



# INVESTING IN IMPACT

## MID-YEAR RESULTS REPORT 2006



Investing in our future

**The Global Fund**  
To Fight AIDS, Tuberculosis and Malaria





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STUDENTS AT JAMBIANI SCHOOL IN ZANZIBAR RECEIVE MALARIA PREVENTION TRAINING AS PART OF THE STANDARD CURRICULUM.



# LIST OF TERMS AND ABBREVIATIONS USED

# EXECUTIVE SUMMARY

<b>ACT</b>	Artemisinin-based combination therapy	<b>LLIN</b>	Long-lasting insecticidal net
<b>AMREF</b>	African Medical and Research Foundation	<b>M&amp;E</b>	Monitoring and evaluation
<b>ARV</b>	Antiretroviral	<b>MDG</b>	Millennium Development Goal
<b>CADRE</b>	Centre for AIDS Development, Research and Evaluation	<b>MDR-TB</b>	Multidrug-resistant tuberculosis
<b>CBO</b>	Community-based organization	<b>MEASURE</b>	Monitoring and Evaluation to Assess and Use Results
<b>CCM</b>	Country Coordinating Mechanism	<b>NMCP</b>	National Malaria Control Program
<b>CSS</b>	Community systems strengthening	<b>OECD</b>	Organisation for Economic Co-operation and Development
<b>DFID</b>	UK Department for International Development	<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief (U.S.)
<b>DOTS</b>	Directly Observed Treatment, Short course (internationally-approved tuberculosis control strategy)	<b>PMTCT</b>	Prevention of mother-to-child transmission
<b>DQA</b>	Data Quality Audit	<b>PR</b>	Principal Recipient
<b>EARS</b>	Early Alert and Response System	<b>PSI</b>	Population Services International
<b>EFA-FTI</b>	Education for All – Fast-track Initiative	<b>RBM</b>	Roll Back Malaria Partnership
<b>FBO</b>	Faith-based organization	<b>SWAp</b>	Sector-wide approach
<b>G8</b>	Group of Eight	<b>TB</b>	Tuberculosis
<b>GAVI</b>	Global Alliance for Vaccines and Immunization	<b>TERG</b>	Technical Evaluation Reference Group
<b>GEF</b>	Global Environment Facility	<b>TC</b>	Testing and counseling
<b>HBC</b>	High-burden country (used in reference to tuberculosis disease burdens)	<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>HMN</b>	Health Metrics Network	<b>UNGASS</b>	United Nations General Assembly Special Session
<b>HSS</b>	Health systems strengthening	<b>UNICEF</b>	United Nations Children's Fund
<b>ITN</b>	Insecticide-treated bed net	<b>USAID</b>	United States Agency for International Development
<b>LFA</b>	Local Fund Agent (independent consultants contracted by the Global Fund to assess and verify program results as they are reported by the Principal Recipients of grants)	<b>VCT</b>	Voluntary counseling and testing
		<b>WHO</b>	World Health Organization

**1. By 15 May 2006, the Global Fund had signed grant agreements worth US\$ 4 billion for 333 grants in 127 countries.** In just over three years, the Global Fund has disbursed US\$ 2.26 billion to grant recipients. Many grants are still at an early stage, with an average age of 22 months at this point in time.

**2. Overall, financial disbursements are in line with the progress of the grant portfolio.** Global Fund grants are disbursed incrementally, based on program performance. As of 15 May 2006, 93 percent of committed grant amounts had been disbursed based on grant lifespans elapsed (in other words, 64 percent of total grant amounts disbursed against 69 percent of total grant lifespans elapsed). Of money disbursed by the Global Fund, an estimated 63 percent had been spent by the end user, with a further 14 percent tied up in commitments.

**3. Results as of 1 June 2006 show that the entire portfolio of grants supported by the Global Fund has:**

- Resulted in 544,000 people currently on antiretroviral (ARV) treatment
- Reached 1.43 million people with tuberculosis (TB) treatment under Directly Observed Treatment, Short course (DOTS)

- Distributed 11.3 million insecticide-treated bed nets (ITNs) to protect families from malaria
- Reached 5.7 million people with HIV counseling and testing
- Reached 12 million people with community outreach for HIV prevention
- Provided 560,000 orphans with basic care and support
- Reached 7.3 million people with treatment for malaria (including 2.5 million with artemisinin-based combination therapy (ACT) treatment for drug-resistant malaria)
- Trained 1.5 million additional service deliverers to fight HIV, TB or malaria.

**4. The number of people receiving services is doubling every year, leading to rapidly accelerating scale-up.** There have been 42 percent increases in ARV treatment, 43 percent in TB treatment and 47 percent in ITNs distributed in the first half of 2006. Since the same time last year, results have more than doubled, with 150 percent, 140 percent and 265 percent increases respectively for these interventions. TB and HIV scale-up has been steady, while malaria results have accelerated rapidly once procurement bottlenecks have been removed.

**5. The Global Fund is showing progress in reaching international targets for malaria, TB and HIV. By mid-2006, the results of programs supported by the Global Fund had reached from nine to 29 percent of international targets for the top three indicators (ARV therapy, TB treatment under DOTS, ITN distribution).** In addition, the overall targets going forward for Global Fund-supported programs (which include funding from other sources) are to achieve 84 percent of international targets on ITNs distributed in sub-Saharan Africa by 2009, 28 percent of TB detection under DOTS and 19 percent of people on ARVs. However, even with the input of donor partners considered, there remains a large funding gap for the work ahead to reach the Millennium Development Goals (MDGs). Treatment for HIV/AIDS in particular will require an exponentially greater level of funding.

**6. An evaluation of grants that are at least 18 months old shows that 75 percent of grantees are making the money work, financing programs that exceeded, reached or showed adequate performance against targets.** Twenty-one percent showed inadequate performance but demonstrated potential, and four percent showed unacceptable performance. This evaluation was conducted on 140 grants that have reached or are approaching the end of Phase 1 (the first two years of grant funding).

**7. Taken together, these 140 grants achieved 87.5 percent of their targets, with a range of 60 to 105 percent for the main services provided.** While some of the grants fell below their individual targets, the overachievement of high-performing grants ensured that the collective targets of grant-financed programs were reached. Performance was very strong for HIV treatment (86 percent of overall targets reached), prevention (85 percent), orphan care (97 percent), TB treatment (100 percent) and training of service deliverers (105 percent). Performance was lower for malaria treatment (60 percent) and ITN distribution (60 percent) due to delays at the early stages of some grants. However, when the problems in malaria grants were overcome, results tended to catch up quickly. This explains why malaria results for the overall portfolio were strong, despite underperforming at the evaluation of their first stage of implementation.

**8. Phase 2 is an investment in performance, with US\$ 1.5 billion committed to grants for programs that showed results and 16.2 percent of requested funding reallocated to new grants.** As of 15 May 2006, the Global Fund had committed US\$ 1.5 billion in funding to grants for Phase 2 of implementation (typically years three to five) – almost the financial equivalent of two new rounds of funding.

A total of US\$ 300 million in grantee-requested funding for Phase 2 (16.2 percent of the total proposal amount) was reallocated to new grants, either due to budget cuts in grants that were judged unable to spend the money or grants discontinued due to poor performance. Reallocated funds financed the equivalent of one-third of new grant proposals in Round 5.

**9. Performance-based funding concepts are applied to each disbursement decision, and evidence shows that the amounts disbursed are strongly related to results.** There is a strong correlation between the performance ratings of disbursement requests and amounts disbursed: A-rated disbursement requests (met or exceeded targets) had received 79 percent of their grant amounts, B1-rated (satisfactory performance against targets) 72 percent, B2-rated (poor performance but showing potential) 64 percent and C-rated (unacceptable performance) 38 percent.

**10. Performance-based funding appears not to penalize poor countries.** Countries with the lowest wealth, health systems or human resources for health have no worse performance during Phase 1 of implementation. The Global Fund measures performance relative to country-owned targets, not absolute performance across countries. Surprisingly, the poorest countries have significantly lower budget reductions at Phase 2 (6.4 percent, as compared to 21 percent for wealthier countries). Phase 2 is an investment in performance, and in poverty.

**11. Continued analysis suggests that the performance-based funding model works well in fragile states, with 66 percent of grants in fragile states A- or B1-rated.** There are weaknesses, however, in that there are fewer A-rated grants (nine percent in fragile states compared to 27 percent in stable states). Rather than focus on problem grants, technical assistance is required for B1 grants – the majority here as elsewhere – to help them scale up. Many fragile states have developed a model where government and civil society have to implement in partnership due to difficult conditions. This “fragile states model” is of importance to all grants, as most grants experience some level of fragility in their systems when implementing.

**12. Civil society organizations remain strong Principal Recipients (PRs), with 30 percent of their grants A-rated, 70 percent B1-rated and no grants B2- or C-rated.** Dual-track financing – where a grant proposal is split into two with one governmental and one civil society PR – can increase a country’s financial absorptive capacity and ensure that obstacles in one area do not slow all other activities.

**13. Important implementation lessons are being learned from performance-based funding.** There is a need for a new strategy to shift from technical assistance to poor performers to targeted implementation support to help merely adequate performers scale up. For example, sub-Saharan Africa has no more poorer-performing grants than any other region, but it needs coaching and assistance to increase performance of the the majority of its grants, which are B1-rated, in order to accelerate programmatic results and become A-rated grants. This would have the greatest payoff in terms of increasing results in sub-Saharan Africa. Assistance is often most needed as programs are scaling up implementation and begin to show results, not just when problems arise or implementation is slow.

**14. The Global Fund is putting the Paris Declaration on Aid Effectiveness into practice and coordinating the input of global initiatives to help measure progress against targets set out in the Declaration.** The Global Fund is representing global initiatives in health, the environment and education at the core of implementing and measuring the Declaration at the country level. In addition, this year the Global Fund has invested heavily in partnerships in order to harmonize with sector-wide approaches (SWAps), the UK Department for International Development (DFID), the Global Alliance for Vaccines and Immunization (GAVI), the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) and the World Bank. This shows the flexibility of Global Fund implementation arrangements, which will continue to be improved and expanded with the input of partners and grant recipients.

**15. The Global Fund has strengthened its performance measurement system, introducing site verifications of results for all grants in 2006 and data quality assessments and audits by the end of 2007.** These tools have been developed with partners including the World Health Organization (WHO), Health Metrics Network (HMN), the United States Agency for International Development (USAID) and PEPFAR to coordinate the strengthening of monitoring and evaluation (M&E) systems in countries. Weaknesses remain, however, in the Global Fund’s procurement and financial reporting in a standard manner across all grants.

**16. Community systems strengthening (CSS) is needed alongside health systems strengthening (HSS) for the large range of community services (including home-based care) required for the implementation of many prevention and treatment programs.** Community systems require similar levels of coordination as overall health systems, in addition to

the provision of a basic package of supplies and training to boost service delivery in very difficult conditions. The Global Fund must ensure that grants include the necessary strengthening measures to deliver community services.

**17. There are still many challenges to accelerating results at the rate planned by the Global Fund.** Health and community systems and capacity need to be scaled up to support the annual doubling in the delivery of services. Conditions for health investment in countries need improving, including: longer-term, costed health plans; better links to development plans; strengthening of financial accountability, supply chain and strategic information systems; and strengthening of wider national structures to ensure quality and accreditation of the scale-up of service delivery, training and HSS. The Global Fund can play its part, but this requires a much wider, partner-driven effort.

**18. The scale and focus of the Global Fund provide the opportunity for donors to invest in impact against HIV/AIDS, TB and malaria.** Global Fund grants are already contributing significantly to international targets for the three diseases, and there are early signs of impact on the diseases in some countries as a result of grant funding, including declining numbers of malaria cases and related deaths, reductions in HIV-related mortality as a result of access to treatment and declining TB prevalence. Sustainable financing is critical in order for impact to be generalized in the coming three to five years.



# 1. INTRODUCTION

In 2005, countries proved that they could use Global Fund money to deliver results. Despite challenges, countries are making the money work. Previous progress reports by the Global Fund have shown the performance of investments in scaling up HIV, tuberculosis and malaria services, given the right mix of performance incentives, clear focus, investment in systems and partners to deliver services to people in need. This progress report gives an update on the Global Fund's results, which have doubled since June 2005, and examines the steps required to go from approved grant funding to impact on the three diseases and contributions to wider international targets such as the Millennium Development Goals (MDGs).

1. This report consolidates earlier analysis in answering some important questions on the challenges the Global Fund faces:

**What are the implementation bottlenecks in funded programs?**

**Can the Global Fund believe the data coming from funded countries?**

**Are Global Fund grants contributing to the strengthening of monitoring, health and wider community systems?**

**Are the Global Fund and its partners working towards collective efficiency and harmonization goals?**

**Are Global Fund grants providing additional finance and catalyzing a wider response to the epidemics?**

**Does performance-based funding penalize weaker countries?**

**Will grant-financed programs contribute significantly to international goals and wider impact against AIDS, TB and malaria?**

This report sets out the achievements and challenges of the Global Fund's performance-based funding model – to ensure that financing reaches and is accountable to people in need of urgent services.

## WORKING TOWARDS IMPACT

2. The Global Fund evaluates the performance of its operational structures, its grants and its effects on the systems through which it works. Impact on the three diseases – the ultimate goal – is at the apex of its four-level evaluation framework (see Figure 1), which is situated in the broader context of global efforts to fight the three diseases. Each section of this report highlights the steps in the evaluation framework, working towards impact.

## OPERATIONAL PERFORMANCE – DISBURSEMENT SPEED

3. At the level of operational performance is the work to ensure rapid disbursements to funded programs. As of 15 May 2006, overall disbursements to countries were in line with time elapsed in grants (64 percent of total grant commitments disbursed as compared to 69 percent of grant lifespan elapsed). This is 93 percent of the expected amount disbursed based on grant age. (Most encouragingly, of the 140 grants that were at least 18 months old, 75 percent exceeded, reached or showed adequate performance against targets. Despite the challenges, most grantees are making the money work).



**EVALUATION FRAMEWORK**

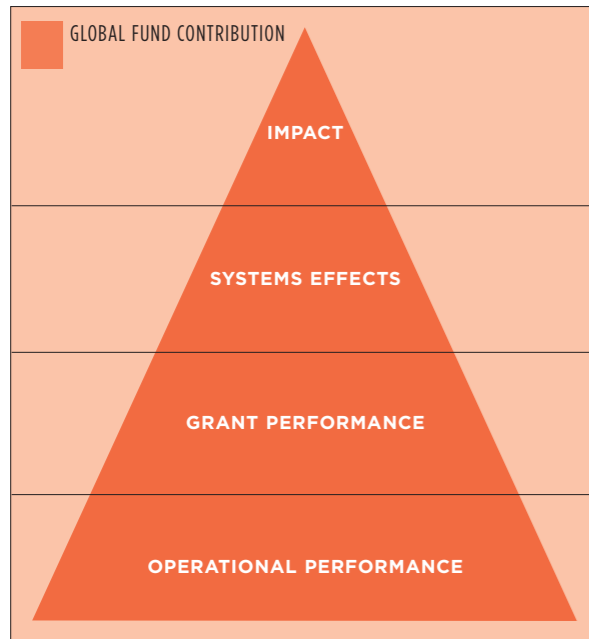


FIGURE 1: THE GLOBAL FUND'S FOUR-LEVEL EVALUATION FRAMEWORK

**THE FOUR LEVELS OF THE GLOBAL FUND'S MEASUREMENT FRAMEWORK (SEE FIGURE 1) ARE AS FOLLOWS:**

**4. IMPACT:** the ultimate measure of the success of the Global Fund. Impact indicators are included in all grant agreements, and the Global Fund's contributions at the global level – for example, to the Millennium Development Goals – are assessed.

**3. SYSTEM EFFECTS:** assesses the impacts (positive and negative) that the Global Fund has on the existing systems through which it works, in particular in funded countries.

**2. GRANT PERFORMANCE:** includes measures for the performance of grants and is the cornerstone of ongoing performance-based funding decisions made by the Global Fund. Together with its primary technical partners, the Global Fund developed a joint *Monitoring and Evaluation Toolkit*, which defines simplified measures across the three diseases and is available to guide grant recipients in determining their program indicators.

**1. OPERATIONAL PERFORMANCE:** includes measures for the performance of the core functions of the Global Fund and its Secretariat, including resource mobilization, grant management, proposal and grant signing, disbursements and Secretariat costs.

**GRANT PERFORMANCE – ACCELERATING RESULTS**

4. The strong evidence of program scale-up is shown in Chapters 2 and 3 of this report. From January to 1 June 2006, Global Fund-supported programs showed increased results by more than 40 percent to reach 544,000 people with antiretroviral (ARV) treatment for HIV and 1.43 million people with treatment for TB under Directly Observed Treatment, Short course (DOTS), and to distribute 11.3 million insecticide-treated bed nets (ITNs) to prevent malaria. Since the same time last year, results have more than doubled.

**SYSTEMS EFFECTS – BUILDING SYSTEMS, MAKING AID MORE EFFECTIVE**

5. The third step of the Global Fund's evaluation framework is to build systems and to work more effectively with partners. Chapter 4 of this report describes how the Global Fund has worked increasingly hard to build partnerships. It shows how

global initiatives (funding initiatives that target a particular disease or a defined set of development interventions such as Global Fund grants) can have the focus and flexibility to strengthen broader horizontal systems by supporting health systems strategies and plans. The flexibility of the Global Fund to work within a wide range of situations and with various partners – such as in Ethiopia with Global Alliance for Vaccines and Immunization (GAVI), in Mozambique with sector-wide approaches (SWAPs), with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in several countries, with multi-country grants and in fragile states – is a strong step towards collective impact.

6. At the same time, these partnerships must include progress measurement and time-bound improvements. Beginning in 2006, the Global Fund put itself at the center of the international measurement effort to improve aid effectiveness, ensuring that global initiatives are well represented: the Global Fund has been delegated responsibility for representing GAVI, the Global Environment Facility (GEF) and the Education for All Fast-track Initiative

(ETA-FTI). The Global Fund is one of the great experiments in “upstream” harmonization and pooled financing (consolidating donor finance to achieve the global scale and coordination to fight HIV, TB and malaria). At the same time, there are many challenges to “downstream” harmonization that go beyond the Global Fund and require the concerted effort of all partners.

**IMPACT – EARLY EVIDENCE OF IMPACT ON THE 5 MILLION LIVES LOST EACH YEAR**

7. The evaluation framework of the Global Fund builds towards impact, the subject of Chapter 5 of this report. The scale and performance focus of the Global Fund provide the opportunity for many donors and technical partners to collectively make an impact on the three diseases and contribute directly to the Millennium Development Goals (MDGs). AIDS, TB and

malaria account for well over five million lives lost each year, and additional morbidity and economic impacts. Chapter 5 documents steps taken to measure impact on the three diseases and shows that Global Fund grants have made significant progress towards international targets. There are some remarkable early successes and evidence of impact being seen as a result of the hard work of several Global Fund-financed programs. The challenge will be to scale up current levels of financing in order to generalize impact on the three diseases.

8. The Global Fund must learn from its challenges to increase its successes as it moves through each step from operational performance to grant performance to systems effects to impact in the coming three to five years. As an international financing mechanism, the Global Fund has the necessary scale and focus to allow donors to invest in impact on HIV, TB and malaria.



IN THE FIRST PHASE OF VIET NAM'S GRANT TO COMBAT HIV/AIDS, SUPPORTED PROGRAMS PROVIDED TREATMENT FOR OPPORTUNISTIC INFECTIONS TO MORE THAN 2,000 PEOPLE LIVING WITH AIDS, AND COMMUNITY-BASED CARE TO MORE THAN 10,000 PLWHAS.



## 2. ACCELERATING RESULTS: DOUBLING EVERY YEAR

Once people get into the rhythm, the results can really scale up. That is the way with health issues. Initially, the drug supply was the problem. Now it is all about capacity for implementation to meet the increasing demand. The Global Fund has provided the most predictable financing to support scale-up.

- RECIPIENT COUNTRY HEALTH MINISTER



LAO PDR IS CONSIDERED A HIGH-BURDEN COUNTRY FOR TUBERCULOSIS. IN PART THROUGH THE SUPPORT OF THE GLOBAL FUND, THE GOVERNMENT AIMS TO HALVE TB PREVALENCE IN LAO BY 2010 BY INCREASING DETECTION AND TREATMENT, AND BY EXPANDING TRAINING TO HEALTH WORKERS.

### ACCELERATING RESULTS

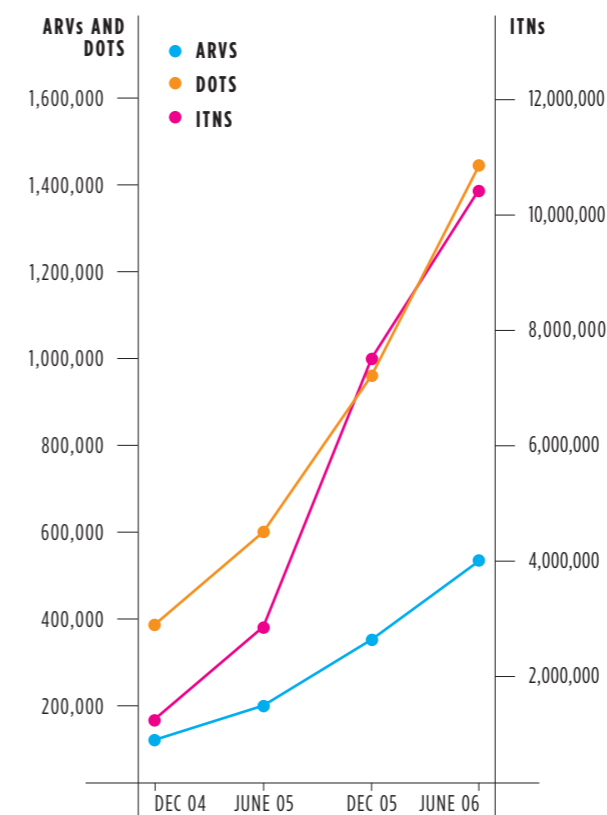


FIGURE 2: INCREASES SINCE DECEMBER 2004 IN GLOBAL FUND-FINANCED ARV THERAPY, TB TREATMENT AND ITN DISTRIBUTION

9. In the early stages of the Global Fund, progress was measured by the number of grant agreements signed (333 in 127 countries as of 15 May 2006) and the amounts disbursed (US\$ 2.26 billion by 15 May 2006). Many grants are still at an early stage - the average age of a Global Fund grant is at this point only 22 months. However, the grant portfolio is now funding services for millions of people in the fight against AIDS, tuberculosis (TB) and malaria. The results are increasing rapidly, with returns on investments doubling each year (see Figure 2).



## TOP THREE INDICATORS – MID-YEAR RESULTS

	June 2006	Percent increase since Dec 2005	Percent increase since June 2005
<b>HIV:</b> PEOPLE ON ARV TREATMENT	544,000	42%	150%
<b>TB:</b> PEOPLE TREATED UNDER DOTS	1,430,000	43%	140%
<b>MALARIA:</b> INSECTICIDE-TREATED BED NETS DISTRIBUTED	11,300,000	47%	265%

FIGURE 3: MID-YEAR GRANT RESULTS TO 1 JUNE 2006 ON THE GLOBAL FUND'S TOP THREE INDICATORS

## 2.1 OVERALL PORTFOLIO RESULTS: RAPID ACCELERATION

10. Results for the Global Fund's top three indicators have increased significantly since December 2005 and dramatically since June 2005 (see Figure 3). The number of people on antiretroviral (ARV) therapy has increased 150 percent since the same time last year, the number of people treated for TB under Directly Observed Treatment, Short course (DOTS) has increased by 140 percent, and the number of insecticide-treated bed nets (ITNs) distributed to protect families from malaria has increased by 265 percent. The scaling up of ITNs, in particular, has shown very rapid growth over the last year because once early problems in malaria grants are removed, their results can increase very quickly.

11. In addition to the top three indicators, there is a wide range of other prevention and treatment services that are measured. Further mid-year results include:

- 5.7 million people reached with HIV counseling and testing;
- 7.3 million people reached with malaria treatment;
- 560,000 orphans provided with basic care and support;
- 12 million people reached with community outreach activities;
- 1.5 million people trained to deliver services for the prevention and treatment of AIDS, TB or malaria;
- 4,395 people treated for multidrug-resistant TB (MDR-TB).

12. The Global Fund's performance-based funding model has introduced a focus on results to each country it funds, supporting the continued attention to performance by making each financial disbursement dependent on satisfactory results. This model holds implementing partners accountable to those who need health services. Grant funding is not "owned" by the people and organizations managing or implementing programs, and it can be lost if it is not efficiently managed and used to reach people in need of services.

## 2.2 ACHIEVING RESULTS: COUNTRY EXAMPLES

13. The above results show only the surface of the work required to scale up prevention and treatment programs in countries. This requires continual synergy between committed systems building and service delivery, which Global Fund financing supports. The rapid acceleration of programs in many countries is illustrated by the direct experiences of fighting malaria in Ethiopia, HIV in the United Republic of Tanzania and TB in China. These experiences provide some context to the analysis of grant performance in this report.

### 1. MALARIA IN ETHIOPIA: FROM DEFENSIVE TO OFFENSIVE IN 12 MONTHS

**Malaria needs hitting hard with a blow ... the Global Fund allowed us to move from the defensive to the offensive.**  
- RECIPIENT COUNTRY HEALTH MINISTER

14. In June last year, the Ethiopian Principal Recipient (PR) of a Global Fund grant had not yet delivered any ITNs despite a target of two million bed nets. This was in part due to procurement bottlenecks and supply-side constraints on the availability of long-lasting insecticidal nets (LLINs). As part of the evaluation of its Phase 1 performance at about the 18-month mark, this grant was approved for continued funding on the condition that it deliver two million ITNs to people in need before the next malaria season.

15. The urgency of these conditions provided clear incentives for the country to come up with innovative solutions to solve the problems that were slowing down program implementation. They requested technical support from the United Nations Children's Fund (UNICEF), increased their procurement office capacity and removed delays in the supply chain. Performance-based funding provided major incentives to focus the efforts of the program to tackle problems. Two million ITNs were distributed within four months and before the malaria season. Other results included:

- 4,416 health workers were trained on ITN use (target 1,798);
- 5,222 health workers were trained on malaria diagnosis and treatment (target 1,758);
- Two million artemisinin-based combination (ACT) treatment doses were distributed to target districts;

- 50 percent of target districts developed an epidemic preparedness plan.

16. Given the establishment of robust systems, the Ethiopian PR now intends to deliver an additional seven million ITNs in 2006 and move to cover 60 percent of the population at risk, in line with the Millennium Development Goals (MDGs). Given its current level of performance, the budget for 2006 has been accelerated by the Global Fund to allow rapid scale-up of the response in order to achieve impact. This is a good example of a malaria grant which can be slow to get started in Phase 1, but can then catch up rapidly once initial problems are solved.

17. Within 16 months, there is a strong chance that the grant will go from inadequate performance to the full achievement of its targets, to achieve impact on levels of malaria-related illness and death. As the PR stated, "Next year we will see whether we can shatter malaria. What I like is that the Global Fund has been flexible. If it wasn't, we couldn't have achieved the two million ITNs. By being flexible, you save lives. It makes you innovative, you can take the shortest path to reach the beneficiary and show results."

### 2. HIV IN THE UNITED REPUBLIC OF TANZANIA: SCALING UP HIV TREATMENT BY TWO TO FOUR TIMES IN 2006

**We need to move closer to the people, but as you move down the system, human resources become more of a problem. With large hospitals, you can shift resources and putting people on ARV treatment can release hospital beds and resources, but at the lower level, resources are simply not there. The pharmacists, the lab technicians ... we need to put together the teams.**

- PRINCIPAL RECIPIENT FOR TANZANIA

18. The Global Fund grants in the United Republic of Tanzania cover a range of implementing agencies including the Ministry of Finance and Health, African Medical and Research Foundation (AMREF), Population Services International (PSI) and Pact. Using a range of public, private and civil society implementers ensures a comprehensive scaling-up of the HIV response in the United Republic of Tanzania, including an ambitious plan for HIV treatment.





GRANT-SUBSIDIZED CAFETERIAS IN ULAANBAATAR, MONGOLIA PROVIDE DAILY HOT LUNCHES TO PATIENTS COMING FOR TREATMENT, AND ALSO SERVE AS A DOTS SERVICE DELIVERY POINT.

19. So far in 2006, grant-funded programs have increased the number of people on ARV treatment from 19,000 to 32,000 – an increase of almost 70 percent. Over 50,000 patients have been enrolled on treatment, the majority of whom are symptomatic. Just as importantly, program implementers are building the systems with Global Fund money – and that of partners, including the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) – to bring treatment from the national and district levels to the local level of the health system to reach 200 health facilities. This will allow from two to four times more people to be reached in 2006, and the country has set the ambitious target of 100,000 people on treatment by the end of 2006.

20. The major challenge is human resources, particularly at the local level. The Global Fund has requested a human resources plan and will re-program some of its resources to ensure that the gaps are filled so that the country’s ambitious scale-up plan to increase ARV treatment can occur in 2006. So that he can manage such a scale-up, respond rapidly and ensure that people receive services, the Tanzanian Chief Medical Officer requests an ARV results update every 15 days. The ambition to scale up, build systems and provide focused management is a good example of the incentives provided by performance-based funding.

21. The HIV program goes far beyond treatment, and country ownership has been an important ingredient in HIV prevention. As one health worker commented, **“There is behavior change. We have not done enough studies, but for us living here in Tanzania, things have changed since the 1990s.”** There are now encouraging signs of modest declines in HIV prevalence from 10 percent to 7 percent in the United Republic of Tanzania. The Global Fund is contributing to the studies required to confirm any trends and show impact over the medium term.

### 3. TB IN CHINA: REACHING INTERNATIONAL TB TARGETS IN 2006

**We knew at the start that the Global Fund was hugely ambitious to deal with one hundred-plus countries. Given the challenges, it has exceeded all expectations, no one would have seen it possible to do with Global Fund money what has been done.**  
**– PRINCIPAL RECIPIENT FOR CHINA**

22. China has the second-highest TB burden in the world after India. The total funds available for the country’s national TB program have increased 2.6 times since 2002 with significant contributions from the Global Fund as well as rapid increases in domestic spending. Global Fund financing has also helped scale up the country’s TB response by improving human resource capacity and supporting infrastructure (including by funding the provision of microscopes, x-ray machines and computers) from provincial levels right down to the county and local levels of the health system.

23. The program has shown rapid increases from its baseline at the start of the project (see Figure 4), reaching international targets for DOTS coverage, case detection and treatment success by 2006:

- **Increase in DOTS coverage rate from 56 percent to 100 percent;**
- **Increase in case detection under DOTS from 45 percent to 78.7 percent (compared to a 70 percent international target);**
- **Achievement of a 91 percent treatment success rate (compared to an 85 percent international target).**

24. There are early signs that TB prevalence may be falling in China. However, major challenges remain, including the interaction of TB with the country’s growing HIV epidemic.

25. As the PR in China commented, **“It was very important for China to reach the global targets in the 24 provinces (funded by the Global Fund grant). China has achieved the global target and kept its promise, for which the Global Fund made a great contribution.”**

#### REACHING INTERNATIONAL TB TARGETS IN CHINA

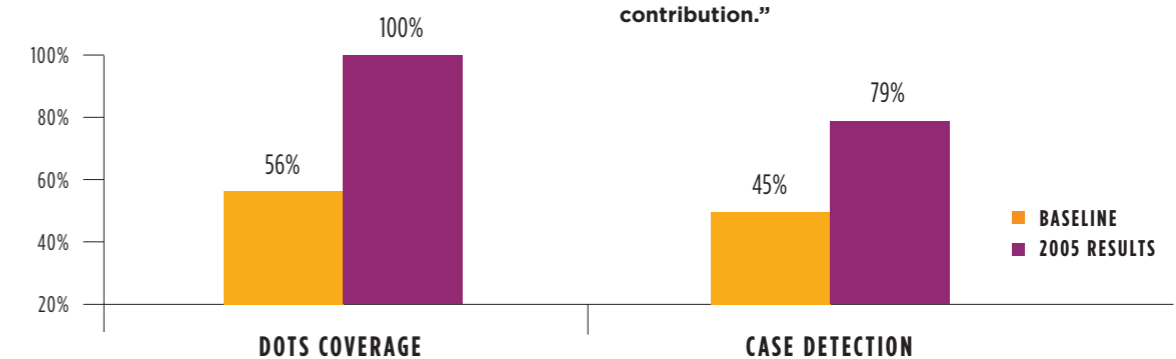


FIGURE 4: THE INCREASE IN DOTS COVERAGE AND CASE DETECTION RATES IN 24 PROVINCES IN CHINA FINANCED BY THE GLOBAL FUND



## 2.3 PERFORMANCE SYSTEMS – THE RELIABILITY OF RESULTS

26. There is still considerable work required to build strong performance and monitoring systems in most countries. The Global Fund recommends that grant recipients invest five to ten percent of funds to build monitoring and evaluation (M&E) systems as a basis for grant management and to ensure quality data for performance-based funding decisions by the Global Fund.

27. Grant-funded programs go through a number of checks and safeguards to ensure the quality of programmatic data:

- I. Initial M&E assessment before grant agreement signing.
- II. PR management assessment.
- III. Two to four independent Local Fund Agent (LFA) verifications of programmatic data each year with occasional site visits.
- IV. Comprehensive review after 18 months of implementation as part of the Phase 1 evaluations process, including reviews by the Country Coordinating Mechanism (CCM), LFA and the Strategic Information and Finance units of the Global Fund Secretariat.
- V. Working closely with partners to organize M&E technical support through the joint partner coordinating facility for M&E, and development of data quality and audit tools.
- VI. Joint partner data sharing; partners have agreed on common simplified indicators as part of the second edition of the *Monitoring and Evaluation Toolkit* (published in January 2006). Partners also share data in regular international meetings to identify concerns, inconsistencies, overlap and plan strengthening measures.

28. Three important additional strengthening measures are being rolled out in 2006:

- **On-site programmatic spot checks by LFAs of selected indicators for all grants in 2006 to ensure people are receiving services;**
- **Implementation of an M&E self-assessment checklist through national partner stakeholder**

**meetings to identify and budget for M&E strengthening measures for all grants by the end of 2007;**

- **Comprehensive data quality audits (DQA) of M&E systems and data for ten percent of grants.**

29. The Global Fund also strongly supports the harmonizing principles of the “Three Ones” initiated by Joint United Nations Programme on AIDS (UNAIDS) – **one** agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; **one** national AIDS coordinating authority, with a broad-based multi-sectoral mandate; and **one** agreed country-level M&E system.

30. An excellent example of harmonization on data has been the effort of major partners – PEPFAR, the World Health Organization (WHO), UNAIDS, World Bank, UNICEF – to share data on ARV treatment, country by country. On the basis of these data-sharing meetings, the Global Fund has produced regional breakdowns of its ARV figures consistent with partner figures. The Global Fund uses national program outcomes of people currently on ARV treatment but only counts them when:

- **The Global Fund grant supports an essential element of ARV treatment on a national scale;**
- **The grant-funded program is performing adequately and there are no significant data quality issues;**
- **Financial contributions by the Global Fund are significant (over US\$ 10 million);**
- **Overlap is compared to PEPFAR and WHO results on a country-by-country basis to finalize consistent partner figures.**

31. Global Fund-financed ARV results are shown in the map in Figure 5. Country-by-country results are available in Grant Performance Reports (available on the Global Fund’s website at [www.theglobalfund.org](http://www.theglobalfund.org)), and summarized in Appendix 1 of this report, which also provide answers to commonly-asked questions on the reliability of data.

## REGIONAL DISTRIBUTION OF GLOBAL FUND MID-YEAR RESULTS

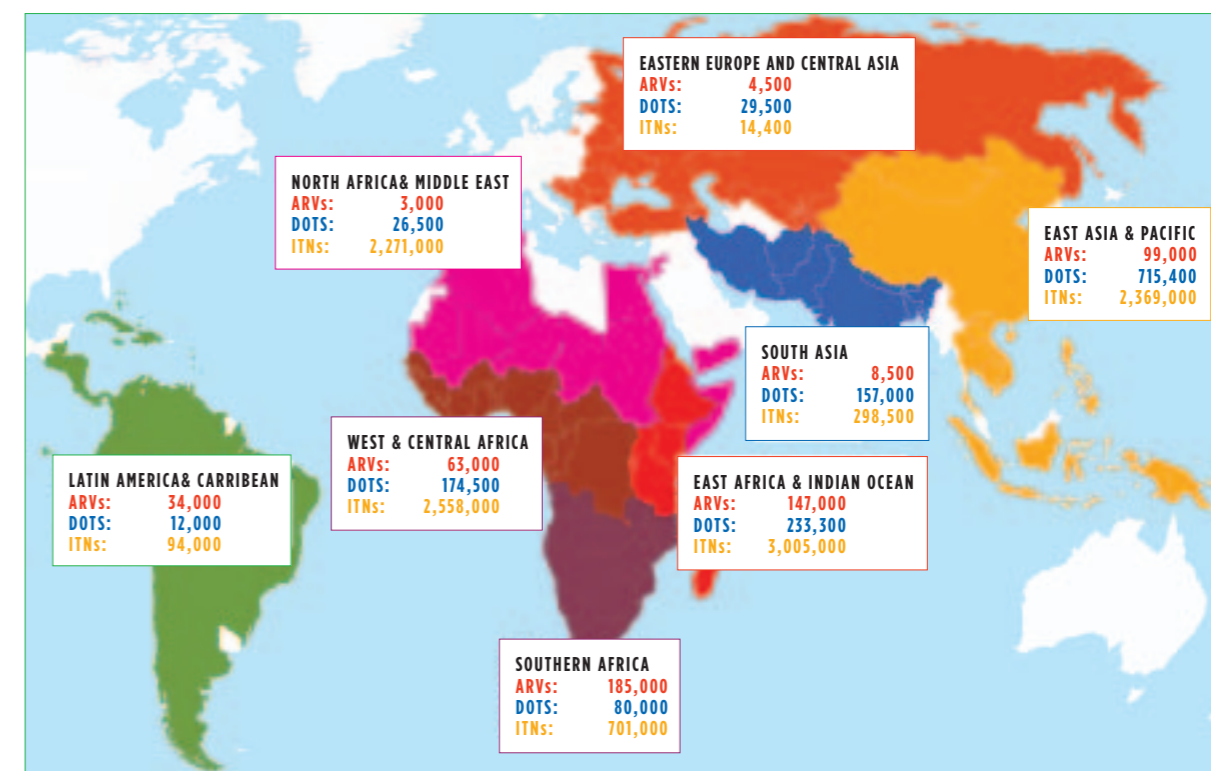


FIGURE 5: THE GLOBAL FUND’S MID-YEAR RESULTS FOR PEOPLE ON ARV THERAPY, ITNS DISTRIBUTED AND TB TREATMENT UNDER DOTS

## GLOBAL FUND RESULTS AGAINST 2006 TARGETS

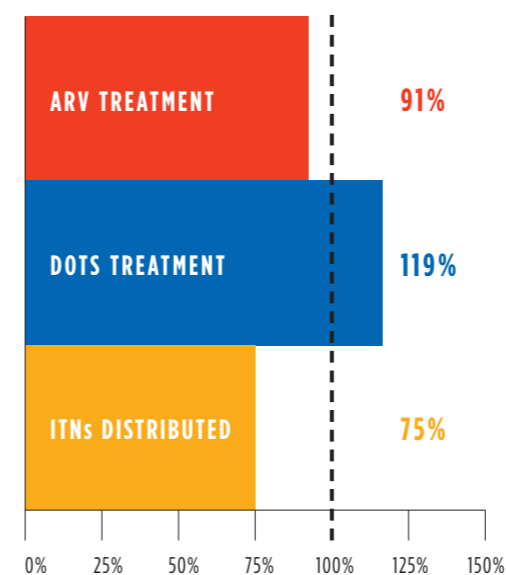


FIGURE 6: THE PERCENTAGE OF YEAR-END TARGETS FOR 2006 REACHED BY MID-YEAR

## 2.4 DOUBLING RESULTS TO REACH TARGETS

32. The rapid growth in Global Fund-financed results means that excellent progress has been made towards the targets set for the grant portfolio as a whole in 2006. These portfolio targets comprise the targets set out in all Global Fund grant agreements for the top ten programmatic indicators. At the mid-year point, DOTS treatment targets for 2006 have already been met, and ARV and ITN results have already reached 91 percent and 75 percent of year-end targets, respectively (see Figure 6).



## 87.5 PERCENTAGE OF OVERALL PROGRAMMATIC TARGETS ACHIEVED

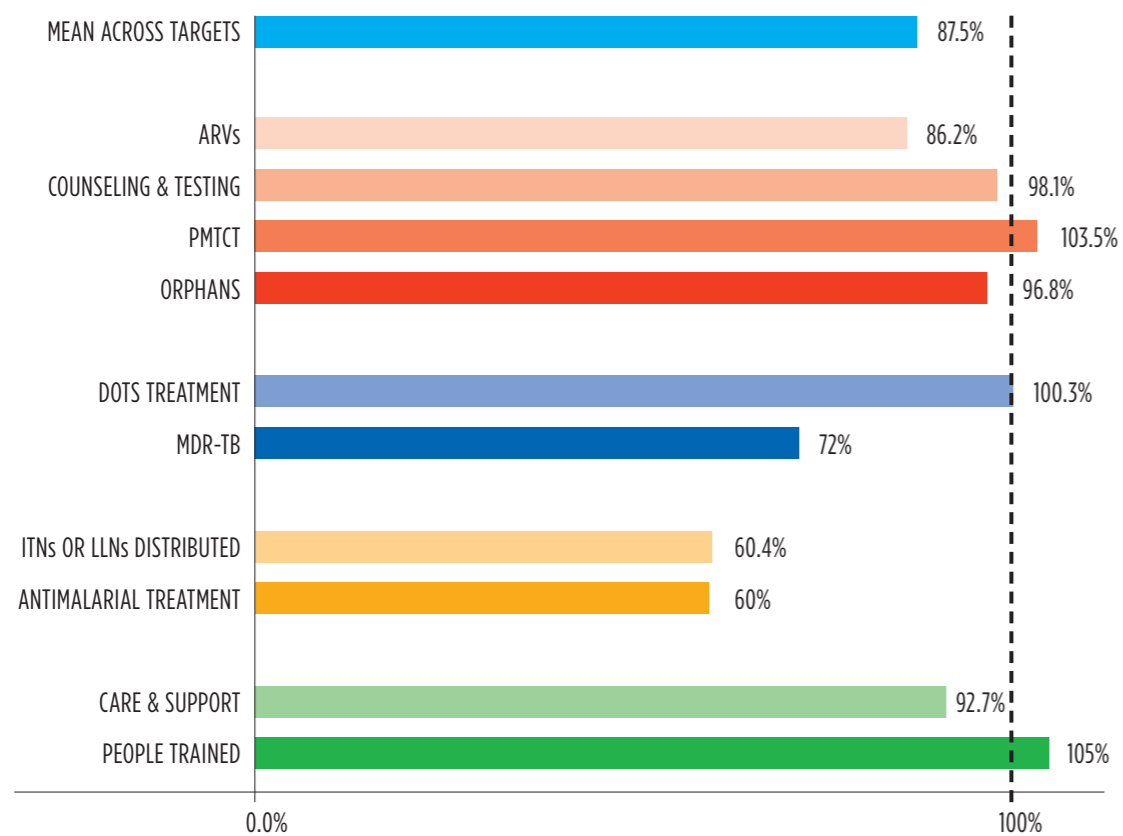


FIGURE 7: RESULTS AGAINST TARGETS FOR THE TOP TEN PROGRAMMATIC INDICATORS OF 140 GRANTS THAT HAD REACHED THE 18-MONTH MARK AS OF 15 MAY 2006

33. As described later in Chapter 5, targets are country driven and, when added together, are relatively ambitious, contributing significantly to global targets for ITN coverage and TB treatment. Scaling up of ARV treatment to reach universal access for those in need will require considerable additional financing not currently covered by the Global Fund portfolio.

34. An analysis of 140 Global Fund grants evaluated at the 18-month mark for continued funding shows results against targets across a wide range of service delivery areas. Overperforming grants tend to compensate for the minority of grants that underperform. Across the top ten indicators, the mean performance against targets is 87.5 percent (see Figure 7).

35. The results of HIV treatment, prevention and care in these grant-funded programs ranged from 86 to 104 percent, providing evidence of the scale-up of a comprehensive HIV response. In addition, capacity building through training showed strong performance in reaching 105 percent of targets (this consisted of 103 percent for health and 107 percent for non-health service deliverers trained). Standard TB treatment

targets were reached. MDR-TB treatment results showed satisfactory performance of 72 percent of targets reached, with room there for improvement. (Only six of the 140 grants evaluated included a MDR-TB component). Round 5, which included 24 approved proposals for TB, will be particularly important for boosting the TB response in general and MDR-TB in particular in future.

36. Malaria grants evaluated after 18 months performed below targets on both ITN distribution and malaria treatment, reaching 60.4 percent and 60 percent of targets, respectively. The analysis of this subset of malaria grants included grant evaluations dating back to January 2005 and reflects the delays that can occur early in malaria programs. Procurement delays, particularly for ACTs and LLINs, can slow the performance of malaria grants during Phase 1. However, when these problems are solved, very rapid catch-up of results can occur. If the results of the delayed Ethiopian malaria grant (see section 2.2, "Achieving results: country examples"), which caught up in four months, were included in these ITN distribution results, the total would increase from 60.4 percent to 94 percent of targets reached.



A WOMAN IS STANDING WITH HER THREE CHILDREN IN FRONT OF THEIR INSECTICIDE-TREATED BED NET IN THEIR HOME IN THE VILLAGE OF JAMBIANI, ZANZIBAR. ZANZIBAR HAS BEEN FEARED FOR ITS DEADLY MALARIA FOR CENTURIES. WITH GRANTS FROM THE GLOBAL FUND AND OTHER DONORS, ZANZIBAR'S HEALTH AUTHORITIES BELIEVE MALARIA CAN BE BROUGHT UNDER CONTROL OVER THE COMING FIVE YEARS.



## 2.5 SUSTAINABLE FINANCING TO ACCELERATE RESULTS IN THE FUTURE

37. Current results still fall far short of those needed to match the threat of the three diseases and to rise to the challenge of universal access to ARV therapy and the MDGs. Sustainable financing is required to maintain the results of the hard work of funded programs and to scale them up.

38. The Global Fund has shown itself to be an efficient mechanism for disbursing funds. Approximately 99 cents of every dollar raised by the Global Fund goes directly to grants. Grant funds are disbursed to PRs relatively quickly and in line with

time elapsed in the grant's lifespan (see Figure 8). Global Fund grants are disbursed incrementally based on program performance and triggered by periodic disbursement requests from recipients and verified progress reports. As of 15 May 2006, 64 percent of committed grant amounts had been disbursed, in line with 69 percent of grant lifespans elapsed. Given that roughly the same percentage of the grant amount should be disbursed as the percentage of the grant lifespan that has elapsed, this is 93 percent of expected disbursements based on grant age.

### APPROVALS, COMMITMENTS AND DISBURSEMENTS TO 15 MAY 2006 US\$ MILLIONS

ROUND	DATE	APPROVED	SIGNED	DISBURSED	MEAN TIME ELAPSED	MEAN PERCENT DISBURSED	DISBURSEMENT / TIME
1	April 2002	1,302	1,022	641	78%	71%	91%
2	January 2003	1,510	1,112	743	76%	69%	91%
3	October 2003	785	615	412	77%	71%	92%
4	June 2004	1,014	1,014	412	51%	48%	94%
5	September 2005	777	268	53	8%	39%	488%
<b>TOTAL</b>		<b>5,388</b>	<b>4,032</b>	<b>2,261</b>	<b>69%</b>	<b>64%</b>	<b>93%</b>

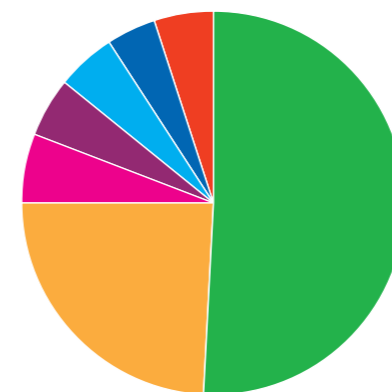
FIGURE 8: FINANCIAL STATUS OF THE GLOBAL FUND – APPROVALS, COMMITMENTS AND DISBURSEMENT BY FUNDING ROUND AND TOTAL

39. Resources from the Global Fund go to a wide range of implementing agencies and activities at the PR and sub-recipient levels: approximately 50 percent of funds are budgeted for commodities, 50 percent for capacity building (including 22 percent for human resources and training and 11 percent for physical infrastructure) (see Figure 9). The LFA and PR monitor sub-recipient spending, but it is not routinely captured by the Global Fund. The available evidence, however, suggests relatively high expenditure rates at the sub-recipient level. Of the 91 grants with sub-recipient

information at the point of Phase 1 evaluation, the expenditure rate was 63 percent (with an estimated 14 percent in additional legal or contractual commitments, such as procurement orders). This is similar to the results in 2005, which showed an expenditure rate of 67.8 percent (with an estimated 14 percent in additional legal or contractual commitments). This demonstrates a very strong level of financial expenditure by grant recipients, particularly as the Global Fund provides a cash buffer to grants to ensure that funds do not run short.

### IMPLEMENTING ENTITIES

- GOVERNMENT 51%
- NGOs AND CBOs 24%
- FBOs 6%
- PRIVATE SECTOR 5%
- ACADEMIC 5%
- COMMUNITIES 4%
- OTHER 5%



### TYPE OF EXPENDITURE

- COMMODITIES, PRODUCTS, DRUGS 48%
- HUMAN RESOURCES 22%
- ADMINISTRATION 11%
- INFRASTRUCTURE AND EQUIPMENT 11%
- MONITORING AND EVALUATION 2%
- OTHER 6%

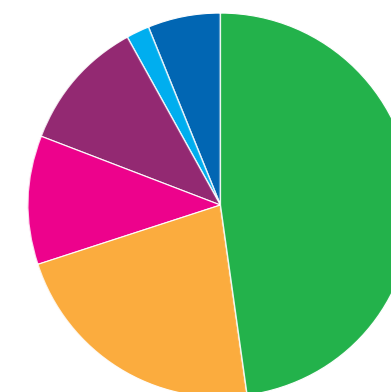


FIGURE 9: DISTRIBUTION OF GLOBAL FUND PORTFOLIO BY IMPLEMENTING ENTITY (LEFT) AND TYPE OF EXPENDITURE (RIGHT) AS OUTLINED IN TWO-YEAR BUDGETS SUBMITTED IN INITIAL APPROVED PROPOSALS (ROUNDS 2-5 ONLY).

40. The scope of activities and expenditures support the important synergies between capacity building and service delivery, which allow the Global Fund to finance sustainable results for the future. These investments aim to support the annual targets set for the portfolio through 2009 and sustain accelerated scale-up (see Figure 10).

41. The Global Fund's mid-year results show that overall, grant-funded programs are putting the money to work, with results more than doubling since the same time last year. Despite continued challenges – for example, for malaria treatment in the early stages

of grants – the performance in the portfolio is strong overall. The Global Fund is already contributing significantly to international results and targets through its grant-funded programs. The first steps towards impact on the three diseases are in place.

42. However, a long-term vision and sustainability of financing for the Global Fund are crucial for the international community to be able to rise to the challenge of the goals it has set itself. The results of the Global Fund portfolio so far show that it provides a unique opportunity to significantly scale up the global response to AIDS, TB and malaria and invest in impact.

### GLOBAL FUND TARGETS, 2004–2009

	2004	2005	2006	2007	2008	2009
HIV: ARV TREATMENT	125,000	350,000	600,000	875,000	1,200,000	1,600,000
TB: DOTS TREATMENT	300,000	700,000	1,200,000	1,800,000	2,600,000	3,500,000
MALARIA: ITNs DISTRIBUTED	2,000,000	5,000,000	15,000,000	30,000,000	60,000,000	100,000,000

FIGURE 10: ANNUAL TARGETS FOR THE TOP THREE PROGRAMMATIC INDICATORS IN THE GLOBAL FUND GRANT PORTFOLIO, 2004-2009



## 3. INVESTING IN PERFORMANCE: THE MONEY AT WORK

What made the difference is that you gave us a clear warning that we were in the red zone, that we could lose our money if we didn't deliver results. We looked at it, we could focus, and we both saw the problem, and that was the adjustment we made to get the results. Performance-based funding helped us think through implementation.

- TEDROS ADHANOM GHEBREYESUS, MINISTER OF HEALTH FOR ETHIOPIA

43. Performance-based funding ensures that grant funds are accountable to the people in need of services and not owned by the international, national or local agencies that provide the services. It is in keeping with the innovative governance arrangements of the Global Fund, which puts the voices of those affected by the diseases to the forefront. It also provides important performance incentives and focus to identify problems, develop solutions and boost implementation. Overall, the aim is to ensure the money works for those who need it.

44. Performance-based funding aims to gear financing to the pace of implementation, not to a fixed calendar. If grants are implementing slower than planned, funds can be taken from their budgets and reallocated. If implementation is faster, funds can be accelerated. The investment in Phase 2 grants has been remarkable, equivalent already to twice the funds committed to all grants approved in Round 5. The "savings" or reallocated funds have been used immediately, funding the equivalent of over one-third of new grants in Round 5.

45. The review of the first phase of funding of Global Fund grants also provides an opportunity to learn valuable lessons from performance-based funding and program implementation.

**What can we learn from the variations in performance by region, disease and Principal Recipient (PR)?**

**Can we rely on the data and performance systems for these investment decisions?**

**Does performance-based funding penalize poorer countries?**

**Does it work in fragile states?**

**Does the demand-driven approach to financing support the right areas?**

**Can we learn from performance to fund strengthening measures?**

46. This chapter analyzes the results and learns from some of the difficult questions it raises. A remarkable 140 difficult investment decisions have been made based on Phase 1 performance. Many healthy tensions have come to the surface, but ultimately US\$ 1.5 billion has been invested in performance.

PEOPLE COLLECT THEIR INSECTICIDE-TREATED BED NETS PROVIDED BY SARVODAYA, ONE OF SRI LANKA'S LARGEST NGOS. FUNDING FOR THIS NGO IS PART OF THE GLOBAL FUND'S SUPPORT FOR THE COUNTRY'S EFFORTS TO FIGHT MALARIA, WORTH ALMOST US\$ 11 MILLION OVER FIVE YEARS.

DONATED BY  
THE GLOBAL FUND  
TO FIGHT  
AIDS TUBERCULOSIS AND MALARIA  
DISTRIBUTED WITH THE  
SARVODAYA



### 3.1 A MAJORITY OF GRANTS PUT THE MONEY TO WORK

47. Performance-based funding brings many of the challenges of implementation to the surface. This allows countries and partners to respond to them in a transparent manner, though it runs the risk that partners focus on “problem grants” and do not give credit to the 75 percent of grants that are performing well and are putting the money to work.

48. Of the 140 grants that have been evaluated (see Figures 11 and 12), 75 percent met or exceeded targets (rated A or B1), 21 percent showed inadequate performance but documented potential (rated B2) and four percent met unacceptable targets (rated C). The most difficult investment decisions were in the 21 percent of grants rated B2, due to the difficulty in assessing their potential. Strong incentives and technical support are required to increase the percentage of A-rated grants (21 percent of the 140 grants), as this is where rapid scale-up can be unleashed.

#### 75 PERCENT OF GRANTS ARE PERFORMING

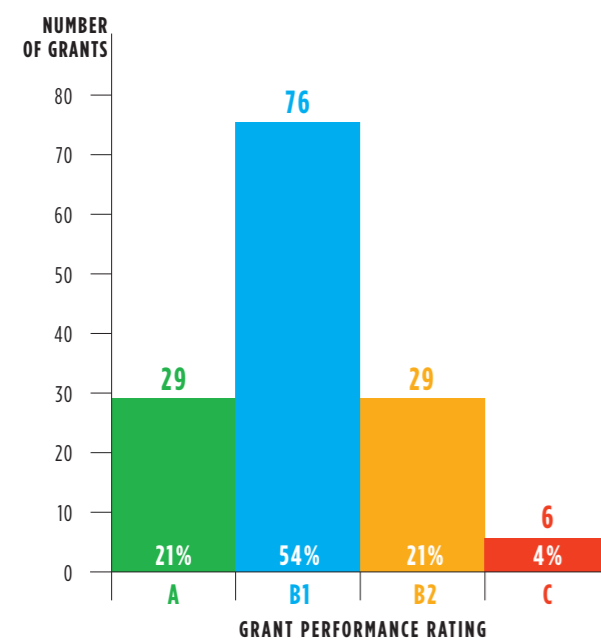


FIGURE 11: PROGRAMMATIC PERFORMANCE FOR TOP INDICATORS WHEN EVALUATED FOR PHASE 2 FUNDING

### 3.2 ACHIEVING OVERALL PROGRAMMATIC TARGETS

49. The 140 grants evaluated as of 15 May 2006 for Phase 2 funding had achieved significant programmatic results, including:

- 194,000 people reached with antiretroviral (ARV) treatment;
- 3.3 million insecticide-treated bed nets (ITNs) distributed;
- 701,000 people treated for tuberculosis (TB) under DOTS;
- 3.3 million people counseled and tested for HIV;
- 218,000 orphans provided with care and support services;
- 3.9 million people treated for malaria.

50. There were still relatively low numbers treated for multidrug-resistant TB (MDR-TB) (1,762 people). Round 5 TB grants approved in late 2005 will significantly scale up this intervention.

### COUNTRIES AND GRANTS EVALUATED FOR PHASE 2 FUNDING

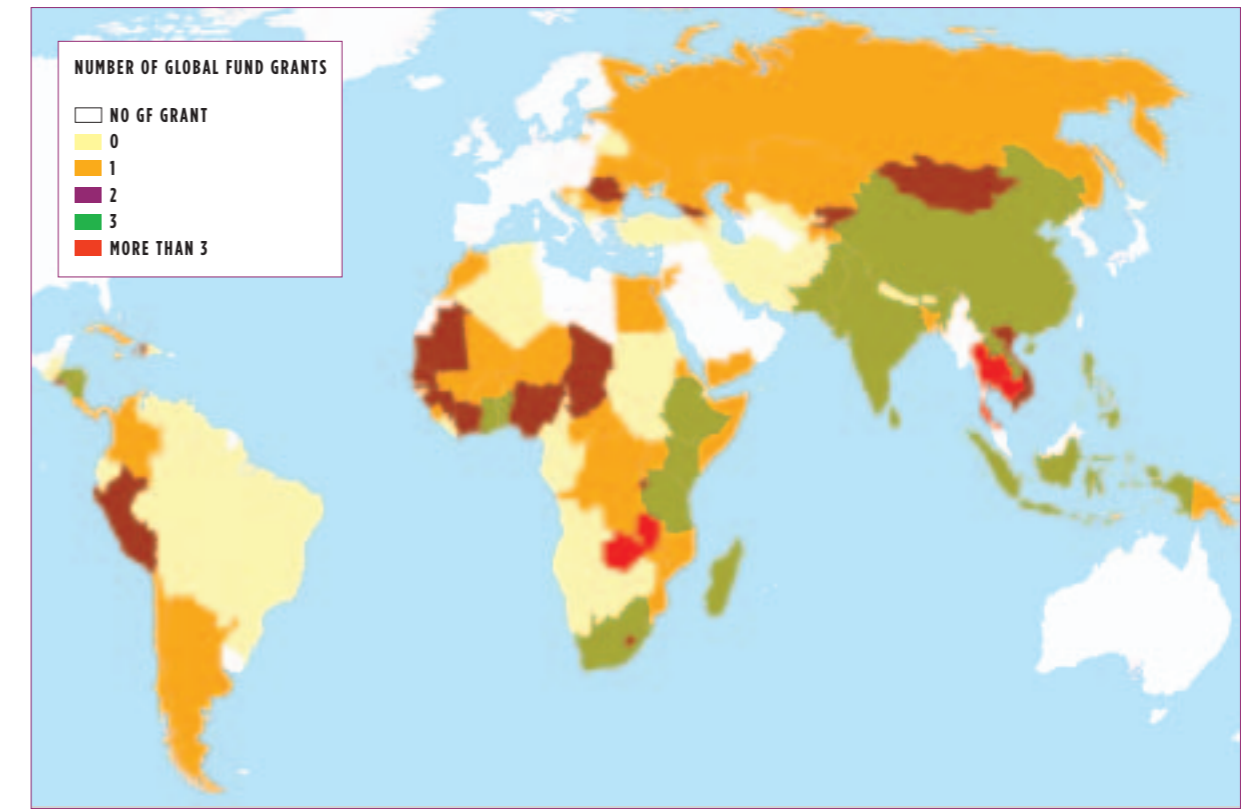


FIGURE 12: MAP OF COUNTRIES WITH GRANTS THAT HAVE GONE THROUGH EVALUATIONS FOR PHASE 2 FUNDING (TYPICALLY FOR YEARS THREE TO FIVE OF THE GRANT LIFESPAN)

51. Analysis of the 140 grants against their targets showed that the mean performance across the top programmatic areas was 87.5 percent, varying from 60 to 105 percent (see Figure 13). Performance was very strong for HIV treatment (86 percent), prevention (85 percent) and orphan care (97 percent), TB treatment (100 percent) and training of service deliverers for the three diseases (105 percent). Performance was lower for ITN distribution and treatment due to delays at the early stages of some grants. However, several of these grants were able to catch up after strong time-bound conditions were placed on them at the time of Phase 2 funding approval. For example, if Ethiopia’s results in delivering ITNs four months after its program evaluation were included, the collective performance would increase from 60 percent to 94 percent of targets met. This shows the importance of performance-based funding for identifying implementation issues so that they can be dealt with by partners and countries transparently to boost results.

#### PROGRAMMATIC RESULTS AGAINST TARGET

INDICATOR	RESULT	TARGET	RATIO
ARVs	193,914	224,961	86.2%
COUNSELING AND TESTING	3,315,270	3,379,356	98.1%
PMTCT	85,382	82,519	103.5%
ORPHANS	217,956	225,135	96.8%
CARE AND SUPPORT	327,025	352,818	92.7%
DOTS TREATMENT	701,347	699,276	100.3%
MDR-TB	1,762	2,447	72%
ITNs OR LLINs DISTRIBUTED	3,338,996	5,529,390	60.4%
ANTIMALARIAL TREATMENT	3,921,462	6,537,607	60%
PEOPLE TRAINED	526,787	501,692	105%

FIGURE 13: PROGRAMMATIC PERFORMANCE FOR TOP INDICATORS AT THE TIME OF EVALUATION FOR PHASE 2 FUNDING



### 3.3 INVESTING IN PERFORMANCE

52. The 140 grants evaluated for Phase 2 funding represent programmatic results financed by total disbursements of almost US\$ 1 billion in 84 countries. Phase 2 decisions provide the opportunity to commit funds on the basis of proven performance. A total of US\$ 1.5 billion was approved in Phase 2 funding for 135 of the grants, with 81 percent of the funds going to A- or B1-rated grants that showed satisfactory to excellent performance. The remaining 19 percent of approved continued funding involved difficult investment decisions on the basis of inadequate or unacceptable performance but documented potential (B2/C-rated). All of these grants had Board-mandated conditions on their continued funding to ensure that the programs worked hard to catch up on performance, as illustrated by the Ethiopia malaria example in section 2.2.

53. Grantees make requests for continued funding, but the full amount requested may not be approved for a number of reasons, including slow expenditure

levels during Phase 1, revised (and reduced) budgets or grant termination (known as a “NO-GO” decision). US\$ 300 million (or 16.2 percent) of funding requested by grant recipients to 15 May 2006 was reallocated to other grants, with 10.5 percent reallocated because of slow expenditure rates or reduced budgets and 5.7 percent due to grants terminated as a result of poor performance (see Figure 14).

54. The decision to reduce the approved Phase 2 amount is also made on the basis of performance, supporting the commitment that grant funding must go to programs that are reaching people with services. Seventy-five of these Phase 2 reductions were from B2- or C-rated grants with inadequate or unacceptable performance. Overall, A-rated grants received most of their full Phase 2 proposal amounts, B1-rated grants had six percent of their proposal amounts reduced, B2-rated grants lost 38 percent and C-rated grants lost 90 percent (see Figure 15).

55. Phase 2 funding is an investment in performance. Figure 16 shows that as a result of Phase 2 funding decisions made up to 15 May 2006, Global Fund investments shifted towards grants with proven results. Seventy-two percent of the total proposal amounts went to A- and B1-rated grants.

#### FUNDING IMPLICATIONS OF PHASE 2 DECISIONS (US\$)

ORIGINAL GRANT PROPOSAL	1,848,374,094	100.0%
<b>BOARD-CONFIRMED AMOUNT</b>	<b>1,548,917,445</b>	<b>83.8%</b>
TERMINATED GRANTS	104,893,133	5.7%
BUDGET REDUCTIONS	194,563,516	10.5%
<b>OVERALL REALLOCATED FUNDS</b>	<b>299,456,649</b>	<b>16.2%</b>

FIGURE 14: BREAKDOWN OF BOARD-APPROVED AND -DECLINED PHASE 2 AMOUNTS TO 15 MAY 2006

#### FINANCIAL DECISION BASED ON PERFORMANCE (US\$)

	BOARD CONFIRMED PHASE 2 AMOUNTS	% NO GO DECISIONS	TOTAL REALLOCATED (NO GOs AND BUDGET REDUCTIONS)	% REALLOCATED
<b>A</b>	350,676,366	0%	13,324,819	3.7%
<b>B1</b>	906,066,142	0%	61,086,758	6.3%
<b>B2</b>	286,460,652	12.2%	174,246,503	37.8%
<b>C</b>	5,714,285	86.5%	50,798,569	89.9%
<b>OVERALL</b>	<b>1,548,917,445</b>	<b>5.7%</b>	<b>299,456,649</b>	<b>16.2%</b>

FIGURE 15: TABLE OF PHASE 2 AMOUNTS BY PERFORMANCE CATEGORY

After Phase 2 approval, 81 percent of grant funds were invested in A- and B1-rated grants (see Figure 16 below).

56. Phase 2 is only one point in the performance-based funding cycle. Funding decisions are also made throughout the grant lifespan, disbursement by disbursement. It is, therefore, encouraging to see that overall, periodic disbursement decisions made before the point of evaluation for Phase 2 funding also reflect performance (see Figure 17). A-rated grants had received 89 percent of their Phase 1 grant amounts by the time of evaluation for Phase 2 funding (above the 83 percent expected at month 20 when evaluation for Phase 2 occurs). B1-rated grants had received 85 percent, B2-rated grants 74 percent and C-rated grants 61 percent of their Phase 1 budgets. This shows a clear correlation between periodic disbursements and performance ratings.

57. In addition, a new disbursement decision-making tool has been implemented to document the performance basis for ongoing disbursement decisions. An early analysis also shows a correlation between performance and disbursements for the 202 grants reporting disbursement ratings so far in 2006, as shown in Figure 17. (A-rated grants had received 79 percent, B1-rated 72 percent, B2-rated 64 percent and C-rated 38 percent).

### 3.4 LEARNING FROM VARIATIONS IN GRANT PERFORMANCE

58. An essential element of the Global Fund’s performance-based system is that at each stage of the grant implementers and partners can identify issues transparently and take corrective action. The Global Fund is a network organization relying on a system of partners, rather than implementing directly itself. To mobilize the power of this network, it is essential that the Global Fund shares its lessons learned on grant financing and performance.

#### SHIFTING INVESTMENT TO PERFORMANCE

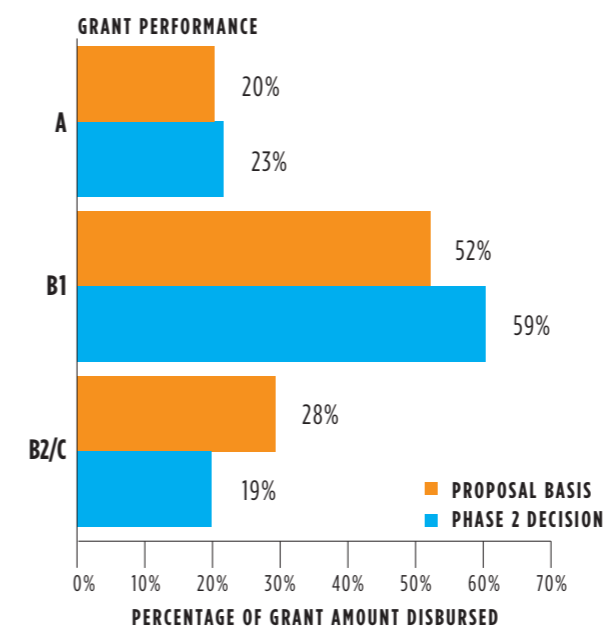


FIGURE 16: PHASE 2 INVESTMENTS FOLLOW PERFORMANCE

#### DISBURSEMENT DECISIONS REFLECT PERFORMANCE

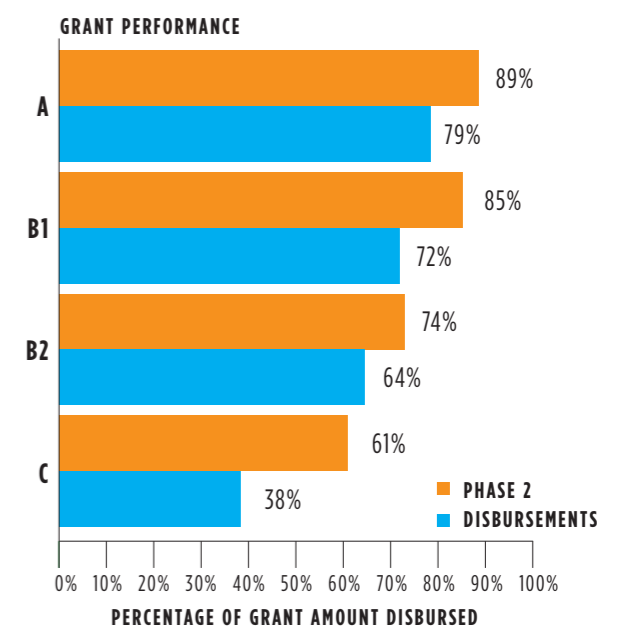


FIGURE 17: PERCENTAGE OF GRANT AMOUNTS DISBURSED IN PHASE 1 COMPARED TO PHASE 2 BY PERFORMANCE CATEGORY

### 3.4.1 BOTTLENECKS IN GRANT PERFORMANCE

59. The Grant Performance Reports for each grant are available on the Global Fund's website at [www.theglobalfund.org](http://www.theglobalfund.org), showing overall goals, time-bound targets, financial information and assessments of progress for each disbursement. Partners are encouraged to consult these reports to assess the status of individual grants.

60. A number of common bottlenecks have emerged from Phase 2 analysis. These vary by disease. Malaria grant-funded programs often show initial delays due to procurement capacity and limited or slow international supply of artemisinin-based combination (ACT) drugs and long-lasting insecticidal nets (LLINs), but once these are resolved, implementation can then begin very rapidly. HIV treatment grants reach successive barriers to scale-up as they move through the levels of the health system, from national to provincial and down to county and village levels. As capacity is built at the national level, the needs increase as one moves from the regional to the local level. TB grant-funded programs often have greater existing infrastructure to draw upon as a result of a longer history of ongoing systems. Finance is often provided to scale up existing programs. However, innovative methods and assistance may be required later in the grant lifecycle to increase TB case detection methods and mobilize new partnerships (including public/private partners), and to respond more effectively to interactions with HIV and to the treatment of MDR-TB. In addition, although national TB case detection and treatment rates have improved, lagging districts often show poorer performance and require targeted support.

61. A major finding is that there may be a need to shift from general technical assistance for "problem grants" to targeted implementation support to help adequately-performing grants scale up programs. For example, sub-Saharan Africa has no more poorer-performing grants than any other region but needs coaching and assistance to help turn its B1-rated grants, which are the majority of the region's grants, into A-rated grants (see section 3.4.4). This would have the greatest payoff in terms of increasing results across sub-Saharan Africa. Assistance is often most needed as programs are scaling up implementation and begin to show results, not just when problems arise or implementation is slow. Box 1 shows a list of areas in which the Global Fund and its partners are learning from the experiences of performance-based funding:

#### BOX 1: IMPLEMENTATION ISSUES: LEARNING FROM PERFORMANCE-BASED FUNDING

**1.** Malaria grants suffer initial procurement delays, but when solved can catch up rapidly. Global supply chain issues for both LLINs and ACTs need innovative solutions.

**2.** Health products need rapid, fast tracking of health procurement for the three diseases and capacity building of national supply chains.

**3.** ARV treatment can result in increased availability in human resources, medical resources and beds in the health system when scale-up is under way. However, initial human resource capacity to implement ARV treatment programs is a significant bottleneck, particularly at local levels of the health system.

**4.** Complex HIV testing and counseling (TC) procedures can be a major obstacle to ARV enrollment. They need to be simplified, particularly in clinical settings.

**5.** Grants need to build longitudinal adherence systems to manage and track HIV treatment similar to TB treatment.

**6.** Dual-track financing for civil society and governmental recipients can increase absorptive capacity and ensure that delays do not hold up all activities. Civil society implementers can mobilize communities to help increase the demand for health services (for example, through use of ITNs, HIV testing and TB detection and referral).

**7.** HIV prevention activities can be delayed initially by the coordination and governance issues of a wide range of stakeholders: it requires similar prioritizing to HIV treatment and mechanisms need strengthening to coordinate implementers.

**8.** TB programs require innovative services and partnerships (for example, public/private) to raise detection rates above 70 percent.

**8.** After the initial stages of implementation, programs need to identify problem areas and provide direct assistance to sustain scale-up. Programs must improve the adjustment plans and contextual information provided as part of performance evaluation.

**10.** Management and financial as well as technical assistance is essential to both civil society and governmental grant recipients. Assistance is often most needed as programs are scaling up implementation and begin to show results, not just when problems arise or implementation is slow.

### 3.4.2 CIVIL SOCIETY IS A STRONG IMPLEMENTER

62. Variations in performance by PR type provide important insight into implementation issues (see Figure 18A). Civil society organizations have proven themselves to be successful program implementers as PR. None of the 27 grants for which they were PR received a B2 or C rating. In addition, 30 percent of grants to civil society organizations had an A-rating (as compared to an average of 21 percent for all grants). However, it is worth noting that civil society and governmental PRs often implement in different conditions, and governments often have larger procurement components than civil society, which can account for significant implementation delays. In total, 65 percent of government-run grants were A- or B-rated.

63. These results show the importance of civil society organizations in improving the financial absorptive capacity and implementation speed of prevention and treatment programs in grant-funded countries. Some governmental PRs work with civil society organizations as grant sub-recipients. In Zambia, the Global Fund has agreed to four different PRs to ensure that funds flow consistently to government, nongovernmental organization (NGO) and faith-based sectors to fight HIV. Although having multiple implementers is sometimes criticized (compared to pooling financing), it has proven to be a flexible, efficient and well-coordinated implementation arrangement. It has extended the financial absorptive capacity of the HIV response in the country.

64. Similarly, in the United Republic of Tanzania the Global Fund has agreed to a range of PRs, including the Ministries of Finance and Health, the African Medical and Research Foundation (AMREF), Population Services International (PSI) and Pact, coordinated through the United Republic of Tanzania's Country Coordinating Mechanism (CCM). This has ensured a comprehensive response and improved absorptive capacity – including where there are clear public sector human resource and spending constraints – beyond the treatment programs.

65. Countries must find ways to make the most use of civil society organizations as implementers alongside the essential role of government. The dual-track PR funding model (having both a civil society and governmental PR) should be taken very seriously where there are significant bottlenecks in grants.

### 3.4.3 THE COMPLETE PACKAGE OF TECHNICAL ASSISTANCE: LESSONS FROM TB

66. TB grants continue to perform well compared to grants for the other diseases: 82 percent of grants are in the A or B1 category, and they are the only grants by disease with no C-rated grants. HIV grants now show a similar number of A-rated grants to TB (26 percent), but have more poorly-performing grants (see Figure 18B). Malaria grants show a much smaller percentage of A-rated performance (six percent). This may be due to the initial bottlenecks (and global issues of LLITN and ACT supply), which are still apparent at the point of the 18- to 20-month evaluation for Phase 2 funding. However, a number of malaria grants caught up rapidly a few months later once the procurement bottlenecks were removed. This explains why the overall malaria results in terms of ITNs distributed are very strong for the whole portfolio.

67. There is an important lesson provided by the comprehensive and well-defined package of technical assistance provided by the Stop TB Partnership. This package includes management and procurement support as well as purely technical support. It also provides implementation support for scale-up rather than just technical assistance focused on poorly-performing programs. The Global TB Drug Facility plays a significant role in ensuring that almost all countries with high TB burdens have a secure supply of anti-TB drugs. There is no equivalent to these initiatives for HIV and malaria.

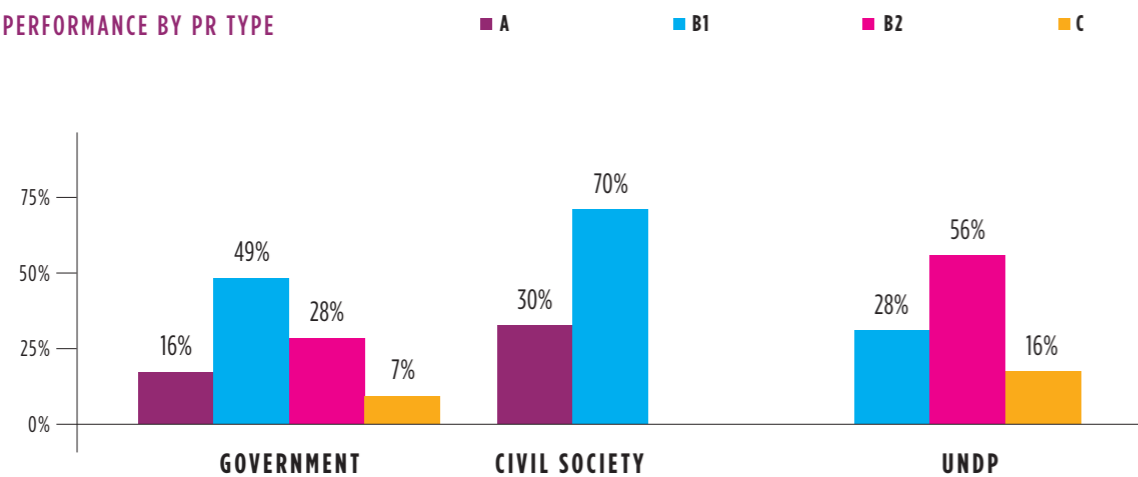
68. Similarly, TB programs could learn from the community-based approaches of AIDS and malaria programs as they aim to increase TB detection rates beyond 70 percent in high-burden countries (HBCs). There are valuable discussions still to be had across programs for the three diseases at the international and CCM level.

### 3.4.4 ACCELERATING PERFORMANCE IN SUB-SAHARAN AFRICA: THE NEED FOR ADDITIONAL APPROACHES TO TECHNICAL ASSISTANCE

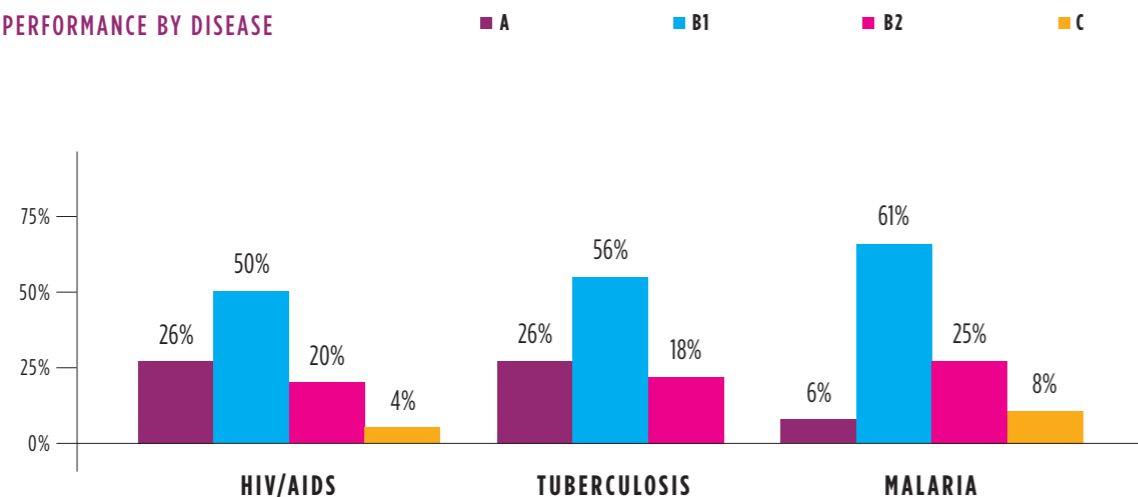
69. Overall performance compared by region varies little, suggesting that performance-based funding does not disadvantage any one region (see Figure 18C). Results are based on individual grant performance measured against country-owned targets and a commitment to ensure that the end user receives needed services.



**A. PERFORMANCE BY PR TYPE**



**B. PERFORMANCE BY DISEASE**



**C. PERFORMANCE BY REGION**

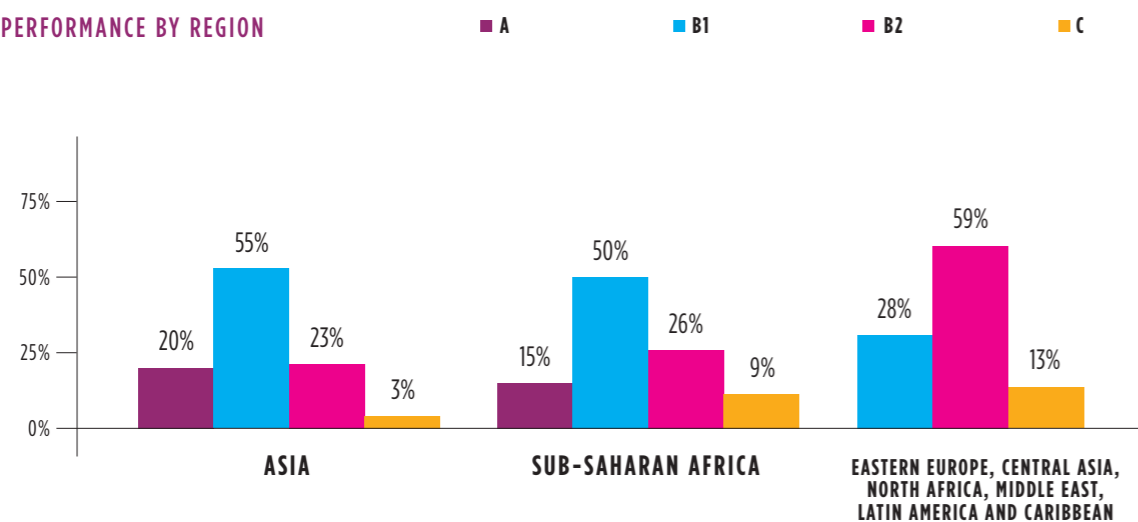


FIGURE 18: VARIATIONS IN PERFORMANCE BY PR, DISEASE AND REGION

70. Sub-Saharan Africa performed no worse than other regions (as shown in Figure 18C). While it continues to show satisfactory performance with 65 percent of grants to the region rated A or B, there are increasing differences at the ends of the performance distribution in the numbers of A- and C-rated grants. Sub-Saharan Africa has a higher percentage of C-rated grants (nine percent versus four percent for all grants) and a lower percentage of A-rated grants (15 percent versus 21 percent) than other regions. The higher number of C ratings is explained by five grants whose programs have specific problems and require significant restructuring and targeted technical assistance.

71. While there are specific needs for technical assistance in the programs funded by the five C-rated grants, the greatest need is to focus support on the region's B1-rated grants. These grants represent half of the region's grants and - with appropriate support - have the potential to become excellent performers and contribute significantly to the region's overall results. It is in the programs funded by these grants where the scale-up of results is likely to occur. For example, HIV grants in the United Republic of Tanzania and Ethiopia are performing adequately, funding programs that have provided 20,000 people with ARV treatment. With the right support, these countries' programs could provide treatment for 100,000 people each. Implementation assistance or coaching is often most needed as grants accelerate and perform (not just when problems arise or implementation is slow).

### 3.5 DOES PERFORMANCE-BASED FUNDING PENALIZE POORER COUNTRIES?

72. The question of whether performance-based funding and Phase 2 decisions penalize the poorest countries requires further attention. In principle, performance-based funding supports these countries. Performance is based on relative rather than absolute performance. Results are compared to targets set by the country, given their constraints and what they

believe they are able to do. For example, Zambia is measured against its own targets, which are based on what can be achieved in the country with that grant as determined by the CCM and the PR, not against results in Eastern Europe or South Asia. In addition, corrective actions to explain deviations from targets can be incorporated at each stage.

73. The Global Fund has provided a preliminary analysis of some of the data (see Figure 19) by looking at Phase 2 grants divided into "low", "middle" and "high" categories in terms of wealth, health systems performance and human resources for health capacity<sup>(1)</sup>. The performance ratings and percent of financial reductions at Phase 2 are compared across these categories. Performance is no worse in the lowest-income countries (15 percent B2/C-rated compared to 40 percent in middle and 19 percent in higher wealth countries). Performance is actually better in countries with the lowest capacity of human resources for health when compared to all grants (20 percent B2/C-rated as compared to 35 percent in middle-capacity and 14 percent in higher-capacity countries), possibly reflecting the extensive investments the Global Fund makes in human resources.

74. In terms of health systems, there is little difference when it comes to performance or savings. However, countries with the highest level of health systems performance do perform considerably better. There may be areas of health systems (beyond human resources and service delivery) that require additional attention in grants.

75. Surprisingly, poorer countries have a substantially lower percentage of budget reductions in their approved Phase 2 grant amounts (6.4 percent reductions in the lowest-income countries, as compared to 21.4 percent in middle- and 21 percent in higher-wealth countries). This is a very encouraging result, suggesting that Global Fund grants are going towards building needed infrastructure and capacity in the lowest-income countries (see Figure 20). Similarly, countries where the human resource for health capacity is weakest have lower budget reductions at Phase 2. This shows the continued investment of Phase 2 in the lowest-income countries and countries where human resources for health need to be improved. Phase 2 budget reductions are slightly greater in countries where health systems performance is lowest (20.1 percent, as compared to 17.1 percent for the highest health systems performance).

(1) Even categories were generated across all grants with relative measures of: a) wealth categories based on distribution of gross national income per capita; b) health systems capacity based on the WHO 2000 World Health Report, Statistical Annex 10; and c) human resources for health capacity based on the ranking of countries based on Joint Learning Initiative 2003 data and the WHO 2006 World Health Report, Statistical Annex 4. There are issues with definitions and, in particular, continued debate concerning the health systems index.



PERFORMANCE IS NO WORSE IN POORER COUNTRIES OR THOSE WITH WEAK HEALTH SYSTEMS

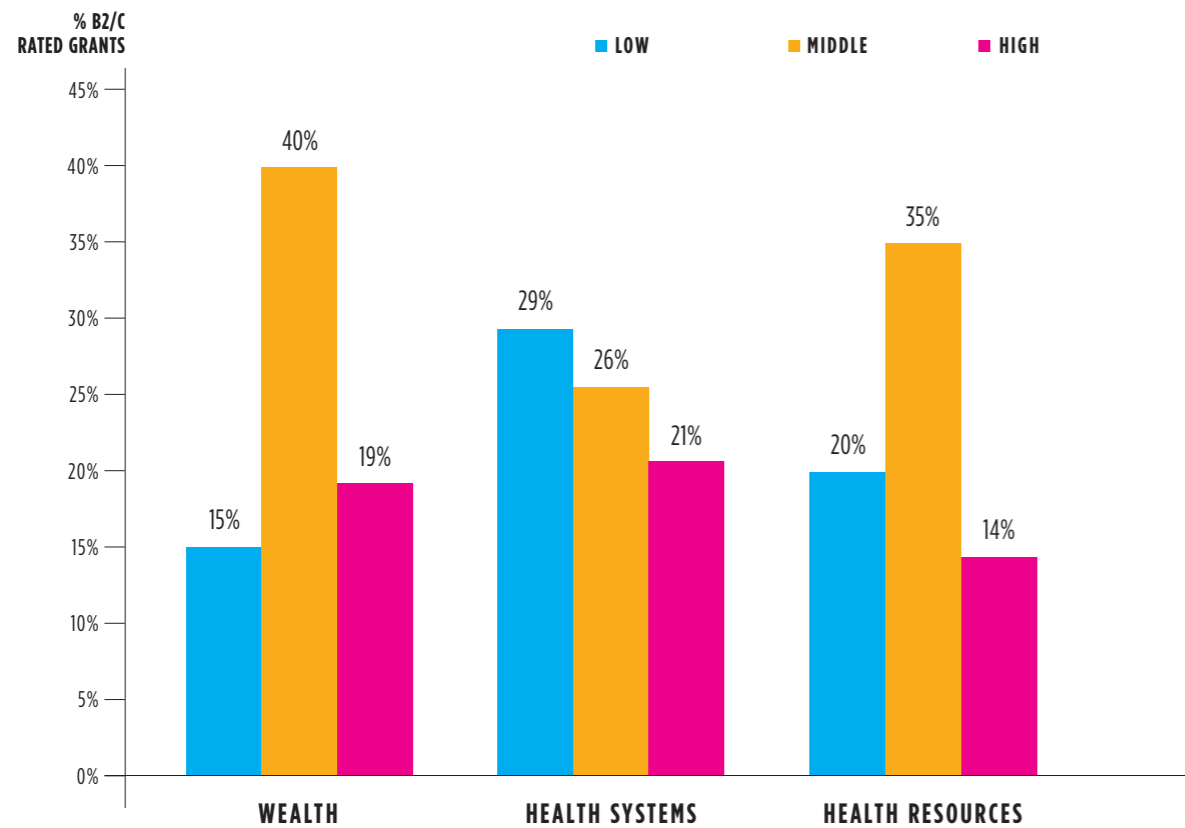


FIGURE 19: PERFORMANCE OF COUNTRIES ASSESSED BY LEVELS OF WEALTH, HEALTH SYSTEMS STRENGTH AND HEALTH RESOURCES CAPACITY

2 Department for International Development, UK (2005). Why We Need to Work More Effectively in Fragile States. (www.dfid.org).  
 3 Available at www.theglobalfund.org/en/files/about/replenishment/fragile\_states\_3rdreplenishment.pdf.

76. Initial analysis suggests that the poorest countries (in terms of wealth, health systems or human resources for health) are not penalized by performance-based funding. Budget reductions after extensive evaluation for Phase 2 funding do not reduce the funding for poorer countries, and in fact the opposite is true. Phase 2 appears to be not only an investment in performance, but also in poverty and human resources for health.

77. However, there are still important interactions between performance-based funding and the lowest-income countries that require monitoring. The lower prevalence of A-performing grants in the lowest-income countries must be investigated further. This inequality could have a disproportionate effect in reducing overall results in the region. Some of the further issues are apparent from the continued analysis of fragile states below.

FINANCIAL REALLOCATIONS AT PHASE 2 ARE LOWER FOR POORER COUNTRIES

	LEVEL OF WEALTH/SYSTEMS PERFORMANCE		
	LOWEST	MIDDLE	HIGHEST
WEALTH	6.4%	21.4%	21.0%
HEALTH SYSTEMS PERFORMANCE	20.1%	11.8%	17.1%
HUMAN RESOURCES FOR HEALTH CAPACITY	10.1%	18.5%	19.3%

FIGURE 20: FINANCIAL REALLOCATIONS IN APPROVED PHASE 2 GRANT AMOUNTS BY LEVELS OF WEALTH, HEALTH SYSTEMS STRENGTH AND HEALTH RESOURCES CAPACITY

GLOBAL FUND INVESTMENTS IN FRAGILE STATES: AN UPDATE

Fragile states comprise 46 countries with a total population of 870 million people, or 14 percent of the world's population. There are several definitions, but the UK Department for International Development (DFID) provides a working definition of a fragile state as one that "cannot or will not deliver core functions to the majority of its people, including the poor"<sup>(2)</sup>.

The Global Fund has committed US\$ 1.5 billion and disbursed US\$ 864 million to 142 grants in fragile states. This accounts for over one-third of the total commitments of the Global Fund. This is a significant commitment compared to general overseas development assistance funding in these countries (14 percent of bilateral aid goes to fragile states), and the performance of grant-funded programs in these countries is, therefore, critical to the overall performance of Global Fund investments.

The Global Fund provided an initial report in 2005 entitled *Global Fund Investments in Fragile States: Early Results*<sup>(3)</sup>. This report provided an analysis of the performance of 19 grants that had passed through evaluations for Phase 2 funding between the 18- and 20-month marks. An update is provided here covering the 47 grants to fragile states that had reached the point of evaluation for Phase 2 funding as of 15 May 2006. The major interim results in an

ongoing study of fragile states include:

- The Global Fund's performance-based funding model seems to work even in fragile states, as 66 percent of grants in fragile states have met or exceeded targets or shown adequate performance.
- There are weaknesses, particularly in that fragile states have fewer A-rated grants, suggesting that technical assistance strategies may need altering in fragile states.
- A broad partnership for implementation (particularly at the sub-recipient level) may provide an important model in difficult implementation situations. This "fragile states model" may be of wider relevance, as there are levels of fragility affecting performance in most countries. The precise mechanisms of implementation need further investigation.

Of grants in fragile states, 66 percent achieved A or B1 performance ratings (see Figure 21), which is a remarkable achievement. The majority of grants in fragile states were rated B1 (57 percent), which was similar to the results in stable states (53 percent B1-rated). These results confirm the findings reported previously, that Global Fund programs in fragile states perform well.

Some differences are emerging at the extreme ends of the distribution, as fragile states have fewer A-rated grants and more B2/C-rated grants. Despite the larger number of B2/C-rated grants,

this has not penalized fragile states financially at the point of evaluation for Phase 2. Fragile states received 32.2 percent of the total US\$ 1.5 billion approved in Phase 2 funding to 15 May 2006 – only slightly lower than the 33.6 percent of total proposal amounts. The Global Fund has, therefore, to date maintained a significant commitment to fragile states throughout the five-year year grant period. The significantly lower percentage of A-rated grants (9 percent in fragile states compared to 27 percent in stable states) requires further attention and may require a change in technical assistance strategies to fragile states.

Fragile states actually rely more on governments as a PR than stable states (see Figure 22). Resources from the Global Fund form a significant source of funding in fragile states, and recipient governments attach a high importance to these funds. However, participation of civil society and faith-based organizations (FBOs) in the implementation of grants at the sub-recipient level was also an important factor in grant successes. Most fragile states have expanded the number of sub-recipients beyond the public sector base. For example, a Cambodia HIV grant has 13 sub-recipients and a Burundi HIV grant has 18. Using broad partnerships for program implementation may be an important implementation model in fragile situations.

(2) Why we need to work more effectively in fragile states. London, United Kingdom Department for International Development, 2005 (www.dfid.org).  
 (3) Available on the Global Fund website at: http://www.theglobalfund.org/en/files/about/replenishment/fragile\_states\_3rdreplenishment.pdf

PERFORMANCE OF FRAGILE STATES

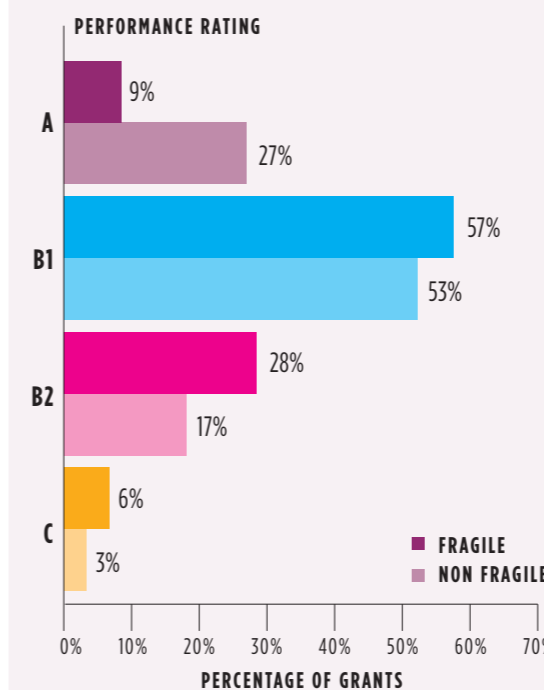
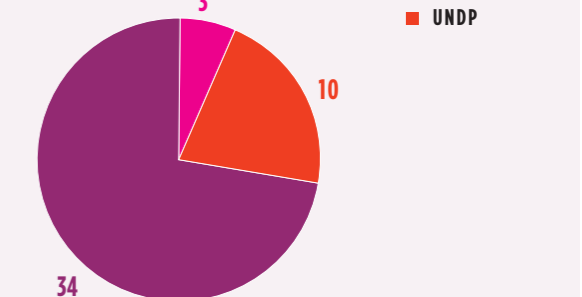


FIGURE 21: PERFORMANCE RATINGS IN FRAGILE AND NON-FRAGILE STATES

PRs IN FRAGILE STATES (N=47)



PRs IN STABLE STATES (N=93)

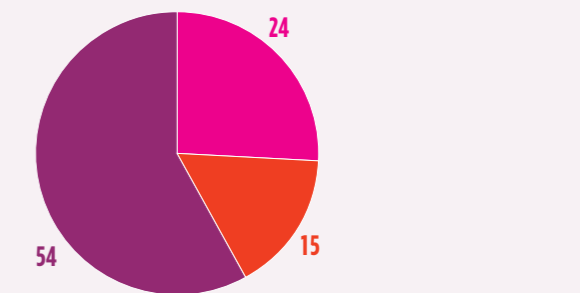


FIGURE 22: PR TYPES IN FRAGILE AND STABLE STATES

GUIDELINES FOR LFA ON-SITE DATA VERIFICATIONS FOR ALL GRANTS EACH YEAR



FIGURE 23: GUIDELINES FOR LFA ON-SITE DATA VERIFICATIONS, CONDUCTED FOR ALL GRANT-FUNDED PROGRAMS EACH YEAR

### 3.6 CAN WE BELIEVE THE PERFORMANCE DATA FROM COUNTRIES?

78. There are well-recognized weaknesses in performance and monitoring systems in many countries in which the Global Fund works. A strong performance monitoring system is essential for reporting and crucial for managing programs at international, national, provincial and local levels.

79. The Global Fund requires robust monitoring and evaluation (M&E) systems, recommending that recipients spend five to ten percent of grant amounts on strengthening these systems. Just as importantly, the Global Fund includes powerful incentives in its

performance-based funding model to establish systems for accurate and externally-verifiable reporting. If a grant cannot show reliable results, funding can be stopped at any stage. The quality of reporting systems is assessed by Local Fund Agents (LFAs) for every grant at the time of signing. In addition, the Global Fund is working with technical partners such as the World Health Organization (WHO), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), Monitoring and Evaluation to Assess and Use Results (MEASURE) and Health Metrics Network (HMN) to build and invest in better national systems to improve health data quality.

80. Nevertheless, the LFAs of the Global Fund have identified inaccuracies in reporting following random desk audits and site visits. (All results submitted to the Global Fund are verified by LFAs). Results and requests for continued funding also pass through the CCM of the country. The CCM includes national and international partners in each grant-funded country who are responsible for providing oversight to program implementation. Global Fund processes encourage transparency and accountability by building M&E into all stages of the grant process.

### QUALITY ASSURANCE FRAMEWORK FOR GRANTS

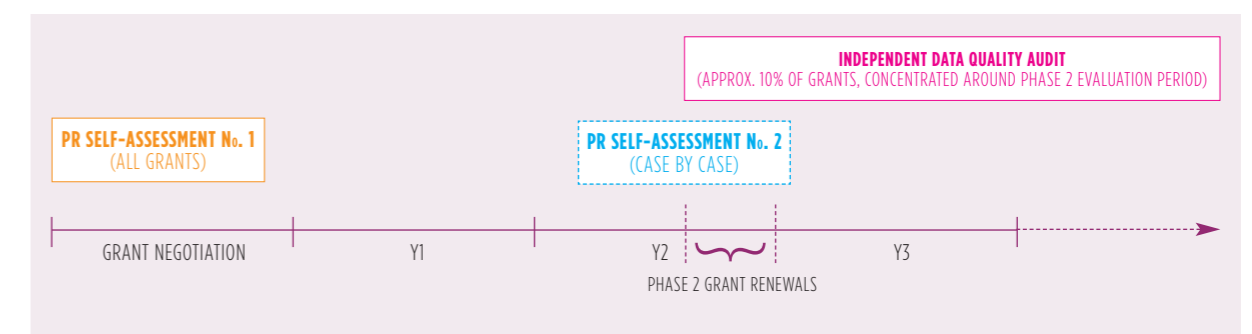


FIGURE 24: QUALITY ASSURANCE FRAMEWORK FOR GLOBAL FUND GRANTS

#### 3.6.1 WHAT ARE THE CHECKS ON DATA REPORTING ALONG THE GRANT LIFECYCLE?

81. Given that these systems are not perfect, the Global Fund has introduced important safeguards and checks on both the results reported and the systems from which they come. The Global Fund is relatively confident in its reported core results, but checks have also revealed weaknesses in country systems. The Global Fund is committed to continuing to build and strengthen M&E systems with its partners.

82. The Global Fund has a number of safeguards for reporting and is pioneering important new measures to strengthen the underlying systems. Each grant is required to:

- **Undergo an initial assessment of the PR's M&E systems and capacity. If the PR already has grants, the system is reviewed to assess its ability to incorporate the planned scale-up in activities.**

- **Submit a detailed M&E plan that specifies how data will be collected for grant management and defines the quality of key services including training.**
- **Dedicate budget amounts to strengthen M&E systems. It is recommended that grant recipients earmark five to ten percent of grant budgets to strengthen M&E systems and capacity. An independent review of performance data before each disbursement is undertaken by the LFA.**
- **Undergo site visit spot checks by LFAs each year to verify for the major indicators that people have received services. This includes all ARV, ITN and DOTS-related indicators, as well as other important indicators.**
- **Undergo a full performance evaluation for Phase 2 funding involving a review of performance data by the LFA, CCM and independently within the Global Fund Secretariat by the Operations and Strategic Information teams.**



83. By the time a grant has reached the point of evaluation for Phase 2 funding, it will have had three to six independent assessments of its performance data, an independent review of its M&E plan and system as well as site visits by the LFA and Global Fund Portfolio Manager. In some situations, these safeguards reveal weaknesses and in a very few examples have been the basis not to recommend continued funding.

84. Site verifications at the point of service delivery have become an essential check. Guidelines have been introduced to ensure site verifications of results in each grant each year. These guidelines specify each step that is required for conducting on-site data verifications (see Figure 23).

### 3.6.2 HOW ARE NATIONAL SYSTEMS BEING STRENGTHENED IN A COORDINATED WAY?

85. An important strengthening measure has been the work with partners (including WHO, HMN, PEPFAR and MEASURE) to define common tools to provide a common quality assurance framework (see Figure 24) to coordinate the strengthening of national M&E systems. This has been piloted and introduced in some priority grants and will be rolled out with partners across the grant portfolio by the end of 2007. Follow-up data quality audits (DQA) on approximately ten percent of grants will follow from January 2007. Efforts are also underway to engage other partners such as Roll Back Malaria and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The harmonization of these tools should also enable, where possible, the joint implementation of M&E assessments and DQAs at the country level.

86. The quality assurance framework relies on two complementary elements: 1) a self-assessment of M&E systems during grant negotiation and, as appropriate, at later stages of the grant life-cycle; and 2) an independent DQA.

87. The implementation of M&E self-assessments and independent DQAs should:

- **Help to better identify M&E capacity gaps and corresponding strengthening measures, including through technical assistance;**
- **Guide investments in M&E before grant agreements are signed, to better inform the development of the grant’s M&E budget within the recommended range of five to ten percent of the overall budget;**
- **Ensure that such investments contribute to the strengthening of national systems (avoiding parallel reporting systems and the fragmentation of M&E at the country level).**

88. The “M&E Systems Self-assessment Checklist” was first implemented in Rwanda in September 2005 in collaboration with PEPFAR. Further pilot implementations were conducted in early 2006 in Bangladesh, Chile, China, Niger, Democratic Republic of the Congo and the Russian Federation. The objective of these additional pilots was to assess the suitability of the Checklist for the three diseases, for different types of PRs (i.e., national agencies, NGOs, civil society and the United Nations Development Programme) and in various regions of the world.

89. The DQA Protocol verifies that appropriate data management systems are in place in countries and verifies the quality of reported data for key indicators at selected sites.

### 3.6.3 REPORTING RESULTS AND MANAGING PERFORMANCE

90. The Global Fund has simplified and focused M&E reporting with basic service and impact indicators for the three diseases agreed on by nine major partners and published in an updated edition of the *Monitoring and Evaluation Toolkit*. The Global Fund does not have its own indicators, but uses those of national and international partners. This increases the potential for harmonized reporting requirements with other donors. Weaknesses remain in reporting systems, but the safeguards that have been introduced should ultimately improve the ability of funded programs to report and, most importantly, to manage their results.

## BOX 2: EXAMPLE OF DIAGNOSIS AND STRENGTHENING MEASURES

An example of the application of the M&E system strengthening tools is shown below. Following a thorough diagnosis of M&E systems, a coordinated action plan was identified to address shortcomings.

STRENGTHS	WEAKNESSES
Goals and objectives of the program are aligned with the national strategy	No national M&E plan
Solid health information system with national coverage	Lack of clarity regarding the periodicity of population-based surveys
Clear terms of reference for sub-recipients (establishing data reporting requirements and timelines)	No monitoring of the quality of services delivered by the grant-funded program
Services are delivered in accordance with national standards	No monitoring of client satisfaction
	No standardized data collection and reporting forms/tools for voluntary counseling and testing (VCT) for HIV or behavioral change communication activities
	Issues regarding data quality of reports submitted by sub-recipients
PLANNED STRENGTHENING MEASURES	TIMELINES
A national M&E plan will be designed and implemented	1st Semester
A methodology for measuring impact (with indicators) will be developed and implemented	1st Semester
Indicators measuring quality of services delivered and client satisfaction will be introduced	2nd Semester
A mapping of all service delivery points will be developed at the national level (including civil society)	2nd Semester
Sub-recipient capacity will be strengthened with regards to data quality	1st Semester
A feedback mechanism to sub-recipients will be developed to resolve data quality issues	1st Semester
A data collection and reporting system with standardized forms/tools will be developed for VCT and behavior change communication.	2nd Semester
TECHNICAL ASSISTANCE	
International technical assistance will be solicited for developing indicators measuring the quality of prevention activities	

## 4. COLLECTIVE EFFICIENCY: BUILDING SYSTEMS

The Global Fund is one of the most flexible and focused funding systems I have ever seen for health systems strengthening. I am glad it is flexible as that is how change can come. There is still a huge gap but whatever we receive from the Global Fund fits in with the health development plan.

- TEDROS ADHANOM GHEBREYESUS, MINISTER OF HEALTH FOR ETHIOPIA

### BOX 3: GUIDING PRINCIPLES OF THE GLOBAL FUND

Seven principles guide the policies and operations of the Global Fund, from its governance and its grant-making to how it works through global and national systems. These principles reflect a consensus by many stakeholders in 2001 which laid the foundations for the creation of the Global Fund.

#### THE GLOBAL FUND:

1. Operates as a financial instrument, not an implementing entity.
2. Makes available and leverages additional financial resources.
3. Supports programs that evolve from national plans and priorities.
4. Operates in a balanced manner with respect to different geographical regions, diseases and healthcare interventions.
5. Pursues an integrated and balanced approach to treatment, care and support.
6. Evaluates proposals through an independent review process.
7. Operates transparently and accountably and employs a simplified, rapid and innovative grant-making process.

91. A major innovation of the Global Fund is that it is a network organization and does not itself implement directly. The Global Fund monitors and supports its investments through a system of country-based and international partners. To pass from financing to grant performance and impact requires this system to work. The Global Fund system has inherent tensions, but also the potential to mobilize a much wider and more sustained response to the three diseases than a traditional development organization could achieve. The principles on which the Global Fund was founded (see Box 3) place it at the center of the harmonization, partnership and aid effectiveness movement.

THROUGH AN INTENSIVE EFFORT THAT PAIRED BED NET DISTRIBUTION WITH POLIO VACCINATION FOR CHILDREN UNDER FIVE, NIGER'S MALARIA PROGRAM DISTRIBUTED TWO MILLION BED NETS IN TWO WEEK-LONG CAMPAIGNS.



## 4.1 SYSTEMS EFFECTS: FROM PRINCIPLES TO ACTION

92. The Global Fund has a particular dependency and catalytic role on the systems through which it implements. It is important to measure both the positive and the negative impacts that the Global Fund has on these systems and how to contribute to improvements. Where possible, corrective actions must be taken – including investments in partnerships – to work better within these systems.

93. This chapter highlights a number of initiatives that show the Global Fund moving from the principles of systems effects and harmonization to action on harmonization. These include:

- Global initiatives implementing the principles of the Paris Declaration on Aid Effectiveness:** The Global Fund has put this at the center of its systems effects work and measurement from 2006 (see section 4.2). The Global Fund is a formal part of the measurement group, working with the Organization for Economic Co-operation and Development (OECD) to operationalize and implement measurement of the Paris Declaration's principles, including supporting two country pilot studies before full roll-out of the baseline survey in 2006. The Global Fund has been delegated the responsibility to ensure that global initiatives in health, environment and education are fully part of this measurement work.
- Community systems effects:** The Global Fund is committed to a wider view of systems effects, including community and nongovernmental sectors. It has commissioned work to assess the needs of community systems for international financing and to identify areas where further support for grants may be needed. For the first time in 2006, the Global Fund and nine partners have incorporated these needs as service delivery areas for funding in its latest edition of the *Monitoring and Evaluation Toolkit*.

- Putting harmonization principles into practice:** In addition to monitoring the Paris Declaration, the Global Fund is implementing the principles of the Declaration in its work, for example, with the Global Alliance for Vaccines and Immunization (GAVI) in Ethiopia. There has been joint coordination with international and country-based partners to ensure that the health systems strengthening (HSS) budget in Ethiopia is funded in a coordinated manner. The Global Fund is now the largest funder of the country's health systems budget. With GAVI and other partners, it is showing that global initiatives have the flexibility and focus to be a major force in building horizontal country systems.
- Building common monitoring and evaluation (M&E) systems:** The Global Fund is leading collective approaches to monitoring and reporting. It has simplified indicators and agreed on the core definitions in its new edition of the *Monitoring and Evaluation Toolkit*, jointly produced by nine major partners. It has instituted data sharing among partners and a joint facility for coordinating technical support.

## 4.2 GLOBAL INITIATIVES: IMPLEMENTING THE PARIS DECLARATION

94. At the Paris High-Level Forum on Aid Effectiveness in March 2005, over 100 donor and partner countries produced and signed the Paris Declaration on Aid Effectiveness (see Box 4) and agreed to monitor progress against 12 indicators that would track progress in increasing harmonization of aid. A baseline survey of these indicators will be conducted in 2006, with follow-ups scheduled in 2008 and 2010.

95. The Global Fund has placed the implementation and measurement of the principles of the Paris Declaration at the center of its systems effects work

### BOX 4: FIVE PRINCIPLES OF THE PARIS DECLARATION

The Paris Declaration<sup>(4)</sup>, signed by over 100 countries, promotes mutual accountability; both donor and recipient countries share the responsibility for ensuring that aid to countries is used effectively.

The partnership commitments included in the Paris Declaration are organized around five key principles:

**OWNERSHIP** – Developing countries exercise effective leadership over their development policies and strategies and coordinate development efforts. Donors are responsible for supporting and enabling developing countries' ownership by respecting their policies and helping strengthen their capacity to implement them.

**ALIGNMENT** – Donors base their overall support on partner countries' national development strategies, institutions and procedures. For example, this means that donors will draw conditions, wherever possible, from a developing country government's development strategy,

instead of imposing multiple conditions based on other agendas.

**HARMONIZATION** – Donors aim to be more harmonized, collectively effective and less burdensome, especially on those countries (such as fragile states) that have weak administrative capacities. This means, for instance, establishing common arrangements at the country level for planning, funding and implementing development programs.

**MANAGING FOR RESULTS** – Both donor and partner countries manage resources and improve decision-making for results. Donors should fully support developing countries efforts in implementing performance assessment frameworks that measure progress against key elements of national development strategies.

**MUTUAL ACCOUNTABILITY** – Donors and developing countries' pledge that they will hold each other mutually accountable for development results.

(4) SOURCE: DEVELOPMENT ASSISTANCE COMMITTEE, OECD, 2005.

### BOX 5: GLOBAL INITIATIVES REPRESENTED BY THE GLOBAL FUND IN THE PARIS PROCESS

#### THE GLOBAL ALLIANCE FOR VACCINES AND IMMUNIZATION (GAVI)

A public/private partnership launched in 2000 to improve access to immunization for children in impoverished countries. Governments in industrialized and developing countries, the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the World Bank, the Bill & Melinda Gates Foundation, nongovernmental organizations (NGOs), vaccine manufacturers from industrialized and developing countries and public health and research institutions work together as partners in the Alliance.

#### THE GLOBAL ENVIRONMENT FACILITY (GEF)

Established in 1991, it helps developing countries fund projects and programs that protect the global environment. GEF grants support projects related to biodiversity, climate change, international waters, land degradation, the ozone layer and persistent organic pollutants.

#### THE EDUCATION FOR ALL – FAST-TRACK INITIATIVE (EFA-FTI)

A global partnership between donor and developing countries to ensure accelerated progress towards the Millennium Development Goal (MDG) of universal primary education by 2015. All low-income countries that demonstrate serious commitment to achieve universal primary completion can receive support from EFA-FTI.



BALTI, MOLDOVA HAS THE HIGHEST PER CAPITA RATE OF HIV IN THE COUNTRY. AN OUTREACH WORKER VISITS AN INJECTING DRUG USER IN HER HOME TO PROVIDE NEEDLE EXCHANGE SERVICE AS WELL AS COUNSELING AND SUPPORT.

THE GLOBAL FUND IS COMMITTED TO MONITORING AID EFFECTIVENESS

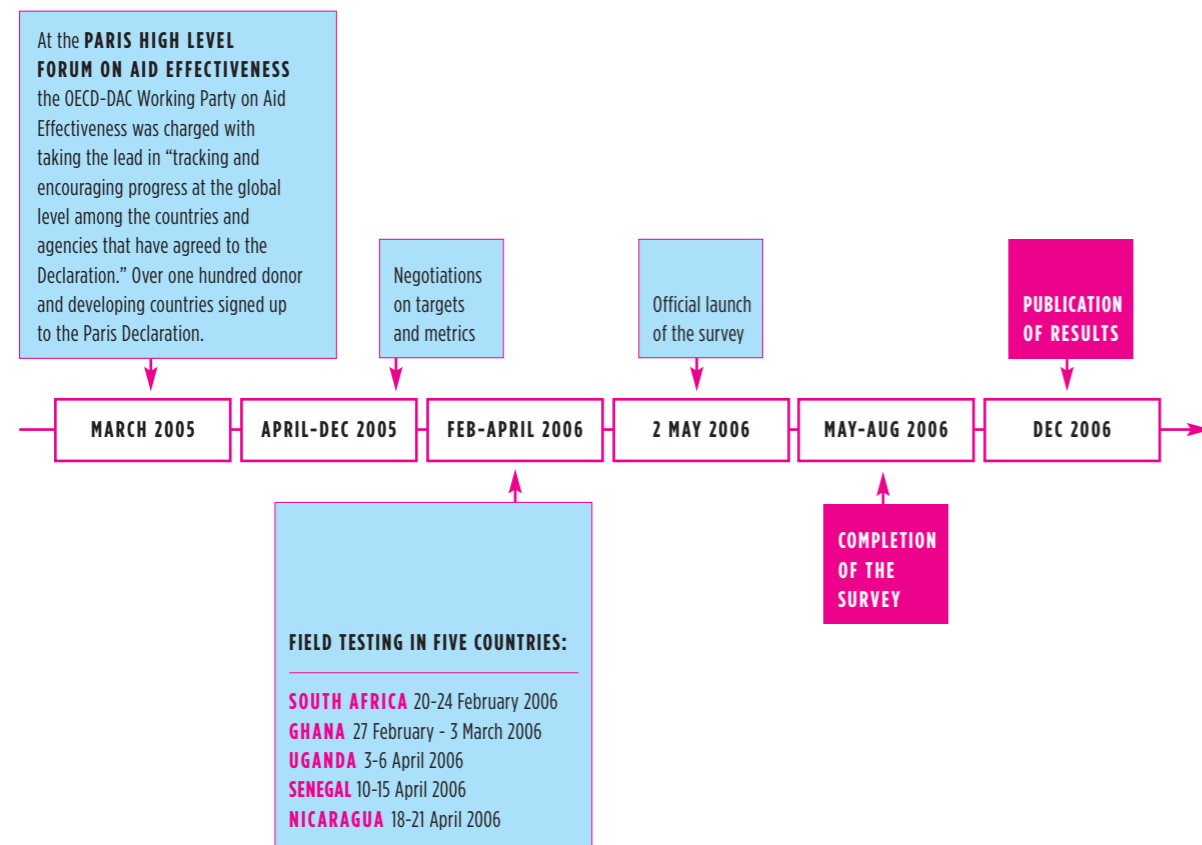


FIGURE 26: TIMELINE FOR BASELINE MONITORING OF INDICATORS OF AID EFFECTIVENESS

## 4.3 COMMUNITY SYSTEMS STRENGTHENING: HARMONIZATION PRINCIPLES ALSO APPLY AT COMMUNITY LEVEL

98. The Global Fund is committed to the widest possible partnerships, embodied in its functioning from the Board to Country Coordinating Mechanisms (CCMs) to the range of implementing entities and end beneficiaries of its services. The Global Fund monitors community structures to assess ways that they can be strengthened to receive health financing more effectively. Similar principles to the Paris Declaration concerning harmonization, ownership, alignment and partnerships occur at the community level in the delivery of services. At the level of service delivery, this work moves from “high-level forums” down to community levels.

99. The Global Fund aims to identify some of the issues and introduce concrete steps so that grant recipients include essential community systems strengthening (CSS) in their funded programs to deliver key services. This work is not focused on Global Fund programs. Rather, it aims to develop concrete steps to encourage countries to strengthen community systems in their Global Fund grants. The Global Fund would like to thank the Centre for AIDS Development, Research and Evaluation (CADRE) in South Africa for their substantive work, which reveals many community issues as part of the Communicating AIDS Needs Project.

### BOX 6: FROM PRINCIPLES TO HARMONIZATION: PARTNERSHIP IN ETHIOPIA

The Global Fund is applying the principles from the Paris Declaration to work with partners to improve aid effectiveness and build health systems in Ethiopia.

- A joint Memorandum of Understanding has been signed with the government and PEPFAR. This formalizes the joint efforts of the two partners behind the national plan. It also aims to coordinate support through the health system depending on the competencies of the different donors (for example, the strong technical competence of PEPFAR in clinic sites and laboratory support). A cadre of health workers is being trained to deliver HIV services along with other health services to strengthen overall health systems and reduce stigma related to AIDS services. As well as improving harmonization, this has allowed the Global Fund grant in Ethiopia to increase antiretroviral (ARV) treatment targets from 25,000 to 100,000 by the end of 2006.
- GAVI and the Global Fund have initiated a partnership to coordinate the efforts of global initiatives in supporting the national health sector strengthening plan in Ethiopia. This involves coordinating missions, and sharing of proposals and grant budgets to ensure that support will fill gaps in the national plan. This is being identified as the first in a set of “first wave of learning countries” to coordinate the support of global initiatives to improve horizontal systems in support of the Paris Declaration.

since 2006. It is a member of the measurement group, working with the OECD to implement measurement of the Declaration’s principles, including supporting two of the country pilot studies in South Africa and Senegal (see Figure 26).

96. The Global Fund is representing three other global initiatives in health, environment and education (see Box 5) in the monitoring effort. The Global Fund and the other initiatives are committed to monitoring indicators to meet the targets for 2010 set out in the Paris Declaration through a biannual monitoring process. This involves a broad-based dialogue to improve aid effectiveness at the country level.

97. The flexibility of the Global Fund to harmonize with the funding and programs of a wide range of partners and in a variety of contexts is increasingly being seen – in Ethiopia with GAVI (see box 6); in Mozambique with the UK Department for International Development (DFID) and sector-wide approaches (SWAPs); with DFID in China, where partners are aiming to use the same performance framework to coordinate investment; with the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) in the United Republic of Tanzania and many of their other focus countries; in Rwanda and India with the World Bank and other partners.

Some of the organization-specific and systemic challenges are highlighted in the direct responses from the community level to experiences of implementation.

#### ON GETTING ADDITIONAL FINANCING TO THE LOCAL LEVEL:

“How do you access those kinds of funds if they are sent to the governments of the respective countries? How do they actually filter down or through to the people who really need that kind of assistance?”

“As poor organizations working for the poor affected and infected communities, you devote your time in writing the proposal with limited resources and at the end of the day, you don’t even get an acknowledgement that they received your proposal.”

“Maybe we can write what is the problem, but there are other technicalities when you are writing a proposal. For example, ‘Is there a market?’ You see, when you say, ‘Is there a market’ (for your services) to a person who is not educated, you are confusing him. The forms have to be simplified, or they must be relaxed.”

#### ON MANAGING FOR RESULTS AND SUSTAINABLE PLANNING:

“We need evaluation skills to see ... to measure ourselves and to see where we are going and what have we done so far ... and other CBOs, NGOs and

any other structures must have evaluation skills, even the government must have a form of evaluation ... if they say they are able to fund a CBO in a place like this, then they must be able to come and see what we have done, what was the impact there.”

“Organizations ... don’t keep track of what is happening. They just live day in and day out to see if they can set their foot at the right place on a daily basis, which is a sad thing because organizations should be planning six or ten months ahead for what they want to do the following year.”

#### ON OWNERSHIP AND ALIGNMENT AT THE COMMUNITY LEVEL:

“When a funder says I fund youth, I fund HIV orphans, I fund women who have households that are affected by HIV/AIDS, so people ... will look and say, ‘No, I don’t even qualify in those things, okay’ ... and quickly they will cook up something that will make them qualify.”

“You have your own programs, then comes a funder that says to you, ‘I will give you 1.5 million, but only if in your program you include this and that and that.’ Now we’ll quickly change our program to fit that of the funder, then the whole thing is changed. Its role is compromised and what we are doing then is just to have a mission statement that contradicts what we are doing because of that. It’s easy to do that and I’m glad you asked that question.”

#### IMPROVING AID EFFECTIVENESS AT COMMUNITY LEVEL: FROM NETWORKING TO COORDINATION:

“So that thing has started to happen, but it has not been there before. It has never been there! Everybody was working in their own different directions and doing their own things. I would definitely agree and say yes, there has been a lot of networking that has been happening.”

“We all meet together with organizations such as TAC (Treatment Action Campaign), the Health Forum, organizations that deal with home-based care, with FAMS (Family and Marriage Society of South Africa) local clinics and so forth. We work together with these organizations and networking is there.”

“We don’t have ... a set program of action that is known to everybody. So if you talk about coordination ... it’s not happening. If you talk about networking, then I would say yes, networking is there. But coordination so to speak in terms of it being a real ... thing, rather than a dream by the organizations, then it’s not happening like that.”

There is much variation in the level of coordination between government and community organizations, and between community organizations themselves, but on the whole, local-level systems for coordinating HIV/AIDS responses need strengthening.



100. The assessment of local responses in a variety of settings is showing that increased levels of funding for HIV are:

- **Enabling significant community-level activity in response to the epidemic;**
- **Contributing to a rapid growth in the number of organizations undertaking HIV/AIDS activities, most notably community-based organizations (CBOs) and NGOs.**

However, there are both organization-specific and systemic challenges that limit the ability of communities to access, absorb and manage this funding.

101. Follow-up work will:

- **Implement CSS work to complement HSS work;**
- **Assess models of successful community organization and coordination in the delivery of services;**
- **Encourage the inclusion of CSS and indicators for their measurement in grant-funded programs.**

#### **4.3.1 PROGRAMS NEED TO STRENGTHEN COMMUNITY CAPACITY TO DELIVER KEY SERVICES**

102. The Global Fund aims to extend the principles of harmonization, ownership, partnerships and additionality to community settings. In response to the needs identified in the CADRE assessment, it has added a service delivery area on CSS in the new 2006 edition of the *Monitoring and Evaluation Toolkit*. Community service deliverers can seek funding to strengthen their service delivery mechanisms. The Global Fund encourages CCMs and Principal Recipients (PRs) to embed CSS in all grants as a part of HSS.

103. The CSS elements are focused on coordinating the outcome of delivery of a basic, coordinated, defined package of HIV, malaria or tuberculosis services at the community level (for example, covering home-based care, outreach prevention, orphan care, training). The indicators include:

- **Community coordination focal points;**
- **Training of new community workers for implementing community-based activities;**
- **Training of existing NGO workers in a basic package of skills (service delivery and management);**
- **Strengthening community organizations' planning and regular monitoring systems.**

104. These activities expand and should be included alongside other HSS activities to ensure delivery of a coordinated, basic package of HIV, malaria or TB services. The close link of these strengthening measures to disease outcome and impact monitoring is shown in Figure 27, below, of indicators as outlined in the *Monitoring and Evaluation Toolkit*. The focused service delivery supported by the Global Fund can be a major force in improving health and community systems.

105. The next stage of the work to be conducted by CADRE in 2006 on systems effects at community level will assess different coordination models that are available to improve the community health response and delivery of services. This will include a review of mentoring organizations, clustering arrangements using local government, volunteer coordination models, network approaches and seed-funding organizations.

106. The commitment expressed in the Global Fund's founding principles (see Box 3) is to practice harmonization at all levels and allow grants to strengthen community systems as an important part of overall health systems. Strengthening community systems will help to extend aid effectiveness principles from the national and international level down to the community level, which is a key part of the Global Fund's approach to funding.



MOTIVATED BY HER COMMUNITY MEMBERS SUFFERING FROM HIV/AIDS, A HOME-BASED CARE ASSOCIATE FOR THE KAGAYI PLWHA ASSOCIATION IN RWANDA MAKES REGULAR HOME VISITS TO PROVIDE CARE AND COMPANIONSHIP.



**BUILDING HEALTH SYSTEMS STRENGTHENING INTO GLOBAL FUND GRANTS**

AREAS	OUTPUTS	OUTCOMES	IMPACT
<b>SERVICE DELIVERY</b>	Health facilities in a district or a region that provide specialized services (Testing and Counseling (TC), PMTCT, ARV, STI, malaria treatment, TB treatment, TB/HIV collaborative activities, other) according to national protocols and guidelines (number and percentage) Health facilities supervised regularly according to national guidelines (number and percentage) Districts with laboratories that have complete capacity and supplies to diagnose TB, malaria and HIV (number and percentage) Number of HIV tests carried out expressed as a proportion of sexually active population (specify age groups)	• Population covered by key services (TC, PMTCT, ARV, malaria treatment, TB treatment) (number and percentage) • Number of outpatient visits for HIV/TB/Malaria / inhabitant • Percentage increase in patient satisfaction	Disease specific outcome/impact indicators should be included (e.g. increased TB detection and cure rate, malaria mortality, see disease specific sections)
<b>HUMAN RESOURCES</b>	Number of health workers (by category and discriminated urban / rural and gender) per 100,000 inhabitants (by category) Annual output of trained health workers per 100,000 population (by category level) Health workers (by category and region) who attended in-service training sessions (by type and length) according to national curriculum during the last year (breakdown by diseases if appropriate) (number and percentage) Health facilities fully staffed per level of health care and per region and according to national standards (breakdown by disease program if appropriate) (number and percentage)	• Health care personnel trained and deployed per category according to human resource development plan (number and percentage) • Percentage increase in patient satisfaction	
<b>COMMUNITY SYSTEMS STRENGTHENING</b>	• Number of sites with community coordination focal points in place • Number of community workers trained for implementing community based activities • Number of existing NGO workers trained in a basic package of skills • Number of community based organizations with plans and regular monitoring systems	• Percentage of local administrative units providing basic defined package of community services (home based care, outreach prevention, orphan care, training)	
<b>INFORMATION SYSTEM &amp; OPERATIONAL RESEARCH</b>	Health facilities or districts reporting all indicators according to national guidelines (including using the National list of indicators) (number and percentage) Health facilities or districts submitting timely reports according to national guidelines (number and percentage) Number of surveys that include core indicators for three diseases implemented according to National M&E plan (specify type) Sentinel surveillance sites performing according to national standards (number and percentage)	• Comprehensive health information management system • Complete disease specific report available on an annual basis • Behavioral surveys indicators available every 4-5 years • Estimated HIV prevalence rate available on a biannual basis	
<b>INFRASTRUCTURE</b>	Health facilities with arrangements for specialized services (CT, PMTCT, ARV, STI, TB/HIV services specify which and how many) (number and percentage)	• Geographical access: % of population living within reach of basic health services	
<b>PROCUREMENT AND SUPPLY MANAGEMENT</b>	• Technicians (by region) that have been trained in procurement and supply management (number and percentage) • Health facilities applying national regulations regarding procurement and supply management (number and percentage) • Batches of anti-TB essential drugs (specify) that have a batch certificate showing acceptable quality testing results, among all batches of drugs procured during a specified time period (number and percentage) • Total number of stock out days for any anti-TB essential drugs stocked (specify), among all storage facilities during a specified time period	• Number and percentage of health facilities or central warehouses with no drug stock out during the last month (or defined period)	

FIGURE 27: SELECTED INDICATORS FOR HEALTH SYSTEMS STRENGTHENING

**GAPS IN HUMAN RESOURCES**

REGION	ESTIMATED SHORTAGES IN CRITICAL COUNTRIES
East Asia & the Pacific	387,170
Latin America & the Caribbean	38,737
North Africa & the Middle East	139,087
South Asia	998,581
East Africa	369,818
Southern Africa	97,561
West & Central Africa	327,516
<b>TOTAL</b>	<b>2,358,470</b>

FIGURE 28: CRITICAL SHORTAGES OF HUMAN RESOURCES FOR HEALTH (DOCTORS, NURSES AND MIDWIVES) BY REGION (WHO, 2006)

## 4.4 HUMAN RESOURCES FOR HEALTH: FILLING GAPS IN HEALTH AND COMMUNITY CAPACITY

107. Global Initiatives such as GAVI, GEF and EFA-FTI provide focus through their specific health-related mandates, along with the flexibility to invest in horizontal health systems. They cannot cover all areas, but are certainly emerging as one of the key funders to fill the gaps in health systems budgets and systems. No area is more crucial to the delivery of the basic Global Fund-financed services than human resources for health. WHO has identified a core set of countries with critical human resource shortages equivalent to a deficit of over two million health-care workers, including doctors and nurses (see Figure 28).

108. It is important that the Global Fund works to fill that gap so countries can deliver crucial services. This requires considerable initial investments. However, there is some evidence emerging that in

the medium term, the fight against the three diseases can free up health capacity. In Ethiopia, Burundi, Botswana and Zanzibar, hospital beds are becoming available due to the early successes of ARV treatment and malaria programs. An important health systems argument for investment in these three diseases is that they can tie up 50 percent of health resources and health facilities in the worst-affected areas.

109. Approximately one-fifth of the Global Fund portfolio is devoted to human resources, supporting the capacity building required to deliver key services. Beyond supporting training for health-care professionals and laboratory staff, the Global Fund has promoted the training and re-training of paramedical staff, community health workers and counselors, bridging the gap in professional medical staff with outreach workers in over 100 countries (see Figure 29). As of 15 May 2006, Global Fund-financed activities supported over 1.5 million health service deliverers worldwide. By the end of 2006, Global Fund grants will be supporting the training and re-training of over 2.5 million people delivering a broad spectrum of HIV, TB and malaria health services.

110. The quality of activities and services being implemented is crucial to achieving desired results. The Global Fund requires training according to specific criteria or guidelines, ensuring that the quality of services provided is of an acceptable standard. The certification for those trained in certain service delivery areas promotes the provision of a standardized high quality of services.

**GLOBAL FUND INVESTMENTS IN TRAINING**

COUNTRY	COMPONENT	PEOPLE TRAINED	DESCRIPTION OF TRAINING
<b>GAMBIA</b>	HIV	<b>160,208</b>	Health workers trained in VCT, prevention of mother-to-child transmission (PMTCT); health professionals trained in the management of HIV-related opportunistic infections; health-care providers trained in the provision of ARV therapy.
<b>BANGLADESH</b>	TB, HIV	<b>59,609</b>	Medical officers, district supervisors, laboratory staff, paramedical staff trained in directly observed treatment, short course (DOTS) implementation; health managers trained; community DOTS providers trained; M&E review training; youth education deliverers trained.
<b>VIET NAM</b>	TB	<b>56,646</b>	Community health workers trained in detection and treatment, HIV/TB prevention and care; National TB program staff trained in program management, information systems; private physicians trained in private practice integration into DOTS.
<b>BENIN</b>	MALARIA, HIV, TB	<b>55,627</b>	Service deliverers trained on promotion of insecticide-treated bed nets (ITNs); health workers trained on new malaria treatment policy; health workers trained in early diagnosis and treatment; service deliverers trained in procurement and supply management; community focal points trained in new treatment guidelines; teachers trained.
<b>TOGO</b>	HIV, TB	<b>49,832</b>	Peer educators trained; health workers trained in the prophylaxis and treatment of opportunistic infections; lab technicians and nurses trained; peripheral community health workers trained in community DOTS.
<b>GHANA</b>	MALARIA, TB, HIV	<b>39,429</b>	Service deliverers trained in Intermittent Presumptive Treatment; community-based agents trained; people trained in home-based care of people living with HIV/AIDS.

FIGURE 29: EXAMPLES OF GLOBAL FUND-FINANCED COUNTRIES WITH LARGE INVESTMENTS IN TRAINING (AS OF 1 JUNE 2006)



#### 4.4.1 STEPS TO ENSURE COMMUNITY HEALTH WORKERS ARE SUPPORTED IN DELIVERING KEY SERVICES

111. The urgent need to fill gaps in existing health-care services in many countries has fostered the growth of paramedical staff to bridge the gap between health facilities such as clinics and the surrounding community. The roles of these outreach workers in supporting the need for basic health care fills the existing gap for medical personnel in areas hard hit by disease. Home-based care initiatives have grown in both number and prominence as increasing numbers of HIV-positive people come to require physical, emotional and/or material assistance to manage the changes they experience in their health and well-being.

112. A number of systems needs are emerging for community health workers:

- **Coordination between home-based caregivers working in the same area, and between home-based caregivers and other local groups and institutions.** Caregivers frequently encounter situations that fall outside their scope of work and require the inputs of other institutions, but referral systems tend to be ad hoc and there is an absence of mechanisms to draw together various contributors to AIDS-related care;
- **Sustainable funding:** There is frequently competition for funding and resources, for example, in urban areas where more than a dozen different home-based caregivers may work in the same general area. While certain groups are well-resourced and have close links with clinics, others operate without resources. In rural areas, access to funding is extremely difficult;
- **Provision of basic package of supplies:** There is often a lack of regular care-giving supplies, such as rubber gloves, medications and cleaning solution, which both undermines the quality of care they can provide and puts the caregivers at heightened risk of infection;
- **Training is uneven** and often only accessible to groups being funded by government departments;
- **Negative attitudes and stigma:** Caregivers frequently experience negative attitudes and reactions from other community members in the course of performing their work.

113. There is clear evidence of a trend towards systematization of the home-based care system. This includes moves towards standardizing training, attempting to regularize caregiver stipends, and providing psychological support and debriefing services for caregivers. Yet, discussions with caregivers and other community figures involved with home-based care suggest that much still remains to be done to support the effectiveness and sustainability of community care systems. Specific needs where the Global Fund and its partners need to encourage countries to budget for improved support and strengthening through Global Fund grants are:

- **The need for local-level forums or coordination groups that can link up the work of home-based caregivers with the efforts of other institutions, including stronger referral networks, joint case management, and systems for following-up the various needs of patients;**
- **Ensuring that all home-based caregivers – funded or otherwise – have access to basic care-giving supplies;**
- **Promoting the role of caregivers in communities to strengthen popular support for their contributions and to generate a more positive environment for community care-giving;**
- **Facilitating local associations or networks of caregivers to provide them with a professional forum to share experiences, receive needed support and organize around their common needs.**

114. The work of these community service deliverers is extraordinary and conducted in the most difficult circumstances (see Box 7).

115. The Global Fund must monitor the full systems effects of the work funded by its grants and encourage grant recipients to implement basic strengthening measures to make effective service delivery possible. This includes reinforcing harmonization at every level (local, regional, global) setting a solid, sustainable foundation for acceleration towards impact.

#### BOX 7: HOME-BASED CARE: SYSTEMS EFFECTS

##### COMPETITION FOR SUSTAINABLE FUNDING

“Recently the clashes are between those who are not funded and those who are funded. [They complain] that it’s unfair. The clashes are about why this organization got the money and why the other did not get the money.”

–CHAIRPERSON OF A FUNDED HOME-BASED CAREGIVERS’ ORGANIZATION

##### RESOURCING AND SUPPLIES

“When you are going to wash a patient, you need gloves and Sunlight soap. Every month the patient needs a new supply of Sunlight, Jaye’s fluid, aqueous cream, energy boosters such as e-pap and the like ... all those things. You leave those things with the patient – you don’t take them with you. We get them when we come for the napkins twice every week. The foodstuffs they get twice a week and the toiletries they only get once a month.’

–FUNDED HOME-BASED CAREGIVERS’ ORGANIZATION

“We make our own ends meet by taking out money from our own pockets. Sometimes we all have to contribute about R2 each so that we can buy Sunlight for our patients, and sometimes we ask for a donation. Like last year we asked for a donation and as a result, we still have gloves and things like that. It’s only the napkins that we don’t have at present.”

–NON-FUNDED HOME-BASED CAREGIVERS’ ORGANIZATION IN THE SAME COMMUNITY

##### COMMUNITY ATTITUDES

“It hurt us terrible ... . These sick people don’t get sick because they want to, so you just tell yourself that you should continue to give help, because what you are doing is really needed ... . [There is] a person who calls me a ‘faeces remover.’ As I’m coming from afar, he always says, ‘You come from afar to bring AIDS from across.’ ... But I go there because I need to work with sick people.

– CAREGIVER

“I cannot go alone into all these homes. Because sometimes people do not like home caregivers because our presence gives away the fact that the person is sick. A lot of people know who we are. And the house you are going to may be a shack, and you do not know the type of people who live there. That sometimes makes you scared to go alone, it is better when you go as a pair.”

– CAREGIVER

“You find that your husband does not understand why you get up every morning as though you are employed full-time to do something that you don’t even get paid for. He’ll ask you, ‘Why is it that you go every morning and yet you don’t even have money to buy bread for the children?’ How do you make him understand that the only reason why you get up each morning is because you love doing what you are doing?”

– CAREGIVER



# 5. MOVING TO IMPACT: EARLY SIGNS OF SUCCESS

You go to the medical ward and now half of the beds are not occupied, before they were mushrooming. A manager came to me as Minister of Health and said, “You are bad for business, our funeral business is going down. There was a time when every weekend we were burying four to eight people, now weeks go by without a funeral.”

- RECIPIENT COUNTRY HEALTH MINISTER



WOMEN ARE WAITING FOR CONSULTATION AT THE MNAZI MMOJA HOSPITAL IN ZANZIBAR.

116. Impact on the three diseases is the ultimate goal of Global Fund grant financing. The Global Fund sees impact as the result of intensive efforts by national and international partners working together to achieve international targets, including the Millennium Development Goals (MDGs) (see Box 8). The four-tiered evaluation framework of the Global Fund, which encompasses operational and grant performance and systems effects (including partnerships), builds to impact at its apex (see Figure 1 in the Introduction to this report), in keeping with the Global Fund’s mandate:

**To attract, manage and disburse additional resources through a new public/private partnership that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals.**

## BOX 8: MILLENNIUM DEVELOPMENT GOALS SUPPORTED BY GLOBAL FUND FINANCING

### GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

### GOAL 4: REDUCE CHILD MORTALITY

Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

### GOAL 5: IMPROVE MATERNAL HEALTH

Target 6: Reduce by three quarters, between 1990 and 2015, maternal mortality ratio

### GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

Target 7: Have halted by 2015, and begun to reverse, the spread of HIV/AIDS

Target 8: Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases

### GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Target 12: Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system (includes a commitment to good governance, development, and poverty reduction - both nationally and internationally)

Target 17: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries



KEY BENEFITS AND RESOURCE NEEDS BY DISEASE

	HIV	TB	MALARIA
<b>ANNUAL LIVES LOST PER YEAR (BASELINE)</b>	2.8 MILLION IN 2005	1.7 MILLION IN 2004	OVER 1 MILLION DIRECT MALARIA DEATHS
<b>TARGET: ANNUAL LIVES SAVED (2015)</b>	APPROX. 3 MILLION INFECTIONS AVERTED 9.8 MILLION PEOPLE ON ARV BY 2010	0.8 MILLION <sup>1</sup>	0.5 MILLION DIRECT MALARIA DEATH <sup>1</sup> TWO-THIRDS REDUCTION IN UNDER FIVE MORTALITY
<b>TARGET: TOTAL LIVES SAVED OVER PERIOD (2006-2015)</b>	31.1 MILLION INFECTIONS AVERTED <sup>2</sup> 9.8 MILLION PEOPLE ON ARV BY 2010	14 MILLION LIVES SAVED 30 MILLION TB CASES PREVENTED 50 MILLION TB PATIENTS TREATED	2.5-5 MILLION DIRECT MALARIA DEATHS AVERTED <sup>1</sup>
<b>RESOURCE NEEDS (2006-2015)</b>	US\$ 55.1 BILLION <sup>3</sup> (for 2006-2008 only)	US\$ 56 BILLION	US\$ 30 BILLION <sup>3</sup>
<b>RESOURCE NEEDS (2007)</b>	US\$ 18.1 BILLION	US\$ 3.5 BILLION	US\$ 2.9 BILLION
<b>GLOBAL FUND SHARE OF INTERNATIONAL RESOURCES</b>	21%	67%	64%

FIGURE 30: PROJECTED IMPACT AND RESOURCE NEEDS OF ADEQUATE INVESTMENT IN THE CONTROL OF HIV, TB AND MALARIA

Notes: 1. Estimated to have halved in 2015 from baseline. 2. 2005-2015. 3. Estimated based on annual resource needs. Estimates based on: Breman et al. (2004). American Journal of Tropical Medicine and Hygiene. 71 (Suppl 2): 1-15. Global Fund (2006). Funding the Global Fight Against HIV/AIDS, Tuberculosis and Malaria. Rowe et al. (2006). International Journal of Epidemiology. doi:10.1093/ije/dyl027 Roll Back Malaria Partnership (2005) Global Strategic Plan to Roll back Malaria 2005-2015. Stop TB Partnership and WHO (2006). The Global Plan to Stop TB 2006-2015. Stover et al. (2006). Science 311 (5766): 1474-6. UNAIDS (2005). Resource Needs for an Expanded Response to AIDS in Low- and Middle-income Countries UNAIDS (2006). Report on the Global AIDS Epidemic. WHO (2006). Global Tuberculosis Control. WHO and UNAIDS (2006). Progress on Global Access to HIV Antiretroviral Therapy. WHO and UNICEF (2005). World Malaria Report 2005.

## 5.1 INVESTING IN HIV, TUBERCULOSIS AND MALARIA: OVERALL BENEFITS AND COSTS

117. HIV, TB and malaria result in an annual loss of well over five million lives and enormous burdens of illness and economic impacts on households, communities and countries. The achievement of international goals for the control of HIV, TB and malaria by 2015 would result in approximately 50 million lives saved (see Figure 30). In the worst-

affected areas, these diseases can contribute up to 50 percent of the burdens of illness in addition to the numbers of deaths. There are few disease issues that can have such a direct impact on the loss of human life in the poorest countries – and fewer where sustainable and adequate levels of financial support would result in such a radical reversal in suffering and death.

### GLOBAL FUND SHARE OF INTERNATIONAL FINANCING FOR THE THREE DISEASES

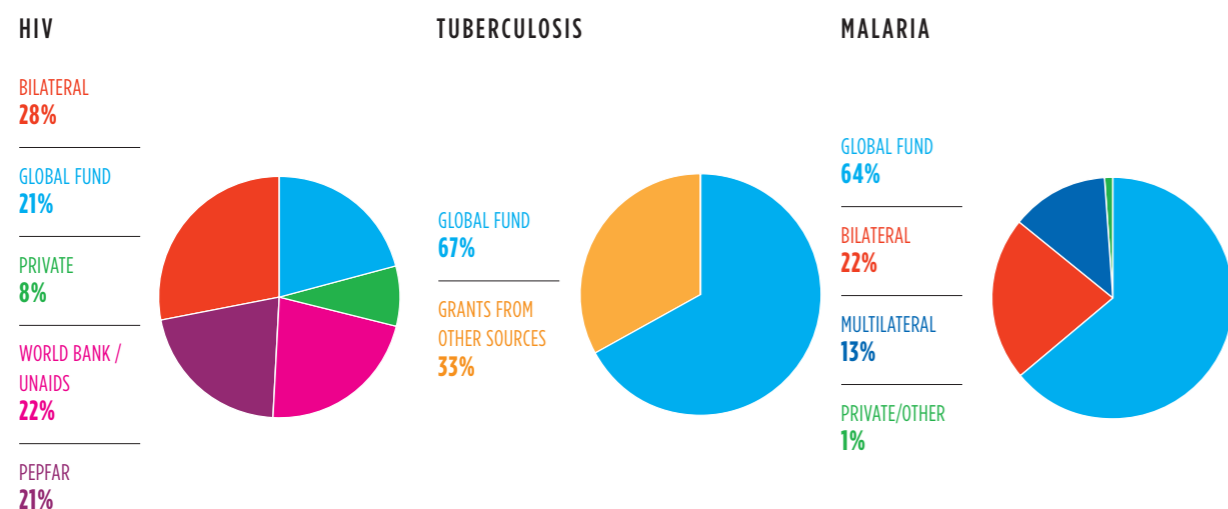


FIGURE 31: GLOBAL FUND SHARE OF INTERNATIONAL FINANCING FOR HIV, TB AND MALARIA

118. There are many funding partners involved in fighting the three diseases globally. The Global Fund currently accounts for 21 percent of international funding commitments for HIV, 67 percent for TB and 64 percent for malaria (see Figure 31). It is, therefore, a major international financing mechanism for investing in impact on the diseases and for the harmonization and pooled efforts of donors.

119. Global resource needs in 2006 are estimated at US\$ 14.9 billion for HIV, US\$ 3.1 billion for TB and US\$ 2.8 billion for malaria. Although international commitments are accelerating the delivery of prevention and treatment services, they are not yet on a scale to constitute an investment in impact on the three diseases. Some countries are showing encouraging early signs of impact, but the achievement of the MDGs will require significantly greater commitment and financing to generalize these results. The world's worst-affected countries are now showing their ambition through their Global Fund grants to meet international targets. These countries require sustained financing to achieve their goals to make an impact on the three diseases.

## 5.2 ARE PROGRAMS FINANCED BY THE GLOBAL FUND REACHING INTERNATIONAL TARGETS?

120. The Global Fund is showing some progress in reaching international targets as shown in Figure 32. By mid-2006, Global Fund-supported programs contributed 29 percent of treatments needed to achieve international target for TB control under DOTS, 18 percent of antiretroviral (ARV) targets – and nine percent of insecticide-treated bed net (ITN) distribution needed to achieve international targets for malaria. These grant-funded programs are still at a relatively early stage of implementation. However, it will be important to track the increasing contributions of these grants to global targets in the coming three to five years.

### GLOBAL FUND RESULTS IN 2006 AND TARGETS FOR 2009 COMPARED TO INTERNATIONAL TARGETS

TARGETS AND RESULTS	ITNs DISTRIBUTED SUB-SAHARAN AFRICA	TB CASES DETECTED UNDER DOTS	PEOPLE ON ARV
<b>INTERNATIONAL TARGETS (2005)</b>	69 MILLION <sup>2</sup>	3.8 MILLION <sup>4</sup>	3 MILLION
<b>GLOBAL FUND RESULTS (MID-2006)</b>	6.3 MILLION <sup>3</sup>	1,400,000	544,000
<b>GLOBAL FUND CONTRIBUTION (MID-2006)<sup>1</sup></b>	9%	29%	18%
<b>INTERNATIONAL TARGETS (2009)</b>	76 MILLION <sup>2</sup>	12 MILLION <sup>4</sup>	8.3 MILLION
<b>GLOBAL FUND TARGETS (2009)</b>	64 MILLION <sup>3</sup>	3.5 MILLION	1.6 MILLION
<b>GLOBAL FUND CONTRIBUTION (2009)<sup>1</sup></b>	84%	28%	19%

FIGURE 32: GLOBAL FUND ACTUAL AND PROJECTED CONTRIBUTIONS TO INTERNATIONAL TARGETS BY 2009

Note: Global Fund figures may include deliveries that are co-financed by others. 1) Global Fund results compared to estimated international targets. 2) Estimates based on 60 percent of high-risk population in sub-Saharan Africa clusters. 3) Figures for sub-Saharan Africa clusters. 4) Estimated cumulative number of new sputum smear-positive cases detected under DOTS strategy since mid-2004, based on Stop TB Partnership and WHO (2006) and WHO (2006) Global tuberculosis control. Estimates based on: Stop TB Partnership and WHO. (2006). The Global Plan to stop TB 2006-2015. UNAIDS. (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries WHO. (2006). Global tuberculosis control.

121. Global Fund-financed programs have set ambitious targets to achieve 84 percent of international targets on ITN distribution by 2009 and 28 percent of TB treatment targets; but only 19 percent of ARV targets. Although ARV targets for the Global Fund increase significantly from the current 544,000 people to 1.6 million by 2009, this is only a fraction of the number of people that need to be provided with ARV treatment by 2009 if the world is to achieve its commonly-agreed targets. Urgent and drastic increases in funding levels are needed if the world is to have any hope of coming near these ambitious goals. To achieve and maintain the international targets for TB and malaria, additional funding will also be required to re-treat bed nets with insecticides and replace worn-out bed nets, and to considerably accelerate TB control program scale-up.

### 5.2.1 MALARIA: MASSIVE SCALING UP OF INTERVENTIONS UNDERWAY

122. One of the most important global targets for malaria control is the Abuja target of protecting 60 percent of populations at high risk in malaria-endemic areas of sub-Saharan Africa. Populations at high risk number more than 115 million in the region.

#### EXAMPLES OF GLOBAL FUND ITN RESULTS AGAINST INTERNATIONAL TARGETS

COUNTRY	ESTIMATED NEEDS, 2005	ITN TARGETS (ESTIMATED) 2005	GLOBAL FUND RESULTS TO DATE	PERCENT OF TARGET
ETHIOPIA	9,960,000	5,980,000	2,030,000	34
NIGER	3,450,000	2,070,000	1,930,000	93
GHANA	3,660,000	2,190,000	780,000	35
ZAMBIA	2,380,000	1,430,000	490,000	34
TOGO	1,200,000	720,000	370,000	51
BENIN	1,720,000	1,030,000	360,000	35
BURUNDI	1,350,000	810,000	260,000	33
GAMBIA	270,000	160,000	84,000	53
NAMIBIA	210,000	130,000	50,000	3
SWAZILAND	50,000	30,000	20,000	63

NOTE: Needs are estimated based on population and ITN targets and are estimated as 60 percent of the needs. Numbers are rounded.

FIGURE 33: ITN NEEDS, TARGETS, AND GLOBAL FUND-FINANCED RESULTS IN SELECTED COUNTRIES

Assuming that one ITN were delivered to each person, 69 million would be needed to achieve the Abuja target. There is significant progress being made towards this ambitious goal (see Figure 33):

- **Two million ITNs were distributed in 2000, three million in 2001, five million in 2002 and 13 million in 2003. Global procurement reached 25 million ITNs in 2005.**
- **Programs supported by the Global Fund have distributed a total of 11.3 million ITNs as of 15 May 2006, with roughly 6.3 million of those distributed in sub-Saharan Africa.**
- **A number of countries have ambitious programs to reach 60 percent of their high-risk populations in 2006-2007, including Eritrea, Malawi, Namibia, United Republic of Tanzania (including Zanzibar) and Zambia. Zanzibar aims to cover 100 percent of its population in 2006 through a concerted national effort supported by the Global Fund and U.S. funding.**
- **Initial evidence of impact includes Burundi, where with rapid roll-out of ITNs and artemisinin-based combination (ACT) treatment, malaria cases declined by 39 percent by 2005. This was significant, as 50 percent of child deaths were due to malaria at baseline (in 2000).**

#### GLOBAL FUND TARGETS AND RESULTS FOR ITNS COMPARED TO INTERNATIONAL TARGETS FOR SUB-SAHARAN AFRICA

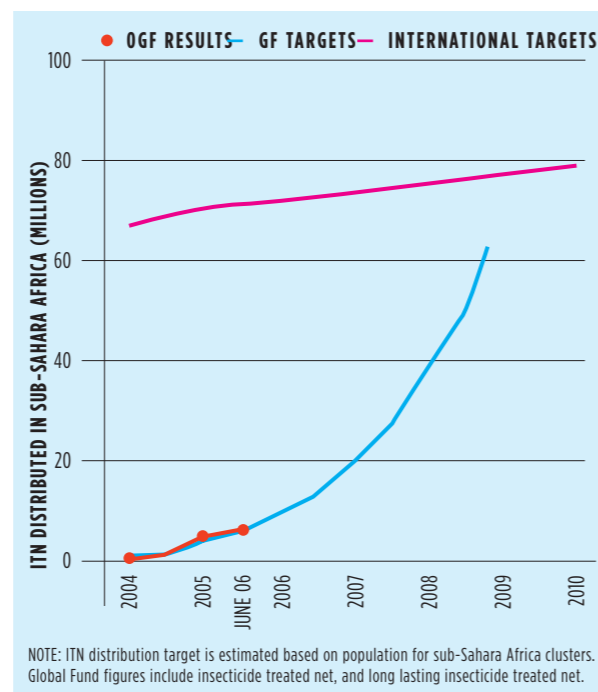


FIGURE 34: NUMBER OF ITNS DISTRIBUTED IN SUB-SAHARAN AFRICA AS AGAINST GLOBAL FUND AND INTERNATIONAL TARGETS

- **In Eritrea, there has been a 50 percent decline in malaria cases, and ITN use by children under five has reached 60 percent. In Zanzibar, there has been a 34 percent reduction in clinical malaria cases associated with increasing ITN use to 67 percent of children under five.**

123. Despite encouraging increases in ITN use and access to effective treatment and early signs of impact, the results are still a small fraction of the numbers needed to achieve the Abuja target and the MDGs. In addition, to understand the actual usage of ITNs, population-based surveys are needed. Partners such as the United Nations Children's Fund (UNICEF) and Monitoring and Evaluation to Assess and Use Results (MEASURE) conducted surveys such as the "Multiple Indicator Cluster Survey" and "Demographic and Health Surveys" in many grant-funded countries in 2005. The results of surveys will be available at the end of 2006 and in 2007. A number of programs supported by the Global Fund are nevertheless showing encouraging scale-up of ITN distribution, as illustrated in Figure 33.

124. Looking forward, if the MDGs are to be achieved, a one-third reduction in under-five mortality by 2010 and a two-thirds reduction by 2015 are expected in malaria-endemic areas. Correct ITN use results on average in a 50 percent reduction of uncomplicated malaria episodes and 5.5 fewer deaths per 1,000 children per year in malaria-endemic sub-Saharan Africa. Increasing the coverage of ITNs not only reduces malaria episodes and deaths, but also reduces indirect deaths due to malaria-caused anemia. Global Fund-financed programs also procure effective malaria drugs to further prevent malaria deaths.

125. Figure 34 shows the exponential increase required in ITN distribution to reach international ITN targets. It also shows that the targets of programs supported by the Global Fund will contribute significantly to an impact on malaria and the MDGs. To reach the MDGs for malaria control, an estimated US\$ 30 billion will be needed from 2006 to 2015, roughly US\$ 3 billion per year. It has been estimated (based on macroeconomic models) that reducing malaria burdens by 50 percent by 2015 would have annualized net benefits of US\$ 3 to US\$ 10 billion<sup>(5)</sup>. Investments in malaria reduce mortality and malaria burdens, and are likely to pay off directly in terms of economic returns in malaria-affected countries.

(5) Teklehaimano et al. *Coming to grips with malaria in the new millennium*. Millennium Project 2005. New York, United Nations, 2005.

### 5.2.2 TB: NEW ROUNDS OF FINANCING NEEDED TO REACH INTERNATIONAL GOALS

126. The international target for TB control is, by scaling up quality programs under DOTS, to achieve a 70 percent case detection rate in all high-burden countries (HBCs) and an 85 percent rate of successful treatment by 2005 (WHO will produce its report on 2005 results in 2007 due to the delay in reporting on treatment outcomes). These are essential interim targets to halt and begin to reverse TB disease burdens by 2015, as envisioned in the MDGs. Significant progress has been made towards the interim goals to date:

- As of 15 May 2006, Global Fund-supported programs reported 1.4 million people with TB detected under DOTS. The result is approximately 29 percent of expected new cases contributing to international increases in case detection since mid-2004.
- A number of countries with high TB disease burdens, such as China, reached the Stop TB Partnership's targets for 2005 with the support of the Global Fund. Increases in case detection in China went from 45 percent at baseline to 78.7 percent in 2005. The treatment success rate was 91 percent.
- There are early signs of declining TB prevalence in a number of HBCs, including China, India and Indonesia.

#### GLOBAL FUND TARGETS AND RESULTS FOR DOTS COMPARED TO INTERNATIONAL TARGETS

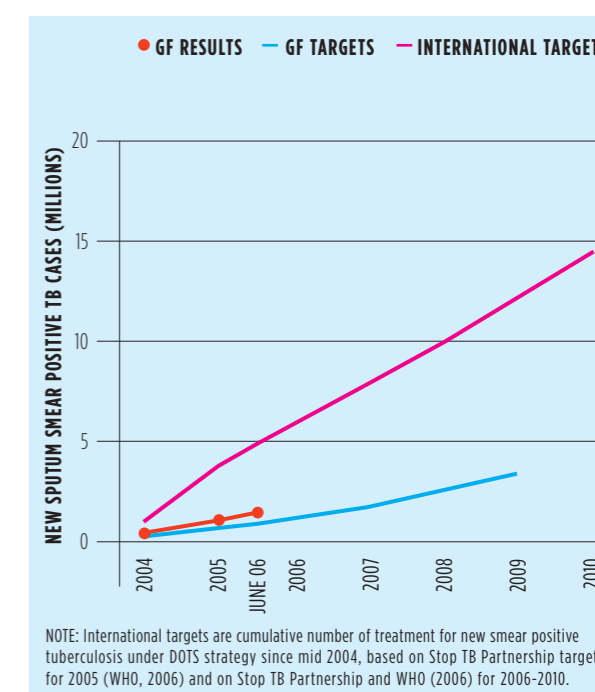


FIGURE 35: GLOBAL FUND TARGETS AND RESULTS FOR NEW SPUTUM SMEAR-POSITIVE TB DETECTED UNDER DOTS COMPARED TO INTERNATIONAL TARGETS BY 2010



127. Looking forward, the target for TB control is to reduce the prevalence and mortality of TB by 50 percent by 2015 compared with the 1990 baseline. The HIV pandemic has caused a significant negative impact on TB control, particularly in sub-Saharan Africa where TB is the leading cause of death in people living with HIV. Unless efforts to control HIV and TB epidemics are dramatically scaled up in the most severely hit regions, MDG targets to halve TB will likely be missed. However, if the world manages to achieve the MDG targets through serious resource mobilization and political commitment, TB may eventually be eradicated by 2050.

128. Figure 35 shows Global Fund results and targets against international targets. Although Global Fund results are ahead of targets, there is a long way to go to reach international goals. A significant scaling up of TB support is required, and it began with the approval of Round 5 grant proposals to the Global Fund in late 2005. Twenty four new TB grants were approved worth a total of US\$ 221 million over the first two years. After grant agreements have been signed for all new TB grants, the Global Fund will increase its overall TB targets accordingly.

**EXAMPLES OF GLOBAL FUND ARV RESULTS AGAINST INTERNATIONAL TARGETS**

COUNTRY	ARV NEEDS, 2005	3 BY 5 TARGETS, 2005 (ESTIMATED)	GF RESULTS TO DATE	PERCENT OF TARGET
THAILAND	135,000	67,500	70,000	104%
ZAMBIA	183,000	91,500	56,000	61%
MALAWI	169,000	84,500	46,000	54%
CÔTE D'IVOIRE	111,000	55,500	21,000	38%
CAMEROON	108,000	54,000	22,000	41%
RWANDA	49,000	24,500	22,000	90%
NAMIBIA	41,000	20,500	19,000	93%
CHINA	78,000	39,000	14,000	36%
SWAZILAND	42,000	21,000	13,000	62%

NOTE: ARV needs are from WHO and UNAIDS (2006) Progress on global access to HIV antiretroviral therapy. 3 by 5 targets are estimated as half of ARV needs. Numbers are rounded.

FIGURE 36: ARV NEEDS, TARGETS, AND GLOBAL FUND RESULTS IN SELECTED COUNTRIES

129. Global Fund grant recipients propose expanding TB case detection in the next few years to reach international targets. By 2009, 28 percent of cumulative treatment will have been provided by Global Fund-supported programs. Taken on an annual basis, these programs will provide almost 41 percent of the target for TB treatment in 2009.

130. Once fully implemented, the Global Plan to Stop TB<sup>(6)</sup> is expected to provide treatment to 50 million people in the next decade. Overall, 14 million lives will be saved from 2006 to 2015. The cost of treatment per patient is inexpensive, at around US\$ 20 to US\$ 35 among most of the 22 HBCs (with a low of US\$ 10 in India to a high of US\$ 145 in the Russian Federation)<sup>(7)</sup>. Each person with smear-positive TB who is diagnosed and treated saves the treatment costs of others who would potentially have been infected. Thus, TB treatment is also an excellent investment in prevention. The Global Plan costs about US\$ 150 per disability-adjusted life year gained, or less than US\$ 1 per day of life saved.

**GLOBAL FUND ARV TARGETS AND RESULTS**

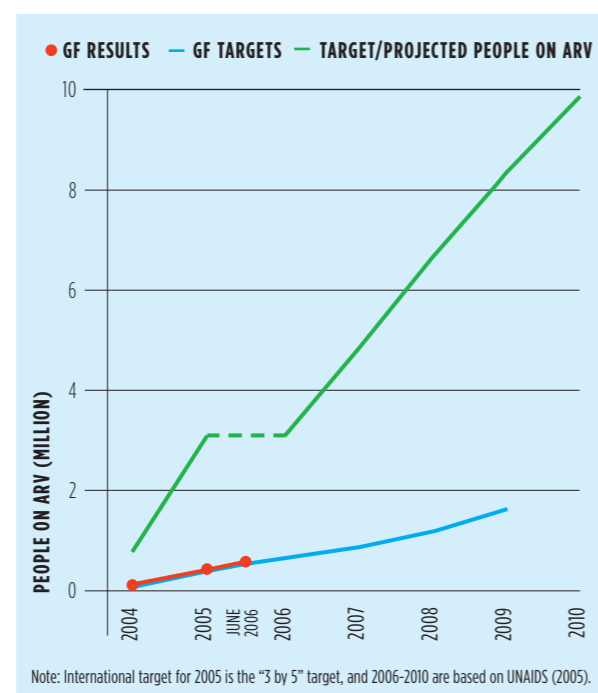


FIGURE 37: GLOBAL FUND TARGETS AND RESULTS FOR ARV TREATMENT COMPARED TO INTERNATIONAL TARGETS

**5.2.3 HIV: A DIFFERENT LEVEL OF FINANCING REQUIRED TO REACH UNIVERSAL ACCESS**

131. Under the leadership of WHO and UNAIDS, the world aimed to provide three million people needing ARVs with treatment by 2005 in an initiative known as “3 by 5”. Actual global treatment figures by the end of 2005 were 1.3 million people on ARVs – significantly higher numbers than were considered possible in low- and middle-income countries before the initiative began in 2003, but less than half of the target. Towards the end of the “3 by 5” initiative, at their summit in 2005, the G8 (Group of Eight) countries endorsed a new goal of universal access to ARVs for those in need by 2010.

132. Global Fund-financed programs have contributed to international targets in a number of regions:

- **Global Fund-supported programs have provided ARV treatment to 544,000 people to date, or 18 percent of the “3 by 5” target. The Global Fund has also demonstrated the effectiveness of country-driven targets, as overall grant-financed program targets for ARV treatment have been reached.**
- **Some Global Fund-supported programs have set ARV treatment targets for 2006-2007 that go beyond WHO/UNAIDS targets, including Cambodia, Cuba, Djibouti, Ethiopia, Guyana, Jamaica, Peru, the Russian Federation, Swaziland and Zambia, among others. Ethiopia and the Russian Federation intend to reach universal access to ARVs for those in need by the end of 2007-2008.**
- **A few Global Fund-supported programs already have results that represent a significant percentage of their “3 by 5” targets, including Malawi (54 percent), Rwanda (90 percent), Thailand (104 percent) and Zambia (61 percent) (see Figure 36).**
- **In addition, country, community and personal ownership of HIV prevention is beginning to show some impact, with early signs of declining HIV prevalence in a number of countries, including Rwanda and the United Republic of Tanzania**
- **ARV treatment is already having a significant impact on the mortality of people on treatment, and in some countries is now freeing up capacity in health centers with beds now available that were previously 50 percent occupied by patients with AIDS-related conditions.**

- **Some countries are building sustainable ARV treatment programs. For example, the Russian Federation has plans to provide universal access to HIV treatment by 2008 and to increase domestic resources to sustain the program.**

133. A broad range of stakeholders representing various constituencies convened for the UNAIDS resource estimation exercise expected to reach 9.8 million people on ARVs by 2010. This will cover 68 percent of ARV needs, defined as people living with HIV two years before death<sup>(8)</sup>. This is in line with the universal access targets that the G8 has agreed to support.

134. The Global Fund’s 2009 target is to provide 1.6 million people with ARV therapy. In other words, Global Fund-supported programs aim to deliver 19 percent of the international target expected for 2009 (which is 8.3 million people on ARVs out of an estimated international need of treatment for 12.4 million people). Global Fund-supported programs will continue to contribute significantly to the global ARV scale-up, but it is clear that to achieve universal access to treatment for those in need, availability of ARVs requires much more rapid acceleration and significantly greater investments of additional financial resources worldwide (see Figure 37).

135. In the coming years, there will be the opportunity to save millions of lives through investing in effective prevention measures. Such investments will again lead to substantial savings by reducing the future number of people needing AIDS treatment. Between 2005 and 2015, it is estimated that 31.1 million HIV infections could be averted globally if an effective package of prevention, testing and treatment activities is funded and implemented. The total cost for the prevention package for this ten-year period would be US\$ 122 billion. However, US\$ 147 billion would be needed to provide the treatment and care for 31.1 million people who would otherwise be infected<sup>(9)</sup>. The difference of US\$ 25 billion would be the net savings.

(6) Stop TB Partnership and WHO. *The Global Plan to stop TB 2006–2015*. Geneva, World Health Organization, 2006.

(7) *Global tuberculosis control*. Geneva, World Health Organization, 2006.

(8) *Resource needs for an expanded response to AIDS in low- and middle-income countries*. Geneva, Joint United Nations Programme on AIDS, 2005.

(9) Stover J et al. The global impact of scaling up HIV/AIDS prevention programs in low- and middle-income countries. *Science*, 2006, 311(5766):1474–1476.

## 5.3 EARLY SIGNS OF IMPACT

136. The Global Fund is starting a concerted effort alongside partners to plan for and show early signs of impact in the coming three to five years. Since impact on HIV/AIDS, TB and malaria will come as a result of the collective efforts of all national and international partners, collaboration with global efforts is very important to document impact at the national and international levels. The major initiatives and impact indicators are shown in Figure 38.

137. The Roll Back Malaria Partnership and its Monitoring & Evaluation Reference Group provides technical advice on monitoring and evaluation issues, including measuring the progress at impact level. The Secretariat, in close collaboration with Roll Back Malaria partners such as UNICEF and MEASURE, is working to ensure that adequate information will be collected in the countries where Global Fund-supported grants operate, particularly through population-based surveys.

138. The Stop TB department of WHO, in collaboration with national TB control programs, updates estimation models of TB epidemiology based on scientific understanding and available information in countries. This forms the basis of measuring the impact of TB control and its progress towards achieving the related MDGs. To improve understanding of epidemiology and knowledge of TB and, through this, to refine TB measurements at the impact level, the Global Fund Secretariat actively engages in ongoing discussions with partners and is advocating strengthening surveillance systems to conduct surveys where feasible – including disease prevalence surveys – and to promote operations research.

139. Measurements of HIV at impact level, such as the estimated number of people infected with HIV, are driven by UNAIDS and WHO with national partners. The Global Fund Secretariat fully supports this important work and promotes better quality information in countries. Most international attention has been on scaling up ARV treatment to reduce mortality, but impact on preventing HIV should also be monitored.

140. One way to measure the impact of prevention efforts is to estimate the number of averted infections, which the Global Fund is currently working on with the U.S. Census Bureau and partners, including the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The Secretariat has agreed with the U.S. Census Bureau to investigate methods to estimate infections averted using country data. Baseline projections are being prepared with possible calibration using population-based survey results as they become available. An example of a standard model is shown in Figure 39, together with the baseline developed for the Cambodia epidemic based on national data (see Figure 40).

141. The Global Fund will initially look at early signs of impact in Cambodia and Malawi using this approach, as well as in regions of India. An update will be provided to technical partners (including the UNAIDS reference group), and the first studies should be available in 2007. These will then be expanded to a number of countries as jointly agreed by PEPFAR and the Global Fund.

142. In addition, capturing existing country data and stories of early signs of impact will be as important as the modeling and estimation approaches. A selection by disease and country are included below.

### EARLY SIGNS OF IMPACT ON TB IN INDONESIA

143. Approximately 80 percent of new TB cases in the world are concentrated in 22 HBCs, which includes Indonesia. Home to 220 million inhabitants, Indonesia was estimated to have 539,000 new TB cases and 101,000 TB deaths in 2004.

144. A TB program in Indonesia was funded by a five-year, US\$ 69 million grant from the Global Fund. As of June 2006, US \$32 million had been disbursed, filling the funding gap identified in Indonesia's national TB plan. The grant allowed a rapid strengthening of Indonesia's TB control program with the capacity to identify and treat an increasing number of people with TB. Diagnostic capabilities and drug management have been improved, and monitoring and supervision have been enhanced. In 2004, a total of 210,000 treatments were financed through the Global Fund grant, including treatment for 129,000 new smear-positive TB patients, equivalent to 53 percent of the entire new smear-positive cases estimated to occur in Indonesia. This is nearly a 40 percent increase from 2003. The treatment success rate, which indicates the overall quality of the program, has reached the global target of 85 percent. This improvement is the result of a collaborative effort between national and international partners fueled by Global Fund financing.

### IMPACT INDICATORS FOR MAJOR INITIATIVES

DISEASE TARGET	MEASUREMENT		
	MORBIDITY	INFECTIONS AVERTED	MORTALITY
HIV/AIDS	% of young women and men who are HIV infected (MDGs, UNGASS)	% reduction of infants born to HIV infected mothers who are infected (UNGASS)  Estimated number of infections averted (PEPFAR)	% of adults and children still alive 12 months after ART (UNGASS)
TUBERCULOSIS	Estimated number of TB cases per 100,000 (MDGs)		Estimated number of death due to TB per 100,000 (MDGs)
MALARIA	Incidence of clinical malaria cases; estimated or notified per 100,000 (MDGs)		Death rates associated with malaria (MDGs)

FIGURE 38: MAPPING OF DISEASE IMPACT INDICATORS FOR MAJOR INITIATIVES

### STANDARD MODEL SHOWING BASELINE WITH INFECTIONS AVERTED FOR HIV IN CAMBODIA

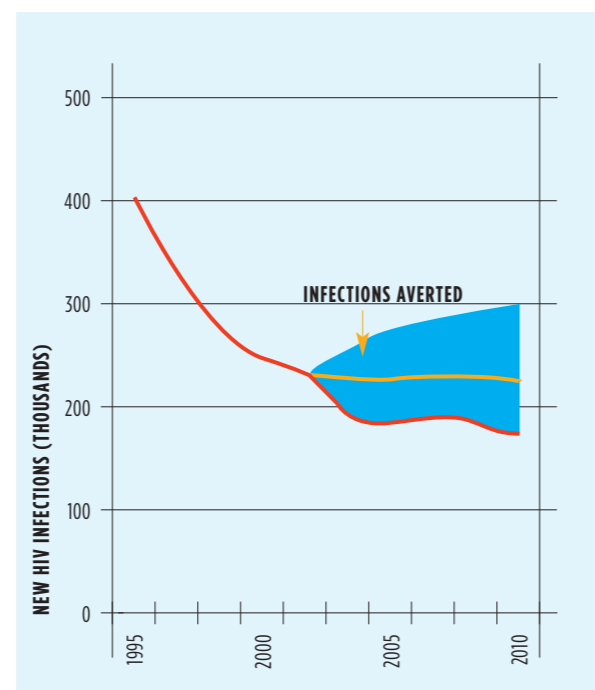


FIGURE 39: MODELING OF HIV INFECTIONS AVERTED IN CAMBODIA 1995-2010

### BASELINE HIV EPIDEMIC IN CAMBODIA

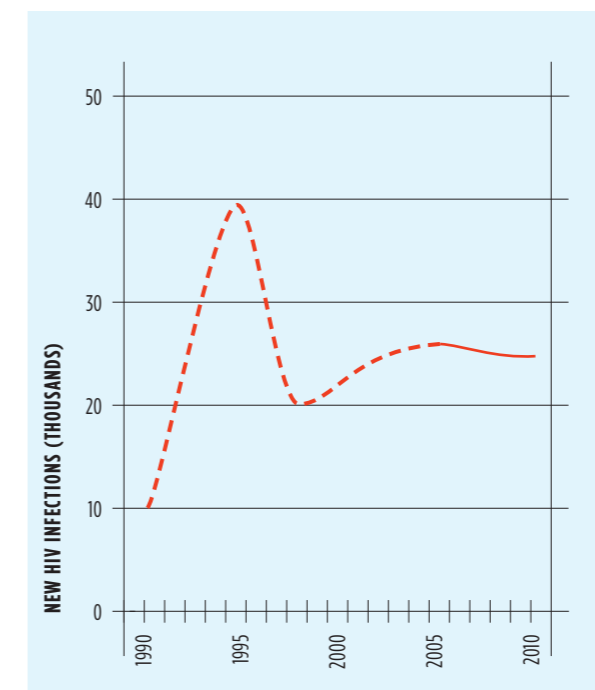


FIGURE 40: BASELINE DATA OF THE HIV EPIDEMIC IN CAMBODIA 1990-2010

### EARLY SIGNS OF DECLINING TB CASES IN INDONESIA

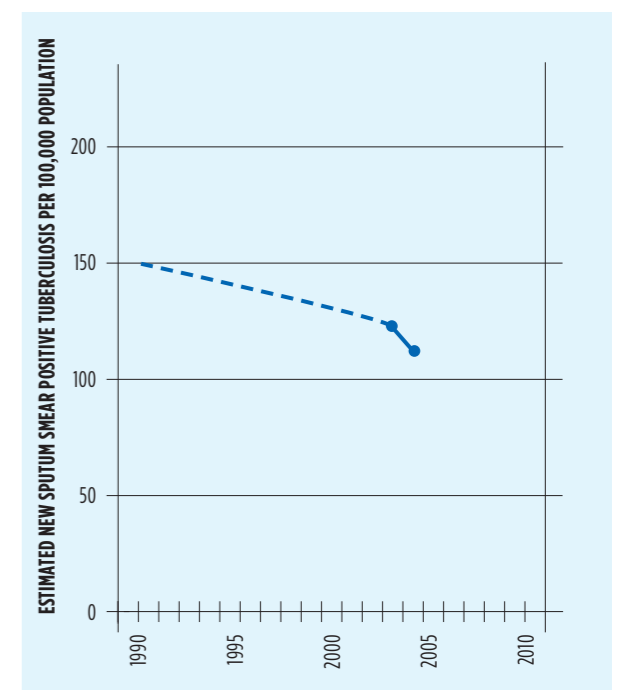


FIGURE 41: NEW SMEAR-POSITIVE TB CASES IN INDONESIA  
SOURCE: WHO (2005, 2006) GLOBAL TUBERCULOSIS CONTROL. (2003 THE PREVIOUS ESTIMATE)



145. A national prevalence survey conducted in 2004 has indicated that the burden of TB in Indonesia has declined substantially over the past two decades. It is now estimated that TB incidence was 245 per 100,000 population in 2004, compared to 343 per 100,000 in 1990. With another US \$37 million expected to be disbursed through its ongoing TB grant and a second grant coming onstream later this year, Indonesia's TB control effort is set to considerably accelerate the reduction in its TB burden (see Figure 41).

### EARLY SIGNS OF MALARIA IMPACT IN SUB-SAHARAN AFRICA

146. Controlled trials of ITNs have consistently demonstrated reductions in all-cause child mortality and other significant health benefits for young children and pregnant women in impoverished rural areas of sub-Saharan Africa. For example, a worst-case scenario of intense, perennial malaria transmission in western Kenya has shown that high-level coverage of ITNs provided significant and sustained benefits to young children and pregnant women, the two main target groups for malaria prevention and control in sub-Saharan Africa.

147. In the initial trial, all-cause child mortality was reduced by 23 percent, and episodes of clinical malaria and moderate-to-severe anemia dropped among children less than five years of age. In addition, among pregnant women who slept under ITNs, levels of the malaria parasite and severe malaria-related anemia were reduced by 38 percent and 47 percent, respectively, and there were 28 percent fewer low-birth weight babies born to these mothers.

148. Recognition of the dramatic health benefits resulting from high-level coverage of ITNs in a wide variety of transmission settings in sub-Saharan Africa led to the call by African heads of state at the summit in Abuja, Nigeria, in April 2000 to ensure that at least 60 percent of children under five and pregnant women were sleeping under ITNs to prevent malaria and had full access to prompt, effective treatment for malaria.

149. The launch of the Global Fund in 2002 has provided critical support to many countries that had previously been reluctant to change their drug policies to more effective treatment regimens or to adopt ITNs as part of malaria prevention efforts due to the significant costs associated with the adoption of such policies. Positive results of Global Fund investments in malaria prevention and control, in collaboration with other funding agencies, are clearly beginning to be seen even at this early stage of grant implementation.

150. **Eritrea:** About two-thirds of Eritrea's population lives in malaria-endemic areas. In 1997 and 1998 Eritrea experienced a series of malaria epidemics that resulted in more than 424,000 cases and over 500 hospital malaria deaths in 1998 alone. Following these severe outbreaks, Eritrea established a comprehensive National Malaria Control Program (NMCP). The NMCP has had strong national leadership, has been successful in attracting increased financial support through the Global Fund, the World Bank, United States Agency for International Development (USAID) and others, and has effectively implemented evidence-based strategies at a national scale. By 2003, more than 60 percent of all children less than five years of age and 50 percent of all ages in malarious areas were sleeping under ITNs during the transmission season. In addition, the Ministry of Health has established and trained a large network of village health agents who provide combination anti-malarial treatment for uncomplicated malaria and refer more serious cases to health facilities. Over the past five years, the number of reported malaria cases has decreased by more than 50 percent (see Figure 42). In addition, malaria mortality has decreased by more than half in both young children and in the population as a whole.

151. **Zanzibar:** The entire population of Zanzibar is at risk of malaria for large parts of the year. Malaria is by far the greatest single cause of illness on the island, accounting for over 40 percent of outpatient clinic visits. In 2002, Zanzibar was one of the first recipients of a Global Fund grant for malaria, with a second successful grant application in 2004. The first 700 ITNs were bought through donations from tourists and were sold to affected families at half price. With the arrival of Global Fund support, the country's NMCP has been able to distribute 300,000 free ITNs to the most vulnerable groups of young children and pregnant women. In addition, Zanzibar now provides ACT treatment to those with malarial illness. During the last three years, the NMCP has documented that 67 percent of children under five now sleep under an ITN. This has so far resulted in a 34 percent reduction in clinical cases. In addition, a reduction in malaria mortality is also beginning to be documented. A concerted effort in 2006 funded by the Global Fund and USAID and the U.S. Centers for Disease Control aims to cover all households with ITNs and undertake indoor residual spraying, with follow-up to ensure consistent ITN use. The aim is to virtually eliminate malaria-related mortality from the population by 2007.

152. **Burundi:** Around 80 percent of Burundi's population of 7.2 million is at risk of malaria. In 2000, more than 50 percent of outpatient visits were for malaria. In addition, malaria was estimated to contribute directly and indirectly to 48 percent of child deaths. In 2000, Burundi was one of the first African countries to adopt a national policy of using ACT therapy (for drug-resistant malaria) as the first-line treatment for malaria. The early Global Fund grant gave the country financial security to proceed with implementing this more effective treatment regimen along with improved access to confirmed diagnosis and ITNs on a national scale. Since the end of 2003, the NMCP has distributed more than 260,000 ITNs to young children and pregnant women. In 2005, Burundi reported 1.9 million malaria cases, a 39 percent decrease from the 3.1 million cases reported in 2000.

### DECLINING HIV INCIDENCE AND AIDS-RELATED MORTALITY IN THAILAND

153. In the 1990s, Thailand's successes in bringing down HIV transmission were widely recognized and celebrated. If the pace of the HIV epidemic had remained unchanged during the 1990s, there may have been as many as 7.7 million HIV-infected people and 850,000 people with AIDS in 2005. By contrast, the current estimates are that there are 572,500

people living with HIV and 49,500 people with AIDS. Now, with Global Fund support, Thailand is making rapid and impressive progress towards achieving universal access to ARV therapy and establishing a nationally-financed ARV program for all affected Thai nationals.

154. During the past two years, with Global Fund financial support, nearly 2,000 health-care workers have been trained to provide ARV therapy, prevention education and management for opportunistic infections. Over 900 health-care facilities have been equipped to carry out HIV/AIDS diagnosis and treatment, and reference laboratories have been equipped with essential equipment such as CD4 counters and viral load machines. As a result of all these efforts, almost 80,000 people have been enrolled in ARV programs nationally in Thailand with significant reductions in mortality for these groups (see Figure 43).

155. This scale-up would have been much slower without Global Fund resources. It has, therefore, saved the lives of many Thai people who have been able to benefit from the recent expansion of ARV in the country. Preliminary analysis of ARV survival carried out by the Bureau of AIDS, Tuberculosis and Sexually Transmitted Diseases in the Ministry of Public Health suggests that AIDS-associated mortality has reduced

### EVIDENCE OF DECLINING MALARIA MORTALITY AND MORBIDITY IN ERITREA

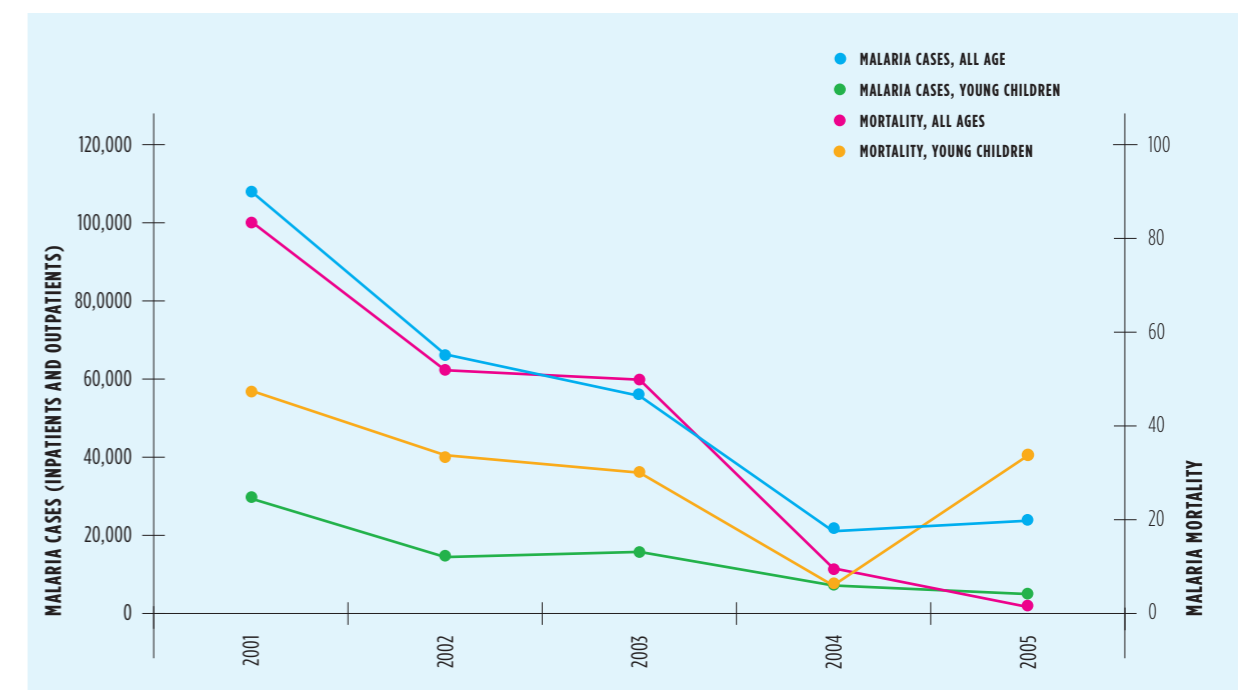


FIGURE 42: DECLINING MALARIA CASES AND MORTALITY IN ERITREA AMONG CHILDREN UNDER 5 AND OVER 5

to less than ten percent for those on ARV treatment compared to an almost 95 percent two-year mortality without ARVs. With the support of Global Fund financing, the Thai national health infrastructure has also been upgraded to ensure the continued expansion of quality ARV services. The government of Thailand anticipates fully taking over the financial responsibility for ARV provision for all Thai citizens under the country's national Universal Health Care Scheme.

## 5.4 SYSTEMATIC EVALUATION OF IMPACT: THE FIVE-YEAR EVALUATION

156. It is important to highlight the early successes in impact on AIDS, TB and malaria. An exceptional effort (financial, political and in terms of sustained work by countries) is required if these early successes are to be generalized to achieve global impact over the next three to five years. The Five-year Evaluation aims to systematically assess the overall impact of the Global Fund in grant-funded countries (see Box 9).

### DIRECTION AND DESIGN

157. The independent Technical Evaluation Reference Group (TERG) to the Global Fund has recommended a direction and design for the evaluation as follows:

- A synthesis evaluation report on the first two overarching questions (Global Fund organizational efficiency and partner environment) will be presented to the Board in November 2007.
- Recognizing that impact cannot be measured before grants reach their full five-year term, a concluding synthesis report on health outcomes and disease impact will be presented to the Board in November 2008.
- In many countries, the Global Fund is one of several major international investors. Therefore, the Global Fund should not attempt to evaluate the impact of its efforts alone, but should recognize the contributions of all relevant partners.
- For the purposes of the Five-year Evaluation, the Global Fund defines impact as “the measurement or estimation of overall program impact on disease morbidity and/or mortality, brought about by all control initiatives and programs combined, irrespective of their financing source(s) in a country or region”.
- The early phase of the evaluation should contribute to the development of the Global Fund’s strategy for the period mid-2006 to 2010.

### ENGAGING STAKEHOLDERS

158. Within the overarching questions, priority questions and issues for the Five-year Evaluation are being developed with extensive stakeholder consultation. Currently, a formal stakeholder assessment is underway, designed to compile and analyze the views of partners and stakeholders on the strengths and weaknesses of the Global Fund. Results will help to further shape the scope and scale of the evaluation. A wide range of participants are involved, including all registered participants in the Partnership eForum; invited attendees of the Partnership Forum in July 2006; Board members, alternates and focal points; members of the donor community and technical partners; Country Coordinating Mechanism members; and Principal Recipients (PRs), Local Fund Agents (LFAs) and civil society representatives. The Five-year Evaluation will provide a comprehensive review of the impact of the Global Fund from the widest possible range of perspectives and contribute to the organization’s next strategic plan.

### THAILAND AIMS TO FURTHER REDUCE HIV INCIDENCE ALONGSIDE IMPACT ON HIV MORTALITY

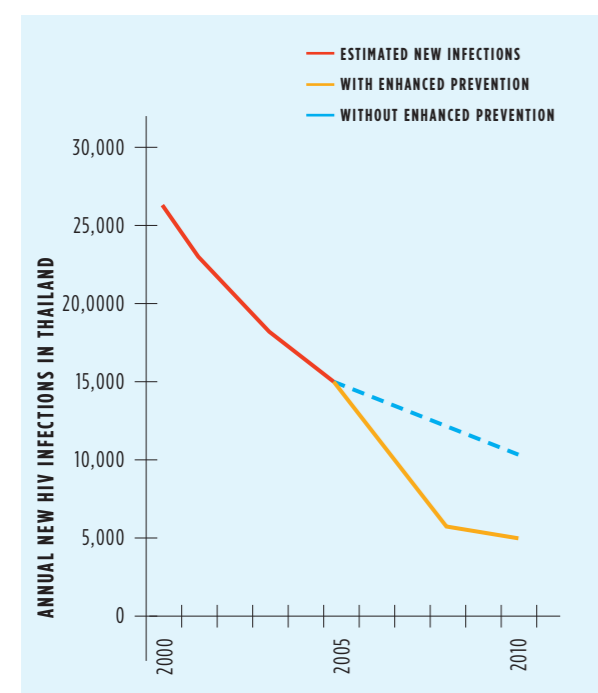


FIGURE 43: PROJECTED REDUCTIONS IN NEW HIV INFECTIONS WITH AND WITHOUT ENHANCED PREVENTION ACTIVITIES IN THAILAND

### BOX 9: OVERARCHING QUESTIONS FOR THE FIVE-YEAR EVALUATION

1. Does the Global Fund as an organization (Board, Secretariat, TRP, LFAs) through both its policies and operations, reflect the core principles, including: **a.** Acting as a financial instrument rather than implementation agency; and **b.** Furthering country ownership?

In fulfilling these principles, does the Global Fund as an organization perform in an efficient and effective manner?

2. How effective and efficient is the Global Fund partnership system in supporting HIV, malaria, and TB programs at country level?

3. What is the Global Fund’s contribution to reducing the burden of the three diseases? What has been the overall reduction on the burden of the three diseases?



NICASALUD, THE PRINCIPAL RECIPIENT IN NICARAGUA, SENDS TEAM TO REMOTE LOCATIONS SUCH AS THE BLUEFIELDS REGION TO ASSIST LOCAL INHABITANTS WITH INDOOR RESIDUAL SPRAYING TO PREVENT MALARIA.



## 6. CHALLENGES TO INVESTING IN IMPACT

The scale, focus and performance of the Global Fund's grants to date suggest that it is possible to invest in substantial, measurable impact against HIV, TB and malaria over the coming three to five years. The ability of countries to use global financing effectively to accelerate the scale-up of services; the increasing efforts with partners to make the money work harder; progress against international targets; and some early signs of success: all of these indicate that conditions are in place to turn financial investments into impact. The challenge is to scale up financing, country and partner commitments to generalize local successes into national and global impact.



There will be many challenges along the way: for the Global Fund; for countries to build systems and manage accelerating results; for partners to make aid more effective; and for donors to find the resources to invest in impact. The challenges highlighted in this report include:

1. Strengthen performance-based funding incentives so that finance is used rapidly and effectively and focused on providing services to the end user in need;
2. Ensure Global Fund grants support the important balance of service delivery and systems-building required to continue to accelerate results;
3. Strengthen the transparency and sharing of grant data, with particular improvements required for procurement and financial expenditure data, to allow countries and partners to respond to improve implementation;
4. Use the flexibility of Global Fund mechanisms to build on and formalize work with a wide range of partners to support grant implementation. Ensure implementation assistance is best targeted to assist the needs of country programs;
5. Evaluate procurement delays, and new approaches to strengthening supply chains in country and innovative approaches to improve global supply, particularly for malaria;
6. Strengthen investments to build impact and MDG targets into grant agreements, and ensure that the relevant data, baselines and follow-up surveys are funded with partners in order to show and learn from early signs of impact;
7. Work with partners to continue to translate international principles into practice, as agreed in the Paris Declaration for Aid Effectiveness, and to measure the progress of global partnerships against the targets for 2010;
8. Recognize that harmonization principles also apply at community level, and include basic community systems strengthening measures in grants to support delivery of key services;
9. Strengthen country ownership and involvement through the principles of the CCM without creating parallel structures;
10. Learn from early country models of impact on HIV, TB and malaria and assess how best to generalize them in different settings;
11. Scale up funding for HIV, TB and malaria. To reach the goals of universal access requires a completely new and sustainable level of international finance;
12. Contribute to the wider learning process of the Five-year Evaluation of the Global Fund system as a broad group of stakeholders. The Global Fund has shown remarkable results in a short period of time, but there are many areas where it has not yet got it right. This extensive evaluation should help the strategic process to improve the Global Fund to invest in impact in the next five years.

159. The Global Fund cannot tackle these challenges alone. It needs to work intensively with partners to improve the critical conditions for health investment for countries and donors including:

- **Longer-term, costed national health and disease plans;**
- **Better links from health to development and sector spending frameworks;**
- **Strengthened financial, accountability, supply chain and information systems;**
- **Strengthened wider national structures to ensure the quality and accreditation of the scale-up of service delivery, training and health systems;**
- **Improved country and community ownership, participation and involvement in the governance and implementation of the fight against HIV, TB and malaria.**

**The Global Fund is a network rather than a traditional development organization.**

**The successes and challenges laid out in this report go far beyond what can be achieved by one organization.**

**It requires mobilization from community, national, international and donor levels to rise to the challenge of investing in impact, and in doing so, contribute to the collective efforts which are the Millennium Development Goals.**

# APPENDICES



# APPENDIX 1: ANTIRETROVIRAL RESULTS BY COUNTRY AND RELATED QUESTIONS

This brief outlines the methods and principles involved in determining the number of people as of 1 June 2006 on ARV treatment through the implementation of Global Fund grants. The Global Fund has undertaken this research in close consultation with its partners as part of the World Health Organization (WHO) “3 by 5” initiative and the implementation of the Joint United Nations Programme on AIDS (UNAIDS)-initiated “Three Ones” for the coordination of HIV response at the national level. This fact sheet is intended to provide further details and breakdown of the results together with answers to frequently asked questions.

### Question 1: How many people are receiving ARV treatment from programs supported by Global Fund grants?

As of 1 June 2006, programs supported by the Global Fund have a reported 544,000 people currently on ARV treatment for HIV/AIDS.

### Question 2: What is the regional breakdown of people receiving ARV treatment?

The map below and the accompanying table show the regional breakdown of people on ARV treatment. East Africa has the highest number of people on ARV treatment, followed by Southern Africa, East Asia and the Pacific, and West and Central Africa.

### Question 3: What is the country-by-country breakdown of people receiving ARV treatment?

The regional totals are further broken down into country-by-country results in the table below. These figures are as of 1 June 2006. For a complete explanation of the methodology used, please see below.

### Question 4: How is the number of people on treatment determined?

There are three stages of calculation of the number of people receiving treatment:

**Step 1: Verified grant results:** results from each grant of unique individuals currently on treatment are verified by the Local Fund Agent (LFA) in the country, then submitted to the Global Fund and compiled in a database.

**Step 2: Country compilation:** in countries where there are multiple grants, data from each grant is assessed individually against the criteria shown below to determine if the Global Fund provides significant support to the national ARV program or to a more restricted project. Grant data for all of the grants in the country are then compiled to produce overall country estimates.

**Step 3: Partner harmonization:** country-level data is then shared and compared with the results of other international partners – WHO HIV/AIDS program, U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), World Bank, UNAIDS and others. The partners discuss the consistency of country-level data and consider issues of data reliability and reporting as well as making a judgment concerning the level of contribution that each organization makes to the national effort.

EAST AFRICA	147,000
SOUTHERN AFRICA	185,000
EAST ASIA & THE PACIFIC	99,000
WEST AND CENTRAL AFRICA	63,000
LATIN AMERICA & THE CARIBBEAN	34,000
SOUTH ASIA	8,500
EASTERN EUROPE & CENTRAL ASIA	4,500
NORTH AFRICA & THE MIDDLE EAST	3,000
<b>TOTAL</b>	<b>544,000</b>

THE ABOVE REGIONAL NUMBERS ARE ROUNDED FROM THE COUNTRY TABLES ON THE NEXT PAGE

Three international meetings have occurred to harmonize data so far: in December 2004, June 2005 and December 2005. Results were provided to the WHO “3 by 5” program where they were harmonized so as to report national figures that represent unique numbers of individuals on ARVs by country. Overlap with PEPFAR is calculated as discussed below.



FIGURE 44: PROGRAMMATIC PERFORMANCE FOR TOP INDICATORS AT PHASE 2 EVALUATION

The Global Fund reports national ARV results in cases where the grant receiving Global Fund financing fulfills all the following criteria:

- **supports an essential element of ARV treatment on a national scale;**
- **is performing well and there are no significant data quality issues raised;**
- **contributes significant financial resources to the national effort (i.e., over US\$ 10 million has been disbursed).**

Any overlap with results generated through PEPFAR and “3 by 5” programs is examined on a country-by-country basis in order to finalize consistent partner figures.

In addition, only patients documented to be currently on ARV treatment at the time of grant reporting are included in these calculations (in accordance with the standard indicators in the joint partner *Monitoring and Evaluation Toolkit*).

**Question 5: Can you provide some examples of countries where the Global Fund reports on national results?**

Below are a few examples of 1) countries that fulfill the previous criteria, so that results reported by the Global Fund will be the same as national results, and 2) countries where results from more restricted projects are reported. How the decision to use or not use national results was made is also explained.

**Countries where the Global Fund reports national results:**

**Rwanda:** The Global Fund provides funding for first-line procurement under the national program for 60 percent of first-line ARV drugs. PEPFAR supports second-line treatment and the World Bank also contributes significant financing. Procurement is pooled in a “common basket” approach that is coordinated under a national procurement facility. There are significant financial and programmatic contributions to the national program beyond drug procurement.

**Thailand:** The Global Fund supports 70 to 80 percent of the investment in laboratory infrastructure, CD4 count and viral load machines, and 25 percent of the CD4 count and viral load reagents. The Global Fund purchases ARV drugs that cover 25 percent of the national ARV therapy program. The Global Fund supports the provincial data coordinators for monitoring and evaluation (M&E) and care programs for people living with HIV/AIDS in 140 hospitals.

**Malawi:** The Global Fund is the major funder of the national program, having disbursed over US\$ 40 million to date. This supports the purchase and distribution of the majority of ARVs for 64 treatment sites. The Global Fund supports crucial ARV activities

on a national scale and the grant is performing well.

**Ethiopia:** The Global Fund has become the major financier for the purchase of first-line ARV drugs for the national program, with PEPFAR providing second-line and pediatric ARV drugs under a new national road map to coordinate national activities. Further coordination has occurred so that ARV sites are supported jointly under the national program.

Following the “Three Ones” principle, the national program does not report in parallel to PEPFAR and the Global Fund, rather they report only the total number of people treated by the national program. Key activities are supported on a national scale and Global Fund resources of over US\$ 74 million have been disbursed. This joint arrangement has allowed more efficient use of resources, and national targets are being substantially accelerated so that the target for 2006 is now to treat 100,000 people, up from 25,000.

**Countries where the Global Fund does not report national results:**

**Botswana, Nigeria, South Africa, Uganda:** Going by the criteria applied above, the Global Fund does not significantly support national programs in Botswana, Nigeria, South Africa or Uganda at present.

In Uganda, recent performance and management issues mean that it does not fulfill the criteria for national results. In Botswana, despite the fact that the Global Fund supports national-level ARV therapy site activities and training, financial disbursements have not been significant enough to fulfill the criteria, and there have been limited programmatic progress updates. In South Africa, although the Global Fund supports major elements of the national ARV treatment program, these efforts are mainly focused in two provinces, Western Cape and Kwa Zulu-Natal. The Global Fund is not yet sufficiently confident in the quality of data reporting in Nigeria to be able to include the national figure or results initially reported by the country. Results are in the process of review; the number supplied above refers to a minimum verified number of people on ARV treatment.

**Question 6: What types of programs and which elements of ARV treatment are financed?**

Global Fund financing supports a wide variety of programs across countries, sometimes financing a direct project, an NGO or a faith-based network, provincial or national programs, and also basket national funding and sector-wide approach (SWAp) programs. The type of program supported is dependent on the country’s choice of implementation arrangements to scale up ARV treatment. No matter what type of program is being used, the Global Fund requires the grant to identify unique people currently receiving ARV treatment and to assess the grant’s

performance against country-owned and country-derived targets.

The Global Fund provides **flexible financing**, encourages grantees to use the financing as part of existing programs and allows grantees to use other funds to finance ARV treatment as part of a sustainable program. Direct attribution of people on ARV treatment solely to Global Fund financing is not required. The Global Fund requires the programs it finances to be performing well against ambitious targets and to provide unique people with HIV treatment.

Drug provision accounts for about one-third of many ARV treatment programs. Supporting someone on ARV treatment requires a range of activities and resources, including drug provision, human resources, treatment of opportunistic infections, laboratory and testing facilities, and health systems strengthening (HSS). The Global Fund provides financing wherever there are gaps and assesses whether this is on a national scale (see above) to count as a contribution to a national program. If the Global Fund contributes significantly to a national program, it allows the country to use the reported national results as performance measures. This is the case if the Global Fund is financing all or a proportion of the total cost, and if financing is used for drug purchases or for other significant costs on a national scale (human resources, clinical and other facilities).

**Question 7: Is there overlap with the U.S. government program PEPFAR?**

Yes, there is frequent collaboration and joint financing in support of ARV treatment at the country level between PEPFAR and the Global Fund. PEPFAR’s focus is reporting on a set of 18 selected countries (although it includes all international U.S. government efforts). The Global Fund supports programs in over 100 countries with ARV results reported from 69 countries in Latin America, Africa, Asia and Eastern Europe.

**The joint figure of unique people on ARV treatment in programs supported by either the Global Fund or PEPFAR was at least 875,000 as of 1 June 2006.** This was the number of unique

individuals supported by both programs in support of the WHO’s “3 by 5” initiative. (PEPFAR mid-year results only include focus countries.) The figure below illustrates the reported figures for each program and the combined total.

**Question 8: How is the overlap with PEPFAR assessed?**

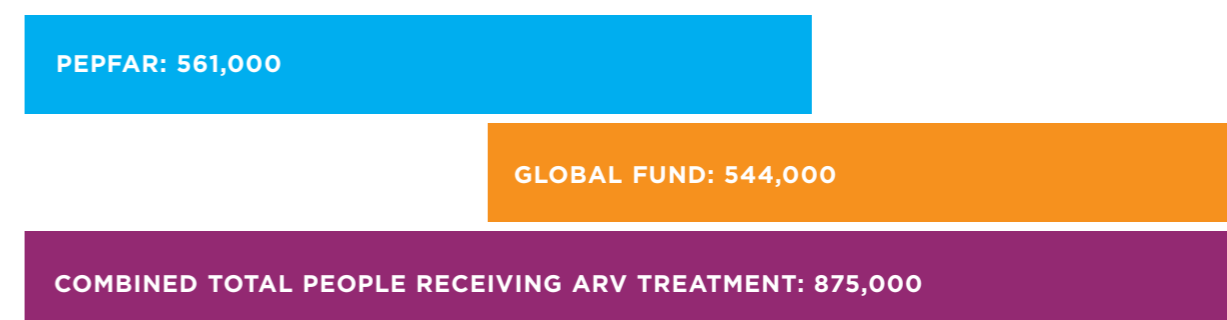
The Global Fund assesses issues of double counting and overlap with all partners working and reporting at the country level. However, we formalize these discussions with PEPFAR and make available to WHO a joint Global Fund-PEPFAR result on contributions to “3 by 5” (which reports on individual people currently on ARV treatment).

In assessing overlap, the Global Fund reviews the data country-by-country with PEPFAR and WHO:

**Step 1:** First, the two organizations jointly assess where both programs have made a significant contribution to a national program and where there is likely to be overlap. They also compare the results to WHO “3 by 5” figures as these provide the upper limit of national ARV figures.

**Step 2:** Data from all sources is compared on a country-by-country basis. The aim is to calculate the number of individual people supported on treatment, thus contributing to the overall “3 by 5” results. A grid is used to assess the elements each program contributes. It should be understood that this is a conservative estimate and demonstrates the lower range of the number of individual people put on treatment by the combined financing of the two programs.

Overlap exists because the Global Fund is a financing organization (it does not put people on treatment itself) and its goal is to harmonize its funding to support sustainable national programs alongside other donors. The Global Fund aims to support national strategies and to fill in significant gaps in available financing, rather than have standalone parallel Global Fund projects and individuals on treatment relying solely on Global Fund financing (though the Global Fund is flexible and supports a range of country situations and programs).





**Question 9: What happens to people on ARV treatment once Global Fund grants to a country end?**

A major reason to promote joint financing is to ensure the sustainability of the financing of country ARV programs. This is an important reason why the Global Fund does not require complete attribution to identify Global Fund individuals on treatment. It requires programs to be performing and Global Fund financing to be additional to existing funds, but encourages the use of other finances, including increasing national commitments.

When Global Fund financing to a country is stopped for any reason (performance or other), the Global Fund provides **continuity of financing for ARV treatment for an additional two years**. This does not fund additional scale-up, but aims to sustain financing to people currently on ARV treatment in order to give the country enough time to find other sources of financing to support the ongoing program.

The Global Fund encourages countries to access additional resources through future rounds of financing, as well as seek complimentary funding from other sources. By raising increasing and additional financing, the Global Fund aims to ensure the sustainability and scale-up of country ARV treatment programs through regular and additional rounds of financing to meet country needs.

**Question 10: Can we be confident that the reported number of people on ARV treatment is accurate and that the figures are not exaggerated?**

The Global Fund is confident that the reported global number of people on ARV treatment is a conservative estimate of the results of programs it supports. In addition, the Global Fund uses a relatively strict application of criteria to assess if the contribution of the Global Fund-supported program to the overall national program is warranted. There have been several instances where, although significant support is provided by Global Fund grants the Global Fund has chosen not to include these results in overall national ARV figures, such as when there have been data quality or other performance problems.

There are, of course, well-acknowledged reporting and data verification challenges in individual situations. The Global Fund makes available five to ten percent of its grant finances to improve M&E systems. Just as significantly, it includes powerful incentives in its performance-based funding model to establish systems for accurate and externally-verifiable reporting. If a grant cannot show reliable results, financing can be stopped at any stage. The quality of reporting systems is assessed by the LFA for every grant at the time of grant signing.

Nevertheless, the LFAs of the Global Fund have identified inaccuracies in reporting following random desk audits and site visits. All results submitted to the Global Fund (generally two times per year, or when a disbursement is required) are verified by the LFAs. Results and requests for continued funding also pass through the Country Coordinating Mechanism (CCM) of the country. The CCM includes national and international partners in-country who are responsible for providing oversight. Global Fund processes encourage transparency and accountability by building M&E into all stages of the grant process.

Challenges to the accurate reporting and comparison of results between partners do exist. There are gaps in the ability of LFAs to verify all of the country results. LFAs generally combine desk audits with follow-up random site visits. The goal is that in 2006 all grants receive random site visits from their LFA. Even these proposed visits will not be able to cover all sites and indicators. An external data quality self-assessment and a quality audit are also being rolled out in 2006. The goal of this program is to help guide financing to improve M&E systems, while at the same time allowing transparent and external auditing.

The Global Fund has helped to harmonize data sharing among international partners and to mobilize support of national systems. Considerable progress has been made in recent years, and this will continue despite challenges in global reporting and in the implementation of the principles of the “Three Ones” in countries.





# APPENDIX 2: PHASE 2 GRANTS

BOARD SUBMISSION DATE	COUNTRY	GRANT NUMBER	COMPONENT	GLOBAL REGION	PRINCIPAL RECIPIENT TYPE	2 YEAR GRANT AMOUNT	SECRETARIAT GRADE	BOARD DECISION	BOARD APPROVED AMOUNT (US\$)*
1-Feb-05	Benin	BEN-102-G01-M-00	Malaria	Sub-Saharan Africa: West & Central Africa	UNDP	2,389,185	B1	Conditional GO	583,965
1-Feb-05	Burundi	BRN-102-G01-H-00	HIV/AIDS	Sub-Saharan Africa: East Africa	GOV	4,877,000	B1	GO	3,780,000
1-Feb-05	China (People's Republic)	CHN-102-G01-T-00	Tuberculosis	East Asia & the Pacific	GOV	25,370,000	A	GO	22,700,000
1-Feb-05	China (People's Republic)	CHN-102-G02-M-00	Malaria	East Asia & the Pacific	GOV	3,523,662	B1	GO	2,882,997
1-Feb-05	Ghana	GHN-102-G01-H-00	HIV/AIDS	Sub-Saharan Africa: West & Central Africa	GOV	4,965,478	B1	Conditional GO	9,204,744
1-Feb-05	Ghana	GHN-102-G02-T-00	Tuberculosis	Sub-Saharan Africa: West & Central Africa	GOV	2,336,940	B1	Conditional GO	3,350,115
1-Feb-05	Haiti	HTI-102-G01-H-00	HIV/AIDS	Latin America & the Caribbean	CIV	24,603,680	A	GO	35,547,100
1-Feb-05	Haiti	HTI-102-G02-H-00	HIV/AIDS	Latin America & the Caribbean	UNDP	6,754,697	B1	GO	0
1-Feb-05	Honduras	HND-102-G01-H-00**	HIV/AIDS	Latin America & the Caribbean	UNDP	12,583,466	B2	Conditional GO	14,273,782
1-Feb-05	Honduras	HND-102-G02-T-00	Tuberculosis	Latin America & the Caribbean	UNDP	3,790,500	B2	Conditional GO	2,806,514
1-Feb-05	Honduras	HND-102-G03-M-00	Malaria	Latin America & the Caribbean	UNDP	4,096,050	B2	Conditional GO	3,108,090
1-Feb-05	India	IDA-102-G01-T-00	Tuberculosis	South Asia	GOV	5,650,999	A	GO	3,134,000
1-Feb-05	Lao PDR	LAO-102-G01-H-00	HIV/AIDS	East Asia & the Pacific	GOV	1,307,664	B2	Conditional GO	2,100,000
1-Feb-05	Lao PDR	LAO-102-G02-H-00	Malaria	East Asia & the Pacific	GOV	3,155,152	B2	Conditional GO	9,553,935
1-Feb-05	Madagascar	MDG-102-G01-M-00	Malaria	Sub-Saharan Africa: East Africa	CIV	1,750,299	B1	GO	249,764
1-Feb-05	Madagascar	MDG-202-G02-H-00	HIV/AIDS	Sub-Saharan Africa: East Africa	CIV	747,199	A	GO	756,425
1-Feb-05	Madagascar	MDG-202-G03-H-00	HIV/AIDS	Sub-Saharan Africa: East Africa	CIV	3,032,048	B1	GO	1,992,068
1-Feb-05	Moldova	MOL-102-G01-C-00	HIV/TB	Eastern Europe & Central Asia	GOV	5,257,941	A	GO	6,461,106
1-Feb-05	Mongolia	MON-102-G01-T-00	Tuberculosis	East Asia & the Pacific	GOV	644,000	A	GO	1,086,000
1-Feb-05	Morocco	MOR-102-G01-H-00	HIV/AIDS	North Africa & the Middle East	GOV	4,738,806	A	GO	4,499,948
1-Feb-05	Panama	PAN-102-G01-T-00	Tuberculosis	Latin America & the Caribbean	UNDP	440,000	A	GO	130,000
1-Feb-05	Rwanda	RWN-102-G01-C-00	HIV/TB	Sub-Saharan Africa: East Africa	GOV	8,409,268	A	GO	6,231,778
1-Feb-05	Senegal	SNG-102-G01-H-00**	HIV/AIDS	Sub-Saharan Africa: West & Central Africa	GOV	6,000,000	C	Conditional GO	5,714,285
1-Feb-05	Senegal	SNG-102-G02-M-00	Malaria	Sub-Saharan Africa: West & Central Africa	GOV	4,285,714	C	NO GO	0
1-Feb-05	Tajikistan	TAJ-102-G01-H-00	HIV/AIDS	Eastern Europe & Central Asia	UNDP	1,474,520	A	GO	950,725
1-Feb-05	United Republic of Tanzania	ZAN-102-G01-M-00	Malaria	Sub-Saharan Africa: East Africa	GOV	781,220	B1	GO	371,860
1-Mar-05	Argentina	ARG-102-G01-H-00	HIV/AIDS	Latin America & the Caribbean	UNDP	12,177,200	A	Conditional GO	13,889,174
1-Mar-05	Cuba	CUB-202-G01-H-00	HIV/AIDS	Latin America & the Caribbean	UNDP	11,465,129	A	Conditional GO	14,687,698
1-Apr-05	Democratic Republic of Congo	ZAR-202-G01-T-00	Tuberculosis	Sub-Saharan Africa: West & Central Africa	UNDP	6,408,741	B1	Conditional GO	1,231,426
1-Apr-05	El Salvador	SLV-202-G01-H-00	HIV/AIDS	Latin America & the Caribbean	UNDP	12,856,729	B1	Conditional GO	6,682,235
1-Apr-05	Ethiopia	ETH-102-G01-T-00	Tuberculosis	Sub-Saharan Africa: East Africa	GOV	10,962,600	B1	Conditional GO	16,018,049
1-Apr-05	Mongolia	MON-202-G02-H-00	HIV/AIDS	East Asia & the Pacific	GOV	1,271,623	A	GO	1,725,480
1-Apr-05	Multi-country Africa(RMCC)	MAF-202-G01-M-00	Malaria	Sub-Saharan Africa: Southern Africa	CIV	7,090,318	A	GO	14,342,025
1-Apr-05	Multi-country Western Pacific	MWP-202-G01-H-00	HIV/AIDS	East Asia & the Pacific	GOV	3,036,000	B2	Conditional GO	2,127,925
1-Apr-05	Multi-country Western Pacific	MWP-202-G02-M-00	Malaria	East Asia & the Pacific	GOV	2,416,850	B1	GO	2,113,450
1-Apr-05	Multi-country Western Pacific	MWP-202-G03-T-00	Tuberculosis	East Asia & the Pacific	GOV	1,699,100	B1	GO	1,039,706
1-Apr-05	Philippines	PHL-202-G01-M-00	Malaria	East Asia & the Pacific	CIV	7,244,762	B1	GO	4,584,783
1-Apr-05	Philippines	PHL-202-G02-T-00	Tuberculosis	East Asia & the Pacific	CIV	3,434,487	A	GO	8,003,577
1-May-05	Benin	BEN-202-G03-H-00	HIV/AIDS	Sub-Saharan Africa: West & Central Africa	UNDP	11,348,000	B1	GO	5,976,228
1-May-05	Chile	CHL-102-G01-H-00	HIV/AIDS	Latin America & the Caribbean	CIV	13,574,098	B1	GO	24,485,318
1-May-05	Ghana	GHN-202-G03-M-00	Malaria	Sub-Saharan Africa: West & Central Africa	GOV	4,596,111	A	GO	4,253,380
1-May-05	Indonesia	IND-102-G03-H-00	HIV/AIDS	East Asia & the Pacific	GOV	6,924,971	B2	Conditional GO	904,793
1-May-05	South Africa	SAF-102-G02-C-00	HIV/TB	Sub-Saharan Africa: Southern Africa	GOV	12,000,000	B2	NO GO	0
1-May-05	Swaziland	SWZ-202-G01-H-00	HIV/AIDS	Sub-Saharan Africa: Southern Africa	GOV	29,633,300	B1	Conditional GO	22,910,845
1-May-05	Zambia	ZAM-102-G01-H-00	HIV/AIDS	Sub-Saharan Africa: Southern Africa	GOV	21,214,271	B1	GO	na
1-May-05	Zambia	ZAM-102-G02-M-00	Malaria	Sub-Saharan Africa: Southern Africa	GOV	17,039,200	B1	GO	21,382,000
1-May-05	Zambia	ZAM-102-G03-T-00	Tuberculosis	Sub-Saharan Africa: Southern Africa	GOV	12,447,294	B1	GO	na
1-May-05	Zambia	ZAM-102-G04-H-00	HIV/AIDS	Sub-Saharan Africa: Southern Africa	CIV	6,614,958	A	GO	na
1-May-05	Zambia	ZAM-102-G05-M-00	Malaria	Sub-Saharan Africa: Southern Africa	CIV	852,600	B1	GO	na
1-May-05	Zambia	ZAM-102-G06-T-00	Tuberculosis	Sub-Saharan Africa: Southern Africa	CIV	2,307,962	A	GO	32,582,000
1-May-05	Zambia	ZAM-102-G08-H-00	HIV/AIDS	Sub-Saharan Africa: Southern Africa	CIV	8,073,013	B1	GO	48,027,778
1-Jun-05	Cambodia	CAM-102-G01-H-00	HIV/AIDS	East Asia & the Pacific	GOV	11,242,538	B1	Conditional GO	4,472,091
1-Jun-05	Timor-Leste	TMP-202-G01-M-00	Malaria	East Asia & the Pacific	GOV	2,300,744	B1	Conditional GO	618,727
1-Jun-05	Estonia	EST-202-G01-H-00	HIV/AIDS	Eastern Europe & Central Asia	GOV	3,908,952	B1	GO	6,337,628
1-Jun-05	United Republic of Tanzania	ZAN-202-G02-H-00	HIV/AIDS	Sub-Saharan Africa: East Africa	GOV	1,116,000	B1	GO	1,186,637
1-Jun-05	Uganda	UGD-102-G01-H-00	HIV/AIDS	Sub-Saharan Africa: East Africa	GOV	36,314,892	B2	Conditional GO	12,563,525
1-Jul-05	Armenia	ARM-202-G01-H-00	HIV/AIDS	Eastern Europe & Central Asia	CIV	3,166,641	A	GO	4,083,250
1-Jul-05	Benin	BEN-202-G02-T-00	Tuberculosis	Sub-Saharan Africa: West & Central Africa	UNDP	2,173,404	B1	GO	930,700
1-Jul-05	Burundi	BRN-202-G02-M-00	Malaria	Sub-Saharan Africa: East Africa	GOV	13,792,126	B1	Conditional GO	3,973,999
1-Jul-05	Central African Republic	CAF-202-G01-H-00	HIV/AIDS	Sub-Saharan Africa: West & Central Africa	UNDP	8,198,921	B1	GO	16,705,731
1-Jul-05	Costa Rica	COR-202-G01-H-00	HIV/AIDS	Latin America & the Caribbean	GOV	2,279,501	B2	Conditional GO	1,304,370
1-Jul-05	Ethiopia	ETH-202-G02-M-00	Malaria	Sub-Saharan Africa: East Africa	GOV	37,915,011	B2	Conditional GO	35,960,200
1-Jul-05	Indonesia	IND-102-G01-T-00	Tuberculosis	East Asia & the Pacific	GOV	21,612,265	B1	GO	47,156,959
1-Jul-05	Jordan	JOR-202-G01-H-00	HIV/AIDS	North Africa & the Middle East	GOV	1,778,600	A	GO	705,300
1-Jul-05	Lao PDR	LAO-202-G03-T-00	Tuberculosis	East Asia & the Pacific	GOV	1,524,338	A	GO	2,006,053
1-Jul-05	Serbia & Montenegro	SER-102-G01-H-00	HIV/AIDS	Eastern Europe & Central Asia	CIV	2,718,714	B1	Conditional GO	856,798
1-Jul-05	Swaziland	SWZ-202-G02-M-00	Malaria	Sub-Saharan Africa: Southern Africa	GOV	978,000	B2	Conditional GO	842,500
1-Jul-05	United Republic of Tanzania	TNZ-102-G01-M-00	Malaria	Sub-Saharan Africa: East Africa	GOV	8,790,612	B2	Conditional GO	11,037,104
1-Jul-05	Ukraine	UKR-102-G04-H-00	HIV/AIDS	Eastern Europe & Central Asia	CIV	23,354,116	B1	Conditional GO	67,192,109
1-Aug-05	Croatia	HRV-202-G01-H-00	HIV/AIDS	Eastern Europe & Central Asia	GOV	3,363,974	B1	GO	1,581,218
1-Aug-05	Global (LWF)	WRL-102-G01-H-00	HIV/AIDS	Eastern Europe & Central Asia	CIV	485,000	B1	GO	215,000
1-Aug-05	Kazakhstan	KAZ-202-G01-H-00	HIV/AIDS	Eastern Europe & Central Asia	GOV	6,502,000	B1	GO	15,583,999
1-Aug-05	Sri Lanka	SRL-102-G03-T-00	Tuberculosis	South Asia	GOV	2,384,980	B1	Conditional GO	2,605,034
1-Aug-05	Thailand	THA-202-G03-H-00	HIV/AIDS	East Asia & the Pacific	CIV	5,993,913	B1	GO	7,468,345

BOARD SUBMISSION DATE	COUNTRY	GRANT NUMBER	COMPONENT	GLOBAL REGION	PRINCIPAL RECIPIENT TYPE	2 YEAR GRANT AMOUNT	SECRETARIAT GRADE	BOARD DECISION	BOARD APPROVED AMOUNT (US\$)*
1-Sep-05	Bulgaria	BUL-202-G01-H-00	HIV/AIDS	Eastern Europe & Central Asia	Gov	6,894,270	A	Go	8,817,612
1-Sep-05	Burkina Faso	BUR-202-G02-H-00	HIV/AIDS	Sub-Saharan Africa: West & Central Africa	UNDP	7,130,400	A	Go	9,287,122
1-Sep-05	Côte d'Ivoire	CIV-202-G01-H-00	HIV/AIDS	Sub-Saharan Africa: West & Central Africa	UNDP	18,099,398	B1	Conditional Go	28,332,131
1-Sep-05	Eritrea	ERT-202-G01-M-00	Malaria	Sub-Saharan Africa: East Africa	Gov	2,617,633	B1	Conditional Go	5,293,792
1-Sep-05	Kenya	KEN-202-G05-M-00	Malaria	Sub-Saharan Africa: East Africa	Gov	10,526,880	B2	Conditional Go	17,173,497
1-Sep-05	Mali	MAL-102-G01-M-00	Malaria	Sub-Saharan Africa: West & Central Africa	Gov	2,023,424	B2	Conditional Go	568,892
1-Sep-05	Malawi	MLW-102-G01-H-00	HIV/AIDS	Sub-Saharan Africa: Southern Africa	Gov	41,751,500	B1	Conditional Go	136,862,764
1-Sep-05	El Salvador	SLV-202-G02-T-00	Tuberculosis	Latin America & the Caribbean	UNDP	1,918,344	A	Go	1,455,615
1-Sep-05	Sri Lanka	SRL-102-G01-M-00	Malaria	South Asia	Gov	730,140	B1	Conditional Go	1,347,083
1-Sep-05	Sri Lanka	SRL-102-G02-M-00	Malaria	South Asia	CIV	4,467,480	B1	Conditional Go	708,932
14-Oct-05	Cambodia	CAM-202-G02-H-00	HIV/AIDS	East Asia & the Pacific	Gov	5,370,564	B1	Conditional Go	9,395,061
14-Oct-05	Cambodia	CAM-202-G03-M-00	Malaria	East Asia & the Pacific	Gov	5,013,262	B1	Go	4,827,336
14-Oct-05	Cambodia	CAM-202-G04-T-00	Tuberculosis	East Asia & the Pacific	Gov	2,505,255	B1	Conditional Go	3,664,478
14-Oct-05	Thailand	THA-102-G01-H-00	HIV/AIDS	East Asia & the Pacific	Gov	30,933,204	B1	Conditional Go	78,420,496
14-Oct-05	Romania	ROM-202-G01-H-00	HIV/AIDS	Eastern Europe & Central Asia	Gov	21,801,000	B1	Go	5,060,313
14-Oct-05	Peru	PER-202-G01-H-00	HIV/AIDS	Latin America & the Caribbean	CIV	15,718,354	B1	Conditional Go	7,180,618
14-Oct-05	Peru	PER-202-G02-T-00	Tuberculosis	Latin America & the Caribbean	CIV	20,153,818	B1	Conditional Go	5,447,632
14-Oct-05	Togo	TGO-202-G01-H-00	HIV/AIDS	Sub-Saharan Africa: West & Central Africa	UNDP	14,185,638	B2	Conditional Go	1,269,839
14-Oct-05	Sierra Leone	SLE-202-G01-T-00	Tuberculosis	Sub-Saharan Africa: West & Central Africa	CIV	2,569,103	B1	Conditional Go	3,129,454
14-Oct-05	Indonesia	IND-102-G02-M-00	Malaria	East Asia & the Pacific	Gov	11,754,947	B1	Conditional Go	11,950,000
1-Nov-05	Romania	ROM-202-G02-T-00	Tuberculosis	Eastern Europe & Central Asia	Gov	16,870,000	B1	Conditional Go	0
1-Nov-05	Viet Nam	VIN-102-G01-H-00	HIV/AIDS	East Asia & the Pacific	Gov	7,500,000	B1	Go	4,500,000
1-Nov-05	Yemen	YEM-202-G01-M-00	Malaria	North Africa & the Middle East	Gov	4,159,632	B2	Conditional Go	7,718,574
1-Dec-05	Bangladesh	BAN-202-G01-H-00	HIV/AIDS	South Asia	Gov	6,010,140	A	Go	13,700,890
1-Dec-05	Côte d'Ivoire	CIV-304-G03-T	Tuberculosis	Sub-Saharan Africa: West & Central Africa	UNDP	2,870,122	A	Go	959,985
1-Dec-05	Georgia	GEO-202-G01-H-00	HIV/AIDS	Eastern Europe & Central Asia	Gov	4,018,332	B1	Go	8,107,312
1-Dec-05	Nicaragua	NIC-202-G01-M-00	Malaria	Latin America & the Caribbean	CIV	3,404,671	B1	Go	2,188,608
1-Dec-05	Nicaragua	NIC-202-G02-T-00	Tuberculosis	Latin America & the Caribbean	CIV	1,271,820	B1	Go	1,535,744
1-Dec-05	Nicaragua	NIC-202-G03-H-00	HIV/AIDS	Latin America & the Caribbean	CIV	4,025,689	B1	Go	6,104,840
1-Dec-05	Nigeria	NGA-102-G01-H-00***	HIV/AIDS	Sub-Saharan Africa: West & Central Africa	Gov	8,708,684	C	NO GO	0
1-Dec-05	Nigeria	NGA-102-G03-H-00***	HIV/AIDS	Sub-Saharan Africa: West & Central Africa	Gov	17,772,103	C	NO GO	0
1-Dec-05	Kenya	KEN-202-G04-T-00	Tuberculosis	Sub-Saharan Africa: East Africa	Gov	4,928,733	B2	Conditional Go	3,832,672
6-Jan-06	Chad	TCD-202-G01-T-00	Tuberculosis	North Africa & the Middle East	Gov	1,263,963	B1	Conditional Go	1,775,358
6-Jan-06	Ethiopia	ETH-202-G03-H-00	HIV/AIDS	Sub-Saharan Africa: East Africa	Gov	55,383,811	B1	Conditional Go	84,001,277
6-Jan-06	Guinea	GIN-202-G01-H-00	HIV/AIDS	Sub-Saharan Africa: West & Central Africa	Gov	4,804,696	B2	Conditional Go	4,846,409
6-Jan-06	Thailand	THA-102-G02-T-00	Tuberculosis	East Asia & the Pacific	Gov	6,999,350	B2	Conditional Go	4,455,857
6-Jan-06	Thailand	THA-202-G05-M-00	Malaria	East Asia & the Pacific	Gov	2,280,000	B1	Conditional Go	3,002,000
1-Feb-06	Mauritania	MRT-202-G02-M-00	Malaria	North Africa & the Middle East	UNDP	824,044	B1	Go	2,074,949
1-Feb-06	Mauritania	MRT-202-G01-T-00	Tuberculosis	North Africa & the Middle East	UNDP	1,104,742	B1	Go	1,623,147
1-Feb-06	India	IDA-202-G03-T-00	Tuberculosis	South Asia	Gov	7,080,000	B1	Conditional Go	22,020,000
1-Feb-06	Pakistan								



## APPENDIX 3: TOP TEN INDICATORS

### TOP TEN SERVICE INDICATORS OF PEOPLE REACHED (FOR ROUTINE REPORTING [GENERALLY EVERY SIX MONTHS])

1. Number of people currently receiving antiretroviral therapy (**ARVs**)
2. Number of **a.** New smear-positive **TB cases detected**, **b.** cases successfully treated and **c.** TB cases enrolled for multidrug-resistant treatment
3. Number of **insecticide-treated bed nets (ITNs)** distributed to people (or, where appropriate, houses receiving Indoor Residual Spraying)
4. Number of people receiving **anti-malarial treatment** (as per national policy)
5. Number of people **counseled and tested for HIV**, including provision of results
6. Number of HIV-positive pregnant women receiving a complete course of ARV prophylaxis to reduce mother-to-child transmission (**PMTCT**)
7. Number of **condoms** distributed to people
8. Number of people benefiting from **community-based programs** (specify **a.** Prevention **b.** Orphan support **c.** Care and support)
9. Number of people receiving **treatment for infections associated with HIV** (specify **a.** Preventive therapy for TB/HIV **b.** STIs with counseling)
10. Number of **service deliverers trained** (**a.** Health services **b.** Peer & community programs)

### TOP TEN OUTCOME/IMPACT INDICATORS (FOR MEDIUM TERM REPORTING [1-5 YEARS])

1. Percentage age 15-24 who are HIV infected (**HIV prevalence**) (applicable to most-at-risk populations in concentrated/lower epidemics)
2. Percentage still alive 12 months after initiation of ARV (**reduced mortality**)
3. Percentage of infants born to HIV-positive mothers who are HIV infected (**reduced mother to child HIV transmission**)
4. Percentage age 15-24 who had **sex with more than one partner** in last year
5. **Primary abstinence** (% never had sex, in 15-19 year olds). **Secondary abstinence** (% never had sex in the last year of those who ever had sex, in 15-24 year olds)
6. Percentage age 15-24 with non-regular partners in the last year who reported **consistent use of condoms** with these partners
7. **TB case detection rate** and **treatment success rate**
8. Estimated all active TB cases per 100,000 population (**TB prevalence rate**)
9. **Malaria-associated deaths** (in high endemic areas, all-cause under-five mortality)
10. **Incidence of clinical malaria cases** (estimated and /or reported)

## APPENDIX 4: PERFORMANCE INDICATORS FOR REPLENISHMENT

NO.	PRINCIPLE	INDICATOR
1	PROMOTING MULTISECTORAL INVOLVEMENT	Increase in total dollars raised from private sector
		% of CCMs that meet the requirements set by GF Board
2	PROMOTING LOCAL OWNERSHIP AND SUSTAINABILITY	% of grants identified as underperforming by EARS
		% of grants addressed successfully out of those identified by EARS prior to Phase 2 evaluation
		% of under-performing grants at Phase 2 evaluation identified previously by EARS
		% of grants with complete progress & financial data published in grant performance report at time of disbursement
		% of GF-supported countries which have relevant national strategies/plans that specifically mention GF funding
3	RAPID INVESTMENT OF RESOURCES	% of countries receiving GF public sector grants which report GF funding in the budget
		Number and change in trained and employed health personnel
		Average time between grant approval and first disbursement
		Actual disbursements compared to target disbursements
		Principal recipient expenditure rate of funds disbursed
4	ENSURING PERFORMANCE BASED MANAGEMENT	Global Fund top 3 Indicators
		% of agreed top 10 coverage targets reached by all grants in Phase 1
5	BALANCED BY DISEASE	% of grant funds for AIDS/malaria/TB

# APPENDIX 5: PHASE 2 TIMETABLE 2006-2007

COUNTRY	COMPONENT	GRANT NUMBER	2 YEAR GRANT AMOUNT (US\$)	PROGRAM START DATE*	REQUEST FOR CONTINUED FUNDING EXPECTED	ESTIMATED SECRETARIAT RECOMMENDATION TO THE BOARD
Uganda	Malaria	UGD-202-G02-M-00**	23,211,300	15-Mar-04	15-Sep-05	1-Dec-05
Uganda	Tuberculosis	UGD-202-G03-T-00**	4,692,021	15-Mar-04	15-Sep-05	1-Dec-05
Nepal	HIV/AIDS	NEP-202-G01-H-00**	4,365,996	1-Apr-04	1-Oct-05	1-Dec-05
Nepal	Malaria	NEP-202-G02-M-00**	1,007,665	1-Apr-04	1-Oct-05	1-Dec-05
India	HIV/AIDS	IDA-202-G02-H-00	26,116,000	1-May-04	1-Nov-05	1-Jan-06
Chad	Tuberculosis	TCO-202-G01-T-00	1,263,963	1-May-04	1-Nov-05	1-Jan-06
Togo	Malaria	TGO-304-G02-M	3,479,336	1-May-04	1-Nov-05	1-Jan-06
Togo	Tuberculosis	TGO-304-G03-T	1,752,982	1-May-04	1-Nov-05	1-Jan-06
Comoros	Malaria	COM-202-G01-M-00	1,534,631	1-Jun-04	1-Dec-05	1-Feb-06
Dominican Republic	HIV/AIDS	DMR-202-G01-H-00	14,698,774	1-Jun-04	1-Dec-05	1-Feb-06
Jamaica	HIV/AIDS	JAM-304-G01-H	7,560,365	1-Jun-04	1-Dec-05	1-Feb-06
Vietnam	Tuberculosis	VTN-102-G02-T-00	2,500,000	1-Jun-04	1-Dec-05	1-Feb-06
Botswana	HIV/AIDS	BOT-202-G01-H-00	18,580,414	1-Jul-04	1-Jan-06	1-Mar-06
Colombia	HIV/AIDS	COL-202-G01-H-00	3,482,636	1-Jul-04	1-Jan-06	1-Mar-06
Egypt	Tuberculosis	EGY-202-G01-T-00	2,480,219	1-Jul-04	1-Jan-06	1-Mar-06
Georgia	Malaria	GEO-304-G02-M	645,700	1-Jul-04	1-Jan-06	1-Mar-06
Guinea-Bissau	Tuberculosis	GNB-304-G01-T	1,503,587	1-Jul-04	1-Jan-06	1-Mar-06
Somalia	Malaria	SOM-202-G01-M-00	8,890,497	1-Jul-04	1-Jan-06	1-Mar-06
Rwanda	HIV/AIDS	RWN-304-G02-H	14,860,735	15-Jul-04	15-Jan-06	1-Apr-06
Bolivia	HIV/AIDS	BOL-304-G01-H	6,019,023	26-Jan-04	26-Jan-06	1-Apr-06
Bolivia	Malaria	BOL-304-G02-M	6,099,563	26-Jul-04	26-Jan-06	1-Apr-06
Bolivia	Tuberculosis	BOL-304-G03-T	2,381,646	26-Jul-04	26-Jan-06	1-Apr-06
Bangladesh	Tuberculosis	BAN-304-G02-T	11,172,846	1-Aug-04	1-Feb-06	1-Apr-06
Haiti	Malaria	HTI-304-G03-M	7,390,556	1-Aug-04	1-Feb-06	1-Apr-06
Haiti	Tuberculosis	HTI-304-G04-T	8,131,836	1-Aug-04	1-Feb-06	1-Apr-06
Philippines	HIV/AIDS	PHL-304-G03-H	3,496,865	1-Aug-04	1-Feb-06	1-Apr-06
Papua New Guinea	Malaria	PNG-304-G01-M	6,106,557	1-Aug-04	1-Feb-06	1-Apr-06
Chad	HIV/AIDS	TCO-304-G02-H	7,380,156	1-Aug-04	1-Feb-06	1-Apr-06
Zimbabwe	Malaria	ZIM-102-G02-M-00	6,716,250	1-Aug-04	1-Feb-06	1-Apr-06
Russian Federation	HIV/AIDS	RUS-304-G01-H	31,596,307	15-Aug-04	15-Feb-06	1-May-06
Somalia	Tuberculosis	SOM-304-G02-T	5,601,215	16-Aug-04	16-Feb-06	1-May-06
Bangladesh	Tuberculosis	BAN-304-G03-T	5,470,228	1-Sep-04	1-Mar-06	1-May-06
China	HIV/AIDS	CHN-304-G03-H	32,122,550	1-Sep-04	1-Mar-06	1-May-06
Eritrea	HIV/AIDS	ERT-304-G02-H	8,124,910	1-Sep-04	1-Mar-06	1-May-06
Niger	HIV/AIDS	NGR-304-G01-H	8,475,297	1-Sep-04	1-Mar-06	1-May-06
Niger	Malaria	NGR-304-G02-M	4,815,109	1-Sep-04	1-Mar-06	1-May-06
South Africa	HIV/AIDS	SAF-304-G04-H	15,521,457	1-Sep-04	1-Mar-06	1-May-06
Dominican Republic	Tuberculosis	DMR-304-G02-T	2,636,816	1-Oct-04	1-Apr-06	1-Jun-06
Gabon	HIV/AIDS	GAB-304-G01-H	3,154,500	1-Oct-04	1-Apr-06	1-Jun-06
Gambia	HIV/AIDS	GMB-304-G01-H	6,241,743	1-Oct-04	1-Apr-06	1-Jun-06
Gambia	Malaria	GMB-304-G02-M	5,665,500	1-Oct-04	1-Apr-06	1-Jun-06
Rwanda	Malaria	RWN-304-G03-M	13,045,293	1-Oct-04	1-Apr-06	1-Jun-06
Sudan	Malaria	SUD-202-G01-M-00	12,855,490	1-Oct-04	1-Apr-06	1-Jun-06
Sudan	Tuberculosis	SUD-202-G02-T-00	5,842,932	1-Oct-04	1-Apr-06	1-Jun-06
Thailand	HIV/AIDS	THA-304-G06-H	911,542	1-Oct-04	1-Apr-06	1-Jun-06
Belize	HIV/AIDS	BEL-304-G01-H	1,298,884	1-Nov-04	1-May-06	1-Jul-06
Benin	Malaria	BEN-304-G04-M	1,383,931	1-Nov-04	1-May-06	1-Jul-06
Guinea-Bissau	HIV/AIDS	GNB-404-G02-H	1,166,801	1-Nov-04	1-May-06	1-Jul-06
India	HIV/TB	IDA-304-G04-C	2,667,346	1-Nov-04	1-May-06	1-Jul-06
Multi-country Americas (CARICOM)	HIV/AIDS	MAG-304-G01-H	6,100,900	1-Nov-04	1-May-06	1-Jul-06
Madagascar	HIV/AIDS	MDG-304-G04-H	13,415,118	1-Nov-04	1-May-06	1-Jul-06
Madagascar	Malaria	MDG-304-G05-M	5,232,448	1-Nov-04	1-May-06	1-Jul-06
Macedonia, FYR	HIV/AIDS	MKD-304-G01-H	4,348,599	1-Nov-04	1-May-06	1-Jul-06
Swaziland	Tuberculosis	SWZ-304-G03-T	1,340,400	1-Nov-04	1-May-06	1-Jul-06
Tajikistan	Tuberculosis	TAJ-304-G02-T	1,301,485	1-Nov-04	1-May-06	1-Jul-06
Tanzania	HIV/TB	TNZ-304-G03-C	23,951,034	1-Nov-04	1-May-06	1-Jul-06
Afghanistan	HIV/AIDS	AFG-202-G01-I-00	3,125,605	1-Dec-04	1-Jun-06	1-Aug-06
Belarus	HIV/AIDS	BLR-304-G01-H	6,818,796	1-Dec-04	1-Jun-06	1-Aug-06
Guatemala	HIV/AIDS	GUA-304-G01-H	8,423,807	1-Dec-04	1-Jun-06	1-Aug-06
Liberia	HIV/AIDS	LBR-202-G01-H-00	7,658,187	1-Dec-04	1-Jun-06	1-Aug-06
Liberia	Tuberculosis	LBR-202-G02-T-00	4,534,017	1-Dec-04	1-Jun-06	1-Aug-06
Liberia	Malaria	LBR-304-G03-M	12,140,921	1-Dec-04	1-Jun-06	1-Aug-06
Nigeria	Malaria	NGA-202-G04-M-00	20,994,149	1-Dec-04	1-Jun-06	1-Aug-06
Paraguay	Tuberculosis	PRY-304-G01-T	1,194,902	1-Dec-04	1-Jun-06	1-Aug-06
Russian Federation	Tuberculosis	RUS-304-G02-T	6,306,869	1-Dec-04	1-Jun-06	1-Aug-06
Rwanda	Tuberculosis	RWN-404-G04-T	5,946,347	1-Dec-04	1-Jun-06	1-Aug-06
Serbia (Serbia and Montenegro)	Tuberculosis	SER-304-G02-T	2,428,986	1-Dec-04	1-Jun-06	1-Aug-06
Uzbekistan	HIV/AIDS	UZB-304-G01-H	4,760,755	1-Dec-04	1-Jun-06	1-Aug-06
Zanzibar (Tanzania)	Tuberculosis	ZAN-304-G03-T	959,482	1-Dec-04	1-Jun-06	1-Aug-06
Burkina Faso	Tuberculosis	BUR-404-G03-T	7,505,405	1-Jan-05	1-Jul-06	1-Sep-06
Central African Republic	HIV/AIDS	CAF-404-G02-H	4,695,012	1-Jan-05	1-Jul-06	1-Sep-06
Central African Republic	Tuberculosis	CAF-404-G03-T	2,033,885	1-Jan-05	1-Jul-06	1-Sep-06
Cameroon	HIV/AIDS	CMR-304-G01-H	14,641,407	1-Jan-05	1-Jul-06	1-Sep-06
Cameroon	Malaria	CMR-304-G02-M	16,938,794	1-Jan-05	1-Jul-06	1-Sep-06
Cameroon	Tuberculosis	CMR-304-G03-T	2,986,220	1-Jan-05	1-Jul-06	1-Sep-06
Cameroon	HIV/AIDS	CMR-404-G04-H	6,347,296	1-Jan-05	1-Jul-06	1-Sep-06
Comoros	HIV/AIDS	COM-304-G02-H	685,600	1-Jan-05	1-Jul-06	1-Sep-06
Algeria	HIV/AIDS	DZA-304-G01-H	6,185,000	1-Jan-05	1-Jul-06	1-Sep-06
Gabon	Malaria	GAB-404-G02-M	7,419,624	1-Jan-05	1-Jul-06	1-Sep-06
Guinea-Bissau	Malaria	GNB-404-G03-M	1,885,791	1-Jan-05	1-Jul-06	1-Sep-06
Guyana	HIV/AIDS	GVA-304-G01-H	8,881,686	1-Jan-05	1-Jul-06	1-Sep-06
Guyana	Malaria	GVA-304-G02-M	2,055,675	1-Jan-05	1-Jul-06	1-Sep-06
Mozambique	HIV/AIDS	MOZ-202-G02-H-00	21,959,684	1-Jan-05	1-Jul-06	1-Sep-06
Mozambique	Malaria	MOZ-202-G03-M-00	12,217,393	1-Jan-05	1-Jul-06	1-Sep-06
Mozambique	Tuberculosis	MOZ-202-G04-T-00	9,202,140	1-Jan-05	1-Jul-06	1-Sep-06
Nigeria	Malaria	NGA-404-G05-M	20,467,000	1-Jan-05	1-Jul-06	1-Sep-06
Namibia	HIV/AIDS	NMB-202-G01-H-00	26,082,802	1-Jan-05	1-Jul-06	1-Sep-06
Namibia	Tuberculosis	NMB-202-G02-T-00	904,969	1-Jan-05	1-Jul-06	1-Sep-06
Namibia	Malaria	NMB-202-G03-M-00	3,719,354	1-Jan-05	1-Jul-06	1-Sep-06
Pakistan	Malaria	PKS-304-G04-M	1,548,636	1-Jan-05	1-Jul-06	1-Sep-06
Pakistan	Tuberculosis	PKS-304-G05-T	5,605,431	1-Jan-05	1-Jul-06	1-Sep-06
Tajikistan	HIV/AIDS	TAJ-404-G03-H	2,508,720	1-Jan-05	1-Jul-06	1-Sep-06
Vietnam	Malaria	VTN-304-G03-M	13,388,402	1-Jan-05	1-Jul-06	1-Sep-06
Zanzibar (Tanzania)	Malaria	ZAN-404-G04-M	5,089,361	1-Jan-05	1-Jul-06	1-Sep-06

\* PROGRAM START DATES ARE NOT ALWAYS THE OFFICIAL GRANT START DATES

\*\* THESE GRANTS HAVE BEEN GRANTED AN EXTENSION

COUNTRY	COMPONENT	GRANT NUMBER	2 YEAR GRANT AMOUNT (US\$)	PROGRAM START DATE*	REQUEST FOR CONTINUED FUNDING EXPECTED	ESTIMATED SECRETARIAT RECOMMENDATION TO THE BOARD
Congo (Democratic Republic of the)	HIV/AIDS	ZAR-304-G02-H	34,799,786	1-Jan-05	1-Jul-06	1-Sep-06
Congo (Democratic Republic of the)	Malaria	ZAR-304-G03-M	24,966,676	1-Jan-05	1-Jul-06	1-Sep-06
Madagascar	Tuberculosis	MDG-404-G08-T	3,982,018	1-Feb-05	1-Aug-06	1-Oct-06
Suriname	HIV/AIDS	SUR-305-G01-H	2,188,432	1-Feb-05	1-Aug-06	1-Oct-06
Suriname	Malaria	SUR-404-G02-M	2,963,950	1-Feb-05	1-Aug-06	1-Oct-06
Djibouti	HIV/AIDS	DJB-404-G01-H	7,271,400	1-Mar-05	1-Sep-06	1-Nov-06
Ecuador	HIV/AIDS	ECU-202-G01-H-00	7,453,979	1-Mar-05	1-Sep-06	1-Nov-06
Ethiopia	HIV/AIDS	ETH-405-G04-H	41,895,884	1-Mar-05	1-Sep-06	1-Nov-06
Ghana	Malaria	GHN-405-G04-M	18,561,367	1-Mar-05	1-Sep-06	1-Nov-06
Multi-country Americas (OECS)	HIV/AIDS	MAE-305-G01-H	2,553,861	1-Mar-05	1-Sep-06	1-Nov-06
Madagascar	Malaria	MDG-405-G06-M	10,042,388	1-Mar-05	1-Sep-06	1-Nov-06
Madagascar	Malaria	MDG-405-G07-M	9,261,672	1-Mar-05	1-Sep-06	1-Nov-06
Sao Tome and Principe	Malaria	STP-405-G01-M	1,941,359	1-Mar-05	1-Sep-06	1-Nov-06
East Timor	Tuberculosis	TMP-304-G02-T	967,650	1-Mar-05	1-Sep-06	1-Nov-06
Zambia	HIV/AIDS	ZAM-102-G07-H-00	6,395,758	1-Mar-05	1-Sep-06	1-Nov-06
Angola	Malaria	AGO-305-G01-M	28,473,354	1-Apr-05	1-Oct-06	1-Dec-06
Bhutan	Malaria	BTN-405-G01-M	1,000,957	1-Apr-05	1-Oct-06	1-Dec-06
Bhutan	Tuberculosis	BTN-405-G02-T	560,568	1-Apr-05	1-Oct-06	1-Dec-06
Georgia	Tuberculosis	GEO-405-G03-T	1,829,218	1-Apr-05	1-Oct-06	1-Dec-06
India	HIV/AIDS	IDA-405-G05-H	4,158,465	1-Apr-05	1-Oct-06	1-Dec-06
India	Tuberculosis	IDA-405-G08-T	6,819,000	1-Apr-05	1-Oct-06	1-Dec-06
Indonesia	HIV/AIDS	IND-405-G04-H	31,129,618	1-Apr-05	1-Oct-06	1-Dec-06
Mongolia	Tuberculosis	MON-405-G03-T	1,958,259	1-Apr-05	1-Oct-06	1-Dec-06
Sudan	Malaria	SUD-202-G03-M-00	14,257,853	1-Apr-05	1-Oct-06	1-Dec-06
Sudan	HIV/AIDS	SUD-305-G04-H	7,842,140	1-Apr-05	1-Oct-06	1-Dec-06
Togo	HIV/AIDS	TGO-405-G04-H	11,517,643	1-Apr-05	1-Oct-06	1-Dec-06
Uzbekistan	Malaria	UZB-405-G02-M	1,343,466	1-Apr-05	1-Oct-06	1-Dec-06
Uzbekistan	Tuberculosis	UZB-405-G03-T	6,056,522	1-Apr-05	1-Oct-06	1-Dec-06
Burundi	Tuberculosis	BRN-405-G03-T	1,887,175	1-May-05	1-Nov-06	1-Jan-07
Central African Republic	Malaria	CAF-405-G04-M	10,592,816	1-May-05	1-Nov-06	1-Jan-07
Iran (Islamic Republic of)	HIV/AIDS	IRN-202-G01-H-00	5,698,000	1-May-05	1-Nov-06	1-Jan-07
Kenya	Malaria	KEN-405-G06-M	81,749,756	1-May-05	1-Nov-06	1-Jan-07
Lao PDR	HIV/AIDS	LAO-405-G04-H	3,014,946	1-May-05	1-Nov-06	1-Jan-07
Lao PDR	Malaria	LAO-405-G05-M	3,289,689	1-May-05	1-Nov-06	1-Jan-07
Sierra Leone	HIV/AIDS	SLE-405-G02-H	8,574,255	1-May-05	1-Nov-06	1-Jan-07
Sierra Leone	Malaria	SLE-405-G03-M	8,886,123	1-May-05	1-Nov-06	1-Jan-07
Uganda	HIV/AIDS	UGD-304-G04-H	70,357,632	1-May-05	1-Nov-06	1-Jan-07
Uganda	Malaria	UGD-405-G05-M	66,432,148	1-May-05	1-Nov-06	1-Jan-07
Zimbabwe	HIV/AIDS	ZIM-102-G01-H-00	10,300,000	1-May-05	1-Nov-06	1-Jan-07
Azerbaijan	HIV/AIDS	AZE-405-G01-H	6,098,600	1-Jun-05	1-Dec-06	1-Feb-07
Somalia	HIV/AIDS	SOM-405-G03-H	10,004,644	1-Jun-05	1-Dec-06	1-Feb-07
Tanzania	HIV/AIDS	TNZ-405-G04-H	79,741,826	1-Jun-05	1-Dec-06	1-Feb-07
Tanzania	HIV/AIDS	TNZ-405-G05-H	7,895,004	1-Jun-05	1-Dec-06	1-Feb-07
Tanzania	HIV/AIDS	TNZ-405-G06-H	2,373,516	1-Jun-05	1-Dec-06	1-Feb-07
Tanzania	HIV/AIDS	TNZ-405-G07-H	13,180,952	1-Jun-05	1-Dec-06	1-Feb-07
Tanzania	Malaria	TNZ-405-G08-M	54,201,787	1-Jun-05	1-Dec-06	1-Feb-07
China	Tuberculosis	CHN-405-G04-T	27,890,000	1-Jul-05	1-Jan-07	1-Mar-07
China	HIV/AIDS	CHN-405-G05-H	23,936,918	1-Jul-05	1-Jan-07	1-Mar-07
Equatorial Guinea	HIV/AIDS	GNQ-405-G01-H	4,398,764	1-Jul-05	1-Jan-07	1-Mar-07
Guyana	Tuberculosis	GVA-405-G03-T	701,125	1-Jul-05	1-Jan-07	1-Mar-07
India	Malaria	IDA-405-G07-M	30,158,833	1-Jul-05	1-Jan-07	1-Mar-07
Kosovo (Serbia and Montenegro)	Tuberculosis	KOS-405-G01-T	2,122,401	1-Jul-05	1-Jan-07	1-Mar-07
Mali	HIV/AIDS	MAL-405-G02-H	23,483,234	1-Jul-05	1-Jan-07	1-Mar-07
Niger	Malaria	NGR-405-G03-M	11,257,988	1-Jul-05	1-Jan-07	1-Mar-07
Senegal	Malaria	SNG-405-G03-M	23,179,297	1-Jul-05	1-Jan-07	1-Mar-07
Sri Lanka	Malaria	SRL-405-G05-M	1,322,367	1-Jul-05	1-Jan-07	1-Mar-07
Sri Lanka	Malaria	SRL-405-G06-M	797,200	1-Jul-05	1-Jan-07	1-Mar-07
Yemen	HIV/AIDS	YEM-305-G02-H	2,784,684	1-Jul-05	1-Jan-07</	



TWO-THIRDS OF ERITREA'S POPULATION LIVES IN MALARIA-ENDEMIC AREAS, AND CHILDREN UNDER FIVE ARE PARTICULARLY AT RISK. THE GLOBAL FUND GRANT SUPPORTS THE DISTRIBUTION OF INSECTICIDE-TREATED BED NETS, AND PROVIDES TRAINING FOR COMMUNITY HEALTH ASSOCIATES IN THE EARLY RECOGNITION OF MALARIA.



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