GF/B6/9

REPORT OF THE PORTFOLIO MANAGEMENT AND PROCUREMENT COMMITTEE (PMPC)

Outline: This paper presents the results of the deliberations of the PMPC. It contains nine decision points on topics related both to portfolio management, and to procurement and supply management. It has information points on several additional items, as well as three annexes that provide supplemental information that has informed the process of developing recommendations.

Summary of Decision Points:

Background

1. The Portfolio Management and Procurement Committee met most recently on 9 – 10 September 2003 in Geneva. At that meeting, it made (or reaffirmed[1]) recommendations to the Board on:
    - TRP renewal;
    - Eligibility;
    - Round 4;
    - Pharmaceutical Product Quality Monitoring Processes;
    - Diagnostics and Other Non-Pharmaceutical Products;
    - In Kind Donations;
    - Potential Conflicts of Interest.

2. This report outlines the issues debated and highlights decision points that arose from the discussion. Where applicable, the text references an annex, which provides more information on the topic and explains the rationale behind the recommendations emerging from the Committee.

3. The Committee discussed several additional topics which no decisions are required, as described in Part 3.

Part 1: Portfolio Management

A. TRP Renewal

1. The current policy on TRP renewal, as approved by the Board at its Fifth Meeting, is that one -third of TRP members will be rotated off the TRP after each Round, with members expected to serve a maximum of three Rounds. While the necessity of a regular rotation and renewal of the TRP is not disputed, three rounds of experience have revealed several important disadvantages of the current policy. In particular, there is concern that high turnover of TRP members results in the loss of valuable experience, slowing down the work of the TRP and diminishing the possibility of building upon lessons learned.

2. As a result, the Chair of the TRP has recommended a number of changes to the current policy. Because these changes will enhance the review process and ensure continuity and sustainability of the TRP, the PMPC supports the recommendations and requests the Board to approve the changes. Additional background information, rationale and justification are provided in the TRP report to the Board, document GF/B6/6.

[1] Recommendations on eligibility and procurement were based on discussions carried out during the 13 – 14 May 2003 PMPC meeting and reaffirmed during the September meeting.

Decision 1

Following TRP renewal, approximately one-quarter of the TRP members will be rotated each year.

Members appointed from 2003 onwards will be appointed to serve a term of up to four years.

After each Round, the Chair and Vice Chair of the TRP will recommend to the selection panel the members whom should be asked to remain on the TRP (up to a maximum of four years' service for each TRP member).

The selection panel will select replacement TRP members from among the TRP Support Pool.

B. Eligibility Criteria

3. At its Fourth meeting, the Board of the Global Fund decided that "poverty and disease-related need (which encompasses both current disease burden and risk of growth) are the criteria that will be used to determine eligibility to apply for financing from the Global Fund." For the Third Round of applications to the Global Fund, countries were grouped into income categories according to the World Bank classification system.

4. All "Low Income" and "Lower-Middle Income" countries were eligible to apply (with "Lower-Middle Income" countries having to meet additional requirements of co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources). "Upper-Middle Income" countries were eligible only if they faced a "very high current disease burden" (and also had to meet the requirements of co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources).

5. For the Fourth and subsequent rounds of Global Fund financing, the Board requested WHO and UNAIDS to examine in more detail how to categorize countries into a matrix based on disease-related need and poverty, with a particular emphasis on how to broaden the criteria for "disease-related need" from a focus solely on current disease burden to one that fully encompasses vulnerability and the risk of growth of an epidemic.

6. The PMPC reviewed and thanked WHO and UNAIDS for the work that they carried out on this topic. Their analysis revealed several difficulties with the matrix approach:
    a. There are no strictly epidemiological rationales for classifying countries into categories such as "highest," "high," "medium," and "low" disease burden.
    b. The inevitable inaccuracies and uncertainties in data necessitate a degree of caution in the use of epidemiological data for eligibility purposes. In some cases, such as when prevalence rates for a

number of countries cluster around a particular value, these uncertainties make it difficult to justify a division or fixed cut-off point.

c. There are no indicators that can accurately and robustly predict a country's vulnerability to a rapidly increasing epidemic.

7. Therefore, WHO and UNAIDS provided recommendations for cut-off points in the "Upper-Middle Income" group of countries based on current disease burden,[2] but emphasized that they should be understood as options to guide investment decisions. WHO and UNAIDS recommended against using disease-related need to subdivide the "Lower-Middle Income" category of countries (e.g., to determine different co-financing requirements for this group based on disease-related need).

8. In light of this analysis, the PMPC recommends that the Global Fund continue with the general approach adopted at the Fourth Board meeting for the Third Round. There was consensus about the approach to three of the four income categories ("Low," "Lower-Middle," and "High"), about the need to include a list of eligible countries, and about the fact that regional proposals from groupings that include any eligible proposals should be considered as eligible. There was also consensus about the need to further develop operational and transparent definitions of "co-financing," "focusing on poor and vulnerable populations," and "moving over time towards greater reliance on domestic resources."

9. For "Upper-Middle Income" countries, there was no consensus recommendation. The majority preferred that the "Upper-Middle Income" countries would be eligible only if they met additional criteria related to their current disease burden (in addition to the requirement established for the Third Round of applications that these countries demonstrate evidence of co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources). These disease-related criteria were adopted from the recommendations of WHO and UNAIDS.

10. The majority felt that this approach best reflected the Global Fund's mandate to focus on poor and needy countries (particularly in a resource-constrained environment).

11. A minority felt that all "Upper-Middle Income" countries should be eligible to apply (agreeing with the majority that these countries would be eligible only if they demonstrated evidence of co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources). They felt that this approach best reflected the Global Fund's mandate to finance the most technically sound proposals. They noted that these requirements for co-financing, focusing on poor and vulnerable populations, and moving over time towards greater reliance on

[2] For HIV/AIDS a ratio is proposed that accounts for both disease burden and capacity to fund programs from domestic resources.

domestic resources could be stricter than the similar requirements for "Lower-Middle Income," such that the Global Fund might be financing only a small percentage of an application coming from an "Upper-Middle Income" country.

Decision 2

For the Fourth and subsequent rounds of applications to the Global Fund:

- ***a) Countries classified as "Low Income" by the World Bank are fully eligible to apply for support from the Global Fund;***
- ***b) Countries classified as "Lower-Middle Income" by the World Bank are eligible to apply for support from the Global Fund but must meet additional requirements, including co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources;***
- ***c) Countries classified as "High Income" by the World Bank are not eligible to apply for support from the Global Fund.***

The lists of countries covered by a) and b) for the Fourth Round are included in Annexes 2A and 2B, respectively.[3]

Regional proposals that include any eligible countries may submit applications to the Global Fund.

Decision 3, Option One

For the Fourth and subsequent rounds of applications to the Global Fund:

- ***a) Countries classified as "Upper-Middle Income" by the World Bank are eligible to apply for support from the Global Fund only if they face very high current disease burden. This is defined (based on technical input from WHO and UNAIDS) for each disease as follows:***
  1. ***HIV/AIDS: if the country's ratio of adult HIV seroprevalence (as reported by UNAIDS, multiplied by 1000) to GNI per capita (Atlas method, as reported by the World Bank) exceeds 5;***
  2. ***Tuberculosis: if the country is included on the WHO list of 22 high-burden countries, or on the WHO list of the 36 countries that account for 95% of all new TB cases attributable to HIV/AIDS;***
  3. ***Malaria: if the country experiences more than 1 death due to malaria per 1000 people (as reported by WHO).***

[3] These Annexes have been revised since they were originally reviewed by the PMPC, as a result in changes in the World Bank's classification of certain countries (due to changes in income). The PMPC has reviewed the new lists included in Annex 3. Future revisions will similarly be brought to the attention of the PMPC.

b) Eligible countries must meet additional requirements, including co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources.

The list of countries covered by a) for the Fourth Round is included in Annex 2C.

Decision 3, Option Two

For the Fourth and subsequent rounds of applications to the Global Fund:

a) Countries classified as "Upper-Middle Income" by the World Bank are eligible to apply for support from the Global Fund but must meet additional requirements, including co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources.

The list of countries covered by a) for the Fourth Round is included in Annex 2D.

C. Process for Revisions to the Guidelines for Proposals

12. The PMPC reviewed the work carried out by the Secretariat in revising the Guidelines for Proposals, as well as the processes used for previous revisions of the Guidelines.

13. The PMPC unanimously endorsed continuing with the approach adopted for revising the Guidelines for the Third Calls for Proposals, when the Board asked the Secretariat and the PMPC to revise the Guidelines as appropriate. Further, the Committee felt that it was appropriate that this approach be continued for subsequent Calls, rather than continuously readdressing this with the full Board.

Decision 4:

The PMPC recommends that the Board request the Secretariat, in consultation with the PMPC, to revise the Guidelines for Proposals for the Fourth Round and subsequent Rounds as needed.

D. Round 4

14. The PMPC also agreed that the Board should discuss the launch of the Fourth Call for Proposals at the Sixth Board Meeting in Thailand, although the Committee felt that it would only be appropriate to discuss this after the discussion on the comprehensive funding policy, and after the approval of proposals from Round 3.

Decision 5:

A forecast of the resources available for Round 4 will be presented to the Sixth Board Meeting in October 2003 to enable the Board to make a decision on the opportunity and timing for announcing the Call for Proposals for Round 4

Part 2: Procurement and Supply Management

A. Introduction

1. At its Fourth meeting, the Board decided that the Procurement and Supply Management Advisory Panel (PSM-AP) should provide recommendations to the PMPC on several topics related to procurement and supply management (see GF/B5/2, p 19-21). The PSM-AP has provided technical recommendation to the PMPC in its "Report to the Portfolio Management and Procurement Committee (PMPC), 2 May 2003."

B. Pharmaceutical Product Quality Monitoring Processes

2. Based on the recommendations of the Procurement Supply Management Advisory Panel and discussions with technical partners, the PMPC concluded that no international system exists to assess National Drug Regulatory Authorities (NDRA) laboratories (or laboratories recognized by the NDRA) for quality monitoring of single and limited source pharmaceutical products.

Decision 6

National Drug Regulatory Authorities (NDRA) laboratories or laboratories recognized by the NDRA should be used for quality monitoring by the PR. To ensure the respective laboratories have adequate capacity for full pharmacopoeial testing, they must meet one of the following criteria:

- ***Acceptance for collaboration with WHO pre-qualification project;***
- ***Accredited in accordance with ISO17025 and/or EN45002;***
- ***Accepted by a stringent authority.[4]***

C. Diagnostics and Other Non-Pharmaceutical Products

[4] For the purposes of this policy a stringent drug regulatory authority is defined as a regulatory authority in one of the 28 countries which is either a Pharmaceutical Inspection Cooperation Scheme and/or International Conference on Harmonization.

3. Drawing on the technical recommendations from the PSM-AP, the PMPC also addressed polices for diagnostics and other non-pharmaceutical products, developing a series of recommendations.

Decision 7

The principles for procurement and quality assurance of pharmaceuticals that were adopted during the Third Board meeting of the Global Fund apply to diagnostics and other non-pharmaceuticals: namely that a Principal Recipient (PR) is responsible for procurement, and is required to conduct competitive purchasing in order to obtain the lowest possible price for products of assured quality.

For non-durable products, the same principles as for pharmaceuticals should be followed, namely that a PR is required to select from lists of pre-qualified products, where they exist, or products accepted by stringent regulatory agencies or products accepted by national standards.

For durable products the lowest possible price should take into account the Total Cost of Ownership (TCO), including the cost of reagents and other consumables as well as costs for annual maintenance.

Procurement methods for durable products may include either lease or purchase. The PR must provide a plan for service and maintenance of the products.

The Secretariat will work with technical partners such as WHO, UNAIDS and bilateral agencies to ensure availability of information to recipients in regards to quality assurance and procurement systems related to high priority consumables and durables such as condoms, HIV rapid testing kits, $CD4^+$ T cell monitoring, bed nets, microscopes, etc.

D. In Kind Donations

4. The issue of in kind donation was discussed at great length. The PMPC ultimately reached consensus on the following recommendation.

Decision 8

The Board recognizes the potential role of in kind donations in significantly expanding the impact of the GF and in making a significant contribution to resource mobilization efforts through providing leverage for cash resources. In-kind donations also constitute a significant means by which the private sector may be involved with the Global Fund and contribute to achieving its goals, thus reflecting the public – private partnership principles upon which the Global Fund is based.

The Board recognizes the considerable challenges to be confronted in operationalizing in-kind donations. There are different issues involved in managing in-kind donations in the form of services, non-health products, or health products, particularly pharmaceuticals, at both the global and country level.

The Board requests that the PMPC, on the basis of input from the PSM-AP, and working jointly with other Committees, particularly with the Resource Mobilisation Committee, to consider further the different operational issues surrounding in-kind donations of services, non-health, and health products. These general issues include, inter alia:

- ***Guarding against conflicts of interest;***
- ***Potential legal liabilities;***
- ***Long term sustainability;***
- ***Valuation of contribution.***

The Board requests that, on the basis of work done by the private sector and others, the PSMAP will propose strategic options, capturing issues relating to the diversity of products and services, the managerial capacity of the Global Fund Secretariat and Principal Recipients, and the advantages/costs of channelling donations through the Global Fund vis-à-vis other existing mechanisms.

E. Potential Conflicts of Interest

5. The issue of conflict of interest has been discussed previously with specific regard to pharmaceutical procurement (see GF/B5/2, p 21 and "Report of the Third Board Meeting", pages 26-27). However, the PMPC felt that this issue was best addressed in the context of the Governance and Partnership Committee's ongoing work on conflict of interest, rather than separately by the PMPC.

Decision 9

Board refers to the Governance and Partnership Committee the issue of potential conflict of interests when products are manufactured in a state-owned laboratory and the Principal Recipient is a public entity and when products are manufactured or purchased in a state-owned structure and the state is responsible for quality.

F. Other topics (for information only)

6. The PMPC considered the Board decision and advice from the PSMAP on international and national law and recommends no change to the text currently in the Framework Document.

7. The PMPC considered the Board decision relating to supply chain management; advice from the PSMAP did not identify the need for additional recommendations.

Part 3: Information Points to the Board

A. Additionality

1. Based on a brief concept paper prepared by the Secretariat (attached hereto in Annex 3), the PMPC held a preliminary discussion on the principle of additionality.

2. The PMPC noted the complexity of tracking additionality and agreed that this issue should be followed up for operationalization by the Secretariat in conjunction with the MEFA Committee.

B. Neediest and poorest countries

3. At its Fourth meeting, the Board noted with concern that some countries that face high disease burdens and have lower incomes have not received funding in the first two rounds of Global Fund financing.

4. WHO and UNAIDS presented to the May meeting of the PMPC a report on their work supporting applications from a number of these countries. The PMPC lauded WHO and UNAIDS for this initiative and urged that they and other partners continue efforts to ensure that needy and poor countries are not systematically excluded from Global Fund financing.

5. The Secretariat subsequently reported that the CCMs targeted for assistance in the preparation of Round Three proposals had significantly higher success rates than countries that had not been thus targeted.

C. Co-financing

6. Co-financing was introduced as a requirement for upper- and lower-middle income countries in the Third Call for Proposals. At that time, a definition of co-financing had not been discussed by the PMPC and so no definition was included in the Guidelines (with applicants thus being left to demonstrate co-financing in the way they felt was most appropriate).

7. The Secretariat presented the PMPC with a briefing note that set out a definition of co-financing. The PMPC agreed with its recommendation that lower-middle income countries be required to demonstrate that they had secured 20% co-financing, while upper-middle income countries would be required to show 50% co-financing. The PMPC also agreed that parallel co-financing was the preferable approach.

8. The PMPC agreed that the Secretariat would ensure the operationalization of this definition, and requested that the Secretariat report back both on how countries had responded to the request for information on co-financing in Round 3, and how the policy would be operationalized in subsequent Rounds.

Membership list, PMPC

CHAIR	**Professor Francis Omaswa** (Eastern and Southern Africa)		
VICE CHAIR	**Dr. Kate Taylor** (Private Sector)		
CONSTITUENCY	**TITLE**	**NAME**	**SURNAME**
European Commission	Dr.	Lena	Sund
East and Southern Africa	Prof.	Francis	Omaswa
Eastern Europe	Ms.	Zhanna	Tsenilova
France	Mr.	Serge	Tomasi
Italy	Mr.	Sergio	Palladini
China	Dr.	Han	Mengjie
Latin America and Caribbean	Dr.	Eloan	dos Santos Pinheiro
Eastern Mediterranean	Mr.	Ejaz	Rahim
Northern NGOs	Ms.	Mogha	Kamal Smith
NGO Rep. Communities	Dr.	Philippa	Lawson
South East Asia	Dr.	Suwit	Wibulpolprasert
Japan	Dr.	Takeshi	Kasai
UK, Canada & Switzerland	Dr.	Carole	Presern
USA	Dr.	Scott	Evertz
World Health Organization	Dr.	Andrew	Cassels
World Bank	Mr.	Jonathan	Brown
ADDITIONAL INVITEES			
UNAIDS	Mr.	Paul	De Lay
UNAIDS	Dr.	Catherine	Hankins
Secretariat	Prof.	Richard	Feachem
	Mr.	Brad	Herbert
	Ms.	Purnima	Mane
	Ms.	Hind	Khatib Othman
	Mr.	Toby	Kasper
	Mr.	Guido	Bakker
	Ms.	Keri	Lijinsky

Annex 1B

List of participants, PMPC meeting 9 – 10 September 2003

CONSTITUENCY	TITLE	NAME	SURNAME
Portfolio Management and Procurement Committee (PMPC)			
East and Southern Africa (Chair)	Prof.	Francis	Omaswa
European Commission	Ms	Lena	Sund
France	Mr	Serge	Tomasi
Italy	Mr.	Sergio	Palladini
Latin America & Caribbean	Dr.	Eloan	De Santos Pinheiro
Northern NGOs	Ms.	Mohga	Kamal Smith
South East Asia	Dr	Suwit	Wibulpolprasert
South East Asia	As Prof.	Churnturtai	Kanchanachitra
China (Western Pacific)	Dr	Wenjie	Wang (for Mr. Han Mengjie)
Japan	Mr.	Satoshi	Hemmi (for Dr. Takeshi Kasai)
UK, Canada and Switzerland	Dr	Carole	Presern
USA	Dr	Scott	Evertz
World Health Organization	Dr.	Andrew	Cassels
World Bank	Mr	Jonathan	Brown
UNAIDS	Dr	Catherine	Hankins
UNAIDS	Ms.	Valerie	Manda
USAID	Mr.	Paul	Ehmer
Additional Invitees			
Technical Review Panel Chair	Dr	Michel	Kazatchkine
PSM-AP representative	Dr.	Richard	Laing
SECRETARIAT			
Executive Director	Prof.	Richard	Feachem
Focal Point, PMPC	Mr.	Brad	Herbert
	Mrs.	Purnima	Mane
	Mr.	Toby	Kasper
	Ms.	Hilary	Hughes
	Mr.	Bernard	Schwartlander
	Mr.	Barry	Green
	Mr.	Guido	Bakker
	Ms.	Hind	Khatib Othman
	Ms.	Keri	Lijinsky
	Ms.	Naina	Dhingra

Countries classified as Low Income by the World Bank

Countries are fully eligible to apply for support from the Global Fund

Afghanistan
Angola
Azerbaijan
Bangladesh
Benin
Bhutan
Burkina Faso
Burundi
Cambodia
Cameroon
Central African Republic
Chad
Comoros
Congo (Democratic Republic of)
Congo (Republic of)
Cote d'Ivoire
East Timor
Equatorial Guinea
Eritrea
Ethiopia
Gambia, The
Georgia
Ghana
Guinea
Guinea-Bissau
Haiti
India
Indonesia
Kenya
Korea (Democratic Republic of)
Kyrgyzstan
Lao People's Democratic Republic
Lesotho
Liberia
Madagascar
Malawi
Mali
Mauritania
Moldova (Republic of)
Mongolia
Mozambique
Myanmar
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Papua New Guinea
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Solomon Islands
Somalia
Sudan
Tajikistan
Tanzania (United Republic of)
Togo
Uganda
Uzbekistan
Vietnam
Yemen (Republic of)
Zambia
Zimbabwe

Countries classified as Lower-Middle Income by the World Bank

Countries are eligible to apply for support from the Global Fund but must meet additional requirements, including co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources

Albania
Algeria
Armenia
Belarus
Bolivia
Bosnia and Herzegovina
Brazil
Bulgaria
Cape Verde
China
Colombia
Cuba
Djibouti
Dominican Republic
Ecuador
Egypt (Arab Republic of)
El Salvador
Fiji
Guatemala
Guyana
Honduras
Iran (Islamic Republic of)
Iraq
Jamaica
Jordan
Kazakhstan
Kiribati
Macedonia (The Former Yugoslav Republic of)
Maldives
Marshall Islands
Micronesia (Federated States of)
Morocco
Namibia
Paraguay
Peru
Philippines
Romania
Russian Federation
Saint Vincent and the Grenadines
Samoa
Serbia and Montenegro
South Africa
Sri Lanka
Suriname
Swaziland
Syrian Arab Republic
Thailand
Tonga
Tunisia
Turkey
Turkmenistan
Ukraine
Vanuatu
West Bank and Gaza

Option One

Countries classified as Upper-Middle Income by the World Bank but eligible by virtue of very high current disease burden

Countries are eligible only for the component listed
Countries are eligible to apply for support from the Global Fund but must meet additional requirements, including co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources

HIV/AIDS:

Botswana

Tuberculosis:

Botswana

Malaria:

Botswana
Gabon

Option Two

Countries classified as Upper-Middle Income by the World Bank

Countries are eligible to apply for support from the Global Fund but must meet additional requirements, including co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources

Argentina
Belize
Botswana
Chile
Costa Rica
Croatia
Czech Republic
Dominica
Estonia
Gabon
Grenada
Hungary
Latvia
Lebanon
Libya
Lithuania
Malaysia
Mauritius
Mayotte
Mexico
Oman
Palau
Panama
Poland
Saudi Arabia
Seychelles
Slovak Republic
St. Kitts and Nevis
St. Lucia
Trinidad and Tobago
Uruguay
Venezuela

Additionality in the Global Fund: A Concept Paper for the Portfolio Management and Procurement Committee[5]

Additionality of Global Fund resources: Rationale and definition

The Global Fund was set up out of the recognition that there is a considerable gap between the resources currently available for the fight against AIDS, tuberculosis, and malaria, and the sums needed to halt these diseases. The existing commitments from both developed and developing countries are insufficient to reverse the spread of these epidemics, and without substantial additional funds the lives of millions of people globally will be endangered. Further, there is an emerging consensus internationally that the control of infectious diseases is a global public good which has been inadequately financed, and which requires significant new resources.

The concept of *additionality* – that resources raised must be supplemental to existing resource streams – is thus fundamental to the Global Fund, and as such is featured prominently in all key Global Fund policy statements, such as the Framework Agreement. For the Global Fund to fulfill its mandate to make a sustainable and significant contribution to the reduction of infections, illness and death caused by HIV/AIDS tuberculosis and malaria in countries in need, it must mobilize new resources for these three diseases and illustrate that these additional resources have had an impact. If funds are not additional but rather simply diverted from the current commitments of multilateral, bilateral, or national programs into Global Fund coffers, or if funds did not measurably mitigate the impact caused by HIV/AIDS, TB and malaria, then the initiative would have failed. The Global Fund's monitoring and evaluation procedures and results-based disbursement system will illustrate the impact of the funded activities on the HIV/AIDS, TB and malaria epidemics. The challenge remains to prove the additionality of the resources that contributed to those impacts.

Despite complexities in measuring and operationalizing additionality as described below, the Global Fund tentatively considers funds to be additional if total domestic and external expenditures are at least equal to the planned domestic and external financial commitments for the same year. Recipient countries must continue to take a leadership role – both politically and financially – in the fight against AIDS, tuberculosis, and malaria. The availability of Global Fund resources should not diminish commitments made

[5] This concept paper will be updated taking into account PMPC committee members' input from previous meetings and in conjunction with an appropriate institution.

to increase health sector spending (e.g., at the Abuja Summit) and otherwise scale up the responses to AIDS, tuberculosis and malaria. Financing from donor countries and agencies must be additional both at the national and at the global levels. Thus it would be inappropriate for resources pledged either as part of existing bilateral commitments to recipient countries or to international initiatives or organizations to be rerouted to the Global Fund. Natural fluctuations in the balance between domestic and external funding in a given country, however, have the potential to make insisting on additionailty of both domestic and external resources difficult .

This insistence on the need for new resources is supportive of and indeed related to a broader recognition that international development assistance must be dramatically scaled up, as articulated at, for example, the International Conference on Financing for Development in Monterrey, Mexico in March 2002.

The additionality of Global Fund resources in practice

The additionality of Global Fund resources is first addressed in the proposal recommendation phase. CCMs are asked to provide data on existing and future disease-specific resources flows and indicate how the Global Fund financing would supplement these current and future commitments. For Round 3 this information is to be presented in a table that requires the applicant to indicate the value of itemized funds available, the request from Global Fund and the remaining unmet need, which sum up to equal the total resources needed for each disease (see Annex B). The Technical Review Panel considers this information in taking a decision to recommend proposals for approval.

Once a proposal has been approved, additionality is addressed in the grant negotiations with Principal Recipients. At a minimum, this encompasses discussions of the principles, but can also include collection of relevant data to allow the tracking of additionality and the development of plans to measure additionality. The grant agreement signed between the Global Fund and the Principal Recipient typically includes the following language on additionality:

> "In accordance with the criteria governing the selection and award of this Grant, the Global Fund has awarded the Grant to the Principal Recipient on the condition that the Grant is in addition to the normal and expected resources that the Host Country usually receives or budgets from external or domestic sources. In the event such other resources are reduced to an extent that it appears, in the sole judgment of the Global Fund, that the Grant is being used to substitute for such other resources, the Global Fund may terminate this Agreement in whole or in part under Article 21 of this Agreement."

Resource flows will continue to be tracked over the lifecycle of each program through annual reports. Before a second disbursement is made after the first two years, programs will have to demonstrate sustained domestic and external financial commitments to each disease or explain any significant changes in or discrepancies between planned and actual expenditures.

Difficulties in measuring additionality in resource flows

While important, the *ex ante* commitments described above are unlikely to ensure additionality. However, tracking additionality has considerable complexities. Some of the problems of measuring additionality are intrinsic, while others result from the generally weak public expenditure management in the countries that receive the bulk of financing from the Global Fund. We have identified the following difficulties in measuring additionality:

1. The multisectoral nature of Global Fund financing. HIV/AIDS grants often fund programs in health, education, agriculture, youth, and gender that are implemented by both public and private actors. Thus disease-specific resource flows must be tracked through multiple government ministries and sectors of the economy.. Share of expenditure on these diseases in education, agriculture, and other non-health sectors is typically small, and is often not available as a discrete budget item.[6]
2. The definitions of domestic and external financing. Disagreements may arise over the definitions of domestic and external assistance. For example, some countries consider loans as domestic commitments (in light of the fact that they must be repaid, presumably with domestic resources), while others treat them as external financing.

3. The weakness of the expenditure tracking systems necessary to show additionality. Recent IMF-World Bank research found that of 24 highly-indebted poor countries studied (18 of which have been approved for Global Fund financing), none could be classified as requiring little or no upgrading in their public expenditure management systems to be able to track poverty-reducing public spending; 9 required some upgrading and 15 required substantial upgrading.

4. The wide gap between budgets and actual expenditure present in many developing countries reduces the usefulness of relying on published budget figures. Even in well-functioning economies, audited expenditure reports are typically not available for at least six months after the close of a fiscal year. This means that in many countries a single year's audited data might not be available before the conclusion of a two year grant.

Arguments against additionality

There are several arguments that have been raised against the principle of additionality. The first relates to macroeconomic stability, particularly the concern that large inflows of foreign exchange may cause an appreciation of the currency in the recipient country, damaging exports. There has been a renewed interest in this so-called "Dutch Disease" effect in the wake of the possibility of significant increases in development assistance. Most analysts (e.g., from DFID, the World Bank, and the IMF) agree that any deleterious appreciation in the real exchange rate related to a

[6] There has been some progress in developing national accounts for AIDS expenditures, particularly in Latin America, but comprehensive databases of expenditure by disease rather than by sector are rare, particularly in Africa.

shift towards consumption of non-tradable goods and services engendered by increased development assistance can be offset – particularly in the medium-term – through a combination of improved productivity from investment in social capital development and of judicious use of monetary policy. Further, the composition of expenditure can have a considerable effect on the exchange rate: if a high proportion of Global Fund financing is used to purchase imports (e.g., antiretroviral or artemisinin-containing therapy), the exchange rate appreciation will be blunted.

Nonetheless, concerns about the short-term economic impacts of large grants that are in addition to other inflows of foreign exchange may have a dampening effect on the size and/or frequency of applications to the Global Fund (although these decisions will not be apparent to the Global Fund, as they should take place at the CCM before an application is submitted).

A second argument against additionality relates to its impact on the integrity of the budgeting process. If a country's budgeting process is well functioning, it should produce an equitable and efficient allocation of resources among the various competing budgetary priorities. If the Global Fund insists that its resources must be additional to the current resource flows, by definition the delicate balance agreed upon in the budgetary process is upset and skewed in favor of expenditure on AIDS, tuberculosis, and malaria.

This negative impact is compounded by the relatively short time horizon of Global Fund grants, as this reduces their predictability and therefore exacerbates planning dilemmas.[7]

[7] The Global Fund's results-based disbursement strategy should partially mitigate this, as this approach to conditionality is more predictable than most others, as the targets against which monies will be disbursed are chosen by the recipient rather than the donor and so axiomatically are benchmarks that should be readily achievable.