Value for Money Working Group
Background Paper

The Global Fund to Fight AIDS, Tuberculosis, and Malaria

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An Agenda for Global Health Funding Agencies

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The Global Fund to Fight AIDS, Tuberculosis, and Malaria

Denizhan Duran and Rachel Silverman
Under the direction of Victoria Fan and Amanda Glassman

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List of Acronyms and Abbreviations

ACT:	Artemisinin-based combination therapies
AIDS:	Acquired Immunodeficiency Syndrome
AP:	Associated Press
ART:	Antiretroviral treatment
ARV:	Antiretroviral
CBS/SCMA:	Capacity Building Service/Supply Chain Management Assistance
CCM:	Country Coordinating Mechanism
CRWG:	Comprehensive Reform Working Group
DOTS:	Directly observed treatment short course
DQA:	Data quality audit
ETF:	Exchange-Traded Funds
GAO:	Government Accountability Office
Global Fund:	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV:	Human Immunodeficiency Virus
HLP	High-Level Independent Review Panel
IEG:	World Bank Independent Evaluation Group
ITN:	Insecticide-treated net
KPI:	Key Performance Indicators
LFA:	Local Fund Agent
LIC:	Low-income country
LLIN:	Long-lasting insecticide treated nets
LMIC:	Lower-middle income country
LMIS:	Logistics Management Information Services
M&E:	Monitoring and Evaluation
MDAG:	Market Dynamics Advisory Group
NGO:	Non-governmental organization
OAU:	Organization of African Unity
OECD:	Organisation for Economic Co-operation and Development (OECD)
OIG:	Office of the Inspector General
OSDV:	On-site data verification
PEPFAR:	President's Emergency Plan for AIDS Relief
PFSCM:	Partnership for Supply Chain Management
PMI:	President's Malaria Initiative
PMU:	Program management unit
PQR:	Price and Quality Reporting System
PR:	Principal Recipient
PSA:	Procurement Service Agent
PSI:	Population Services International
PSM:	Program and supply management
PU/DR:	Progress Update/Disbursement Request
RSQA:	Rapid Service Quality Assessment
SIID:	Strategy, Investment, and Impact Division (SIID)
Swiss TPH:	Swiss Tropical and Public Health Institute
TB:	Tuberculosis
TERG:	Technical Evaluation Reference Group

TFM:	Transitional Funding Mechanism
TRP:	Technical Review Panel
TWG:	Transitional Working Group
UK:	United Kingdom
UMIC:	Upper-middle income country
UN:	United Nations
UNAIDS:	Joint United Nations Programme on HIV/AIDS
UNOPS:	United Nations Office for Project Services
US:	United States
VOI:	Verification of implementation
VPP:	Voluntary Pooled Procurement
WHO:	World Health Organization

Part I: Funding History, Landscape, and Governance

Created in 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria ('the Global Fund' or 'the Fund') is a public-private partnership dedicated to mobilizing and allocating additional resources to combat human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), tuberculosis (TB), and malaria. The Global Fund describes its mission as "investing the world's money to save lives" to create "a world free from the burden of AIDS, tuberculosis and malaria."[1]

A set of eight principles distinguish the Global Fund from other donors and multilaterals (Appendix A). Unlike most development agencies, it finances but does not implement; it prioritizes country ownership, transparency and efficiency; and it strives to pursue a "balanced approach" in distributing its funding across countries, disease areas, interventions, and treatment versus prevention.[2]

Genesis and Foundation (2002-2006)

As the global impact of the HIV epidemic gained prominence in the late 1990s, and new technologies came online to combat AIDS, TB and malaria, momentum grew towards a strengthened global health response to the three epidemics.[3] At the same time, donors were frustrated with the perceived inefficiencies and complicated bureaucracies at traditional bilateral and multilateral aid mechanisms.[4]

Accordingly, HIV/AIDS, TB and malaria were selected to be one of four focus areas discussed at the July 2000 G8 summit in Okinawa, Japan.[5] Following the summit, the G8 leaders committed to work towards three goals by 2010: to "reduce the number of HIV/AIDS infected young people by 25%"; to "reduce TB deaths and prevalence…by 50%"; and to "reduce the burden of disease associated with malaria by 50%." To that end, they proposed the creation of a new partnership with other governments, multilateral organizations, academia, the private sector, and civil society.[6]

In April 2001, African leaders met in Abuja and echoed the G8's sentiment at a special summit of the Organisation of African Unity (OAU) exclusively focused on HIV/AIDS. Through the Abuja Declaration that followed the summit, African leaders pleaded for a "Global AIDS Fund capitalized by the donor community to the tune of US $5-10 billion accessible to all affected countries."[7]

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[1] The Global Fund. "Who We Are." Accessed 28 June 2012 at http://www.theglobalfund.org/en/about/whoweare/
[2] The Global Fund. The Framework Document of the Global Fund to Fight AIDS, Tuberculosis and Malaria.
[3] The Global Fund. "Our History." Accessed 28 June 2012 at http://www.theglobalfund.org/en/about/whoweare/history/
[4] Steven Radelet (2004). "The Global Fund to Fight AIDS, Tuberculosis and Malaria: Progress, Potential, and Challenges for the Future." Center for Global Development.
[5] WHO (2002). "Going to scale." Scaling Up the Response to Infectious Diseases. Chapter 4.
[6] G8 (2000). G8 Communique Okinawa. Accessed 28 June 2012 at http://www.g8.utoronto.ca/summit/2000okinawa/finalcom.htm
[7] Organisation of African Unity (2001). Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases. African Summit on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases.

Similarly, former United Nations (UN) Secretary General Kofi Annan "propose[d] the creation of a Global Fund, dedicated to the battle against HIV/AIDS and other infectious diseases."[8]

These developments led to a Special Session of the UN General Assembly on HIV/AIDS, held in New York during June 2001.[9] At the session, member states adopted a Declaration of Commitment, which included a pledge to "support the establishment, on an urgent basis, of a global HIV/AIDS and health fund to finance an urgent and expanded response to the epidemic."[10] In July, the G8 reconvened, committing $1.3 billion to the Fund and pledging to begin operations by the close of 2001.[11]

In its communique, the G8 stressed that the new Fund would represent a new approach to global health assistance, with particular focus on "proven scientific and medical effectiveness, rapid resource transfer, low transaction costs, and light governance with a strong focus on outcomes."[12] To put these principles into practice, a Transitional Working Group (TWG) held three meetings in late 2001. The TWG included almost 40 delegates from a range of constituencies, including developing country governments, donors, civil society, industry, and UN agencies. At the close of 2001, each "constituency" elected one or more representatives to sit on the newly created Global Fund Board.[13] The Board met for the first time in January 2002, at which point the Fund adopted its by-laws and began operations.[14] The first round of grants was approved in April 2002, benefitting 36 recipient countries.[15]

Radelet (2004) details how the Global Fund's design responded to several common critiques of traditional foreign aid programs. Whereas other aid programs were criticized for their "top-down, donor-driven approaches," the Global Fund would be "recipient-driven" and emphasize country ownership. Country Coordinating Mechanisms (CCMs), composed of a wide range of country-level stakeholders, would set priorities, draft grant applications, and ensure implementation of the approved programs. The Secretariat would be small and efficient, with no field offices and minimal bureaucracy. The Global Fund also aimed to tie funding to performance rather than inputs, and to defund ineffective programs.[16]

Between 2002 and early 2007, the Fund was led by Professor Richard Feachem. Under his leadership, the Fund's official targets aimed to put 1.6 million people on antiretroviral (ARV) treatment; treat 3.5 million TB cases with directly observed treatment short course (DOTS); and

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[8] Kofi Annan (2001). Remarks to the African Summit on HIV/AIDS, Tuberculosis, and Other Infectious Diseases in Abuja, Nigeria. "Secretary General Proposes Global Fund for Fight Against HIV/AIDS and Other Infectious Diseases at African Leaders Summit." Accessed 28 June 2012 at http://www.un.org/News/Press/docs/2001/SGSM7779R1.doc.htm
[9] WHO (2002). "Going to scale." Scaling Up the Response to Infectious Diseases. Chapter 4.
[10] United Nations General Assembly (2001). Declaration of Commitment on HIV/AIDS: Global Crisis – Global Action. Accessed 28 June 2012 at http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html
[11] G8 (2001). Geneva Communique. Accessed 28 June 2012 at http://www.g8.utoronto.ca/summit/2001genoa/finalcommunique.html
[12] Steven Radelet (2004). "The Global Fund to Fight AIDS, Tuberculosis and Malaria: Progress, Potential, and Challenges for the Future." Center for Global Development.
[13] The Global Fund. "Transitional Working Group." Accessed 28 June 2012 at http://www.theglobalfund.org/en/board/twg/
[14] The Global Fund. "First Board Meeting." Accessed 28 June 2012 at http://www.theglobalfund.org/en/board/meetings/first/
[15] The Global Fund. "Our History." Accessed 28 June 2012 at http://www.theglobalfund.org/en/about/whoweare/history/
[16] Steven Radelet (2004). "The Global Fund to Fight AIDS, Tuberculosis and Malaria: Progress, Potential, and Challenges for the Future." Center for Global Development.

distribute 100 million insecticide-treated bed nets by 2009.[17] Between 2002 and December 2006, the Global Fund approved 6 rounds of grants and disbursed $3.2 billion.[18,19]

Scale-Up, Challenges, and Restructuring (2007-2012)

In late March 2007, Dr. Michel Kazatchkine was selected as the Fund's new executive director following a competitive selection process. Kazatchkine's tenure was marked by rapid scale-up, with disbursements totaling $12.4 billion between 2007 and 2011.[20]

In an article published in January 2011, the Associated Press (AP) called attention to several instances of fraud and corruption at the Global Fund. The AP noted that this corruption had been discovered and disclosed several months prior by the Fund's own Office of the Inspector General (OIG); nonetheless, AP's news article labeled the level of fraud "astonishing," with "as much as two-thirds of some grants eaten up by corruption."[21] The Fund responded in April with its own report, *Results with Integrity*, which reiterated the Fund's "zero-tolerance" approach to corruption, and publicized the "$44 million in fraudulent, unsupported, or ineligible expenditures" which it was attempting to recoup (Appendix B).[22] The affected funds represented 0.3% of the Global Fund's total disbursements between 2002 and 2010.[23]

Following the AP story, Sweden and Germany both suspended contributions to the Fund pending further investigation and reform; pressure also grew from other donors and Board members.[24] Coinciding with the global economic crisis and increasing austerity from donor countries, the scandal exacerbated the Global Fund's funding woes and created urgent impetus for deep reform and restructuring.

Prior to the public controversy, in December 2010 the Board had created a Comprehensive Reform Working Group (CRWG) to review the organization's funding model and organizational structure. The working group prepared its report in advance of the May 2011 Board meeting; the report included a detailed Plan for Comprehensive Reform, which was endorsed and adopted by the Board.[25,26] At the same meeting, the Board voted to establish a High-Level Independent Review Panel (HLP) tasked with examining the Fund's "fiduciary controls and oversight mechanisms." Released in September 2011, the panel's final report emphasized the need for evolution from an

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[17] The Global Fund (2006). Annual Report 2005.
[18] The Global Fund. "Funding Decisions." Accessed 12 July 2012 at http://www.theglobalfund.org/en/fundingdecisions/#10,
[19] The Global Fund. Core Disbursements Details Raw Report. Accessed 15 October 2012 at http://www.theglobalfund.org/documents/core/grants/Core_DisbursementDetailsRaw_Report_en/
[20] The Global Fund. Core Disbursements Details Raw Report. Accessed 15 October 2012 at http://www.theglobalfund.org/documents/core/grants/Core_DisbursementDetailsRaw_Report_en/
[21] Associated Press (2011). "Fraud Plagues Global Health Fund Backed by Bono, Others." Accessed 28 June 2012 at http://www.msnbc.msn.com/id/41221202/ns/health-health_care/#.T-NmIvXvV8E
[22] The Global Fund (2011). Results with Integrity.
[23] The Global Fund. Core Disbursements Details Raw Report. Accessed 15 October 2012 at http://www.theglobalfund.org/documents/core/grants/Core_DisbursementDetailsRaw_Report_en/
[24] Rizza Leonzon (2011). "Germany Suspends Global Fund Contributions." The Development Newswire. Accessed 13 July 2012 at http://www.devex.com/en/news/blogs/germany-suspends-contributions-to-global-fund
[25] The Global Fund (2011). Report of the Comprehensive Reform Working Group.
[26] The Global Fund (2011). Board Meeting 23 Decision Points.

"emergency response to sustainability and heightened fiduciary responsibility" due to increasing demands for "austerity, accountability, and innovation." In particular, the report criticized the Fund's lax approach to risk management, fiduciary controls, and grant oversight.[27]

At its September 2011 meeting, the Board adopted the HLP report, "noting that it presents a compelling case for a rapid and urgent transformation of the Global Fund."[28] The Global Fund subsequently underwent a series of major restructuring and reforms in accordance with its new five-year strategy for 2012-2016, and with a Consolidated Transformation Plan approved by the Board in November 2011.[29] According to the new strategy, the Fund would transform its funding model, management structure, and investment decisions in an effort to save 10 million lives, avert 140-180 million new infections, have 7.3 million people alive on antiretroviral treatment (ART), and distribute 390 million bed nets by 2016.[30] The Consolidated Transformation Plan provided a concrete framework integrating six different areas of reform – resource allocation, risk management, grant management, organizational culture, governance, and resource mobilization – under "a single single plan, which [includes] prioritized action items, deliverables, timelines, and parties responsible for the delivery of each item."[31]

In January 2012, the Board appointed Gabriel Jaramillo as General Manager to lead the Fund's restructuring for a term of one year, with an emphasis on risk and grant management.[32,33] Immediately thereafter, Kazatchkine resigned, citing the Board's decision to "transfer many of [his] responsibilities" to Jaramillo.[34]

By May 2012, the Board had approved a blueprint for reorganization, whereby 75% of secretariat resources would support "impeccable grant management." Further, the Fund shifted human resources toward "high impact" countries (see page 18).[35]

While the Global Fund's reform process is still underway, donors appear pleased with progress thus far. Both Germany and Sweden have pledged additional commitments;[36,37] United Kingdom (UK) International Development Secretary Andrew Mitchell has also praised the new leadership,

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[27] High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (2011). Turning the Page from Emergency to Sustainability: The Final Report of the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis, and Malaria.
[28] The Global Fund (2011). Board Meeting 24 Decision Points.
[29] The Global Fund (2011). Board Meeting 25 Decision Points.
[30] The Global Fund (2011). The Global Fund Strategy 2012-2016: Investing for Impact.
[31] The Global Fund (2011). Consolidated Transformation Plan.
[32] The Global Fund (2012). "The Global Fund Appoints Gabriel Jaramillo as General Manager. Accessed 28 June 2012 at http://www.theglobalfund.org/en/mediacenter/pressreleases/2012-01-24_The_Global_Fund_appoints_Gabriel_Jaramillo_as_General_Manager/
[33] The Global Fund. "Gabriel Jaramillo – General Manager." Accessed 28 June 2012 at http://www.theglobalfund.org/en/about/secretariat/generalmanager/
[34] Global Fund Observer (2011). "Africa: Global Fund Executive Director Michel Kazatchkine to Resign." Accessed 28 June 2012 at http://allafrica.com/stories/201201250003.html
[35] The Global Fund (2012). Report of the General Manager. Twenty-Sixth Board Meeting.
[36] The Global Fund (2011). "Sweden Announces Increased Three-Year Pledge to the Global Fund." Accessed 28 June 2012 at http://www.theglobalfund.org/en/mediacenter/pressreleases/Sweden_announces_increased_three-year_pledge_to_The_Global_Fund/
[37] The Global Fund (2012). "Global Fund Sees Germany's Contribution as Recognition of a New Direction." Accessed 28 June 2012 at http://www.theglobalfund.org/en/mediacenter/pressreleases/2012-03-08_Global_Fund_Sees_Germanys_Contribution_as_Recognition_of_New_Direction/

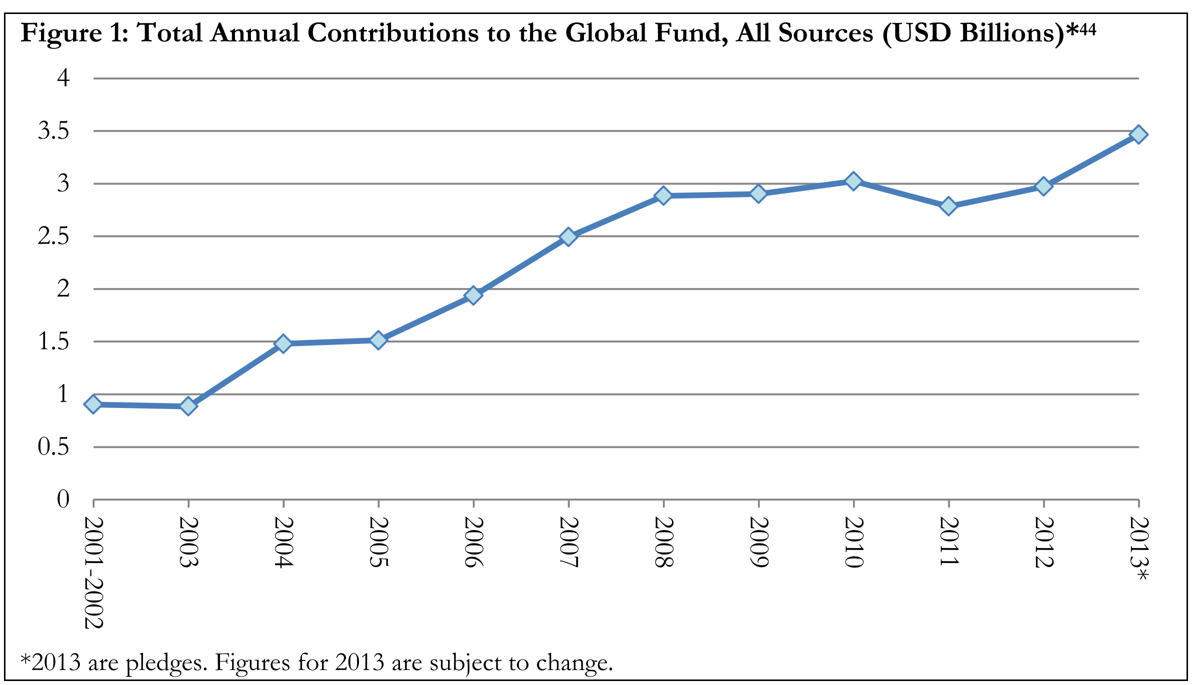
suggesting that the UK would be open to increasing future contributions pending adequate reforms.[38]

In November 2012, following a competitive selection process, the Global Fund announced the appointment of Mark Dybul, former head of PEPFAR, as its new executive director. He assumed leadership of the Fund in January 2013.[39] In the months since his arrival, the Global Fund has begun to roll out a “New Funding Model” for its grant-making, described in greater detail below.

Funding Sources and Trends

As a public-private partnership, the Global Fund mobilizes voluntary contributions from a wide range of potential donors, including governments, businesses, foundations, and individuals.[40] To date, the Global Fund has received a total of $30.5 billion in pledges and $25.6 billion in contributions.[41] Funding sources include 54 countries, about 15 foundations or charitable initiatives, three corporations, and a range of innovative financing schemes including UNITAID, Debt2Health, and Exchange-Traded Funds (ETF).[42,43]

Figure 1: Total Annual Contributions to the Global Fund, All Sources (USD Billions)*[44]



*2013 are pledges. Figures for 2013 are subject to change.

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[38] The Global Fund (2012). “UK Development Minister Praises Reforms at Global Fund. Accessed 28 June 2012 at http://www.theglobalfund.org/en/mediacenter/pressreleases/2012-04-19_UK_Development_Minister_Praises_Reforms_at_Global_Fund/

[39] The Global Fund (2013). “Executive Director, Mark Dybul.” Accessed 28 May 2013 at http://www.theglobalfund.org/en/about/secretariat/executivedirector/

[40] The Global Fund. “Donors and Contributions.” Accessed 28 June 2012 at http://www.theglobalfund.org/en/about/donors/

[41] The Global Fund. Core Pledges and Contributions List. Accessed 9 May 2013 at http://www.theglobalfund.org/documents/core/financial/Core_PledgesContributions_List_en/

[42] The Global Fund. Core Pledges and Contributions List. Accessed 9 May 2013 at http://www.theglobalfund.org/documents/core/financial/Core_PledgesContributions_List_en/

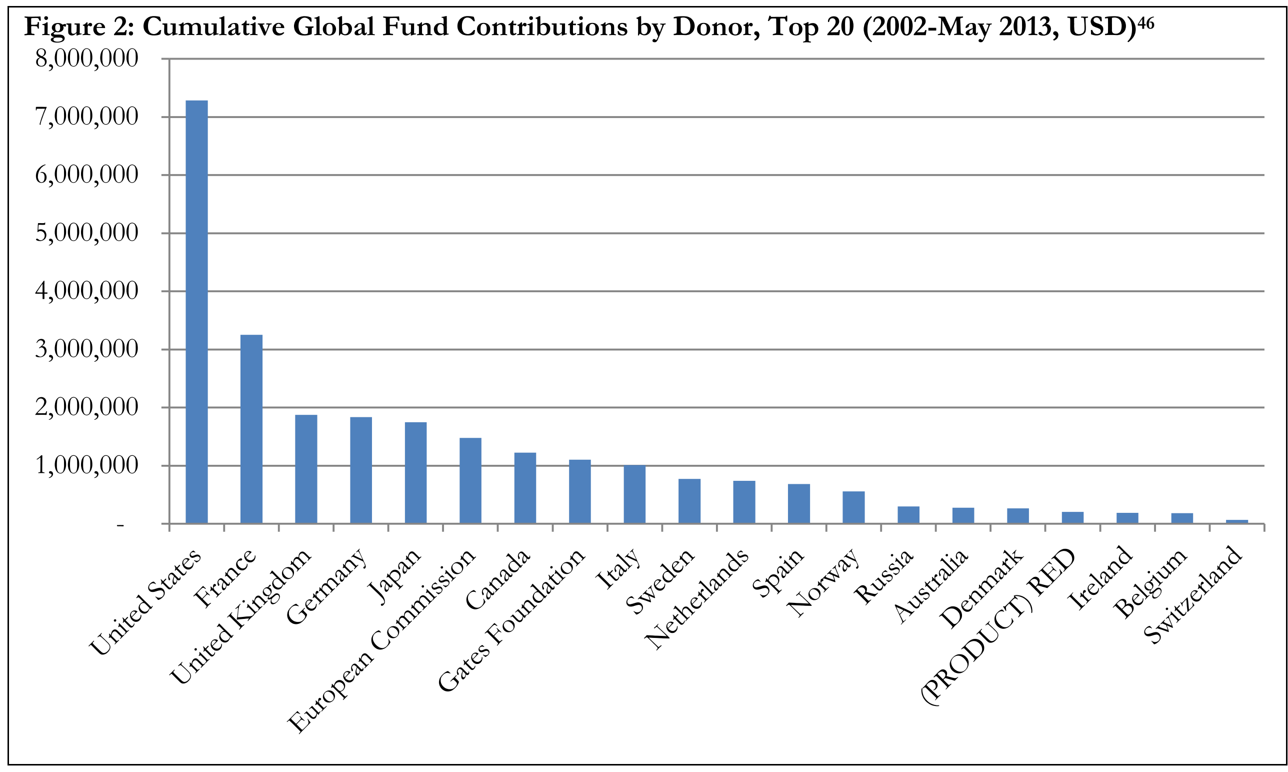
[43] The Global Fund (2012). “Government Donors.” Accessed 28 June 2012 at http://www.theglobalfund.org/en/about/donors/public/

[44] The Global Fund. Core Pledges and Contributions List. Accessed 7 May 2013 at http://www.theglobalfund.org/documents/core/financial/Core_PledgesContributions_List_en/

As shown in Figure 1, annual contributions to the Global Fund rose sharply between 2002 and 2008; funding stayed relatively stable between 2008 and 2012, but appears (tentatively) to be increasing for 2013. In November 2011, resource constraints (illustrated by a slight dip in funding for 2011) forced the Board to cancel its 11th Round of funding for new proposals; however, the Board did maintain some funding for "essential services" to existing grantees (the "Transitional Funding Mechanism"). The Global Fund intends to resume grant-making under its New Funding Model by the end of 2013. The Fund is currently undergoing its fourth "replenishment" to mobilize resources to this end.[45]

Between 2002 and May 2013, the vast majority of contributions (about 93%) came from wealthy government donors, with the top six donors – the United States (US), France, United Kingdom, Germany, Japan, and the European Commission – accounting for almost 70% of all contributions (Figure 2). Combined, the top 20 donors comprised over 98% of all contributions. The Bill and Melinda Gates Foundation is the only private organization to rank among the top ten donors, accounting for 4.3% of total contributions.

Figure 2: Cumulative Global Fund Contributions by Donor, Top 20 (2002-May 2013, USD)[46]



Strategy and High-Level Targets

The Global Fund's 2012-2016 Strategy, approved at the November 2011 Board meeting, is titled "Investing for Impact." The document lays out five broad strategic objectives, excerpted below:

[45] The Global Fund. "Fourth Replenishment." Accessed 7 May 2013 at http://www.theglobalfund.org/en/donors/replenishment/fourth/
[46] The Global Fund (2012). Core Pledges and Contributions List. Accessed 7 June 2013 at http://www.theglobalfund.org/documents/core/financial/Core_PledgesContributions_List_en/

1. **Invest More Strategically**: focus on highest-impact countries and interventions; maximize the impact of Global Fund investments on health systems and maternal and child health;
2. **Evolve the Funding Model**: replace the rounds system with a more flexible and effective model; facilitate the strategic refocusing of existing investments;
3. **Actively Support Grant Implementation Success:** manage grants based on impact, value for money and risk; enhance quality and efficiency of grant implementation;
4. **Promote and Protect Human Rights:** integrate consideration of human rights throughout grant cycle; address rights-related barriers to access; and
5. **Sustain the Gains, Mobilize Resources**: increase the sustainability of programs; attract additional funding from current and new sources.

Through implementation of this strategy, the Global Fund aims "to save 10 million lives and prevent 140-180 million new infections."[47] However, these ambitious goals are contingent upon sustained funding and improved value for money, which we consider in Part II.

Governance

At the highest level, the Global Fund is governed by its Board, which includes representatives from a broad range of constituencies.[48] As outlined in the Global Fund's bylaws, the Board has 20 voting and eight non-voting members (Table 1).

Table 1: Board Composition of the Global Fund[49,50]

Voting Members	Non-Voting Members
❖ **Seven Members: Developing Countries** (one per World Health Organization (WHO) region, plus one for Africa) ▪ As of June 2012: China, Comoros, Ghana, Mexico, Moldova, Nepal, Sudan ❖ **Eight Members: Donors** ▪ As of June 2012: European Commission, France, Germany, Italy/Spain, Japan, Point Seven (Ireland, Denmark, Luxemburg, Netherlands, Norway, and Sweden), United Kingdom/Australia, United States ❖ **Five Members: Civil Society and Private Sector, Including One Member Either HIV+ or from a Community Affected by**	❖ Board Chair and Vice-Chair ❖ Representative from WHO ❖ Representative from the Joint UN Programme on HIV/AIDS (UNAIDS) ❖ Representative from the Partners constituency (other organizations that work with the Global Fund, currently Stop TB Partnership) ❖ Representative from the trustee of the Global Fund (World Bank) ❖ Swiss citizen authorized to act on behalf of the Global Fund per Swiss law ❖ Executive Director of the Global Fund

[47] The Global Fund (2011). The Global Fund Strategy 2012-2016: Investing for Impact.
[48] The Global Fund. "Core Structures." Accessed 28 June 2012 at http://www.theglobalfund.org/en/about/structures/
[49] The Global Fund (2011). Bylaws As Amended 21 November 2011.
[50] The Global Fund. "Core Structures." Accessed 28 June 2012 at http://www.theglobalfund.org/en/about/structures/

Malaria or TB	▪ As of June 2012: Foundation for Professional Treatment South Africa, International HIV/AIDS Alliance, African Council of AIDS Service Organizations, Bill and Melinda Gates Foundation, Anglo American PLC

According to the Global Fund website, the Board is responsible for "strategy development; governance oversight; commitment of financial resources; assessment of organizational performance; risk management; [and] partner engagement, resource mobilization, and advocacy."[51] The Board meets at least twice a year, and attempts to make all decisions by consensus. When disagreements arise, decisions can be taken by a two-thirds majority of those present among each of the following subgroups:

- The ten "donor" votes, i.e. representatives of donor countries (8 votes), the private sector (1 vote), and private foundations (1 vote); and
- The ten "recipient" votes, i.e. representatives of developing country governments (7 votes), NGOs (2 votes), and affected communities (1 votes). [52]

Between Board meetings, the Board Chair and Vice-Chair are empowered to act on behalf of the Board when urgent decisions are required.[53] The Board also has three standing committees:

- *The Strategy, Investment, and Impact Committee* oversees Global Fund strategy and assesses the impact of Global Fund programs;
- *The Finance and Operational Performance Committee* oversees financial management and secretariat operations; and
- *The Audit and Ethics Committee* oversees the Fund's audits, investigations, and ethical standards.[54]

The Board's Coordinating Group includes the Board Chair and Vice-Chair, as well as the Chairs and Vice-Chairs of the three aforementioned committees. The Coordinating Group is designed to provide "a visible and transparent mechanism for coordination between the Board and its Committees in regard to the Board's governance, risk and administration functions."[55]

The Global Fund's day-to-day operations are managed by its Geneva-based secretariat, which reports to the Board and is led by Executive Director Mark Dybul. According to the Fund's website,

[51] The Global Fund. "Board." Accessed 14 April 2013 at http://www.theglobalfund.org/en/about/structures/board/
[52] The Global Fund (2011). Bylaws As Amended 21 November 2011.
[53] The Global Fund (2011). Bylaws As Amended 21 November 2011.
[54] The Global Fund (2011). Bylaws As Amended 21 November 2011.
[55] The Global Fund (2011). Terms of Reference for the Coordinating Group.

"the Secretariat is tasked with executing Board policies; resource mobilization; providing strategic, policy, financial, legal and administrative support; and overseeing monitoring and evaluation."[56]

Beyond the secretariat, there are several other important governing structures.

- The Technical Review Panel (TRP), comprised of independent epidemiologic and public health experts, is tasked with "[reviewing] proposals based on technical criteria and [providing] funding recommendations to the Board."[57] The TRP consists of up to 40 Board-appointed rotating experts.[58]

- The Technical Evaluation Reference Group (TERG) is an independent advisory body responsible for designing and arranging independent evaluation, both for specific programs and for the Global Fund's portfolio-wide and institutional performance. [59]

- The Office of the Inspector General (OIG) is responsible for providing the Board with "independent and objective assurance over the design and effectiveness" of risk management and controls.[60]

- The Market Dynamics Advisory Group (MDAG) provides the Global Fund Board and Secretariat with strategic advice on commodity procurement, supply chains, quality control, and ways to increase demand and utilization of key health technologies.[61]

- The Partnership Forum meets every two to three years, and allows a wide range of stakeholders "to express their views on the Global Fund's policies and strategies" by serving as a "visible platform for debate, advocacy, continued fund raising, and inclusion of new partners."[62]

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[56] The Global Fund. "Core Structures." Accessed 28 June 2012 at http://www.theglobalfund.org/en/about/structures/
[57] The Global Fund. "Core Structures." Accessed 28 June 2012 at http://www.theglobalfund.org/en/about/structures/
[58] The Global Fund. "Technical Review Panel." Accessed 28 June 2012 at http://www.theglobalfund.org/en/trp/
[59] The Global Fund (2011). Bylaws As Amended 21 November 2011.
[60] The Global Fund. "Office of the Inspector General." Accessed 28 June 2012 at http://www.theglobalfund.org/en/oig/
[61] The Global Fund (2011). Bylaws As Amended 21 November 2011.
[62] The Global Fund (2011). Bylaws As Amended 21 November 2011.

Part II: Funding Process and Expenditures

Historical Funding Process

The Global Fund is currently undergoing a major restructuring of its grant-making process, and will soon adopt the "New Funding Model" (discussed below) for future grants. This section provides an overview of the Global Fund's historical model, while the next section outlines recent developments and the distinguishing features of the New Funding Model.

Historically, the Global Fund's 5-year grant cycle distributed funding in "rounds" according to the following eight steps:

1. The Global Fund issued a call for proposals.

2. CCMs developed proposals based on local needs and financing gaps, and submitted them to the Global Fund secretariat. In those grant applications, CCMs elected one or Principal Recipients (PRs) to take responsibility for grant funds and program implementation. PRs usually had one or more sub-recipients.[63]

3. The Secretariat screened proposals to ensure their completeness and eligibility for funding.[64]

4. Eligible proposals were forwarded to the TRP, where they were reviewed for "technical merit." The TRP considered the "soundness of approach, feasibility, and potential for sustainability and impact," and subsequently made one of five funding recommendations to the Board:

   - "Category 1: Proposal recommended for approval without changes (and no or only minor clarifications);
   - Category 2: Proposal recommended for approval provided that clarifications or adjustments are met within a limited timeframe;
   - Category 2B: Relatively weak Category 2 Proposals, on grounds of technical merit and/or issues of feasibility and likelihood of effective implementation. Recommended for approval provided that clarifications or adjustments are met within a limited timeframe;
   - Category 3: Proposal not recommended for approval in its present form but strongly encouraged to resubmit following major revision, taking into consideration the TRP's comments; [or]
   - Category 4: Proposal rejected."[65]

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[63] The Global Fund. "Country Coordinating Mechanisms." Accessed 28 June 2012 at http://www.theglobalfund.org/en/ccm/
[64] The Global Fund (2011). "Funding Model." Governance Handbook. Chapter 3.
[65] The Global Fund. "Technical Review Panel." Accessed 28 June 2012 at http://www.theglobalfund.org/en/trp/

5. Taking into account the TRP recommendations and availability of funds, the Board voted to either approve or reject the grant application.[66]

6. An Internal Appeal Mechanism allowed rejected applicants to appeal the funding decision based upon a "significant and obvious error" by the TRP.[67]

7. Throughout the grant lifecycle, disbursement decisions were based upon performance assessments under a performance-based funding system (described further below). After Phase 1, which lasted two years, the grant was eligible for renewal pending a performance review. If the grant showed adequate performance, including implementation progress and grant management, the grant could be extended for Phase 2, which lasted from the end of year 2 until the end of year 5.[68]

8. At the close of year 5, grants with exceptional performance were invited to apply for a second extension under the Rolling Continuation Channel (RCC), lasting for up to six years.[69]

During the Fund's early years, it sometimes had multiple grant agreements with each PR, even within a single disease area. Under the Global Fund's grant architecture, which was approved in 2009, the Fund instituted a new policy whereby it would "maintain one funding agreement for each Principal Recipient per component," i.e. for each of the three focus diseases or HSS program.[70]

In its review of the Global Fund's grant approval process, the 2011 High Level Panel report noted several key problems with the historical system. In particular, it criticized the process for its lack of focus on value for money in decision-making, including incentives for CCMs to inflate their budget requests, and for the Fund's failure to consider risk management in its grant review process.[71]

Restructuring and the New Funding Model

Beginning in 2011, the Global Fund's funding model underwent a series of reviews and modifications, culminating in the 2013 deployment of the "New Funding Model." This section provides an overview of recent developments and the distinguishing features of the New Funding Model.

[66] The Global Fund (2009). Performance-Based Funding at the Global Fund.
[67] The Global Fund. "Options for Appeal." Accessed 28 June 2012 at http://www.theglobalfund.org/en/trp/appeals/
[68] The Global Fund. "Grant Renewals." Accessed 28 June 2012 at http://www.theglobalfund.org/en/activities/renewals/
[69] The Global Fund (2009). Performance-Based Funding at the Global Fund.
[70] The Global Fund. "Grant Architecture." Accessed 28 June 2012 at http://www.theglobalfund.org/en/activities/grantarchitecture/
[71] High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (2011). Turning the Page from Emergency to Sustainability: The Final Report of the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

In May 2011, the Global Fund Board approved a new policy on prioritization and eligibility criteria, which divided Global Fund resources into two funding pools. The first was a General Funding Pool, which was to comprise at least 90 percent of resources and be open only to low-income and lower-middle income countries (LICs and LMICs), or to upper-middle income countries (UMICs) with extremely high disease burdens. The second was a Targeted Funding Pool, open to disease-specific proposals from all countries except UMICs without a high disease burden. Maximum funding through the Targeted Funding Pool was $12.5 million over five years, or $5 million in a program's first two years. If there were not enough funds to cover all proposals receiving TRP endorsement, the policy laid out prioritization criteria for applications. General Funding Pool proposals were to be ranked via "a three-part composite index comprised of income level, disease burden, and TRP recommendation category." Proposals for the Targeted Funding Pool were to be ranked via a still to-be-determined methodology.[72]

In November 2011, the Board cancelled its eleventh round of funding due to limited resource availability. A Transitional Funding Mechanism (TFM) was approved as an interim measure to provide "limited funding" for "programs that face disruption of essential…services currently supported by the Global Fund; and for which no alternative sources of funding can be secured."[73]

At its November 2011 meeting, the Board also adopted two key documents related to the restructuring of its grant-making process. First, the 2012-2016 Strategy proposed the development of a "new funding model" to be implemented in place of the Rounds system. According to the Strategy, the new model was to have three elements: 1) "an iterative, dialogue-based application process"; 2) "early preparation of implementation"; and 3) "more flexible, predictable funding opportunities." The strategy also sought to simplify and reform the reprogramming process for existing grants to help "better target high-impact areas, respond to emerging evidence or changes in context or normative guidance, address implementation bottlenecks and scale up effective interventions or technologies."[74] Likewise, the more implementation-focused "Consolidated Transformation Plan" outlined key goals and features of the new application process.[75]

In early 2013, the Fund released preliminary details of the New Funding Model, while cautioning that some elements may "need to be adjusted before full implementation in late 2013."[76] Under the NFM, grant-making will occur on a three-year funding cycle. Each country will be provided with a level of available "indicative" funding, determined by an allocation formula; the indicative funding will be available to the country at any point during the three-year allocation window.[77] Countries may also compete for "incentive funding," which is described as "a separate reserve of funding that rewards well-performing programs with a potential for increased, quantifiable impact, and

[72] The Global Fund (2011). Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization of Proposals for Funding from the Global Fund.
[73] The Global Fund. "Transitional Funding Mechanism." Accessed 28 June 2012 at http://www.theglobalfund.org/en/application/
[74] The Global Fund (2012). The Global Fund Strategy 2012-2016: Investing for Impact.
[75] The Global Fund (2011). Consolidated Transformation Plan.
[76] The Global Fund (2013). "Access to Funding." Accessed 9 May 2013 at http://www.theglobalfund.org/en/accesstofunding/
[77] The Global Fund. "Step-by-Step Process." Accessed 9 May 2013 at http://www.theglobalfund.org/en/activities/fundingmodel/process/

encourages ambitious requests."[78] At the time of writing, the size of the incentive pool and the precise criteria for its distribution had not been determined.

Figure 3: The New Funding Model[79]

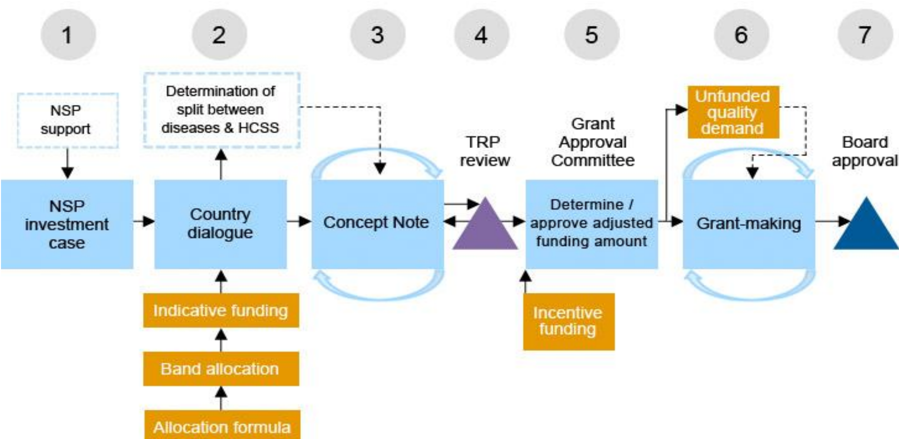

Figure 3 illustrates the application process under the NFM. Grant applications will no longer be separate "projects," but should instead emerge from the country's own national planning process and a "country dialogue" between all relevant stakeholders. The country dialogue will feed into a concept note (i.e. a brief grant application submitted by the CCM), which will then undergo TRP review. The TRP will no longer merely provide recommendations on whether to accept or reject a proposal, but will rather provide feedback to CCMs in order to improve weaker concept notes. [80]

If the TRP provides a positive assessment of the concept note, it will move forward to a Grant Approval Committee, which "will determine an upper ceiling for the budget of each grant…[including] funding availability from a country's indicative funding amount and, if applicable, any available incentive funding." If there are insufficient resources to cover the entire requested amount, the Global Fund may set aside part of the request as "unfunded quality demand," which may receive financing if more resources become available. Next, the Secretariat will enter grant negotiations with the PR to detail activities, budgets, fiduciary conditions, and implementation arrangements, among other considerations – that is, "to transform technically sound concept note into disbursement-ready grants." Once negotiations are complete, grants will be sent to the Global Fund Board for final approval.[81]

Upon release of the NFM, several components of the earlier prioritization policy became moot, including the prioritization score and separation of funds into the General and Targeted Funding Pools. Under the Fund's transitional eligibility list for the NFM, released in early 2013, LICs and

[78] The Global Fund (2013). Frequently Asked Questions on the New Funding Model.
[79] The Global Fund. "Step-by-Step Process." Accessed 9 May 2013 at http://www.theglobalfund.org/en/activities/fundingmodel/process/
[80] The Global Fund. "Step-by-Step Process." Accessed 9 May 2013 at http://www.theglobalfund.org/en/activities/fundingmodel/process/
[81] The Global Fund. "Step-by-Step Process." Accessed 9 May 2013 at http://www.theglobalfund.org/en/activities/fundingmodel/process/

LMICs are eligible without restriction, while UMIC eligibility is contingent upon a "'high', 'severe' or 'extreme' disease burden for a given disease."[82]

While full implementation of the NFM will not occur until late 2013, some countries have already been invited to apply during the transition period. Nine "early applicants"[83] have been invited to pilot the NFM, through which $364 million in " indicative funds" will be made available. In addition, 48 "interim applicants" are invited to access new funds "for renewals, grant extensions and redesigned programs."[84,85]

Value for Money and Aid Effectiveness

The Global Fund defines "Value for Money" through its three elements[86]:

1. Effectiveness: ability of a program "to achieve its objectives in terms of sustainable improvements to health outcomes and impact," particularly through "population coverage of key interventions and reductions in morbidity and mortality."
2. Efficiency: ability of a program "to achieve the most effective approach to the [identified] health problem" at lowest possible cost.
3. Additionality: the requirement that "Global Fund financing [be] additional to existing activities and resources," such that existing allocations to disease control and public health from recipient governments are not displaced, but instead "maintained or increased."

Notably, the Fund's value-for-money framework does not appear to consider the relative cost-effectiveness of different interventions. Instead, the framework appears to select interventions that maximize effectiveness, and then to minimize the costs of the selected interventions:

> "After the applicant has demonstrated the most effective approach to the health problem being addressed, it is important to show that the activities will be carried out efficiently. Efficiency is different from effectiveness in that it is **only concerned with costs**. Efficiency is a management issue, not a medical issue…Effectiveness is what gives value, and efficiency is to achieve that value for the least amount of money. Together, **effectiveness <u>with</u> efficiency give value for money**" [emphasis in the original].[87]

Beginning with round 10, applicants were required to provide information on how their proposals met value for money principles using a checklist. Every principal recipient completes a value for money checklist, which includes the following criteria (quoted and excerpted below):

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[82] The Global Fund (2013). Eligibility List for New Funding in the Transition – 2013.
[83] Zimbabwe, El Salvador, Myanmar, Democratic Republic of the Congo, Kazakhstan, the Philippines, and three regional programs.
[84] The Global Fund (2013). Countries Participating in the New Funding Model.
[85] The Global Fund (2013). The New Funding Model.
[86] The Global Fund (2012). Value for Money Information Note. "Framework for Value for Money in Grant Management." Accessed 13 July 2012 at http://www.theglobalfund.org/en/performance/effectiveness/value/framework/
[87] The Global Fund (2012). Value for Money Information Note.

- *Overall strategy*: Has the overall strategy been accurately translated into the grant? Are targets consistent with the proposal, other grants and national targets?
- *Effectiveness*: Are there any interventions that are *clearly* not based on sound evidence or international guidelines? Is the service package defined and documented? Is a program evaluation/review planned and budgeted? Is the grant planning to use pharmaceutical and health products included in the original proposal?
- *Efficiency and economy*: Has the procurement and supply management (PSM) plan and related budget been reviewed by the program management unit (PMU)? Are there efficiency gains compared to the proposal amount? Are unit costs for major health products in-line with international reference and recent market prices? Is the quantification of health products at minimum appropriate for achievement of targets? Are costs in high-risk areas, such as straining, salaries and overheads, justified? Are other costs reasonable?
- *Additionality*: Are there clear indicators that financing is duplicative to existing activities and resources? Government spending on disease program is expected to be maintained or increased?[88]

According to the TRP's Round 10 report, "the TRP [had] consistently considered value for money as an important proposal review [criterion]." During the Round 10 review process, it began to explicitly consider proposals' value for money in accordance with the aforementioned checklist; however, it found that the checklist was not particularly helpful for guiding its review process. The TRP recommended that in future funding rounds, "applicants should be required to demonstrate that the most effective interventions are being proposed at the lowest cost, (i.e. in the most efficient way)."[89]

Funding Allocations

By Program Type

The Global Fund exclusively funds programs to fight HIV/AIDS, TB and malaria, and to strengthen countries' overall health systems. Between 2002 and May 2013, the Global Fund disbursed about $18.3 billion. With 56% of all disbursements, or about $10.3 billion, HIV accounted for a majority of Global Fund resources. Malaria programs have received 28% of disbursements ($5.1 billion) and TB programs accounted for another 15% of funding ($2.7 billion). While the Global Fund declares health systems strengthening to be a priority, only $139 million (0.8% of all funding) was spent in that area over nine years, and in only 11 countries.[90] However, grants for each of the three disease areas may themselves have health systems strengthening components, so the

[88] The Global Fund. Value for Money Checklist for Round 10 Grant Negotiations.
[89] The Global Fund (2010). Report of the Technical Review Panel and the Secretariat on Round 10 Proposals.
[90] Data source for all funding data is spreadsheets downloaded from http://portfolio.theglobalfund.org/en/DataDownloads/CustomizeReportDownload#

overall portion of funds going to HSS is likely much higher, though impossible to quantify with available data. Figure 4 presents Global Fund disbursements over time in total (black line) and the disbursements by disease area as a percentage of the total disbursements.

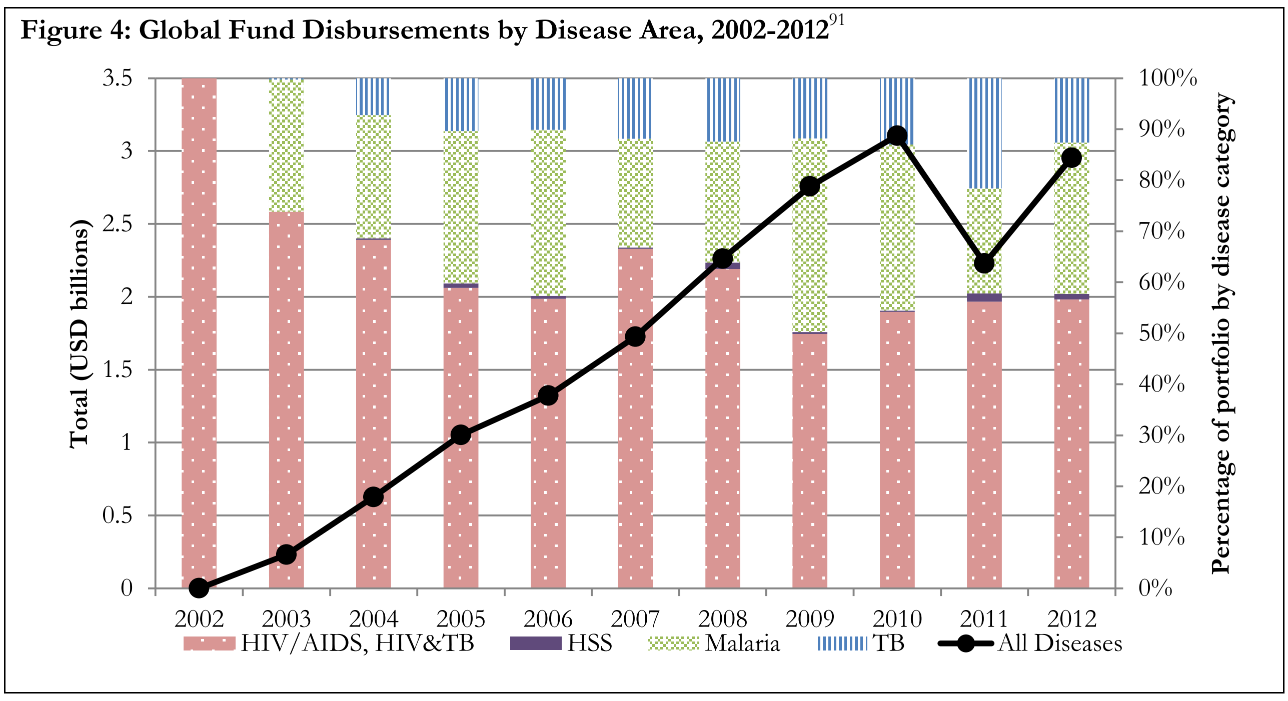

Figure 4: Global Fund Disbursements by Disease Area, 2002-2012[91]

Under the NFM, the Secretariat will provide CCMs in each country with an "indicative split" of funds between the three disease areas and cross-cutting HSS programs. According to the Fund's transition manual, "the program split is based on the burden of HIV, tuberculosis (TB) and malaria as determined by the new allocation formula; sources of external funding; and, in some countries, a transitional provision to ensure the Global Fund's financial commitments…sustain essential services." Applicants are also "strongly encouraged" to use a significant portion of their indicative funds (up to 15% is implied) for HSS. The "indicative split" is to serve as a relatively firm guideline to applicants – concept notes which include significant deviations, defined as "10 percent or more of the overall country allocated amount" (not including HSS funds), require pre-approval from the Grant Approval Committee during country dialogue.[92]

By Country

Appendices C and D provide a breakdown of grant disbursements by funding for the period 2002-May 2013. Ethiopia was the single largest recipient of total funding, as well as disease-specific funding for HIV, with total disbursements of $1.24 billion (all disease areas). The top-ranked

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[91] The Global Fund. "Global Fund Disbursements in Detail." Accessed 7 May 2013 at http://www.theglobalfund.org/documents/core/grants/Core_DisbursementDetailsRaw_Report_en/
[92] The Global Fund (2013). Transition Manual.

recipient for malaria was Nigeria, with $451 million in malaria-specific disbursements; the top-ranked recipient for TB funding was China, with $324 million in TB-specific disbursements.

Prior to 2011, the Global Fund had, by its own admission, "maintained a relatively passive role in influencing investments and shaping demand. While generally ensuring that funding responded to country demand, this model has not always resulted in resources being directed toward the most affected countries and populations, or the highest-impact interventions." Accordingly, the HLP recommended that the Global Fund become "much more assertive" in its approach to resource allocation.[93] The 2012-2016 strategy seeks to address these issues by committing to "increas[e] relative focus on the highest-impact countries"; to "emphasize support for the highest-impact interventions and technologies"; and to "ensure appropriate targeting of most-at-risk populations."[94]

Under the new model, the cross-country distribution of indicative funds will be determined by an allocation formula incorporating disease burden and ability to pay, and adjusted for "qualitative factors…such as major sources of external financing, performance, absorptive capacity, 'willingness to pay', risk, etc." Incentive funds will "reward high impact, well-performing programs and encourage ambitious requests"; however, the precise criteria for the distribution of incentive funds have not yet been released.[95]

In addition, all countries are now required to demonstrate counterpart financing, which is defined as "the minimum level of the government's contribution to the national disease program, as a share of total government and Global Fund financing for that disease." Counterpart financing requirements are set at 5% for LICs; 20% for lower LMICs; 40% for upper LMICs; and 60% for UMICs. Any country receiving Global Fund financing is also required to "increase the absolute value of its contribution to the national disease program and health sector each year" for the duration of the grant.[96]

By Intervention Mix and Budget Category

The Global Fund's internal expenditure reporting system provides some information on the breakdown of expenses by budget category. Between 2008 and 2010, commodities represented 44% of Global Fund expenditures, while human resource costs accounted for 15% of spending and training programs made up 10% of all costs.[97]

Within disease categories, a study of the Fund's flows from 2002-2011 found that within HIV programs, the Fund spent 34% on care and treatment, 29% on prevention, 20% on program

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[93] High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (2011). Turning the Page from Emergency to Sustainability: The Final Report of the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis, and Malaria.
[94] The Global Fund (2011). The Global Fund Strategy 2012-2016: Investing for Impact.
[95] The Global Fund (2013). Frequently Asked Questions on the New Funding Model.
[96] The Global Fund (2011). Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization of Proposals for Funding from the Global Fund.
[97] The Global Fund (2012). Report of the General Manager. Twenty-Sixth Board Meeting.

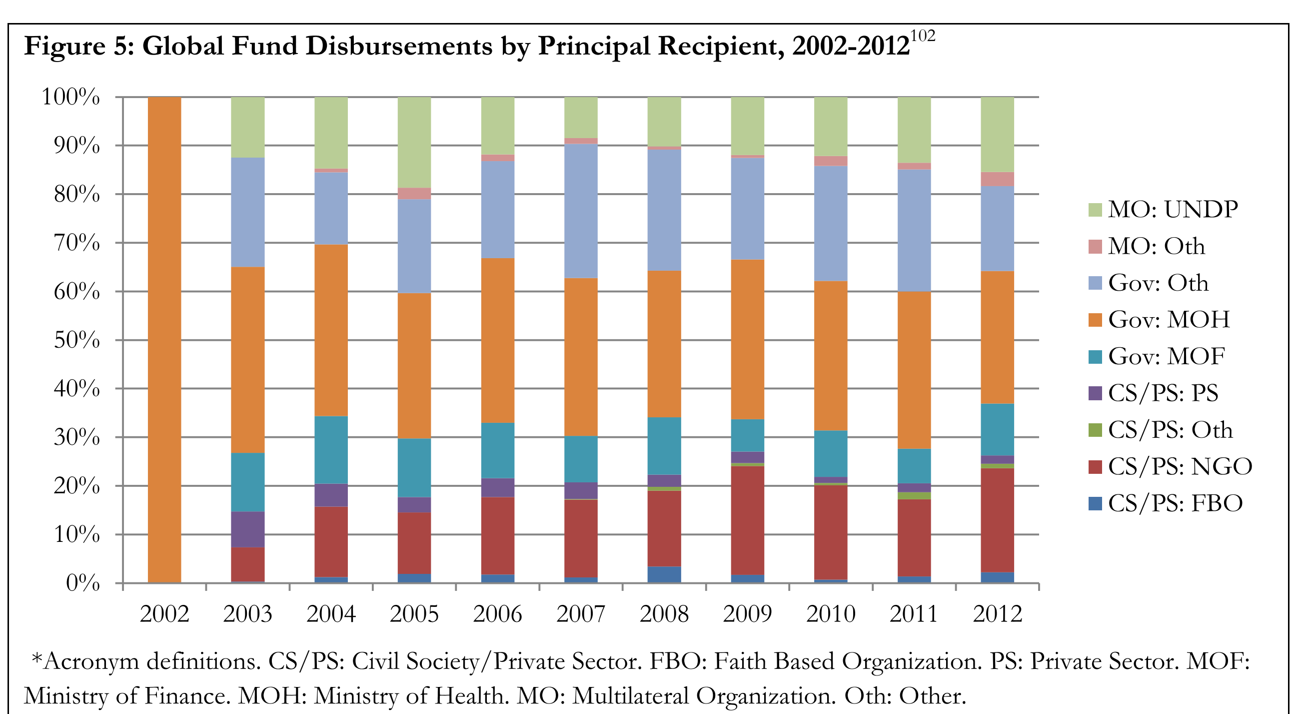
management and administration, 8% on enabling environment, 3% on orphans and vulnerable children, 3% on human resources, and 2% on other areas.[98] Aggregated data on expenditures by service delivery area are not publicly available at the country level.

During its reform process, it was noted that "suboptimal investment approach with regards to…interventions with the greatest impact" represented a priority challenge for the Fund to address.[99] As part of its new strategy, the Global Fund thus intends to focus greater attention on the "highest-impact interventions" by working with recipient countries to identify these interventions in each specific country context, and subsequently supporting "the operational research needed to bring them to scale."[100]

By Principal Recipient

Grants are implemented by Principal Recipients, which are a diverse group of entities drawn from the public sector, NGOs, the private sector, and other development agencies. In 2012, 55% of PRs were governmental entities (mostly ministries of health or finance); 24% were NGOs or faith based organizations; and 18% were multilateral development agencies.[101] Figure 56 presents trends in PR composition over time.

Figure 5: Global Fund Disbursements by Principal Recipient, 2002-2012[102]



*Acronym definitions. CS/PS: Civil Society/Private Sector. FBO: Faith Based Organization. PS: Private Sector. MOF: Ministry of Finance. MOH: Ministry of Health. MO: Multilateral Organization. Oth: Other.

[98] Olga Avdeeva, Jeffrey V Lazarus, Mohamed Abdel Aziz, and Rifat Atun (2011). "The Global Fund's Resource Allocation Decisions for HIV Programmes: Addressing Those in Need." *Journal of the International AIDS Society* 14(51).
[99] The Global Fund (2012). Comprehensive Transformation Plan.
[100] The Global Fund (2012). The Global Fund Strategy 2012-2016: Investing for Impact.
[101] The Global Fund. Global Fund Disbursements in Detail. Accessed 7 May 2013 at http://www.theglobalfund.org/documents/core/grants/Core_DisbursementDetailsRaw_Report_en/
[102] The Global Fund. Global Fund Disbursements in Detail. Accessed 7 May 2013 at http://www.theglobalfund.org/documents/core/grants/Core_DisbursementDetailsRaw_Report_en/

Procurement

As a financing mechanism, the Global Fund has a limited role in procurement and supply management. Accordingly, its activities in this area focus on setting and enforcing procurement policies for purchases made with its resources, and on helping countries to comply with those procurement policies.[103]

The Global Fund's procurement management and oversight mechanisms are as follows. Following grant signature, the PR submits a detailed procurement and supply management plan (PSM) for approval.[104] PRs must also comply with a series of "quality assurance" policies, designed to ensure the safety and efficacy of purchased commodities.[105] PRs are also responsible for reporting all purchases of certain commodities – bednets, condoms, rapid diagnostic tests, and HIV, malaria, and TB treatment[106] – to the Fund's Price and Quality Reporting system (PQR), a web-based database that logs and aggregates information on commodity transactions. The PQR aims to "communicate market information to PRs; improve transparency; enable the Fund to monitor its quality assurance policy; [and] help the Fund and its partners better understand and influence the market for pharmaceutical products."[107]

The Global Fund also offers Procurement Support Services to its grant recipients in an effort "to provide support to countries to resolve procurement bottlenecks and supply chain management challenges and facilitate the timely access to pharmaceuticals and health products."[108] Established in 2010, the Fund's Voluntary Pooled Procurement (VPP) mechanism attempts to reduce prices paid for common commodity purchases. PRs are encouraged but not required to use VPP for procurement of ARVs, rapid HIV diagnostic kits, artemisinin-based combination therapies (ACTs), long lasting insecticide treated nets (LLINs), and rapid diagnostic tests for malaria.[109] Between mid-2009 and the end of 2011, about 23% of Global Fund financed products were procured through the VPP mechanism. The Global Fund estimates that the VPP generated $58 million in net savings between 2010 and 2011, representing savings of 16% over the originally budgeted amounts.[110] The VPP is currently administered by two competitively-selected Procurement Service Agents (PSAs) under two-year contracts. The PSA for LLINs is Population Services International (PSI), while the Partnership for Supply Chain Management (PFSCM) provides ARVs, ACTs, and other products.[111] PFSCM also provides supply chain management and procurement for the US President's Emergency Plan for AIDS Relief (PEPFAR).

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[103] The Global Fund. "Pharmaceutical Procurement and Supply Management." Accessed 28 June 2012 at http://www.theglobalfund.org/en/procurement/
[104] The Global Fund. "Guide to Writing PSM Plans." Accessed 10 May 2013 at http://www.theglobalfund.org/en/procurement/guide/
[105] The Global Fund. "Quality Assurance Information." Accessed 10 April 2013 at http://www.theglobalfund.org/en/procurement/quality/
[106] The Global Fund (2011). A Quick Guide to the Global Fund's Price and Quality Reporting System.
[107] The Global Fund. "Price and Quality Reporting." Accessed 28 June 2012 at http://www.theglobalfund.org/en/procurement/pqr/
[108] The Global Fund. "Procurement Support Services." Accessed 28 June 2012 at http://www.theglobalfund.org/en/procurement/vpp/
[109] The Global Fund. "Procurement Support Services." Accessed 28 June 2012 at http://www.theglobalfund.org/en/procurement/vpp/
[110] The Global Fund (2012). VPP Key Results (2009-2011).
[111] The Global Fund (2010). Procurement Support Services Frequently Asked Questions.

To build long-term supply management capacity in recipient countries, the Fund also offers Capacity Building Service/ Supply Chain Management Assistance (CBS/SCMA). These services include technical assistance to in-country partners in "quantification, storage, distribution, logistics management information systems (LMIS) and quality assurance." Payment for these services is deducted from PR grants and given directly to the service provider.[112]

Beyond VPP, the Global Fund has pushed some of its grantees to procure commodities through international competitive bidding.[113] However, this policy may have caused unintended negative consequences, as the lowest bidders were sometimes not adequately equipped to provide a timely and reliable supply of essential health commodities.[114]

Measurement, Monitoring, Reporting

The Secretariat is guided by a set of Key Performance Indicators (KPIs), which are currently under revision. These indicators feed into annual KPI reports, which aim to provide an overall performance summary of the entire Global Fund organization. The full set of indicators and performance statistics for 2011 is provided as Appendix E. However, 2012 World Bank Independent Evaluation Group (IEG) report criticized the selected indicators for failing to provide a coherent logical pathway from operational performance to impact. According to the report, "the indicators focus on inputs, the definitions are vague in many cases, and the data sources are not obvious. There is no discussion of how many of the targets were set, whether they are valid, and how meeting the targets of each of the indicators contributes to overall impact."[115] Beyond its KPI, the Global Fund's Top 10 indicators have historically been used "measure priority interventions" and "provide a standard benchmark for measuring progress across the entire portfolio of Global Fund grants." (Appendix F).[116] It is not clear whether the Top 10 indicators are currently in use, and, if so, whether they will remain important under the NFM.

According to Global Fund M&E guidance, five to ten percent of a proposal's total budget should be set aside for M&E activities.[117] At the time of the award, each grant agreement includes a monitoring and evaluation plan as well as a signed performance framework, which specifies output, outcome, and impact indicators; baselines and targets; reporting frequencies (every 3, 6 or 12 months); expected disbursement dates; and expected period review date. At the close of each specified reporting period, the PR must report progress to date towards those goals through a Progress Update/Disbursement Request form (PU/DR).[118]

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[112] The Global Fund. "Procurement Support Services." Accessed 28 June 2012 at http://www.theglobalfund.org/en/procurement/vpp/

[113] Richard Tren, Kimberly Hess, and Roger Bate (2009). "Drug Procurement, the Global Fund, and Misguided Competition Policies." *Malaria Journal* 8(305).

[114] Richard Tren, Kimberly Hess, and Roger Bate (2009). "Drug Procurement, the Global Fund, and Misguided Competition Policies." *Malaria Journal* 8(305).

[115] World Bank Independent Evaluation Group (2012). Comparison of the Monitoring and Evaluation Systems of the World Bank and the Global Fund. IEG Working Paper 2012/1.

[116] The Global Fund (2011). Monitoring and Evaluation Toolkit.

[117] The Global Fund (2011). Monitoring and Evaluation Toolkit.

[118] The Global Fund. "Grant Negotiation." Accessed 28 June 2012 at http://www.theglobalfund.org/en/performancebasedfunding/grantlifecycle/2/

According to the 2012 World Bank IEG report, selection of appropriate performance indicators has been a challenge for the Global Fund. "Indicators selected in the earlier grant rounds commonly suffered from a number of deficiencies: there were too many indicators, which often were not well defined, did not come from routine information sources and so required special data collection, and focused mainly on outputs rather than outcomes." Further, "some grant monitoring reports indicate a suspicion that the targets were set too low."[119]

Because the Global Fund lacks on-the-ground field staff, it relies on a designated Local Fund Agent (LFA) in each recipient country to "oversee, verify, and report on grant performance."[120] Most LFAs are accounting or consultancy firms; currently, there are nine competitively-selected LFAs operating in 138 countries. Of those, PwC operates in the largest number of countries (Table 2) and is responsible for grants with the largest disbursements (Figure 6).

Table 2: Global Fund Local Fund Agents (LFAs)[121]

	Number of Countries
PwC (formerly PricewaterhouseCoopers)	73
Swiss Tropical and Public Health Institute (Swiss TPH)	21
KPMG	16
United Nations Office for Project Services (UNOPS)	14
Cardno EM	6
Grant Thornton	2
Crown Agents	2
Deloitte	2
Finconsult	2
Total	**138**

Following submission of the PU/DR, the designated LFA is responsible for verifying its accuracy. The LFA verification of implementation (VOI) includes several components, including on-site data verification (OSDV) once per year in a small subset of facilities (i.e. 8 site visits per PR, disease area, and country).[122,123] To help ensure data quality, the Global Fund also conducts data quality audits (DQA) on up to 20 grants each year. DQAs are performed by independent contractors (not the LFAs) and aim "to provide an in-depth assessment of data quality and monitoring and evaluation (M&E) systems in selected grants and/or programs."[124]

[119] World Bank Independent Evaluation Group (2012). Comparison of the Monitoring and Evaluation Systems of the World Bank and the Global Fund. IEG Working Paper 2012/1.
[120] The Global Fund. "Local Fund Agents." Accessed 28 June 2012 at http://www.theglobalfund.org/en/lfa/
[121] The Global Fund (2013). LFA Selected List.
[122] The Global Fund. "Data Quality Tools and Mechanisms." Accessed 28 June 2012 at http://www.theglobalfund.org/en/me/documents/dataquality/
[123] The Global Fund (2011). LFA Guidelines for On-Site Data Verificiation (OSDV) and Rapid Services Quality Assessment (RSQA) Implementation.
[124] The Global Fund. "Data Quality Tools and Mechanisms." Accessed 28 June 2012 at http://www.theglobalfund.org/en/me/documents/dataquality/

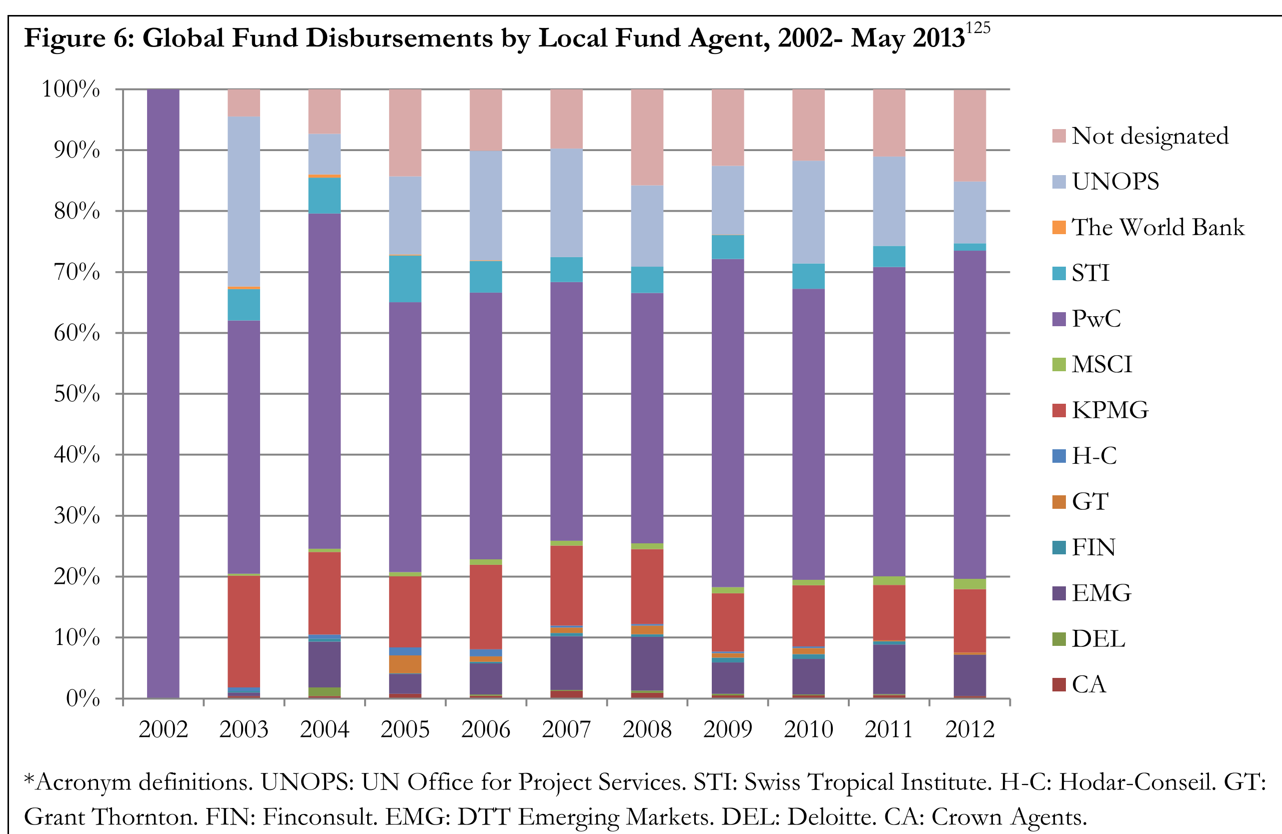

Figure 6: Global Fund Disbursements by Local Fund Agent, 2002- May 2013[125]

*Acronym definitions. UNOPS: UN Office for Project Services. STI: Swiss Tropical Institute. H-C: Hodar-Conseil. GT: Grant Thornton. FIN: Finconsult. EMG: DTT Emerging Markets. DEL: Deloitte. CA: Crown Agents.

Since early 2012, the LFA has also implemented a Rapid Service Quality Assessment (RSQA), which aims "to assess and improve quality of services at the country level," particularly by "[appraising] whether health services are implemented according to internationally recognized and evidence-based technical policies and guidelines." The RSQA includes (1) a "central/policy level questionnaire which assesses the appropriateness of national policy and the availability of national policies and guidelines;" and (2) a "facility level questionnaire [which] assesses compliance of service delivery…with nationally defined standards."[126]

At the time of writing, the Fund's evaluation strategy was undergoing revision to align with the Fund's 2012-2016 strategy. However, the updated M&E toolkit, released in November 2011, outlines priority areas for strengthening, alongside the perceived deficiencies of the status quo in those areas (Appendix G). Among these priorities, the Global Fund wishes to "strengthen routine data monitoring," "further fund and strengthen vital registration systems," "strategically invest in population-based surveys," and "fund and implement evaluations."[127]

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[125] The Global Fund. "Global Fund Disbursements in Detail." Accessed 7 May 2013 at http://www.theglobalfund.org/documents/core/grants/Core_DisbursementDetailsRaw_Report_en/
[126] The Global Fund. "Quality of Services." Accessed 28 June 2012 at http://www.theglobalfund.org/en/me/documents/MEQualityServices/
[127] The Global Fund (2011). Monitoring and Evaluation Toolkit.

Performance-Based Funding

The Global Fund uses a system of performance-based funding, whereby each grant disbursement may be reduced, suspended, or cancelled due to poor grant performance. PRs must provide regular programmatic updates to the LFA detailing their "results achieved against targets, expenditures against budgets, and any deviations from or corrective actions to program activities" (described above). In turn, the LFA is tasked with "verifying" the PR reports and issuing an overall assessment of its performance.[128] The LFA assessment is primarily derived from a comparison of reported results and outcomes against the original targets for each reporting period, but may also incorporate the LFA's analysis of program management, fiduciary controls, and other factors that may have impeded full grant implementation.[129] Based on the LFA's report and recommendations (and it's own assessment of overall performance), the Secretariat assigns the grant a performance rating ranging between A1 (exceeds expectations) and C (unacceptable) (Figure 7).

Figure 7: Global Fund Grant Performance Ratings[130]

Grant rating		Performance Category	Progress against targets
A1		Exceeds expectations	>100%
A2		Meets expectations	100-90%
B1		Adequate	60-89%
B2		Inadequate but potential demonstrated	30-59%
C		Unacceptable	<30%

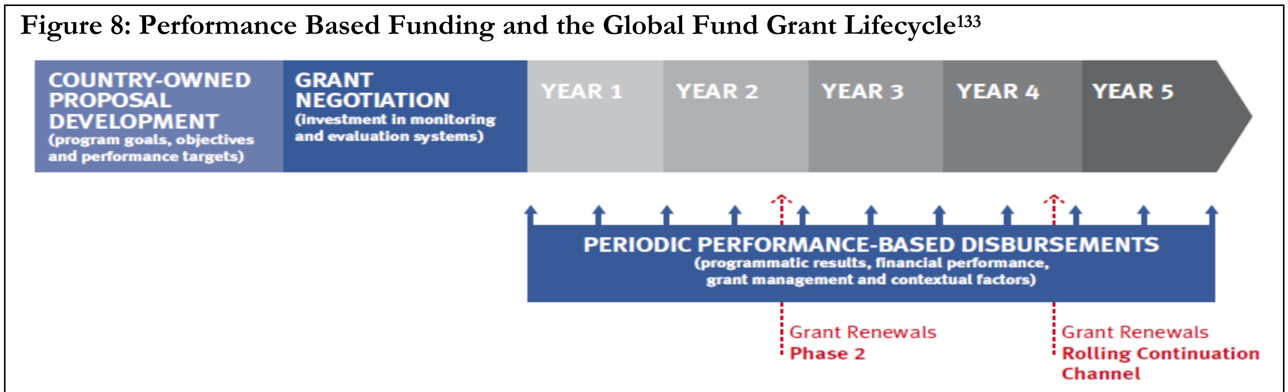
Further disbursements are based upon the performance rating, with each category corresponding "to an indicative funding range, calculated in order to ensure the relationship between results achieved and funds disbursed." However, exceptions are made to the indicative ranges; final funding decisions are based on a combination of the following four considerations: "(1) overall grant performance; (2) contextual factors (force majeure, political and civil issues, etc.); (3) real budget needs in the context of spending ability; and (4) actions needed to address identified weaknesses in management capacity."[131]

Under the Global Fund's historical funding architecture, the Global Fund would conduct a review of grant performance and issue a grant scorecard at the close of Phase 1. On this basis, the Board would decide whether to renew the grant for Phase 2, and whether to maintain or reduce funding

[128] The Global Fund. "Performance-Based Disbursements." Accessed 28 June 2012 at http://www.theglobalfund.org/en/performancebasedfunding/grantlifecycle/3/
[129] The Global Fund (2009). Performance-Based Funding at the Global Fund.
[130] The Global Fund. "Grant Performance Assessment Methodology. Accessed (archive) 25 July 2012 at http://www.theglobalfund.org/en/performancebasedfunding/decisionmaking/methodology/
[131] The Global Fund. "Grant Performance Assessment Methodology. Accessed (archive) 25 July 2012 at http://www.theglobalfund.org/en/performancebasedfunding/decisionmaking/methodology/

levels. If the grant received Board approval, Phase 2 would usually continue for an additional three years.[132] Figure 8 shows the role of performance based funding at each stage in the grant lifecycle.

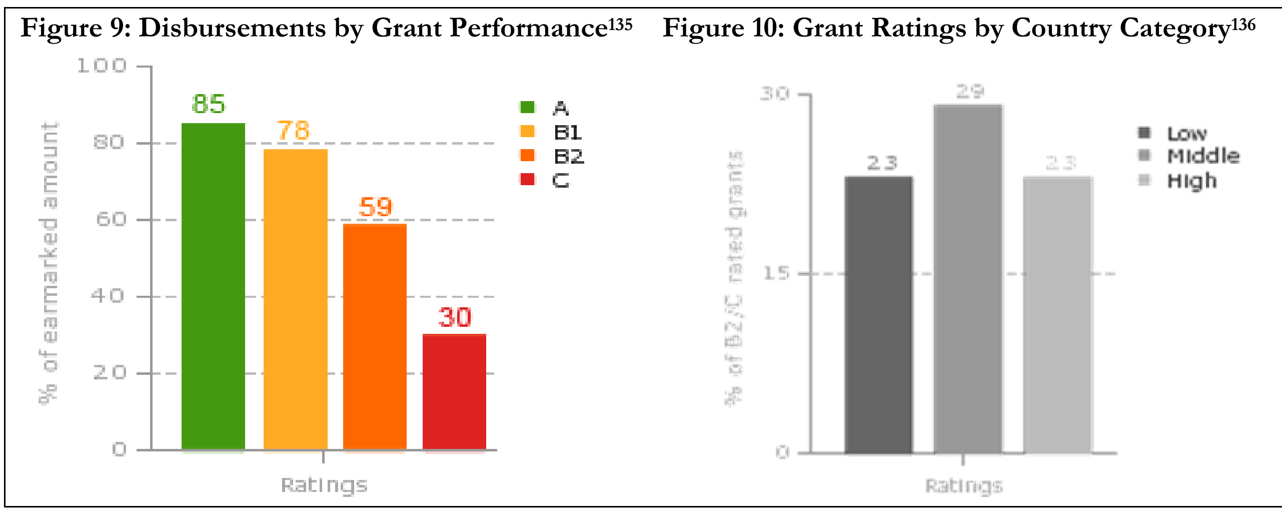
Figure 8: Performance Based Funding and the Global Fund Grant Lifecycle[133]



Among the 125 grants subject to the phase 2 renewal process in 2011, "61 percent received a 'Go' decision to continue funding; 34% received a 'Conditional Go to receive financing after making specific adjustments to the proposals," and 5% received a "No Go," or an end to funding.[134]

Performance-based funding processes appear to have affected the Global Fund's disbursement decisions. Figure 9 was compiled by the Global Fund, and shows the percentage of funds committed to Phase 2 grants during the grant renewal process, disaggregated by the grants' respective performance ratings. While A rated grants, on average, received 85% of the funds earmarked for Phase 2 in the original proposal, C rated grants were allocated only 30% of their original budgets for years 3-5. Low-income countries receive comparable grant ratings to their middle and high-income counterparts (Figure 10).

Figure 9: Disbursements by Grant Performance[135] **Figure 10: Grant Ratings by Country Category[136]**



[132] The Global Fund. "Grant Renewals. Accessed 28 June 2012 at http://www.theglobalfund.org/en/performancebasedfunding/grantlifecycle/4/
[133] The Global Fund (2009). Performance-Based Funding at the Global Fund.
[134] The Global Fund (2012). Report of the General Manager. Twenty-Sixth Board Meeting.
[135] The Global Fund. "In Action." Accessed 28 June 2012 at http://www.theglobalfund.org/en/performancebasedfunding/action/
[136] The Global Fund. "In Action." Accessed 28 June 2012 at http://www.theglobalfund.org/en/performancebasedfunding/action/

Evaluation

In 2006, the Global Fund underwent its first large-scale independent evaluation, led by Macro International. The evaluation included three study areas, and a synthesis report of findings was released in early 2009.

- **Study Area 1:** Organizational efficiency and effectiveness (October 2007)
- **Study Area 2:** Effectiveness of the partner environment (June 2008)
- **Study Area 3:** Impact on the three diseases (February 2009)

The Five-Year Evaluation drew from "primary data collection through district comprehensive assessments; review of secondary data such as Demographic and Health Surveys and country health information system data; quantitative analysis to assess grant performance; review of Global Fund documentation and a broader literature base of literature; and…interviews with Global Fund Board Members, Secretariat Staff, implementers, and partners at the global and country levels." The team conducted assessments in 16 countries for Study Area 2, and "impact evaluations" for Study Area 3 in 18 countries (Table 3).[137] However, the Study Area 3 "impact evaluations" are not limited to Global Fund-specific investments, but rather to the cumulative contributions of all funding sources. Accordingly, it cannot be considered a true impact evaluation, as it does not successfully establish a "causal link between activities and impact." Further, the evaluation design, "including lack of attribution and lack of a framework or cumulative assessment linking grant performance to impacts on the three diseases, made it unclear what criteria was used to draw conclusions. The study exposed may shortcomings of the operations, performance, and outcomes of the Global Fund activities, but the overall conclusion was positive."[138]

Table 3: Five-Year Evaluation Focus Countries, by Study Area[139]

Country	Study Area	Country	Study Area
Benin**	3	Malawi*	2, 3
Burkina Faso*	2, 3	Moldova**	3
Burundi**	3	Mozambique**	3
Cambodia*	2, 3	Nepal	2
DR Congo**	3	Nigeria	2
Ethiopia*	2, 3	Peru*	2, 3
Ghana**	3	Rwanda**	3
Haiti*	2, 3	Tanzania*	2, 3
Honduras	2	Uganda	2
Kenya	2	Vietnam**	2, 3
Kyrgyzstan**	2, 3	Yemen	2
Lesotho**	3	Zambia*	2, 3

* SA3 Primary Data Analysis Countries
** SA3 Secondary Analysis Countries

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137 Macro International (2009). The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Synthesis of Study Areas 1, 2 and 3.
138 World Bank Independent Evaluation Group (2012). Comparison of the Monitoring and Evaluation Systems of the World Bank and the Global Fund. IEG Working Paper 2012/1.
139 Macro International (2009). The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Synthesis of Study Areas 1, 2 and 3.

In its conclusions, the Evaluation noted that "most countries lacked existing data on impact and sometimes outcomes." The report recommended that the Fund "reorient investments from disease specific [M&E] toward strengthening the country health information systems"; it also noted that "there [was] a need for more frequent evaluations," and suggested that the Fund support a series of annual evaluations in a subset of recipient countries.[140]

Third Party Evaluations and Research

The Global Fund has a relatively large literature base that explicitly refers to the Global Fund,[141] unlike other large funders such as PEPFAR, the US President's Malaria Initiative (PMI), and UNITAID. However, it does not appear that the Global Fund has ever been subjected to a true impact evaluation as defined by 3iE, i.e. an evaluation that measures "the net change in outcomes amongst a particular group, or groups, of people that can be attributed to a specific program using the best methodology available, feasible and appropriate to the evaluation question(s) being investigated and to the specific context."[142]

Perhaps the most comprehensive external analysis of the Global Fund is a 2012 review conducted by the World Bank's IEG, which specifically aimed to assess country-level cooperation between the Global Fund and the Bank. The IEG's findings largely mirrored those of the Fund's independent five-year evaluation. Among its most important conclusions and recommendations, the review noted that harmonization remained an important issue; while the Fund was successfully "facilitating donor coordination at the global level", it had "not yet translated into a similar degree of coordination at the country level"; in particular, donors struggled to harmonize their country-level monitoring and evaluation requirements.[143] This finding was also noted in the review conducted by the Organisation for Economic Co-operation and Development (OECD) in 2006-2007.[144]

Other notable studies include:

- Radelet and Siddiqi (2007) associate various country-level characteristics with grant scores, finding that poorer countries receive higher grant scores, and that grants with public sector PRs receive lower scores. They also find that the lowest-scoring grants had KPMG as their LFA, suggesting that grant scores may be biased by LFA assignment.[145]

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[140] Macro International (2009). The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Synthesis of Study Areas 1, 2 and 3.
[141] Celina Schocken (2006). "Overview of the Global Fund to Fight AIDS, Tuberculosis and Malaria." HIV/AIDS Monitor. Center for Global Development. Accessed 28 June 2012 at http://www.cgdev.org/section/initiatives/_archive/hivmonitor/funding/gf_overview
[142] International Initiative for Impact Evaluation. Principles of Impact Evaluation.
[143] World Bank Independent Evaluation Group (2011). The Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank's Engagement with the Global Fund. Global Program Review Volume 6 Issue 1.
[144] The Global Fund. "Measuring Aid Effectiveness." Accessed 28 June 2012 at http://www.theglobalfund.org/en/performance/effectiveness/aideffectiveness/measuring/
[145] Steven Radelet and Bilal Siddiqi (2007). "Global Fund Grant Programmes: An Analysis of Evaluation Scores." *Lancet* 369: 1807-13.

- Similarly, McCoy and Kinyua (2012) analyze the Fund's pattern of disbursements, finding "no correlation between per capita GF disbursements and per capita THE, nor between per capita GF disbursement to government and per capita GHE."[146]

- Noting concerns that poor countries might lack the capacity to absorb large tranches of donor funding, Lu et al. (2006) explore the empirical predictors of faster grant implementation. Surprisingly, they find that low-income status and weak health systems were associated with higher rates of grant implementation in recipient countries.[147]

- A 2011 RAND report on value for money in HIV evaluates whether the Global Fund's architecture facilitated value for money. The report finds that "because there are relatively few mediators between headquarters and primary recipients, the possibility of additional inefficiencies is reduced." However, for both PEPFAR and the Global Fund, it concludes that funding allocations were neither structured nor distributed in a manner that would generate better value for money.[148]

- Katz et al. (2010) find that duration of funding was significantly associated with stronger performance among Global Fund TB grants. On average, relatively new grants (<15 months old) met 60% of their targets, more mature grants (16 to 22 months) met 95% of targets, and most grants reached 100% or more of their targets by month 52. The observed jump in performance may be related to the grant evaluation and renewal process, as it occurs at the 1.5-year mark directly preceding renewal applications. In addition, political stability at the country level increased grant performance, while higher disease burdens were associated with more negative grant performance.[149]

- Komatsu et al. (2007) use output targets from grant agreements to estimate the contribution of Global Fund investments to reaching international targets for intervention coverage. At the time of writing, the paper projected that programs already financed by the Global Fund in Sub-Saharan Africa would contribute 19% to regional ARV targets, 28% to DOTS targets, and 84% to ITN targets by 2009.[150]

- A 2010 paper by Komatsu et al. use grant output reports to extrapolate lives saved by Global Fund investments. Through the close of 2007, they estimate that 681,000 lives (1,097,000 life-years) were saved by ARV provision; 130,000 child deaths averted by ITN distribution;

[146] David McCoy and Kelvin Kinyua (2012). "Allocating Scarce Resources Strategically – An Evaluation and Discussion of the Global Fund's Pattern of Disbursements." PLoS One 7(5).
[147] Chunling Lu, Catherine M Michaud, Kashif Khan, and Christopher J L Murray (2006). "Absorptive Capacity and Disbursements by the Global Fund to Fight AIDS, Tuberculosis and Malaria: Analysis of Grant Implementation." Lancet 368: 483-88.
[148] Sebastian Linnemayr, Gery W Ryan, Jenny Liu, and Kartika Palar. "Value for Money in Donor HIV Financing." RAND.
[149] Itamar Katz, MA Aziz, M Olszak-Olszewski
[150] Ryuichi Komatsu, Daniel Low-Beer, and Bernhard Schwartlander (2007). "Global Fund-Supported Programmes' Contribution to International Targets and the Millennium Development Goals: An Initial Analysis." Bulletin of the World Health Organization: 85(10): 805-11.

and 1.63 million lives saved by DOTS *vis a vis* a baseline of no treatment (or 408,000 lives saved if measured against a baseline of non-DOTS treatment).[151]

- Avdeeva et al. (2011) find that Global Fund's HIV allocations from 2002-2010 were associated with higher disease burden and lower GNI per capita, but that "prevention in most-at-risk populations [was] not adequately prioritized in most of the recipient countries."[152]

Risk Management

The Global Fund is a financier rather than an implementer; throughout its history, it has also emphasized country ownership, including through the absence of any field-based secretariat staff. This model has given rise to several inherent tensions related to risk management and oversight, including the following contradictions noted in the 2011 HLP report:

- "Between the corporate objective to maintain a light touch by the organization and the operational realities that arise from the need to work in capacity-constrained, often fragile environments;"
- "Between a focus on implementation through country-led mechanisms and the need to achieve…high-impact results in a prudent, efficient and transparent manner;"
- "Between maintaining a lean and well-coordinated headquarters staff and challenges in implementation that might require a field presence;" and
- "Between a 'zero-tolerance' policy for misappropriation of funds and a reluctance to classify recipients by risk or define an overall 'risk appetite for the grant portfolio.'"[153]

Prior to the public revelations about corruption in early 2011, several documents had warned the Fund about the need for better risk management. A 2007 report by the US Government Accountability Office (GAO) concluded that the Fund had "limited ability to determine the quality of LFAs' monitoring and reporting and to identify situations in which more oversight of LFAs' performance may be required." According to the report, several of the GAO's sources had also "raise[d] concerns about the quality of grant monitoring and reporting provided by LFAs, particularly their ability to assess and verify recipients' procurement capacity and program implementation."[154] Further, the 2009 five-year evaluation found that the Global Fund lacked "a strategy for organization-wide risk management." The evaluation recommended that the Fund "urgently complete its development of a risk management framework," and "utilize the parameters

[151] Ryuichi Komatsu, Eline L Korenromp, Daniel Low-Beer, Catherine Watt, Christopher Dye, Richard W Steketee et al. (2010). "Live Saved by Global-Fund Supported HIV/AIDS, tuberculosis and malaria programs: estimation approach and results between 2003 and end-2007." *BMC Infection Diseases* 10:109.
[152] Olga Avdeeva, Jeffrey V Lazarus, Mohamed Abdel Aziz, and Rifat Atun (2011). "The Global Fund's Resource Allocation Decisions for HIV Programmes: Addressing Those in Need." *Journal of the International AIDS Society* 14(51).
[153] High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (2011). Turning the Page from Emergency to Sustainability: The Final Report of the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis, and Malaria.
[154] Government Accountability Office (2007). Global Fund to Fight AIDS, TB and Malaria Has Improved Its Documentation of Funding Decisions But Needs Standardized Oversight Expectations and Assessments. GAO-07-627.

associated with risk of poor grant performance – financial, organizational, operational and political – to determine how resources should be mobilized in support of performance."[155]

Following the corruption scandal, risk management became central to the Fund's reform and restructuring agenda. The HLP report considered risk and risk management at length, recommending that the Fund "define a doctrine of risk and manage to it" by "develop[ing] a new risk management framework" for both corporate risk at the organizational level, and operational risk at the grant and country level.[156] Accordingly, the 2012-2016 strategy outlines a "risk-differentiated approach to grant management," whereby a "risk matrix" would be used to define the risk level for each country. The Global Fund would then apply appropriate controls and safeguards that were commensurate with perceived risk.[157] The Consolidated Transformation Plan also includes "transforming risk management" as a central objective, and commits to implementing a comprehensive framework to assess, mitigate, and manage corporate and operational risks.[158]

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155 Macro International (2009). The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Synthesis of Study Areas 1, 2 and 3.
156 High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (2011). Turning the Page from Emergency to Sustainability: The Final Report of the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis, and Malaria.
157 The Global Fund (2011). The Global Fund Strategy 2012-2016: Investing for Impact.
158 The Global Fund (2011). Consolidated Transformation Plan.

Appendices

Appendix A: The Global Fund's Guiding Principles[159]

- The Global Fund is a financial instrument, not an implementing entity.

- The Global Fund will make available and leverage additional financial resources to combat HIV/AIDS, tuberculosis and malaria.

- The Global Fund will base its work on programs that reflect national ownership and respect country led formulation and implementation processes.

- The Global Fund will seek to operate in a balanced manner in terms of different regions, diseases and interventions.

- The Global Fund will pursue an integrated and balanced approach covering prevention, treatment, and care and support in dealing with the three diseases.

- The Global Fund will evaluate proposals through independent review processes based on the most appropriate scientific and technical standards that take into account local realities and priorities.

- The Global Fund will seek to establish a simplified, rapid, innovative process with efficient and effective disbursement mechanisms, minimizing transaction costs and operating in a transparent and accountable manner based on clearly defined responsibilities. The Global Fund should make use of existing international mechanisms and health plans.

- In making its funding decisions, the Global Fund will support proposals which:

    - Focus on best practices by funding interventions that work and can be scaled up to reach people affected by HIV/AIDS, tuberculosis and malaria.

    - Strengthen and reflect high-level, sustained political involvement and commitment in making allocations of its resources.

    - Support the substantial scaling up and increased coverage of proven and effective interventions, which strengthen systems for working: within the health sector; across government departments; and with communities.

    - Build on, complement, and coordinate with existing regional and national programs in support of national policies, priorities and partnerships, including poverty reduction strategies and sector-wide approaches.

[159] The Global Fund. The Framework Document of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

- Focus on performance by linking resources to the achievement of clear, measurable and sustainable results.
- Focus on the creation, development and expansion of government/private /nongovernmental organization partnerships.

- Strengthen the participation of communities and people, particularly those infected and directly affected by the three diseases, in the development of proposals.

- Are consistent with international law and agreements, respect intellectual property rights, such as TRIPS, and encourage efforts to make quality drugs and products available at the lowest possible prices for those in need.

- Give due priority to the most affected countries and communities, and to those countries most at risk.

- Aim to eliminate stigmatization of and discrimination against those infected and affected by HIV/AIDS, especially for women, children and vulnerable groups.

Appendix B: Fraud and Misuse of Funds Reported by the Global Fund, April 2011[160]

COUNTRY	FRAUD (US$)	UNSUPPORTED (US$)	INELIGIBLE (US$)	UNACCOUNTED INCOME/DRUGS	OTHER (US$)	TOTAL (US$)
CAMBODIA	-	222,706	-	1,362,466	-	1,585,172
CAMEROON	33,455	2,199,530	3,370,322	-	-	5,603,307
CONGO (DEMOCRATIC REPUBLIC)	-	1,110,107	933,586	-	-	2,043,693
DJIBOUTI	145,893	4,262,288	857,827	-	-	5,266,008
HAITI	-	519,326	1,253,869	704,730	-	2,477,925
MALI	4,074,444	1,034,935	-	-	122,106	5,231,485
MAURITANIA	6,755,000	-	-	-	-	6,755,000
PHILIPPINES	-	-	2,021,280	-	-	2,021,280
RWANDA	-	-	-	-	-	-
TANZANIA	-	-	-	819,000	-	819,000
UGANDA	-	-	-	-	1,600,000	1,600,000
ZAMBIA	13,000	5,808,446	4,998,389	-	-	10,819,835
TOTAL (US$)	**11,021,792**	**15,157,338**	**13,435,273**	**2,886,196**	**1,722,106**	**44,222,705**

[160] The Global Fund (2011). Report of the Comprehensive Reform Working Group.

Appendix C: Total Disbursements, Top 100 Recipients, 2002 to May 2013 (USD)[161]

Country	Disbursements
Ethiopia	1,235,988,613
India	969,029,866
Tanzania (United Republic)	879,314,503
Nigeria	828,180,958
China	761,558,159
Rwanda	721,860,549
Congo (Democratic Republic)	619,029,221
Malawi	549,175,480
Zambia	544,371,687
Zimbabwe	461,683,596
Indonesia	439,705,727
Uganda	436,821,571
Kenya	378,215,595
Russian Federation	368,469,012
Ghana	368,388,593
South Africa	348,827,925
Thailand	320,622,615
Mozambique	308,771,506
Ukraine	300,122,732
Cambodia	293,126,780
Sudan	268,708,918
Haiti	232,698,893
Burkina Faso	223,190,660
Madagascar	221,874,096
Cameroon	215,415,794
South Sudan	211,336,395
Bangladesh	211,061,833
Namibia	189,357,126
Philippines	183,940,030
Côte d'Ivoire	182,539,457
Viet Nam	164,242,726
Senegal	152,351,258
Burundi	150,369,778
Somalia	148,627,373
Angola	145,402,093
Swaziland	142,104,771
Eritrea	138,111,149
Benin	136,362,520
Togo	133,059,305
Peru	132,996,265
Pakistan	131,298,585
Lesotho	122,862,983
Liberia	119,101,471
Papua New Guinea	116,275,788
Dominican Republic	114,432,935
Mali	112,905,356

[161] Data source for all funding data is spreadsheets downloaded from http://portfolio.theglobalfund.org/en/DataDownloads/CustomizeReportDownload#

Tajikistan	105,732,656
Sierra Leone	101,976,218
Kazakhstan	99,290,917
Lao (Peoples Democratic Republic)	99,072,936
Niger	98,455,845
Guatemala	98,090,957
Gambia	95,360,903
Myanmar	95,340,486
Nepal	89,948,330
Honduras	88,903,047
Uzbekistan	85,292,483
Cuba	76,963,465
Afghanistan	74,806,925
Georgia	71,936,686
Central African Republic	71,852,151
Chad	70,403,573
Belarus	67,187,621
Kyrgyzstan	66,147,219
Romania	64,482,824
Moldova	64,404,512
Multicountry Western Pacific	63,953,496
Bulgaria	62,103,232
Iran (Islamic Republic)	61,345,551
Guinea	60,377,070
El Salvador	60,348,920
Nicaragua	59,416,202
Jamaica	57,509,031
Azerbaijan	55,586,725
Yemen	54,097,968
Congo	49,335,819
Morocco	47,689,502
Bolivia (Plurinational State)	46,731,480
Sri Lanka	45,794,708
Ecuador	44,663,603
Korea (Democratic Peoples Republic)	42,003,911
Colombia	41,486,173
Guinea-Bissau	40,520,398
Brazil	39,295,557
Bosnia and Herzegovina	36,551,752
Multicountry Africa (RMCC)	36,174,717
Guyana	36,088,300
Mongolia	35,602,888
Armenia	34,662,062
Serbia	33,590,142
Paraguay	31,819,756
Timor-Leste	30,749,165
Equatorial Guinea	30,502,700
Gabon	29,272,755
Chile	28,835,307
Argentina	27,014,691
Iraq	26,999,817
Multicountry Africa (West Africa	26,144,320

Mexico	24,664,200
Djibouti	23,803,369

Appendix D: Top Recipients of Funding by Disease Area, 2002 to May 2013 (USD)[162]

Table 1: Top Recipients, HIV Funding

Ethiopia	802,408,775
India	723,290,798
Tanzania (United Republic)	494,112,474
Rwanda	451,844,670
Malawi	415,131,111
Zambia	414,323,935
China	323,861,014
Nigeria	296,669,935
Ukraine	275,757,063
Zimbabwe	271,118,228
Congo (Democratic Republic)	265,451,992
Russian Federation	263,432,596
South Africa	263,115,914
Thailand	234,042,995
Mozambique	197,065,754
Ghana	184,663,534
Kenya	177,091,374
Haiti	173,615,626
Uganda	172,702,806
Cambodia	162,545,296
Namibia	153,021,009
Indonesia	138,025,400
Swaziland	128,061,730
Lesotho	110,804,692
Cameroon	99,001,826
Sudan	97,804,816
Dominican Republic	92,316,117
Mali	89,676,105
Burundi	82,726,806
Eritrea	80,873,115

Table 2: Top Recipients, Malaria Funding

Nigeria	450,531,478
Ethiopia	354,017,804
Tanzania (United Republic)	294,970,327
Congo (Democratic Republic)	272,319,334
Uganda	244,746,811
Madagascar	174,566,615
Rwanda	171,039,178
Kenya	169,373,331
Indonesia	146,958,027
Zimbabwe	142,703,884
Sudan	135,203,415
Ghana	130,022,800
Burkina Faso	121,434,426
China	113,813,913
Côte d'Ivoire	110,945,532
South Sudan	107,378,842
Cameroon	105,831,266
Mozambique	97,006,676
Zambia	90,060,418
Malawi	89,573,929
Cambodia	89,328,343
Papua New Guinea	77,651,456
India	70,942,554
Angola	69,075,879
Philippines	68,459,181
Senegal	66,668,667
Niger	57,155,362
Burundi	56,245,812
Somalia	54,990,410
Togo	51,502,713

[162] The Global Fund. Core Disbursement Details Raw Report. Accessed 9 May 2013 at http://www.theglobalfund.org/documents/core/grants/Core_DisbursementDetailsRaw_Report_en/

Table 3: Top Recipients, TB Funding

China	323,883,233
India	159,976,742
Indonesia	151,093,763
Russian Federation	105,036,415
Bangladesh	98,444,835
Philippines	88,282,650
Pakistan	85,288,674
Nigeria	80,979,544
Ethiopia	79,562,035
Peru	65,722,878
Congo (Democratic	63,368,927
Kazakhstan	53,875,508
Ghana	53,702,258
Rwanda	50,541,770
Zimbabwe	47,861,484
Thailand	46,488,655
South Sudan	45,551,119
Tajikistan	41,896,606
Somalia	40,788,281
Zambia	39,987,334
Sudan	35,700,687
Uzbekistan	35,574,654
Viet Nam	33,309,153
Kenya	31,750,890
Cambodia	28,721,919
Burkina Faso	27,468,276
Georgia	27,400,023
Iraq	26,999,817
Romania	26,575,658
Azerbaijan	26,165,258

Appendix E: Key Performance Indicators, 2011[163]

		Corporate Performance Framework (KPIs)	End 2011 Result[1]	2011 Target	End 2010 Result	Trend
GRANT PERFORMANCE						
		Improved performance (KPI 14) Percentage of grants with previous poor performance whose performance improved within past year	43%	60%	49%	
		Portfolio performance (KPI 13) Percentage of well performing grants	77%	85%	81%	
		Portfolio Results (KPI 12) Percentage of 'Top 10' output targets achieved in GF supported programs	86%	90%	96%	
OPERATIONAL PERFORMANCE						
Portfolio Management	Financing efficiency	**Volume of financing (KPI 11)** Actual disbursements compared to target disbursement	85%	95%	100%	
Portfolio Management	Financing efficiency	**Speed of disbursement processing (KPI 10)** Average time between receipt of LFA-verified PU/DR and date of disbursement (in calendar days)	25	21	23	
Portfolio Management	Financing efficiency	**Speed of grant signing (KPI 9)**[2] Average time between proposal (round-based) approval and first disbursement (in months)				
Portfolio Management	Financing efficiency	Round 9	12.7	8	11.2	
Portfolio Management	Financing efficiency	Round 10	13.2	8	N.A.	N.A.
Portfolio Management	Performance management	**Transparent data (KPI 8)**				
Portfolio Management	Performance management	a- Percentage of grants with complete progress & financial data published within two weeks of disbursement	64%	85%	85%	
Portfolio Management	Performance management	b- Percentage of grants reporting information in the Price Quality Reporting system	95%	100%	93%	
Portfolio Management	Performance management	**Funding follows performance at grant renewal (KPI 7)** Strong performing grants receive higher percentage of the original Phase 2 amount than poor performing grants	44%	30%	27%	
Portfolio Management	Performance management	**Funding follows performance disbursements (KPI 6)** Strong performing grants receive higher percentage of expected disbursements than poor performing grants	24%	30%	23%	
Administrative effectiveness		**Global Fund Secretariat's operating expenses (KPI 5)** Operating expenses as:				
Administrative effectiveness		a - Percentage of grants under management	2.6%	<3%	2.3%	
Administrative effectiveness		b - Percentage of total expenditures	11.3%	<10%	7.7%	
Administrative effectiveness		**Staff diversity (KPI 4)** Performance against three agreed diversity targets:				
Administrative effectiveness		a - gender (women in positions with grade G06 and above)	29%	45%	29%	
Administrative effectiveness		b - ethnicity (staff originating from implementer countries)	39%	40%	41%	
Administrative effectiveness		c - communities (staff affected with HIV/AIDS)	1.9%	2.5%	1.8%	
Resource mobilization		**Private sector contribution (KPI 3)** Total dollar raised (in absolute value) from private corporate sector, foundations and other non-government donors	USD 186m	USD 550m (2011-2013) [USD 150m for 2011]	USD 458m (2008-2010)	
Resource mobilization		**Donor pledges (KPI 2)** Percentage of 2012 funding needs (project grants committed) covered by donor funding (forecast asset available).	49%	70%	N.A.	N.A.
Resource mobilization		**Donor Contributions (KPI 1)** Percentage of pledges for 2011 contributed.	79%	90%	78%	

[163] The Global Fund (2012). Key Performance Indicators: End-Year Results for 2011.

Corporate Performance Framework (KPIs)	End 2011 Result	2011 Target	End 2010 Result	Trend
EFFECTIVENESS[3]				
Value for Money (KPI 21) Percentage change in median price paid for comparable services (an aggregate total of the following services):	7%	5%	13%	↓
a – HIV: ARV drugs price per patient per year	12% decline ($127)		27% decline ($144)	
b – Malaria: ITN price per net	4% decline ($4.5)		1% decline ($4.6)	
c – TB: Proportion of countries with a DOTS unit cost per patient successfully treated within reference range	5% improvement (95% within range)		11% improvement (91% within range)	
Civil society engagement (KPI 19) Percentage of funds allocated to civil society organizations as implementers	37%	35%	38%	→
Community System Strengthening (KPI 24) Overall performance of CSS indicators (average percentage of targets achieved)	95%	end-2010 result	94%	→
Health system strengthening (KPI 18) Overall performance of HSS indicators (average % of targets achieved)	94%	90%	85%	↑
Aid effectiveness (KPI 17) Average gap in achieving Paris Declaration targets (percentage)	15%	0%	18%	↑
Government Health Spending (KPI 16) Percentage of countries receiving Global Fund support which report increasing General Government Expenditure on Health (GGHE)	88%	90%	N.A.	N.A.
HEALTH IMPACT				
Global Health impact (KPI 23) Global progress to achieve the Millennium Development Goals targets is on track at this time:	68%	80%	65%	→
a – HIV: 1. ART coverage; 2. Incidence rate; 3. Mortality rate.	73%		65%	
b – TB: 1. Incidence rate; 2. Mortality rate.	88%		91%	
c – Malaria: 1. Incidence rate; 2. Mortality rate; Under-5 mortality;	44%		41%	
Country Health impact (KPI 22) Percentage of countries with Global Fund funding reporting positive trends towards the MDG 4 and MDG 6	41%	60%	42%	→
a – HIV: 1. ART coverage; 2. Incidence rate; 3. Mortality rate.	40%		39%	
b – TB: 1. Incidence rate; 2. Mortality rate.	51%		51%	
c – Malaria: 1. Incidence rate; 2. Mortality rate; Under-5 mortality;	31%		35%	

Green – A (Meeting or Exceeding expectations) where the performance is >=90% achievement; Yellow – B1 (Moderate) where performance is 60-89% achievement; Orange – B2 (Inadequate) where performance is 30-59% achievement; Red – C (Unacceptable) where performance is <30% achievement.

Performance scale: - Green: < 1 month of delay; Yellow: b/w 1 and 2 months of delay; Orange: b/w 2 and 4 months of delay; Red: > 4 months of delay.

Appendix F: Global Fund Recommended "Top Ten" Grant Performance Indicators[164]

Table 1: Top Ten Indicators for Routine Global Fund Reporting

	Disease	Indicators for routine Global Fund reporting
1	HIV	Number of adults and children with advanced HIV infection currently receiving antiretroviral therapy
2	TB	Number of (a) new smear-positive TB patients detected, (b) new smear-positive TB patients who were successfully treated and (c) laboratory-confirmed MDR-TB patients enrolled in second-line anti-TB treatment
3	Malaria	Number of (a) insecticide-treated nets or re-treatment kits distributed to people and (b) households (or structures or walls) in designated target areas sprayed by indoor residual spraying in the past 12 months
4	Malaria	Number of people with fever receiving antimalarial treatment according to national policy (specify artemisinin-based combination therapy versus other therapy)
5	HIV	Number of women and men aged 15-49 years who received an HIV test in the last 12 months and who know their results
6	HIV	Number of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission
7	HIV	Number of condoms distributed
8	HIV, TB and malaria	Number of people benefiting from community-based programs: specify (a) care and support including orphan support, home-based management of malaria and directly observed therapy (DOT); (b) behavior change communication outreach activities including specific target groups; and (c) disease prevention for people most at risk (except behavior change communication)
9	HIV/TB	Number of TB patients who had an HIV test result recorded in the TB register
10	Strengthening health systems for HIV, TB and malaria	Number of people trained

[164] The Global Fund (2011). Top Ten Indicators Card.

Table 2: Top Ten Indicators for Medium-Term Outcome and Impact

	Disease	Indicators recommended for generalized epidemics and high-endemicity areas	Indicators recommended for concentrated epidemics and low-endemicity areas
1	HIV	Percentage of women and men aged 15-24 years who are infected with HIV	Percentage of populations most at risk who are infected with HIV
2	HIV	Percentage of adults and children with HIV known to be receiving treatment 12 months after initiation of antiretroviral therapy (extend to two, three and five years as the program matures)	
3	HIV	Reduced mother-to-child transmission of HIV: percentage of infants born to mothers who are HIV infected	
4	HIV	Percentage of people aged 15-49 years with more than one sexual partner in the past 12 months reporting the use of condoms during their last sexual intercourse	Percentage of populations most at risk with more than one sexual partner in the past 12 months reporting the use of condoms during last sexual intercourse
5	TB	TB case detection rate and treatment success rate	
6	TB	TB prevalence rate: estimated number of TB cases (all forms) per 100 000 population	
7	Malaria	All-cause mortality rate among children younger than five years of age	Malaria-specific mortality: proportion of deaths attributed to malaria among children younger than five years of age (or other target groups)
8	Malaria	Number of (confirmed) malaria cases seen by health workers (in facilities and/or outreach)	a. Annual parasite index b. Slide-positive or rapid diagnostic test-positive rate
9	Malaria	People sleeping under an insecticide-treated net the previous night (specify the target population: all household residents, children younger than five years of age, pregnant women)	
10	Health systems strengthening	All-cause mortality rate among children younger than five years of age	

Appendix G: The M&E Agenda for 2012-2016[165]

Area	M&E today	M&E agenda over the next five years
Strengthen routine data monitoring (health facility-based and community-based)	Existing data collection systems do not always include data from the public sector, private sector and civil society; health management information system (HMIS) is often dysfunctional and not adequately integrating disease programs. Information generated by programs at the community level is still poor and incomplete.	A high percentage of data collected from the private sector and civil society and communities are integrated into the national reporting, which will provide a comprehensive view of the sector's performance. Capacity is built into integrated HMIS. A set of indicators, tools and the M&E system are adapted to monitor and evaluate community-level service delivery.
Improve data quality	Data quality framework at country level is still weak. Attempts to check inconsistencies in data collection and reporting remain ad hoc.	Agreed data quality framework included in the M&E plan with regular monitoring and supervision. Expand on-site data verification and data quality audits to support continued data quality improvement.
Measure the quality of services delivered	Measurement of the quality of services or use of data for program quality management at all levels is often not embedded in program management	A set of indicators and tools to monitor the quality of service delivery at all levels is defined and systematically implemented.
Monitor service delivery among key populations and by sex	Data for key populations are often not fed back into the program and used for planning and decision-making. Reliable population size estimates are often not available. Addressing gender is limited to disaggregating data and indicators by sex.	Strategic information from programs is generated by identifying (1) the risks associated with disease transmission, (2) inequities in health and (3) the populations most at risk (including gender considerations). Strategic information is used at all levels for program planning, resource allocation and improved monitoring.
Further fund and strengthen vital registration systems	In many countries, vital registration systems are not complete enough to accurately monitor overall and cause-specific mortality.	The vital registration system is improved using domestic resources as well as resources allocated through partners and the Global Fund, so that reliable vital statistics can be produced in each country.
Strategically invest in population-based surveys	Overlap and duplication exist in the surveys implemented. Too much information is collected that is not subsequently used for decision-making.	Surveys are implemented cost-efficiently through good planning, design and coordination. Surveys respond to program and donor needs by providing reliable data and trends for evidence-based decision-making. Increased investments from donors in surveys that measure incidence and prevalence.
Generate strategic information	There is lack of appropriate tools and mechanisms to collect and store core data. There is a lack of analytical capacity at the country level to generate strategic information to address challenges and improve program implementation.	Modern and innovative solutions are implemented to collect, archive and retrieve data. Capacity is strengthened to analyze, interpret and use program data for informed decision-making. An annual review process is institutionalized with a high level of participation from stakeholders.
Fund and implement evaluations	Focus is on monitoring and reliance on routine system and quantitative data. Evaluation function is weak and uncoordinated; conducting evaluations remains ad-hoc.	Periodic evaluations are conducted to complement existing information, in particular for assessing the program impact and outcome and specific areas such as gender, equity, quality of services, and ability of interventions to reach key populations.
Gradually introduce operations research	Focus is monitoring and reliance on routine system and quantitative data.	Periodic research activities to respond to program implementation questions.
M&E of M&E	Many countries have an M&E plan, but it is not always implemented. Implementation is not followed up routinely or the resources needed are not allocated.	Regular M&E system assessment is used to identify priorities for strengthening the M&E system and to allocate resources efficiently. Implementation of M&E plan and costed workplan is followed up as part of the program review process.

[165] The Global Fund (2011). Monitoring and Evaluation Toolkit.