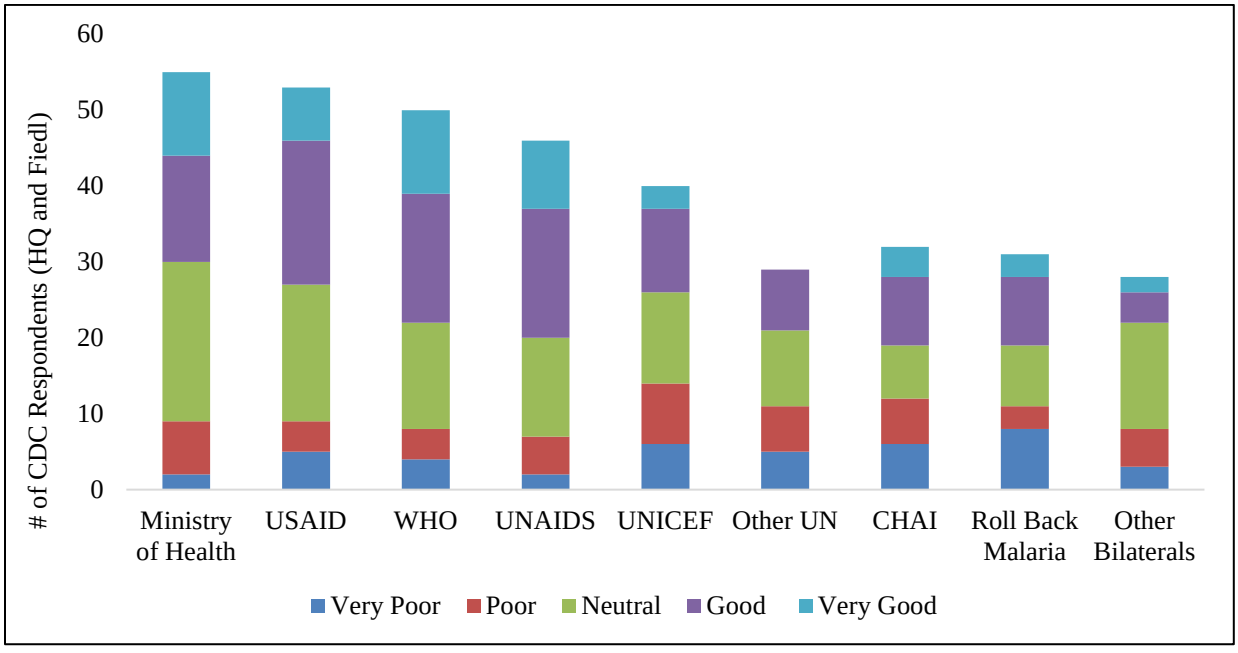
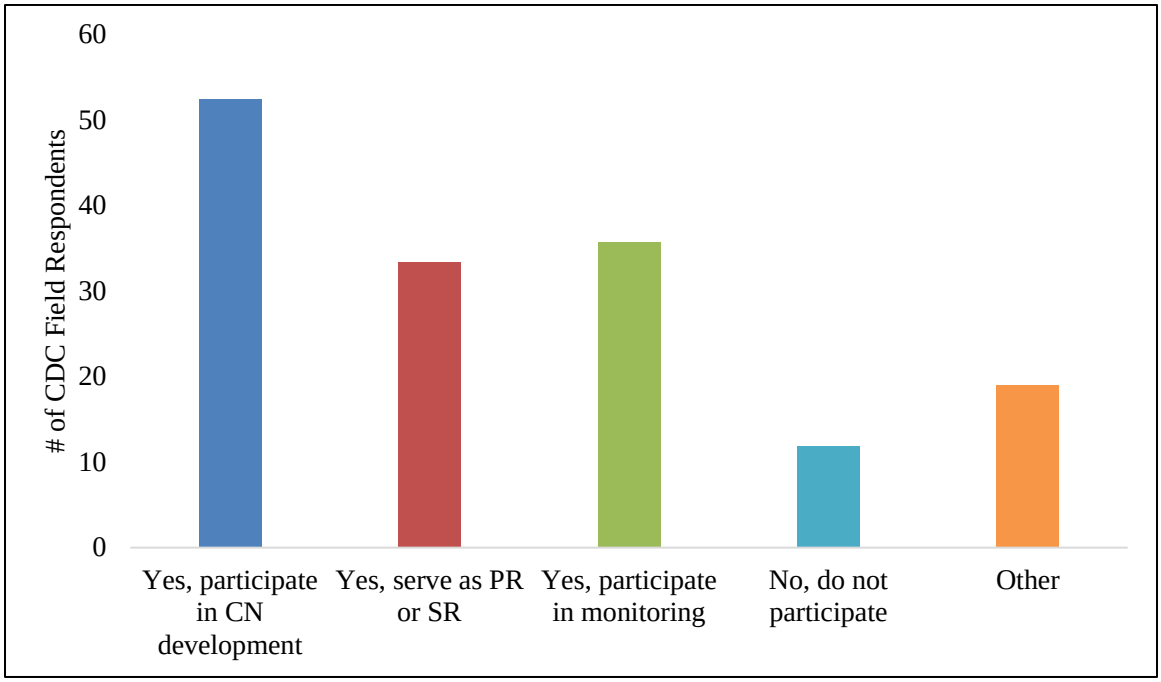


Figure 18: Quality of Contributions to Global Fund Activities from Other Stakeholders (N=56)



Involvement by host country financial and planning institutions (e.g., Ministry of Finance, Ministry of Planning, and Ministry of Treasury) in GF processes is largely during the development of Concept Notes (52%) and monitoring and reporting on grants (35%) (Figure 19). Positively, only 12% reported that such institutions do not participate in GF activities.

Figure 19: Engagement of Host Country Financial and Planning Institutions in Global Fund Activities (N=55)



CDC staff seem generally well aware of the other stakeholders in GF arena but are primarily focused on the MOH. However, they recognized the need to interact with other donors and influencers, for example stating that:

> "These partnerships are not just either direct financial relationships like a cooperative agreement or high level political partnerships—they are in fact technical partnerships and each of those partners in this relationship (GF, CDC, WHO) plays a different role in how global health decisions are made at global level and country level, even down to the lowest level."

> "With GF, a wide range of stakeholders involved in approving grants and reprogramming whereas for PEPFAR it's a small group of technocrats who are only looking at the technical requirements of disease control. The grant architecture for the two is quite different but have to keep complementing each other. We need to understand and work with that."

> "My role with GF was through the Development Partners for Health group, which is one of the bodies that meets with GF and that GF gives updates. It was important to make sure that all donors in this space share information, to have clear objectives, and to not be tasked to do the same work. When I started, I found that there was a lack of info sharing between donors. It was important for me to learn more about GF so I could speak intelligently in their terms about what PEPFAR is supporting and what other countries are contributing in terms of donor support."

EXTERNAL AND INTERNAL COMMUNICATION

In order for CDC staff to be most effective in their collaboration with GF, strong communication and coordination structures are critical, both externally with the Fund Portfolio Management Team (FPMT) and internally between CDC HQ and field staff. With regard to the first element, phone calls with the FPMT seem to be largely ad hoc (52%) or never (29%) (Table 16). The case seems to be similar for in-person meetings, with 53% reporting only ad hoc meetings and 26% reporting never meeting with the FPMT (Table 17). For both modes, field staff report higher rates of ad hoc meetings and HQ staff higher rates of never communicating/meeting with the FPMT.

Table 16: Frequency of Phone Calls with Fund Portfolio Management Team

Response (N=62)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Weekly or every other week	2 (5%)	2 (10%)	4 (6%)
Monthly	1 (2%)	1 (5%)	2 (3%)
Every other month	5 (12%)	1 (5%)	6 (10%)
On an ad hoc basis	25 (61%)	7 (33%)	32 (52%)
Never	9 (20%)	10 (48%)	18 (29%)

Table 17: Frequency of In Person Meetings with Fund Portfolio Management Team

Response (N=62)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Weekly or every other week	1 (2%)	1 (5%)	2 (3%)
Monthly	1 (2%)	0 (0%)	1 (2%)
Every other month	8 (19%)	2 (10%)	10 (16%)
On an ad hoc basis	27 (64%)	6 (30%)	33 (53%)
Never	5 (12%)	11 (55%)	16 (26%)

The most commonly reported challenges affecting communication between CDC staff and the FPMT were CDC not being included in exchanges (29%), a lack of a point of contact to initiate dialogue (25%), and turnover within the FPMT (23%) (Table 18).

Table 18: Challenges Faced in Terms of Communicating with the Fund Portfolio Management Team

Response (N=52; multiple responses allowed)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Not included in communication with FPMT	10 (29%)	5 (29%)	15 (29%)
No POC to initiate communication	9 (26%)	7 (41%)	16 (25%)
Turnover within FPMT	10 (29%)	2 (12%)	12 (23%)
Lack of time for calls	8 (23%)	1 (6%)	9 (17%)
Differences in policy priorities	5 (14%)	4 (24%)	9 (17%)
Differences in technical priorities	5 (14%)	3 (18%)	8 (15%)
Lack of FPMT interest	2 (6%)	3 (18%)	5 (10%)
FPMT does not visit country	2 (6%)	2 (12%)	4 (8%)
Other	9 (26%)	6 (35%)	15 (29%)

However, CDC field staff have made efforts to proactively share information with the FPMT, as appropriate. The majority reported frequently or sometimes sharing official plans once cleared (78%), other unofficial news or contextual updates from the country (69%), updates on program implementation (68%), unofficial updates from the CCM, PRs, or SRs (57%), or official plans in draft form (51%) (Figure 20). Members of the FPMT were also the most likely to be scheduled to attend the COP regional review meetings for those CDC countries implementing PEPFAR, with 35% reporting planned FPMT

participation (Figure 21). An additional 15% reported expected CCM participation and 12% PR or SR attendance.

Figure 20: CDC Field Staff Proactive Sharing of Information with the FPMT (N=45)

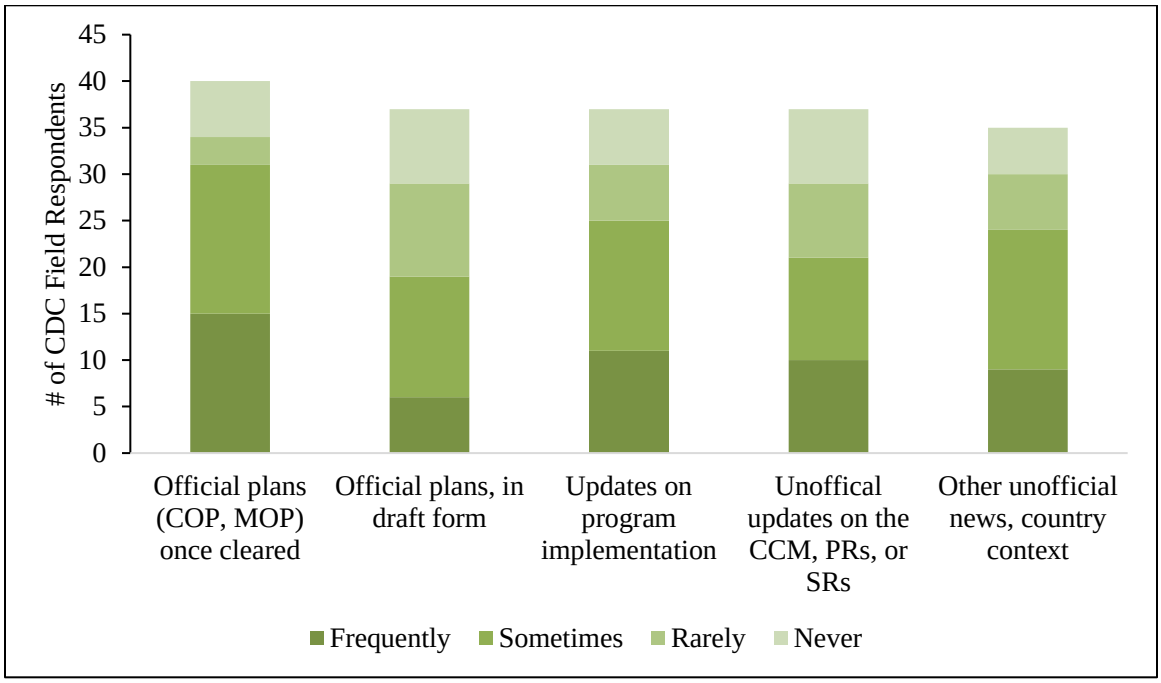
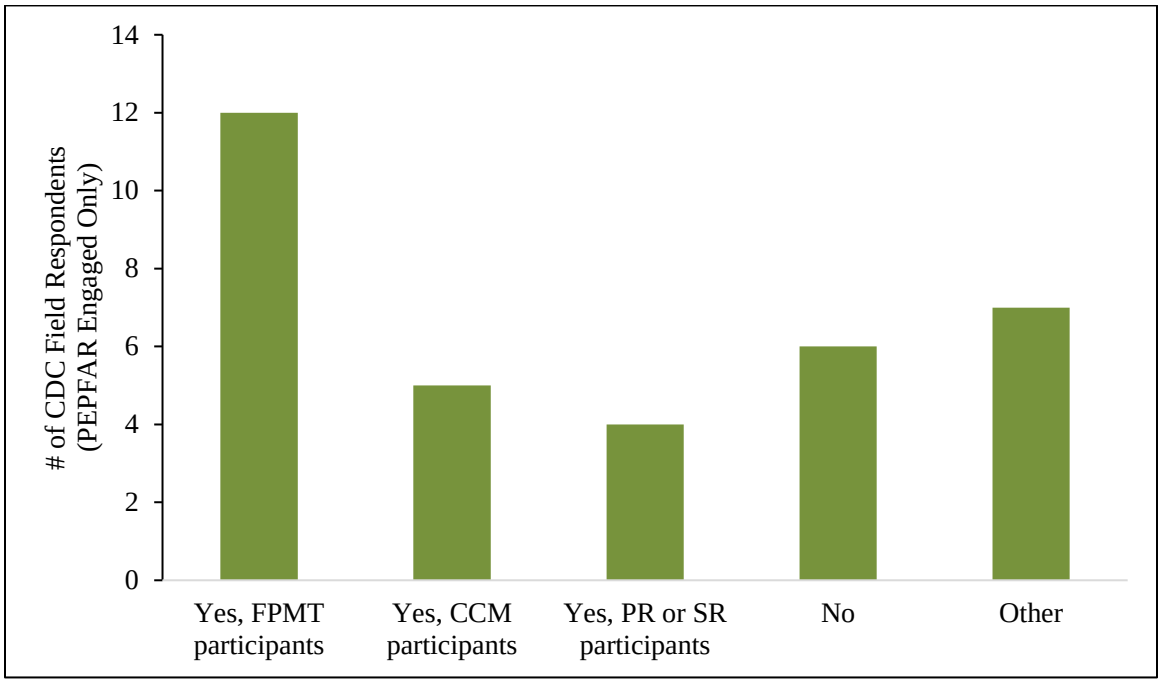


Figure 21: Global Fund Participation in COP Review Meetings (N=38)



Interviewees were consistent in their belief that CDC direct engagement with the FPMT was vital and could be mutually beneficial. Said one, "I got a crash course [in GF] by starting a good relationship with our FPM. We had regular, frequent calls and in person meetings. We became resources to each other because the COP process and other USG politics came up. I was able to provide insights and background on what was going on. We were able to teach one another and make sure we were up to speed." However, they also detailed some of the challenges with building that relationship, explaining that:

> "I frequently heard, 'Well, I'm not on the CCM so I can't meet with the FPM' but there is absolutely no reason that CDC staff cannot meet with the FPM. We need to know those people, nurture those relationships and share info. It's very valuable to CDC in terms of our own processes—we get great feedback on our MOP, COP, and TB work, their input can be fantastic—and there are cost efficiencies in their program that we need to look at."

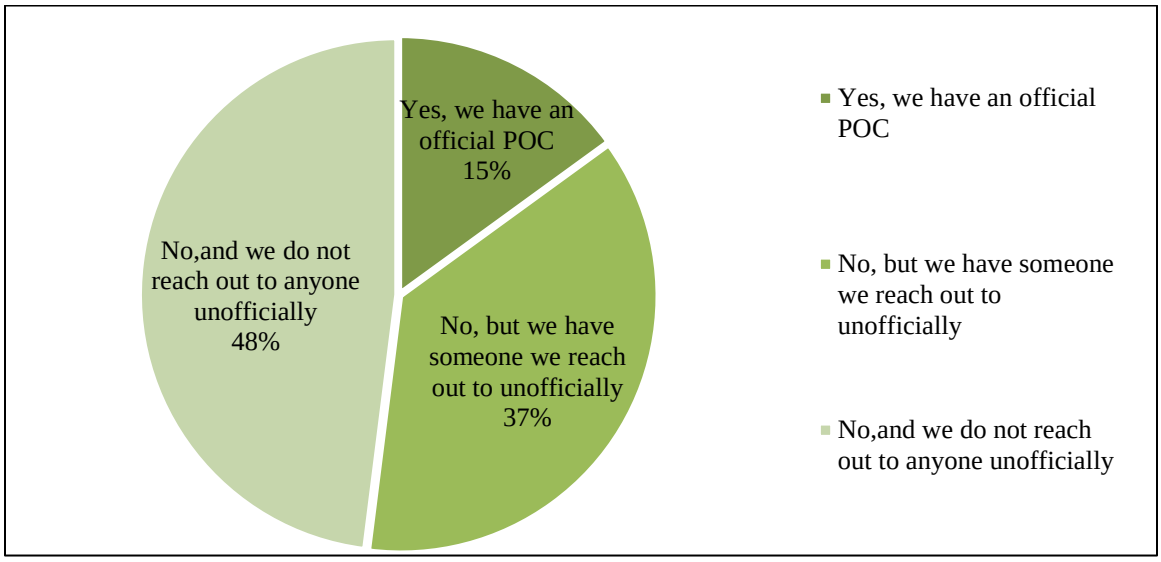
Similarly, another stated that, "Our FPM is helpful and cordial but it is hard to build a relationship because she is not here all the time—we can't consistently engage. The FPMT did try to participate at every stage of the CN. There is a good faith effort but it's hard because they are not in country." From these examples it is clear that there is a desire for more coordination with the FPMT, but structural issues—both real and perceived—may be inhibiting CDC staff from doing so.

In terms of CDC internal communication, low levels of exchange were reported between CDC HQ and field staff on GF issues. Over 65% of HQ staff and 51% of field staff reported being in contact on GF matters only once or twice a year, with an additional 8% of HQ staff and 25% of field staff stating that they are never in touch with each other on such issues (Figure 22). This situation may be due in part to a lack of official points of contact at HQ on GF issues or updates, as only 15% of field staff reporting having such a contact (Figure 23). Almost half (48%) reported not having such an official contact nor reaching out unofficially to any HQ staff on regarding GF.

Figure 22: Frequency of Communication between CDC HQ & Field Staff on Global Fund (N=90)



Figure 23: CDC Field Staff Reporting a HQ Official Point of Contact for Global Fund (N=54)



Interviewees confirmed this, with only two stating that they had someone at CDC HQ with whom they could contact with questions about GF, although both caveated this by explaining that those people would useful solely for specific technical issues. All of the other interviewees were clear that they did not believe there was someone at CDC HQ who could assist, for example saying, “I don’t even know if there is a person at CDC HQ focused on GF,” and “I do think that our division and CDC as a whole could do better in communicating if there is a point of contact for our engagement with GF, either a sole contact or

a group of people, as it's not very clear." Others were more blunt, stating, "I wouldn't know who to turn to. My experience has been that CDC left it to country to figure things out," and "No, I didn't feel like there was anyone I could reach out to. But I didn't need anyone from CDC to help me do my job because no one knew more than me. I wish I could say there was someone I could have reached out to but there was no one who knew enough to assist me." Another interview raised the issue of strategic alignment with in the agency, explaining:

> "There is a disconnect at CDC between the people who engage with GF and those who do at the field level so improving our internal flow of information would be helpful. It's not clear in Atlanta beyond technical people who is working with the Fund and what they are working on. There is no policy link between those who are conducting technical reviews or other high level work and those of us in the field. We don't know how strategy trickles down to the field and how we make sure that our positions are the same on both ends. CDC could do this much better."

In contrast, several interviewees highlighted that the Office of the Global AIDS Coordinator (OGAC) in the Department of State has occasionally served as a resource for them, especially those serving as GF Liaison. They said:

> "The multilateral office at OGAC started to do monthly calls that CDC staff were invited to attend. Those were opportunities to share documents, and have conversations about strategy and what was coming out of Board meetings. We got information that we couldn't get from other sources. It was a forum for liaisons could talk through issues. When HQ support became really important was as the NFM and CN process rolled out. They helped us get tools and documents just a little bit earlier—that brought me a lot of credibility in country, as I was familiar with the material when it was broadly released."

> "I haven't dealt with CDC HQ regarding GF. Mostly what I get from CDC is from all hands meetings on technical issues, including on GF. But from OGAC office we get emails on GF meetings, key decisions, input on GF strategy. We have monthly calls to exchange info and get presentations to build our skills and capacities. They have a focal person at OGAC who helps us."

STAFFING AND KNOWLEDGE

The Concept Note development process was reported as being the most common forms of CDC engagement with GF, as well as one of the most time-consuming. But beyond the Concept Note, CDC staff devote significant effort to GF activities, with 43% of field staff and 29% of HQ staff spending 5%-25% of their time on such issues; an additional 14% and 10% spent more than 25% of their time on GF (Table 19). Given the number of competing demands facing CDC staff, this percentage is quite sizeable,

especially when considering that the vast majority of respondents (93%) stated that their office does not have staff dedicated full time to GF activities (Figure 24). One interviewee articulately made the case for a GF liaison, raising issues of time, effort, and knowledge:

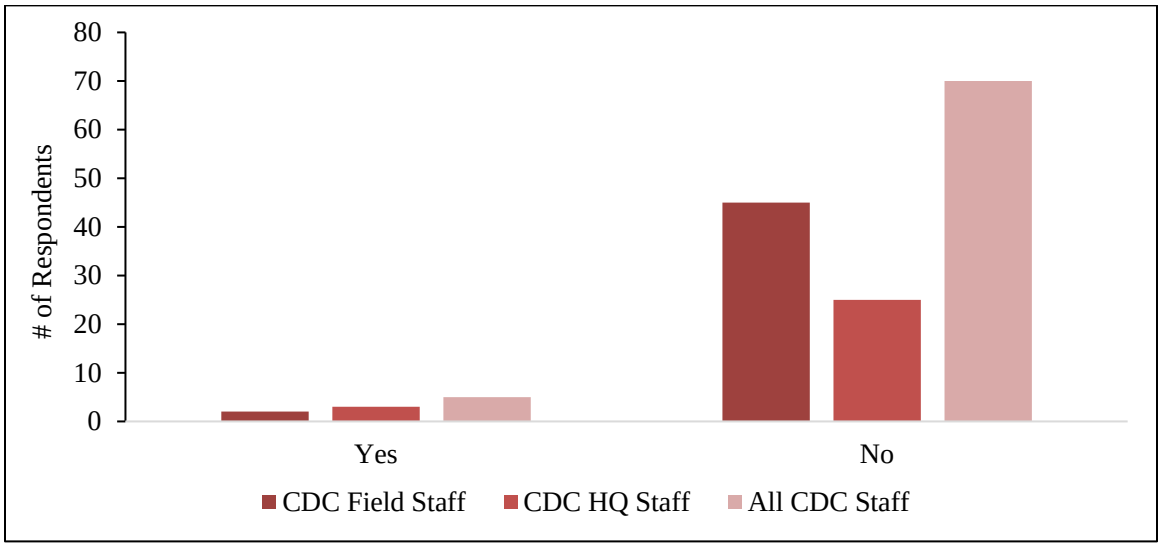
> "As largest donors and implementers in country, there is a natural marriage of GF and USG; we should be on the same page. It doesn't require advocacy to come to philosophical agreement about where everyone should move but the greater challenge has been around mutual awareness and communication. GF processes change constantly, as do USG's, so that means that we need staff who can step away from COP deadline or other major USG deadlines and just pay attention to GF —that's why you need a liaison or dedicated point of contact."

As another explained, "You need dedicated staff to be available to provide the level of support that GF needs if you want to do an optimal job. There must be someone having the open conversations in the off cycle, dealing with implementation challenges, and getting folks on the same page when the CN process comes around."

Table 19: Time Spent on Global Fund Activities Apart from CN Development

Response (N=80)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
More than 50%	1 (2%)	2 (7%)	3 (4%)
25%-50%	6 (12%)	1 (3%)	7 (9%)
5%-25%	21 (43%)	9 (29%)	30 (38%)
0%-5%	21 (43%)	19 (61%)	40 (50%)

Figure 24: Offices with CDC Staff Dedicated Full Time to Global Fund Activities (N=75)



CDC staff report that despite their significant involvement in GF, they have rarely received formal training on the institution or its processes (Table 20). The majority of field staff (63%) and HQ staff (53%) state that they have never received such training. When training has been provided, it has been most frequently done by GF itself (17%), USAID or Department of State (10%), or an external organization (9%); only 5% reported receiving training from CDC HQ and no one identified the country office as their trainer. The lack of formal training seems to persist, as 40% of staff say that they do not currently receive updates on GF policy, strategy, or processes (Table 21). Those who do get them from the Fund Portfolio Manager or other GF staff (39%), an email, call, or newsletter from CDC HQ (18%), Global Fund News Flash (14%), or Global Fund Observer newsletter (12%).

Interviewees most commonly stated that they learned about GF "on the job" or "by doing my work." A few, namely GF Liaisons, mentioned speaking with key contacts in Atlanta and D.C. and participating in a one-week training organized by OGAC on multilaterals in 2015. Some interviewees have taken online GF trainings but found them "focused internally on how things work in Geneva." The issue of understanding overall strategy and politics came up several times, with one saying that we "Need more policy acumen to engage with GF. We [CDC] can't spend our time engaging just bashing GF —we need strategies for supporting what they do." Another respondent elaborated: "GF processes are slow and

frustrating so it takes a lot of time to build relationships, learn who the players are, who is driving decisions on the CCM, how effective the Executive Secretariat is, how can we make sure that they understand what CDC/USG is doing, what the health portfolio is, and how to collaborate." They went on to describe a proposed continuum of learning about GF:

> "The first step to understanding GF, even before the processes, is getting to know the POCs in Geneva, helping understanding what they want and need, what their pain points are and how PEPFAR can address those. Once that's done, we have to get to know people in country and demonstrate our value there, showing up for the meetings even if they are all day, learning how the decision-making process works, the unique aspects of the country. From there we can start understanding the nuts and bolts of GF processes, rather than starting with the details of how the grant requests get put together and how they are doing monitoring. All of those pieces, while they are important, can in isolation inhibit being a real expert on GF. Also, you have to really know the portfolio, read through in incredible detail what's in the grants and map it against what CDC is doing. That really helps illustrate those areas that are ripe for better collaboration."

Another respondent highlighted the need not just for a CDC-focused review of GF, but for a USG-wide approach, saying:

> "One of things we push for in here is to provide training on GF from a CDC perspective but also an interagency perspective so that everyone who is in the USG space is fully versed on GF. That way we can operate as an interagency team and not as individual agencies, secretly working to secure GF resources together."

Table 20: Ever Received Formal Training or Briefing on Global Fund Processes

Response (N=79)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Yes, from CDC HQ	2 (4%)	2 (7%)	4 (5%)
Yes, from CDC Country Office	0 (0%)	0 (0%)	0 (0%)
Yes, from Global Fund	8 (16%)	5 (17%)	13 (17%)
Yes, from USAID or State	3 (6%)	5 (17%)	8 (10%)
Yes, from external organization	5 (10%)	2 (7%)	7 (9%)
No	31 (63%)	16 (53%)	47 (60%)
Other	6 (11%)	5 (17%)	11 (5%)

Other includes: PMI and RBM; GF portfolio manager at CCM meetings; USAID contractor; self-orientation using GF website

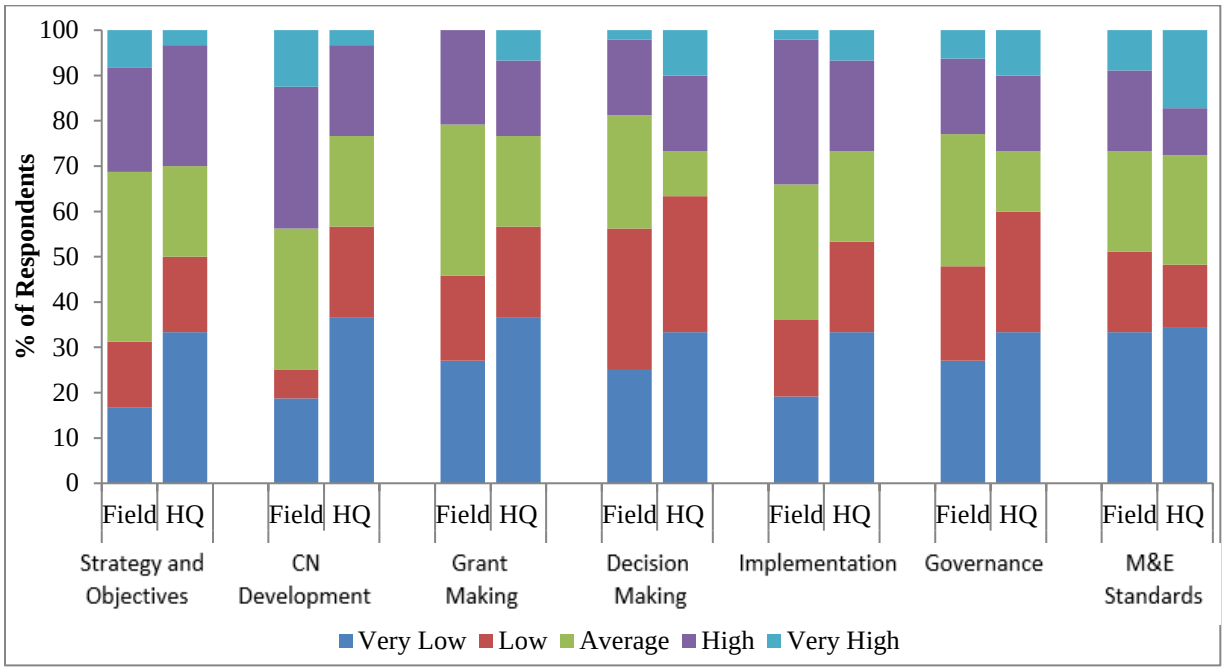
Table 21: Current Method for Receiving Updates on Global Fund Policy, Strategy, or Processes

Response (N=78; multiple responses allowed)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Do not currently receive updates	17 (35%)	14 (47%)	31 (40%)
Email or call from FPM or Global Fund staff	24 (50%)	6 (20%)	30 (39%)
Email, call, or newsletter from CDC HQ	7 (15%)	7 (23%)	14 (18%)
Global Fund News Flash	5 (10%)	6 (20%)	11 (14%)
Global Fund Observer newsletter	4 (8%)	5 (17%	9 (12%)
Other	8 (17%)	6 (20%)	14 (18%)

Other includes: Global Fund website; informal discussion with CCM; PEPFAR Coordinator; WHO colleagues, via email; Implementing partners; OGAC multilateral team; Emails or calls from USAID HQ; GF Liaison; USAID; PAHO; PEPFAR Technical Working Group

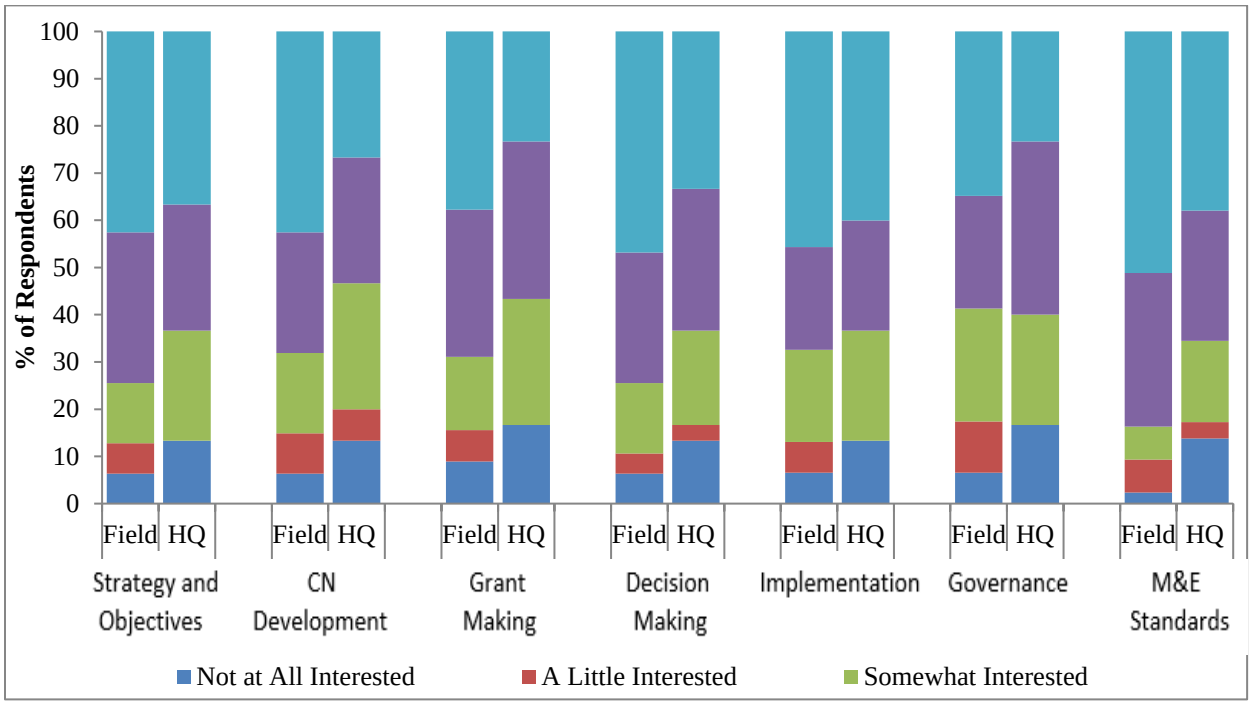
The lack of formal training and updates may contribute to the overall low level of (self-reported) knowledge of GF approaches and processes (Figure 25). For all seven domains queried, over 60% of CDC staff rated their knowledge as "Average" to "Very Low," with the largest reported knowledge gaps for HQ and field staff in decision-making (78%), grant-making (78%), and governance (76%). Knowledge among field staff was highest for Concept Note development, although only 44% rated their knowledge as "High" or "Very High"; HQ staff were strongest with regard to GF strategy and objectives, with 30% rating their knowledge "High" or "Very High".

Figure 25: Self-Reported Level of Knowledge of Global Fund Approaches and Processes (N=78)



Positively, CDC staff are extremely interested in learning more about GF, with at least 59% stating that they are "Quite Interested" or "Extremely Interested" in all seven domains (Figure 26). Monitoring and evaluation (76%), strategy and objectives (70%), and decision-making (70%) were of highest interest overall, including for field staff (84%, 75%, and 75% respectively). HQ staff were most focused on monitoring and evaluation (66%), strategy and objectives (63%), decision-making (63%), and implementation (63%). Desire was 11%-18% higher among field staff compared to HQ staff in all areas except for implementation (4% higher) and governance (1% lower).

Figure 26: Level of Interest in Learning More about Global Fund Approaches & Processes (N=77)



FUTURE CDC TECHNICAL ASSISTANCE

Given the high level of CDC engagement with GF and deep technical expertise of the agency, CDC is well-placed to provide technical assistance to the institution on a wide range of issues. The vast majority of respondents state that CDC should provide technical assistance on numerous issues, particularly epidemiologic analysis and target-setting (91%), laboratory systems planning (84%), disease-specific programs (79%), and strategic planning (75%); six other domains were supported by at least 60% of respondents (Table 22). In terms of how such technical assistance should be delivered, the preferred method of both HQ and field staff was via CDC staff placed in country offices, followed by CDC staff seconded to GF PR(s) (Table 23).

Table 22: Topics/Activities CDC Should Provide Technical Assistance on to Global Fund

Response (N=79; multiple responses allowed)	CDC Field Staff n (%)	CDC HQ & Secondee Staff n (%)	All CDC Staff n (%)
Epi analysis, target-setting	45 (94%)	27 (87%)	72 (91%)
Lab systems planning	44 (92%)	22 (71%)	66 (84%)
Disease-specific programs	38 (80%)	24 (77%)	62 (79%)
Strategic planning	37 (77%)	22 (71%)	59 (75%)
Program M&E	31 (65%)	25 (81%)	56 (71%)
QI systems	35 (73%)	20 (65%)	55 (70%)
Gaps analysis	34 (71%)	19 (61%)	53 (67%)
Proposal development	30 (63%)	22 (71%)	52 (66%)
Program planning	31 (65%)	199 (61%)	50 (63%)
Program implementation	27 (56%)	19 (61%)	46 (58%)
Financial analysis	16 (33%)	11 (36%)	27 (34%)
Other	4 (8%)	3 (10%)	7 (9%)

Table 23: Preferred Method for Provision of Additional Technical Assistance to Global Fund

Preferred Method for Provision of Additional Technical Assistance to Global Fund			
Response (N=78)	CDC Field Staff Ranked Score	CDC HQ & Secondee Staff Ranked Score	All CDC Staff Ranked Score
CDC staff in country office	5.08	5.33	5.18
CDC staff seconded to PR	5.00	4.87	4.95
CDC HQ technical staff	3.60	3.97	3.74
Multilateral institutions	3.44	3.47	3.45
NGO partners	2.50	2.07	2.33
Other	1.38	1.30	1.35

Feedback from interviewees was consistent with the survey results. Data and analysis was a major theme, with one interviewing asserting that "we should share site level data, that rich granular data we have to help GF with the risk assurance to build out their performance indicators. CDC should really be looking at that piece more closely." Another echoed this point, saying:

> "In terms of support, being more engaged technically at country level and doing more data level as the Fund's model evolves in whatever direction. Making sure they have access to our data, all of it, from expenditure analysis to unit price for packages, all of that is very valuable and will help GF as they think about their comparative advantage as a financing mechanism as compared to in country technical partner."

Interviewees were clear that this was primarily the responsibility of the in-county team but that HQ technical advisors would be critical in helping conduct the analysis and educating GF HQ on the findings. Said one:

> "We need someone, in a detailed way, walking the FPM through our analysis process. Like, 'here's our strategy, here's a map of where our focus is, here's what our investment is, here are the cadres we are supporting, here are the health information systems we have invested in.' All of that nitty gritty that CDC has technical expertise in needs to be shared."

BEST PRACTICES AND RECOMMENDATIONS

The survey asked respondents to identify current best practices and offer recommendations to improve CDC operations regarding GF in three domains. The major themes and most common responses are summarized below.

ENGAGEMENT AND TECHNICAL ASSISTANCE

Both the high quantity and quality of CDC engagement with GF were emphasized as best practices, with several statements about engaging "early and often" and ensuring that CDC was part of epidemiologic, gap, and program analyses. Being ready to provide high quality technical assistance is imperative, especially in CDC core areas such as laboratory systems, key populations, health information systems, and monitoring and evaluation. Respondents stated that when CDC was not engaged in the development of the Concept Note and supporting materials (e.g., epidemiologic analysis, data quality assessment, study of treatment outcomes), the quality of outputs was suboptimal and their utility decreased. Reducing the influence of external consultants and requesting direct technical assistance from CDC had resulted in stronger products (including Concept Notes) in other contexts and was considered a best practice. CDC direct assistance was cited as having saved some country programs from losing their grants, preventing large gaps in availability of essential commodities, and/or shifting portfolios to more evidence-based interventions.

Technical and leadership staff within CDC were encouraged by respondents to increase the frequency and volume of engagement with management of GF. Institutionalizing processes (e.g., monthly calls between CDC and FPMT, in person meetings during every FPMT mission to the country) was seen as important, so that continuity in the relationship would not be affected by turnover on either side. Establishing a connection with the FPMT early in a CDC Country Director's tenure was considered imperative, as were short, frequent updates via phone or email; both actions were reported to have helped resolve long-pending Management Actions and outstanding technical issues.

Decreasing duplication, promoting complementarity, and ensuring equity in service packages supported by CDC and GF was a high priority for respondents. Concerns about parallel M&E systems,

the lack of harmonized USG and GF targets, and overall technical guidance were common, but respondents often stated that that these needed to be resolved at the HQ level. Similarly, some respondents wanted CDC leadership to encourage GF resources to be directed primarily at procurement of commodities, rather than for interventions/services, as those were considered the most susceptible to being influenced by local politics and external consultants, rather than scientific evidence.

With many countries facing decreasing support from USG/CDC, the issues of transition and coverage of gaps were raised several times. Stronger communication was desired between USG/CDC, GF, and the Ministry of Health to promote transparency on impending gaps, establishment of monitoring plans, and identification of alternative funding sources to prevent disruption of essential services.

With regard to CCM representation, numerous respondents stated that CDC was hampered by the lack of a dedicated, permanent seat. This was particularly true for countries where i) CDC is the predominant implementing agency of health programs (but where other agencies may have a seat), ii) there is significant overlap between the activities supported by CDC and GF, and iii) CDC and GF share recipient partners. Almost universally, respondents wanted CDC to have its own seat on the CDC, alongside (rather than instead of) other USG agencies. Participation within CCM subcommittees and working groups, and direct support of the CCM Secretariat, were also cited as areas for enhanced activity. With regard to implementation, joint site visits (both with and without respective HQ leadership) were recommended to become more frequent, along with reviews of program data. For the latter, respondents encouraged integration of GF results into required USG data systems and reviews to guarantee participation, transparency, and harmonization. Finally, CDC HQ and field engagement on both mock and real Technical Review Panels was also considered a vital next step and one that would greatly increase the quality and relevance of the reviews.

CDC STAFFING, SKILLS, AND KNOWLEDGE

Interagency GF Liaison positions were considered essential by most respondents, with specific benefits provided by Liaisons including providing weekly updates on GF activities, serving as a triage point for multiple requests, handling complex governance and management issues, and educating

agencies on GF processes. As one interviewee described it, “CDC Country Directors should ensure that senior staff are engaged with GF and bring in the Liaison to talk about GF structures or facilitate conversations about implementation and process.” In addition to Liaisons, almost all respondent strongly advocated for CDC-specific staff dedicated to multilateral engagement; these technical positions would be focused on data analysis, program prioritization, operational planning, and Concept Note development, going beyond the standard focus on governance and process issues of Liaisons. A few individuals suggested that these positions be based at the CCM, Secretariat, or Principal Recipients, but most thought it would be more efficient to have them housed within the CDC office.

A best practice was for position descriptions to clearly state expectations regarding level of effort on GF activities and encourage leadership on GF issues. Where an additional CDC position dedicated to addressing GF was not possible, respondents recommended designating an existing senior position as the primary point of contact and providing the incumbent training on GF processes and systems. The individual would need to be able to convey information between CDC, the CCM, Principal Recipients, the FPMT, the host government, other USG agencies, and other stakeholders, as well as be able to make technical and strategic recommendations. He/she would also “put together briefing packages for the FPM so they can really understand what’s going on, especially from the CDC side,” as one interviewee put it.

In terms of a best practice, several individuals stated that when colleagues with knowledge and skills related GF gave presentations to their teams, the information was very warmly received and put to use. Respondents wanted encouragement of this peer-to-peer learning and integration of GF topics into routine team meetings, retreats, and trainings, including at the major CGH Annual Meeting.

Respondents strongly supported formal training for CDC staff on GF, particularly for Country Directors and senior technical advisors. The ultimate goal is to guarantee that all relevant staff (particularly those working on PEPFAR, PMI, and TB Care 2.0) have a working knowledge of GF. The training was recommended to be provided early in an employee’s time with CDC and could be conducted jointly with HHS, OGAC, or USAID. An orientation visit to GF HQ for Country Directors was considered a good investment, as it would improve understanding of the operational environment,

priorities, and processes. As an interviewee said, “Country Director need to be well-informed when voting on issues in the CCM to move the country ahead. To do that, they need to know the full GF landscape.”

For CDC HQ, recommendations included continuing secondee positions to GF in Geneva and establishing a multilateral team within CGH. In addition, respondents proposed creating a CDC— GF Technical Working Group across Divisions to increase CDC’s visibility and ability to discuss specific policy and technical issues. The group could conduct joint supervisory site visits to countries, exchanges between Atlanta/D.C. and Geneva, and participation on reviews of USG plans (e.g., COP, MOP) and GF Concept Notes.

In addition, respondents suggested the designation of a HQ point of contact for GF Liaisons or a partner support team for GF matters with CGH. These would provide pro-active updates on GF developments to the field and across CDC CIOs, along with providing general problem-solving and communications support. “It would be very advantageous to CDC, especially CGH, to have a person or resource who is well versed in GF who could provide consultation and technical support when needed,” said an interviewee. “I think that our division and CDC as a whole could do better in communicating if there is a POC for our engagement with GF, especially we don’t communicate well what we’re doing in support of GF. Having someone at the CGH level would help,” said another.

Training for CDC Country Officers on the requirements for Concept Note development, potential technical assistance opportunities for CDC HQ, and best practices (both in terms of technical content and methods of coordination) was also suggested. A document enumerating expectations for Country Officers and standards for engaging was desired, as Country Officers were unsure of their particular role in assisting with resolution of GF activities or the strains placed on country teams during Concept Note development.

COMMUNICATION AND COORDINATION WITH STAKEHOLDERS

In terms of communication with the FPMT and other GF staff, CDC respondents stated that it was vital to continue to proactively offer information to the FPMT, including on annual plans and

programs (both those receiving funding and those being discontinued), technical and geographic priority areas, and funding levels (particularly to shared Principal and Sub-Recipients. As one interviewee said, "Everyone needs to understand the priorities up front. Knowing the expectations and what the respective guidance is for each program is crucial."

To improve communication between CDC country and HQ offices, respondents proposed development of a CDC strategy on engagement with GF that would guide and standardize activity in the field. As one interviewee argued, "We should have a team who can provide resources to countries and provide a higher level strategic vision of how we should be engaging with GF, rather than being left entirely to do it on our own. Even an informational packet or a CDC guide to how we engage with GF, perhaps even a strategy document that could be shared would help tremendously."

They also suggested a monthly update on GF issues from HQ to interested parties in the field and at HQ that would include both best practices and lessons learned from the field (and HQ technical assistance providers) as well as news on GF policy changes. Within HQ, technical and strategic meetings and exchanges were encouraged between teams supporting GF activities to discuss shared experiences, lessons learned, and opportunities for future collaboration. One interview felt strongly about this, stating:

> "We don't document well in an internally public space what we're doing with GF. Maybe this is something that can be done at the CGH level, sharing info on how we are coordinating activities because it varies by disease area or country. We should have a more standard approach to how we engage and define our role in that global health space to differentiate CDC from other partners. Our partnership with GF is a strategic one. It's not the same as a partnership with an implementing partner or a MOH or USAID even—it's beyond that and it's important that we build or use our core competencies, to put those on the table and define our role more clearly for our engagement with GF."

In terms of external stakeholders, respondents recommending identifying key stakeholders with similar values and cultivating them as early as possible in key activities, such as Concept Note development. Sensitizing these stakeholders to a data-driven approach and updating them on the latest evidence-based programs was considered essential. Where the Ministry of Health is a Principal Recipient as well as a CDC cooperative agreement partner, CDC should work closely with the relevant management

units of the Ministry to align administrative and technical priorities, discuss distribution of staffing support, and hold joint reviews of financial and program progress.

SUMMARY OF FINDINGS

Overall, this study found that there is a high degree of interest among CDC staff in GF and that engagement with GF is considered very important to their work but that CDC is not necessarily maximally effective in its collaboration. CDC staff face multiple challenges regarding GF, including lack of formal roles and responsibilities, low levels of self-reported knowledge, deficiencies in training, unclear support and communication systems, and deficiency in dedicated staff or time for engagement. There is a desire for more strategic direction, training, and prioritization of GF collaboration, particularly among country-based staff.

CHAPTER 5: PLAN FOR CHANGE

PRIORITY RECOMMENDATIONS

CDC staff, particularly those in country, are deeply engaged with the development and implementation of GF activities and recognize the importance of this work. However, there remains significant opportunity to improve the impact of this engagement and in turn, the effectiveness of GF investments. This analysis yielded numerous suggestions and recommendations to improve collaboration, but the majority centered on a few key proposals to address major bottlenecks. In order to address the most pressing challenges, my advocacy within CDC will focus on the four major recommendations that emerged from the survey and interviews. Namely:

1. CDC should support the hiring of additional GF Liaisons in-country and the establishment of a CGH-level GF or Multilateral Affairs team.
2. CDC should work with GF leadership to encourage CCMs to include a dedicated seat for the agency and/or to promote rotation of USG seats among agencies. This would enable greater direct involvement of CDC staff in GF activities and may result in less reliance on external consultants.
3. CDC should identify and systematically promote training opportunities on GF processes, systems, and priorities, in particular among field staff. These may include existing virtual trainings (from the GF website, partner webinars), live seminars and informational sessions (at meetings and using HQ liaison and seconded staff), and applied learning opportunities such as participation in mock or actual Technical Review Panels.
4. CDC should seek additional financial resources which would enable expansion of field-based TA in support of GF processes and programs. This should include both in-house and seconded cross-cutting subject matter experts who can support HIV, TB, malaria, and health systems strengthening grants and programs, as appropriate. These TA staff should be focused on high impact GF countries which

are also countries with substantial USG financial resources or strategic importance. These additional TA staff would utilize established Ministry of Health relationships and operational knowledge, including via cooperative agreements, to augment the quality of in-country technical support and capacity. Ancillary benefits would be to reduce the reliance on external consultants of suspect quality and the amount of time required by other technical staff already facing demanding workloads.

OPPORTUNITIES FOR AFFECTING CHANGE

In my current role as the Associate Director for Policy for the Division of Global Health Protection and an experienced CDC country office staffer, I am in a position to influence CDC's strategies towards external engagement, including with GF. Through participation on various policy working groups and discussions with senior leadership, I may be able to bring to the forefront the current challenges with the GF partnership and share recommendations for addressing them. Collecting and analyzing the data presented here may serve as a catalyst for reforming and strengthening CDC's engagement with GF, and may be well-timed given changes in leadership at both institutions. I will also be leading the development of my Division's partnership strategy and will be able to incorporate lessons learned and best practices from this research.

In order to ensure utilization of this information by CDC, I will follow Kotter's Eight Step Model for Leading Change, which is described in Figure 27 below. Each step will be undertaken as part of concerted, strategic effort. Before moving to the next stage, I will assess progress, document lessons learned, keep track of stakeholders' responses, and develop effective communication strategies and tools that integrate feedback from others'.

Figure 27: Kotter's Eight Step Model for Leading Change



From "Leading Change: Why Transformation Efforts Fail." John P. Kotter, Harvard Business Review, January 2007.

STEP 1: CREATE A SENSE OF URGENCY

Once the analysis and recommendations documented here are refined and prepared for dissemination within CDC, I will arrange informal meetings with key actors on partnerships within the agency. This will include those who work on multilateral affairs, policy development, resource mobilization, country support, and leadership development at the Division, Center, and possibly Office of the Director levels. During these meetings I will share the most critical findings from this research, highlighting that CDC are highly involved in GF and recognize the importance of doing so, but also are frustrated by their lack of impact and effectiveness. This will speak to CDC's interest in improving staff

morale and promoting efficiency, especially at this time of declining or flat funding for global health. I will stress that the current situation is untenable and will only be exacerbated by the potential roll-out of a new operational approach by GF and/or priorities by USG. I will frame the ongoing leadership and strategic changes at GF and CDC as a major opportunity, stressing that is a unique moment for both agencies and that such leadership turnover will likely not occur for another four years. Their input will be sought on potential champions for reform at all levels of the agency, effective arguments to make with each, and timing for approaching each new champion.

STEP 2: BUILD A GUIDING COALITION

Building on the guidance from those consulted in step 1, I will reach out to potential, well-placed champions to help advance this cause. The goal will get these individuals to recognize the opportunity for reform, understand the key issues, and feel passionately about prioritizing this work within their portfolio. I will highlight the issues and openings more relevant to them, tailoring my arguments for each while not losing the overall messages and cross-cutting objectives. Once they are on board, I will introduce them to each other and the key stakeholders from step 1, helping to solidify the individuals into a single working group. Depending on size, focus, and placement/role within CDC, it may be necessary to form smaller sub-groups. For example, those more distal from direct GF technical engagement, such as individuals from the Office of the Director, may want to concentrate solely on Geneva- or D.C.- level issues.

STEP 3: FORM A STRATEGIC VISION

As a collective, we will define our shared goals, which will likely be to encourage leaders to adopt of our recommendations and allocate resources (both human and financial) needed for implementation. Our vision statement will reflect our joint commitment to advancing a more impactful, strategic collaboration with GF at HQ and field levels through a variety of approaches. We will also sketch out strategies to implement this vision, including how to communicate with leadership, how to ensure buy-in from those who will need to modify behavior or change their roles, and how to message outwardly to GF and other stakeholders.

STEP 4: ENLIST A VOLUNTEER ARMY & COMMUNICATE THE VISION

The coalition will share this vision to leadership via a coordinated, well-timed roll-out. It will begin with presentations to existing working groups, such as the CGH and Division Policy Team. Their feedback and suggestions will be incorporated into the next iteration of the presentation to leadership at the Center and Office of the Director levels. At those sessions we will emphasize the technical and management benefits of reform for both HQ and country staff, and detail the action plan for implementation and coordination with GF management.

To communicate beyond leadership, we will advocate for the inclusion of these recommendations at the CGH Annual Meeting and for the recommended actions to be presented at that time. It should also be discussed on global calls, such as with the Country Directors, Deputy Directors, Locally Employed Staff Advisory Group, and topic-specific Technical Working Groups.

For those unable to join in-person meetings or calls, we will prepare a two-pager with visuals explaining the current situation and challenges, proposed solutions and justifications, and opportunities for their engagement. This outreach will discuss not only the benefits of reform for CDC but also for GF, local Ministries of Health, implementing partners, and other stakeholders.

STEP 5: ENABLE ACTION BY REMOVING BARRIERS

During the presentations and meetings, we will underscore how passionately CDC staff feel about these issues, the frustration and inefficiency in the existing approach, and best practices from those who have found ways to address challenges. We will encourage others to document and share other strategies for improving GF collaboration and brainstorm with them alternative actions that can be taken immediately. If feasible, we will bring in experts from the field, particularly GF Liaisons, who can answer specific questions or provide testimonials on current barriers and lessons learned. We may connect innovators in this field to others who want to pilot our recommendations, or participate in training of new staff so they bring fresh ideas to their postings.

STEP 6: GENERATE SHORT-TERM WINS

To demonstrate proof of concept for these ideas, we will establish an *ad hoc* GF engagement working group, until a formal one is approved by leadership. In addition to serving as a technical assistance provider, the group will work to highlight effective GF engagements in CDC communication materials. For example, in Division and CGH newsletters we will showcase the impact of CDC country teams which have a seat on the CCM and ask them for suggestions about how other CDC offices can successfully advocate for their own seat. We will offer to strategize with teams about how to gain a seat, particularly if their CCM is undergoing restructuring.

For countries willing to push for a GF Liaison, we will assist with developing the scope of work and moving it through the approval process, as well as with recruitment and selection once the job announcement comes out. As another short-term win, during CDC award cycles, we will put forward nominations for individuals and teams which have adopted recommendations, best practices, and innovations in GF collaboration as incentive for others to do so. Finally, we will seek out ways to integrate GF into trainings for HQ and field staff, such as with the monthly trainings held for the Global Health Track of the Commission Corps or orientation for new Global Health Fellows.

STEP 7: SUSTAIN ACCELERATION

Building on this momentum, we will ask CDC leadership to formalize the *ad hoc* GF working group, which will increase its credibility and influence. The group will then define its leadership and concretize its priorities for the year, which may include pushing for CCM representation, advocating for more GF Liaisons, including multilateral issues in CDC training modules, or standardizing strategic technical assistance objectives. The goal will be to sustain the visibility of the group's work and engage even more countries and partners in these efforts, bringing in fresh ideas and innovations. The direction of the group may be affected by CDC and GF leadership announcements and plans but it should seek to address the pressing, persistent issues identified in this research, rather than be fully swept into new initiatives or side projects.

STEP 8: INSTITUTE CHANGE

The issuing of official CDC guidance or development of a strategy on GF engagement and implementation by HQ and field staff is the ultimate goal of this work. In order for the priority recommendations listed earlier to be fully realized, they must be formally, publicly endorsed by leadership and adopted by CDC at all levels. The release of such guidance or strategy may be accompanied by new hiring or reassignments, changes in position descriptions for all staff (to ensure a GF or partnership component), revised training curricula, and negotiations with GF HQ and other agencies on CDC representation on GF structures. Colleagues who have been working on these issues as part of the *ad hoc* group may be called upon to draft this guidance or strategy and assist with dissemination and adoption.

CHAPTER 6: CONCLUSION

PUBLIC HEALTH BENEFITS OF THIS RESEARCH

This research supports CDC country and HQ teams to identify best practices, challenges, bottlenecks, and opportunities for improvement related to engagement with GF. The assessment also provides insight into the status of CDC's current engagement, knowledge levels of GF, expectations for in-country USG coordination, and staffing to maximize the impact of GF planning and implementation. If implemented, the recommendations here will improve the efficiency and impact of both CDC and GF's work to combat HIV/AIDS, TB, and malaria, as well as to strengthen health systems around the world. In a period of flat or declining resources, increasing cost-effectiveness and reducing duplication is critical and will stretch funding so it can reach more individuals in need. Continuing the status quo will slow progress towards attainment of disease elimination goals, both nationally and globally. Even modest changes in how donors interact and collaborate can increase geographic coverage and access to services, leading in turn to significant public health impact.

DRAWBACKS AND LIMITATIONS

As stated earlier, this study only includes data from one side of the CDC— GF relationship; this prevents a true understanding and exploration of the dynamic between the two institutions. However, given the paucity of published information on these groups' interactions and the challenge of getting full access to GF staff for interviews, this study represents a tremendous stride forward in terms of documentation and analysis of donor coordination.

Another limitation of my research is that I utilized data from a 2015 quantitative survey and 2017/2018 qualitative interviews. Much has changed since 2015 in the global health landscape and in CDC and GF operations, including new leadership at both organizations. As such, some of the findings from the 2015 survey may no longer be as valid or relevant, and certain challenges may be less pressing.

Finally, the number of qualitative interviews was relatively low but they did confirm many of the findings from the survey, indicating that the structural and institutional issues persist even a few years after the initial survey. Taken together, the two methodologies suggest enduring challenges in effective collaboration that are not likely to naturally dissipate without intervention.

PLAN FOR FURTHER DISSEMINATION

The consolidated findings from this research will be modified and shared by CDC leadership with staff charged with developing training, policies, and guidance associated with external engagement. Tailored recommendations will be developed for each program area (i.e., HIV, TB, malaria) and disseminated within CDC. The material may be utilized by CDC leaders in the field and at HQ to better leverage CDC resources and systems vis-à-vis GF. Given the frequent turnover and movement of CDC staff, this assessment will also serve as an institutional memory of past and current engagement, as well as a source of recommendations for future action.

APPENDIX A: LIST OF STUDIES INCLUDED IN LITERATURE REVIEW

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APPENDIX B: QUANTITATIVE SURVEY TOOL

A. About You

1. Which best describes your current location and main function? (Select one)
    a. CDC-HQ Leadership
    b. CDC-HQ Technical
    c. CDC Country Office Leadership
    d. CDC Country Office Technical
    e. Other (please specify)
2. Have you served in another location and/or function? (Select all that apply)
    a. CDC-HQ Leadership
    b. CDC-HQ Technical
    c. CDC Country Office Leadership
    d. CDC Country Office Technical
    e. Other (please specify)
3. In which country do you currently work? (Please specify)
4. In which organization/office do you currently work? (Center, drop down with divisions)
    a. CGH OD
    b. CGH/DGHT
    c. CGH/DPDM
    d. CGH/DPDM/PMI
    e. CGH/DGHP
    f. NCHHSTP/DTBE
    g. NCHHSTP/DHAP
    h. NCEZID/DGMQ
    i. UNAIDS (CDC Secondee)

j. WHO (CDC Secondee)

k. Global Fund (CDC Secondee)

l. Other (Please specify)

5. How many years have you worked for CDC?

    a. Less than one year

    b. 1-3 years

    c. 4-6 years

    d. 7-9 years

    e. 9-12 years

    f. 13+ years

6. How many years have you been involved in activities related to the Global Fund?

    a. Less than one year

    b. 1-3 years

    c. 4-6 years

    d. 7-9 years

    e. 9-12 years

    f. 13+ years

7. How would you rate your level of interest in the Global Fund?

    a. Very high

    b. High

    c. Moderate

    d. Low

    e. None

8. How important is the Global Fund to your work?

    a. Very important

    b. Important

c. Somewhat important

d. Not important

B. Engagement

1. What types of engagement do you have with the Global Fund? (Select all that apply)
    a. Discussions with Country Coordinating Mechanisms (CCMs)
    b. Voting or alternate member of CCM
    c. Technical assistance to host country in developing or revising a National Strategic Plan (for purpose of Concept Note development)
    d. Technical assistance to host country in designing and submitting of Concept Notes
    e. Participation in mock Technical Review Panel
    f. Technical assistance to Technical Review Panel review
    g. Coordination for implementation of Global Fund supported programs
    h. Site visits to Global Fund supported sites
    i. Technical assistance for monitoring and evaluation of Global Fund activities
    j. Resolution of Management Actions (aka Conditions Precedent)
    k. Strategic coordination with USG/CDC initiatives
    l. Other (please specify)
2. On which Global Fund grants do you engage? (Select all that apply)
    a. HIV only
    b. TB only
    c. HIV/TB
    d. Malaria
    e. HSS

3. Does your CDC office have a cooperative agreement with any Principal Recipients (PRs) or Sub-Recipients (SRs) of the Global Fund in your country? (Select all that apply.)
    a. Yes, we have a cooperative agreement(s) with one or more PRs
    b. Yes, we have a cooperative agreement(s) with one or more SRs
    c. No
    d. Other (please specify)
4. Have you ever contributed to the technical development of a Concept Note for a program that did not receive USG funds in your country (i.e., supported development of a malaria Concept Note even though CDC only receives PEPFAR funds)? (Multiple responses for 'a' possible)
    a. Yes, we supported _____, _____, and _____ CNs even though we only receive USG funding for _____.
    b. No
5. Does CDC currently engage with the Country Coordinating Mechanism (CCM) in your country/region? (Select all that apply)
    a. Yes, we are a voting member
        1. Please specify title(s) of CDC voting member(s) and alternate(s):
    b. Yes, we are a non-voting member or observer
        1. Please specify title(s) of CDC non-voting member(s) and alternate(s):
    c. Yes, we are members of CCM sub-committees
        1. Please specify names of sub-committees
    d. Yes, we provide financial and/or technical support to the Secretariat
    e. No, we do not engage with the CCM
    f. Don't know

6. Does CDC have a permanent seat or alternate position on the CCM?
    a. Yes, CDC has a permanent seat
    b. Yes, CDC has an alternate seat
    c. No, but the USG has a permanent seat and we alternate with ____ (specify agency)
    d. No, but the USG has a permanent seat and we alternate with ____ (specify agency)
    e. No
7. If you provide TA to the development of Concept Notes, which sections do you provide input on? (Select all that apply)
    a. Country Context
    b. Funding Landscape, Additionality, and Sustainability
    c. Implementation Arrangements and Risk Assessment
    d. Financial Gap Analysis
    e. Programmatic Gap
    f. Modular Template (Program Framework)
    g. Modular Template (Concept Note)
    h. Modular Template (Summary Budget)
    i. Modular Template (Targets)
    j. Other (please specify)
8. What level would you consider your engagement in Global Fund Concept Note development?
    a. Very Substantial
    b. Substantial
    c. Active but not substantial
    d. Limited

e. None

9. How effective do you think you are at influencing the Global Fund Concept Note development?
    a. Very effective
    b. Effective
    c. Somewhat effective
    d. Not effective
    e. Do not know
10. What are challenges has you have faced in in terms of influencing the technical or strategic content of Concept Notes? (Select all that apply)
    a. Excessive influence of external consultants
    b. Excessive influence of CCM leadership
    c. Excessive influence of PRs
    d. Excessive influence of SRs
    e. Excessive influence of other donors
    f. Excessive influence of civil society
    g. Lack of transparency
    h. Length of process
    i. Length of meetings, consultations
    j. Poor quality of external consultants
    k. Document management/control
    l. Unclear communication channels for providing feedback
    m. Lack of interest by Fund Portfolio Management Team
    n. Lack of interest by in-country stakeholders
    o. Lack of or poor leadership/organization by host country government
    p. Other (please specify)

11. How would you rate the overall quality of work produced by external consultants brought in to develop Concept Notes?
    a. Very good
    b. Good
    c. Average
    d. Poor
    e. Very Poor
    f. Don't know
12. During the Concept Note development process, approximately how many people on the CDC team participate, at what level of effort, and for how long?

_____ people at average ____% level of effort for an average of ____ months

13. On what topics/activities do you think CDC should provide technical assistance to the Global Fund? (Select all that apply)
    a. Epidemiologic analysis and target-setting
    b. Disease-specific programs/interventions
    c. Gaps analysis
    d. Strategic planning
    e. Program planning
    f. Financial analysis and budgeting
    g. Proposal development
    h. Program implementation
    i. Program monitoring and evaluations
    j. Other (please specify)
14. How do you think CDC should provide TA to the Global Fund, if additional resources were available? (Please rank)

a. Via CDC in-country technical staff seconded to the Principal Recipient (such as the Ministry of Health) or CCM
b. Via CDC in-country technical staff based in the CDC office
c. Via CDC HQ technical staff
d. Via multilateral institutions (e.g., WHO, UNAIDS)
e. Via a cooperative agreement with an NGO
f. Other

15. Apart from the Concept Note development process, how much time do you spend on Global Fund activities?
    a. More than 50%
    b. 25%-50%
    c. 5%-25%
    d. 0%-5%
16. How often do CDC country offices reach out to you with questions and/or updates on Global Fund issues in their country?
    a. Very often (at least once per month)
    b. Somewhat often (once every 2-3 months)
    c. Rarely (once or twice a year)
    d. Never
17. How often does do you reach out to CDC-HQ with questions and/or updates on Global Fund issues in your country?
    a. Very often (at least once per month)
    b. Somewhat often (once every 2-3 months)
    c. Rarely (once or twice a year)
    d. Never

18. Do you have an official point of contact at CDC-HQ for any questions and/or updates you have on Global Fund issues in country?
    a. Yes, we have an official point of contact
    b. No, but we have someone we reach out to unofficially
    c. No, and we do not reach out to anyone unofficially
19. How many mock Technical Review Panels have you participated in?
    a. 5+
    b. 3-4
    c. 1-2
    d. 0
20. Do you have any best practices or recommendations to share regarding CDC engagement in Global Fund processes?
21. In your opinion, what is the most critical action for CDC to take to improve its engagement with and technical assistance to the Global Fund?

C. Staffing and Knowledge

1. Does your office have any CDC staff who are dedicated full time to Global Fund activities?
    a. Yes (please specify title)
    b. No
2. Do other agencies in country have staff who are dedicated full time to Global Fund activities?
    a. Yes, Department of State
        1. Specify funding source:
    b. Yes, USAID

1. Specify funding source:

c. Other (please specify agency and funding source)

d. No

e. Don't know

3. Does your country have a lead agency that serves as the primary focal point for Global Fund?

    a. Yes, CDC

    b. Yes, USAID

    c. Yes, State

    d. Yes, DOD

    e. No

4. If you answered B or C above, please describe any coordination the other agency does with CDC to get input and feedback on Global Fund activities.

5. Are you aware of the ongoing Global Fund Strategic Review?

    a. Yes

    b. Yes, but only vaguely

    c. No

6. Has your CDC office been asked to provide feedback to the Global Fund Strategic Review?

    a. Yes, and we met with the consultants in person

    b. Yes, and we provided oral feedback over the phone

    c. Yes, and we provided written feedback via email

    d. Yes, but we have not yet responded

    e. No, we have not been asked

7. Have you ever received any formal training or briefing on Global Fund processes? (Select all that apply)

a. Yes, provided by CDC-HQ

b. Yes, provided by a CDC Country Office

c. Yes, provided by the Global Fund

d. Yes, provided by USAID or Department of State

e. Yes, provided by an external organization

f. No

8. Please rate your knowledge of the following Global Fund approaches and processes (1 – 5 with 1 being low and 5 being excellent):

    a. Strategy and objectives = __

    b. CN development = __

    c. Grant making = __

    d. Decision making = __

    e. Implementation = __

    f. Governance = __

    g. Monitoring and evaluation standards = __

    h. Other

9. How interested are you in learning more about the following (1 – 5 with 1 being not interested and 5 being extremely interested):

    a. Strategy and objectives = __

    b. CN development = __

    c. Grant making = __

    d. Decision making = __

    e. Implementation = __

    f. Governance = __

    g. Monitoring and evaluation standards = __

    h. Other

10. How do you currently receive updates about Global Fund policy, strategy, or processes? (Select all that apply)
    a. Email or call from Fund Portfolio Manager or other Global Fund staff
    b. Global Fund Observer
    c. Global Fund News Flash
    d. Email, call, or newsletter from CDC HQ
    e. Other (please specify)
    f. I do not currently receive updates
11. Do you have any best practices or recommendations to share regarding CDC staffing to support the Global Fund?
12. In your opinion, what is the most critical action for CDC to take to improve the structures, knowledge, and skills of its teams, as they pertain to the Global Fund?

D. Communication and Coordination

1. Are your host country's financial institutions (e.g., Ministry of Finance, Ministry of Planning, Ministry of Treasury) active in the Global Fund process? (Select all that apply)
    a. Yes, they participate in the Concept Note development process
    b. Yes, they serve as a PR or SR of a Global Fund grant
    c. Yes, they participate in financial monitoring and reporting for Global Fund grants
    d. Yes, other (please specify)
    e. No, they do not participate in Global Fund activities
2. How involved are the following stakeholders in Global Fund activities (1 – 5 with 1 being not involved and 5 being extremely involved)?
    a. Ministry of Health

b. US Embassy Front Office

c. USAID

d. WHO/PAHO

e. UNAIDS

f. UNICEF

g. Other UN

h. CHAI

i. RBM

j. Other bilaterals

k. Other (please specify)

3. How would you rate the quality of technical or strategic contributions from the following stakeholders to Global Fund activities (1 – 5 with 1 being very poor and 5 being very good)?

    a. Ministry of Health

    b. USAID

    c. WHO/PAHO

    d. UNAIDS

    e. UNICEF

    f. Other UN

    g. Roll Back Malaria

    h. KNCV

    i. Other NGOs

    j. Other bilaterals

    k. Other (please specify)

4. How would you rate the quality of technical or strategic contributions from the following stakeholders to Global Fund activities (1 – 5 with 1 being very poor and 5 being very good)?
    a. Ministry of Health
    b. USAID
    c. WHO/PAHO
    d. UNAIDS
    e. UNICEF
    f. Other UN
    g. Roll Back Malaria
    h. KNCV
    i. Other NGOs
    j. Other bilaterals
    k. Other (please specify)
5. Right now, how frequently does your CDC office have a phone call with the Fund Portfolio Manager for your country/countries?
    a. Weekly or every other week
    b. Monthly
    c. Every other month
    d. On an ad hoc basis
    e. Never
6. Right now, how frequently does your CDC office meet in person with the Fund Portfolio Manager for your country?
    a. Weekly or every other week
    b. Monthly
    c. Every other month

d. On an ad hoc basis

e. Never

7. What are challenges have you faced in in terms of communicating with the Fund Portfolio Management Team (FPMT)? (Select all that apply)

a. CDC not included in USG communication with the FPMT

b. FPMT does not visit country

c. Turnover within the FPMT

d. Lack of interest from the FPMT

e. Lack of time for calls/emails with FPMT

f. Differences in technical priorities between CDC and FPMT

g. Differences in policy or strategic priorities between CDC and FPMT

h. No point of contact to initiate communication

i. Other (please specify)

8. Have or will representatives from organizations involved with the Global Fund be participating in person in your regional COP review? (Select all that apply)

a. Yes, representatives from the FPMT have/will participated

b. Yes, representatives from the CCM have/will participate

c. Yes, representatives from the PRs or SRs have/will participate

d. No

e. Other (please specify)

9. How frequently do you proactively share information with the Fund Portfolio Management Team? (Frequently, Sometimes, Rarely, Never)

a. Official plans once cleared

b. Official plans in draft form

c. Updates on program implementation

d. Unofficial updates on the functioning of the CCM, PRs, or SRs

e. Other unofficial news, country context

10. Do you have any best practices or recommendations to share regarding CDC communication with other stakeholders on the Global Fund?
11. In your opinion, what is the most critical action for CDC to take to improve communication and coordination with the Global Fund?

APPENDIX C: KEY INFORMANT INTERVIEW QUESTIONAIRE

1. Please tell me about yourself. What have your roles at CDC been?
2. How interested are you in engaging with the Global Fund?
3. What do you see as CDC's role re the Global Fund?
4. How did you first start engaging with the Global Fund? What was your role? What did you learn from that experience? How effective do you think you were at achieving your or CDC's goals?
5. How do you currently engage with the Global Fund? What is your role? In what activities do you participate? How effective do you think you are at achieving your or CDC's goals?
6. How did you come to learn about the Global Fund's processes and systems? Did you receive training?
7. What kind of support have you received from CDC HQ to help you engage with the Global Fund? (OR: What kind of support do you provide to countries regarding the Global Fund?)
8. Are there approaches or actions you think help CDC engage more effectively with the Global Fund?
9. What advice would you give to new CDC staff who have been tasked with working with the Global Fund?
10. How do you think CDC should support the Global Fund moving forward? What would you change in terms of our support?

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