



Investing in our future

The Global Fund

To Fight AIDS, Tuberculosis and Malaria

Twenty-second Board Meeting
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Information

REPORT OF THE EXECUTIVE DIRECTOR

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INTRODUCTION

1. For its twenty-second meeting, the Board convenes for the first time in the Eastern Europe and Central Asia region. The HIV epidemic is still rapidly expanding in this region, notably in Ukraine and the Russian Federation, mainly driven by injecting drug use but also among men who have sex with men, sex workers and prisoners. The region is also severely affected by tuberculosis and has the highest rates of multidrug-resistant (MDR) TB in the world: fifteen of the 27 countries with the highest burden of MDR-TB are located in this region. TB is a leading killer of people with HIV across the region.

2. Up to and including round 9, the Board had approved 90 grants in the countries of Eastern Europe and Central Asia with a total value of \$1.4 billion. Around two-thirds of this is for HIV, nearly a third for TB and a small proportion for malaria in five countries in Central Asia. An estimated 225,000 lives have been saved in this region as a result of Global Fund financing. The Fund supports around two-thirds of those currently receiving antiretroviral treatment (ART) in Eastern Europe and Central Asia, however regional ART coverage is still less than 20 per cent of those in need. Coverage of programs to prevent vertical transmission of HIV is high, at around 90 per cent, in large part due to support from the Global Fund.

3. Although many countries in the region show strong political and financial commitment to TB control, TB detection and treatment success rates in most countries in the region fall significantly short of international targets. Twenty-six percent of Global Fund financing in this region has been allocated to interventions targeting MDR-TB, making Eastern Europe and Central Asia the region with the most funding allocated specifically to curative care for MDR-TB. Data submitted to the Stop TB Green Light Committee show that around 35,000 MDR-TB treatment enrolments have taken place in the region to date. Programs supported by Round 9 grants will help to treat an additional 70,000 patients with MDR-TB, however, with an estimated 80,000 MDR-TB annual cases in this region in 2008 alone, much more needs to be done to tackle this problem.

4. Injecting drug use accounts for around 70 per cent of HIV transmission in Eastern Europe and Central Asia and the Global Fund is the main financier of harm reduction interventions in the region. This support has enabled 13 countries to provide evidence-based interventions such as needle and syringe programs and opioid substitution therapy, mostly implemented by civil society organizations. However, recent research suggests that as few as nine needles and syringes are distributed per person who injects drugs in the region - well below levels which could be expected to have an impact on HIV - indicating that further scale-up is still urgently needed. Harassment, stigma and discrimination against drug users and government opposition to opioid substitution therapy in some countries are also significant obstacles to addressing HIV and TB in the region.

5. I extend my warm thanks to the government of Bulgaria for hosting this meeting. Since 2003 Bulgaria has been successfully implementing Global Fund HIV and TB grants with lifetime budgets that total \$92 million. A Round 2 HIV grant complemented by Rolling Continuation Channel funding supports the national effort to sustain low prevalence in the country and build the national AIDS response through reducing risky behaviors among most-at-risk groups such as injecting drugs users, sex workers and men who have sex with men, as well as to ensure access to services for marginalized groups including Roma communities and youth. Bulgaria is also the recipient of two TB grants that support high-quality TB diagnosis, treatment and improved control of MDR-TB.

6. As 2010 draws to a close and we look ahead to 2011, we are observing a significant number of milestones for the Global Fund and in global health. It is 10 years this year since the G8 met in Okinawa and committed to tackling communicable diseases, a step that led to the creation of the Global Fund in Brussels just a year later. It is also 10 years since the historic international AIDS conference in Durban that placed the need to expand access to treatment so firmly on the global political agenda. In September this year, the development community gathered at the United Nations to assess 10 years of work towards achieving the Millennium Development Goals. In October, the Global Fund undertook the major task of its third voluntary replenishment. In 2011 we will observe the tenth anniversary of the landmark United Nations General Assembly on AIDS at which 189 signatories to the Declaration of Commitment called for “the establishment, on an urgent basis, of a global HIV/AIDS and health fund”.

7. As we mark a very eventful decade in global health, the Board begins work in Sofia on a new corporate strategy for the Global Fund, and my first term as Executive Director draws to a close. I feel it is therefore appropriate to reflect in this report on the evolution of the Global Fund over the last few years, including a review the replenishment result and its implications.

8. Looking forward, the report discusses in some depth an agenda of measures that I am currently implementing to ensure that the Global Fund is operating at peak effectiveness and efficiency in the coming years.

9. I extend my sincere thanks to all Board members and delegations for their contribution to the Global Fund this year, especially during the replenishment process. I warmly thank the Board Chair, Minister Tedros, and Vice Chair, Ernest Loevensohn, as well as the Chairs and Vice Chairs of the Committees, for their leadership and support. I thank all the members of the Global Fund partnership, including implementers; civil society and advocacy groups; the Friends groups around the world; foundations and corporations; Roll Back Malaria; the Stop TB Partnership and our UN partners including UNAIDS, WHO and Unicef. Finally, I thank all the hard-working Secretariat staff, including the Deputy Executive Director and the other members of the Executive Management Team.

10. I particularly thank Wilfred Griekspoor for the tremendous contribution he has made to the Global Fund as Chief Financial Officer in 2010. I look forward to welcoming Zubair Hassan when he formally assumes the position of Chief Financial Officer next January.

11. The report is structured as follows:

- **Part 1, “Results, overview of portfolio and progress on initiatives”**, highlights the end-of-year results of the Global Fund across regions and diseases, describes the composition of the portfolio, assesses progress on a number of initiatives to accelerate access to key interventions and discusses a range of operational issues.
- **Part 2, “Third voluntary replenishment and resource mobilization”**, provides an analysis of the replenishment outcome and its implications and describes the Secretariat’s ongoing resource mobilization efforts.
- **Part 3, “The challenges of success and growth”**, describes the evolution of the Global Fund, with a focus on its rapid growth of over the last four years and discusses related challenges.
- **Part 4, “An agenda for a more efficient and effective Global Fund”**, describes progress in implementing measures in the Secretariat to address the challenges of growth and enhance operational performance.

PART 1: RESULTS, OVERVIEW OF PORTFOLIO AND PROGRESS ON INITIATIVES

Summary

- The Global Fund top three indicators for December 2010 show significant progress in scale-up of key interventions in the last year, including a major increase in the number of bed nets distributed.
- New reports from WHO and UNAIDS show that the Global Fund continues to make major contributions to progress against AIDS and TB.
- The initiative on PMTCT and the AMFm are helping to expand access to key interventions.
- The Global Fund has now disbursed around \$12.5 billion through 825 grants in more than 140 countries. Disbursements have been more efficient in 2010 and the Fund is on track to disburse a record amount of around \$3 billion this year.
- The portfolio as a whole continues to perform strongly.
- Round 8 grant signing is virtually complete and Round 9 grant signing is on schedule.
- Since 2005, the Phase 2 review process has led to savings of more than \$1 billion.
- Investigations by the Office of the Inspector-General have revealed systematic misuse of funds in a number of countries. Short term action taken in response to these findings includes the suspension of grants, the application of the Additional Safeguards Policy to several countries and specific measures with regard to higher-risk activities identified by the OIG.

December 2010 results

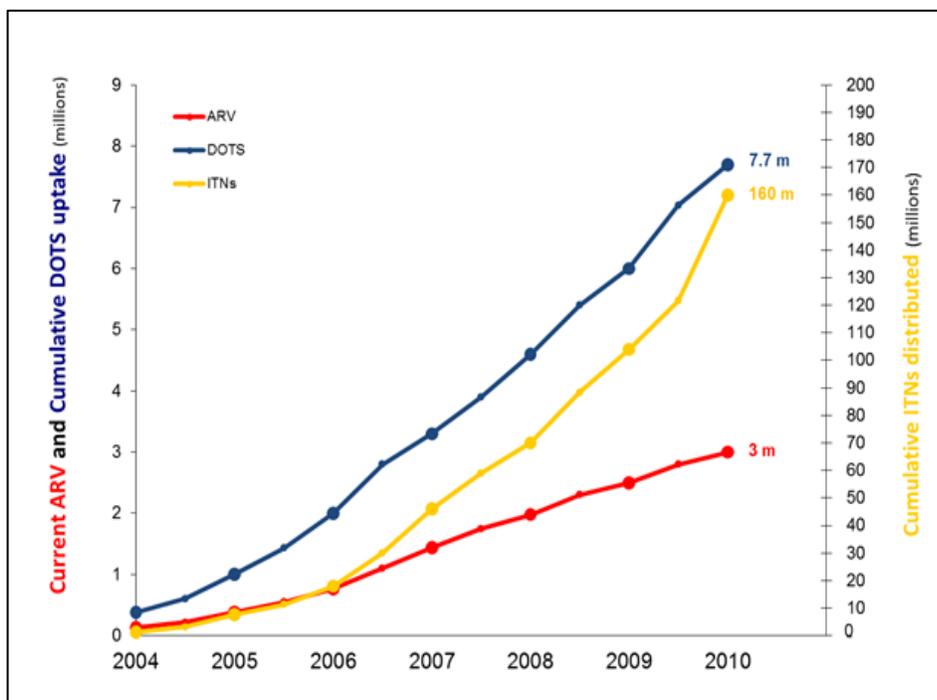
1.1 The Global Fund's latest results were released on December 1. This section provides some preliminary analysis. A detailed analysis will appear in the next Global Fund results report, to be published in time for the next Board meeting.

1.2 The results for the Global Fund's top three indicators show continued impressive scale-up in 2010 (Table 1 and Fig.1). This is especially the case with regard to the increased number of insecticide treated bed nets distributed, which increased by a remarkable 57 per cent in the last year. Cumulative DOTS treatments provided by Global Fund supported programs reached 7.7 million and the number of people receiving antiretroviral treatment with the Fund's support reached 3 million. Based on these results, the Global Fund estimates that 6.5 million lives have now been saved by the programs it supports.

Table 1. Global Fund top three indicators December 2010

Indicator	Dec 2007	Dec 2008	Dec 2009	Dec 2010	% increase in last year
HIV: People on ART	1.4 million	2 million	2.5 million	3 million	20%
TB: DOTS treatment	3.3 million	4.6 million	6 million	7.7 million	29%
Malaria: ITNs distributed	46 million	70 million	104 million	163 million	56%

Fig. 1. Scale-up of interventions for top three Global Fund indicators, 2004-2010



HIV/AIDS

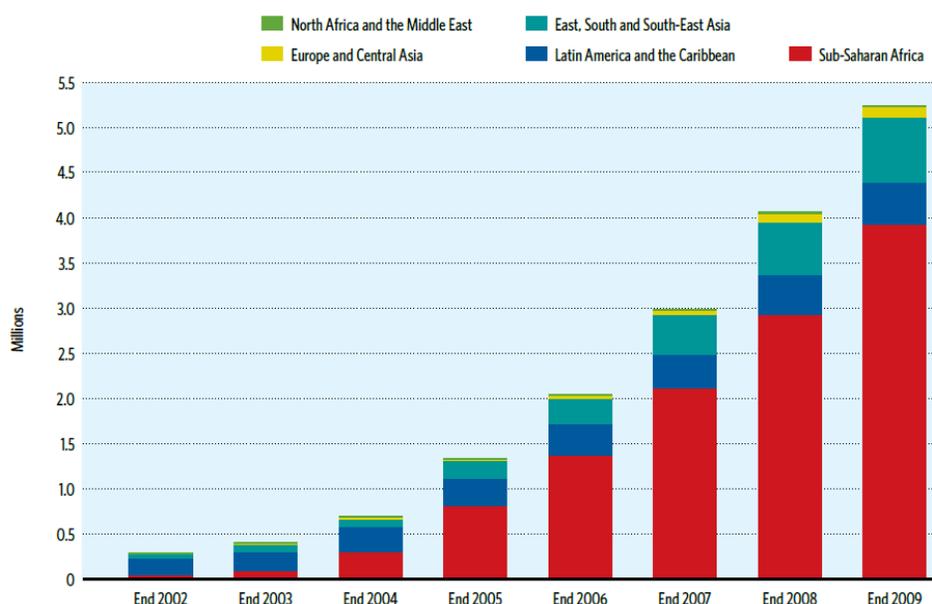
1.3 This year we have seen further significant progress in scaling up HIV treatment and prevention, and additional evidence of impact. While the global AIDS epidemic appears to have peaked, it continues to take an extraordinary toll and is still expanding in some regions and at-risk populations.

Antiretroviral treatment

1.4 In September this year, WHO reported that the number of people receiving antiretroviral therapy (ART) in low- and middle-income countries had increased from just over 4 million in December 2008 to 5.25 million in December 2009 (Fig. 2)¹. This increase of 1.2 million people receiving ART in 2009, or 30 per cent, was the largest ever in a single year; up to half of these people gained access through Global Fund supported programs. Global ART coverage was estimated at 36 per cent at the end of 2009 based on the WHO 2010 treatment guidelines; if based on the 2006 guidelines, global coverage would have stood at 52 per cent. Access to ART in Eastern Europe and Central Asia is still unacceptably limited, reaching just 19 per cent of those in need.

¹ Towards Universal Access: Progress Report 2010. WHO, UNAIDS, Unicef. September 2010

Fig 2. Number of people receiving ART in low- and middle-income countries, by WHO region, 2002-2009



WHO, UNAIDS, Unicef. September 2010

1.5 The Global Fund end-2010 results show that the Fund has contributed to further substantial scale up this year. The Fund is now supporting around 3 million people on ART globally and an additional 500 000 people gained access to treatment through programs supported by the Fund in 2010. It is estimated that the Fund is supporting around half of those on treatment globally, half of those on treatment in Africa, 75 per cent of those on treatment in Asia and just under a third of those on treatment in Latin America and the Caribbean.

1.6 WHO estimates that by December 2009, eight low-and middle-income countries had achieved universal access to ART (at least 80 per cent coverage of the estimated need), and 21 additional countries had reached coverage rates higher than 50 per cent.

1.7 The 2010 revision of WHO guidelines on ART for HIV infection means the estimated number of children and adults needing ART in low- and middle-income countries at the end of 2009 had increased from 10.1 million to 14.6 million. Moving to the new guidelines will result in increased initial investments, but it is expected that fewer hospitalizations and reduced morbidity and mortality rates in the medium term would fully compensate for the increased investment. The reality is that most people who access treatment still do so at an advanced stage of disease with CD4 counts well below 200 copies/mm³, and much more effort is needed to promote earlier HIV testing and treatment. As of December 2009, 45 countries had adopted the new WHO recommendation on ART initiation, and 33 countries had started implementing stavudine (d4T) phase-out plans.

1.8 Globally, women account for around 58 per cent of those on treatment. Of the 21 countries that have provided data on ART coverage for people living with HIV who inject drugs, 14 countries treat 5 per cent or fewer of all such individuals.

1.9 Community-based care is critical for providing ART in the long term. A recent study in Ethiopia showed better clinical outcomes and higher retention rates among patients who were

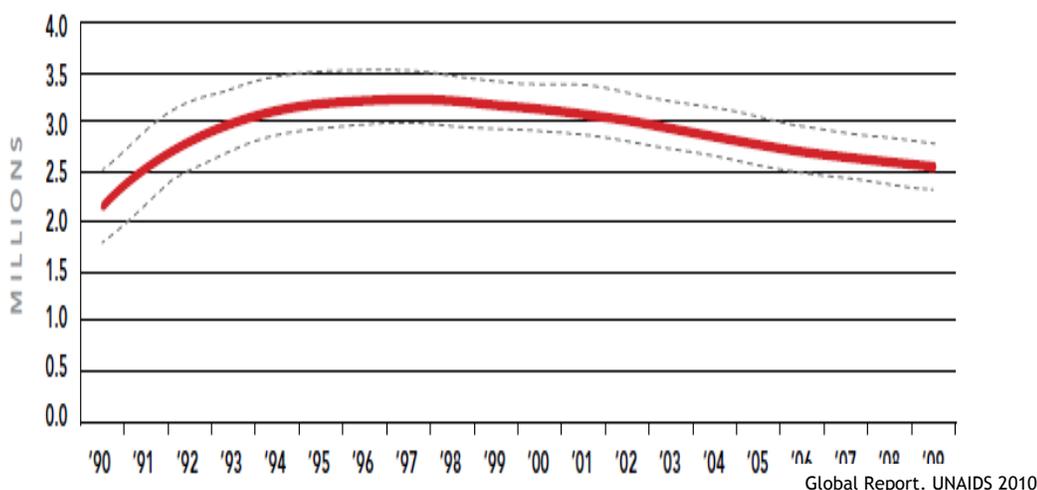
accessing ART through health centres than those accessing it in hospitals². The study highlights the importance of decentralizing long-term care for AIDS, including investments in community-based support.

1.10 The annual number of AIDS deaths worldwide has steadily decreased from a peak of 2.1 million in 2004 to an estimated 1.8 million in 2009. The decline reflects the remarkable impact of treatment, especially in Africa where an estimated 320 000 (20 percent) fewer people died of AIDS-related causes in 2009 than in 2004. AIDS mortality among children has also declined globally in this period, though not to the same extent. UNAIDS estimates that 14.4 million life-years have been gained globally since ART became available in 1996.

HIV prevention

1.11 According to UNAIDS, an estimated 2.6 million people acquired HIV in 2009, more than 20 per cent fewer than the estimated 3.2 million who acquired it when new cases peaked in 1997 (Fig. 3). Since 2001, HIV incidence has fallen by more than 25 per cent in 33 countries, 22 of them in sub-Saharan Africa. This trend reflects both the impact of HIV prevention efforts and the natural course of the epidemic. However, during the same period, incidence increased by more than 25 per cent in seven countries, including five countries in Eastern Europe and Central Asia. UNAIDS estimates that 89 per cent of HIV-prevention investments in this region are not focused on people at higher-risk, such as injection drug users, sex workers and their clients and men who have sex with men.

Fig 3. Number of people newly infected with HIV globally 1990-2009



1.12 A recent analysis by UNAIDS found that HIV incidence has fallen by 25 per cent or more among young people in 15 of the 21 highest-burden countries³. The study provides encouraging evidence of falling incidence linked to increasing safe behaviors.

² Outcomes of Antiretroviral Treatment: A Comparison between Hospitals and Health Centers in Ethiopia. JIAPAC September/October 2010 9: 318-324

³ Young people are leading the HIV prevention revolution. UNAIDS. July 2010.

1.13 The Global Fund contributed to further very substantial increases in the availability of key HIV prevention interventions in 2010 (Table 2).

Table 2: Global Fund results for selected HIV prevention interventions, December 2010

HIV prevention intervention	Cumulative results (end 2009)	Cumulative results (end 2010)	% increase
ARV prophylaxis for PMTCT	790,000	1 million	26%
HIV counselling and testing sessions	105 million	150 million	38%
Condoms distributed	1,839 million	2,700 million	48%

Prevention of mother-to-child HIV transmission

1.14 UNAIDS reported two weeks ago that we are making progress towards the goal of eliminating HIV transmission from mother to child and using PMTCT to expand access to treatment, care and prevention. The total number of children born with HIV has decreased by 24 per cent in the last five years and in 2009 more than 50 per cent of pregnant women living with HIV received ART to prevent transmission of HIV to their infants. Botswana, South Africa, Namibia and Swaziland have achieved universal access to ART prophylaxis for PMTCT. The Global Fund is a major contributor to that progress, having now supported a million pregnant women living with HIV to access ART prophylaxis, the vast majority of whom are in sub-Saharan Africa.

HIV testing and counselling

1.15 The number of facilities providing HIV testing and counselling globally has increased substantially in the last two years, and the median number of HIV tests performed per 1000 population increased from 41 in 2008 to 50 in 2009. One hundred countries reported a total of 67 million HIV tests in 2009. In 2010, the Global Fund financed the provision of 35 million additional HIV testing and counselling episodes, bringing the cumulative total provided by Global Fund-supported programs to 140 million. Two-thirds of countries in sub-Saharan Africa, Latin America and the Caribbean have adopted provider-initiated testing and counselling policies in health care settings. Despite these advances, WHO estimates that the median percentage of people living with HIV globally who know their HIV status is less than 40 per cent.

1.16 Only around 26 per cent of all pregnant women in low-and middle-income countries received an HIV test in 2009 (up from 7 per cent in 2005). This is mainly due to especially low coverage of testing in East, South and South-East Asia (17 per cent), where 55 per cent of the estimated 125 million women who were pregnant in 2009 live.

1.17 Under new WHO guidelines, everyone with TB who is living with HIV should receive ART regardless of their CD4 count. However, the percentage of people with TB who received an HIV test in 2009 was only 26 per cent globally, and 53 per cent in sub-Saharan Africa.

Harm reduction

1.18 Around 30 per cent of new HIV infections outside sub-Saharan Africa occur through injecting drug use. However, coverage of preventive interventions remains inadequate: according to WHO, in 2009 a median of 32 per cent of injecting drug users were reached with HIV prevention programs in the preceding 12 months in 27 low- and middle-income countries that reported data. Of 92

countries that reported information on harm reduction policies for injecting drug users, 36 reported having needle and syringe programs and 33 offered opioid substitution therapy. In all the reporting countries, the number of syringes distributed per injecting drug user per year is far below the internationally recommended target.

1.19 The Global Fund is the major source of external funding for harm reduction programs in developing countries and in large parts of Eastern Europe and Central Asia it is virtually the only donor for these interventions. As we anticipate approval of new proposals to scale up harm reduction in Round 10 and the MARPS channel, I wish to thank the many partners - including UNODC, UNAIDS, WHO, Open Society Institute, the HIV/AIDS Alliance and harm reduction networks - who have supported countries in developing their applications.

1.20 This year has been another year of advocacy by the Global Fund for harm reduction and evidence-based drug policies. Global Fund staff contributed to a special issue of the Lancet on HIV and Injecting Drug and the Fund was highly visible at the International AIDS Conference in Vienna promoting access to prevention, treatment and care services for people who inject drugs, with much focus on Eastern Europe and Central Asia. Work continues at the Secretariat to analyze the Fund's support for harm reduction activities with a view to presenting new data at the International Harm Reduction Conference in April 2011.

1.21 In all regions, people who use illicit drugs are denied harm reduction services, have poor access to ART and are sometimes abused or tortured by law enforcement officials. More high-level advocacy is needed to overcome the political, legal and sociocultural obstacles to providing appropriate interventions for drug-users. I have therefore accepted an invitation from former President Fernando Henrique Cardoso of Brazil to be a Commissioner on the Global Commission on Drug Policy, which will meet in early 2011.

1.22 If we are to end the AIDS epidemic we must begin to see a dramatic decline in new infections among people who inject drugs and should aim to virtually eliminate HIV infections among people who inject drugs by 2015.

Male circumcision

1.23 Although male circumcision as a preventive intervention is being implemented in a number of high-burden countries including Botswana, Kenya, Tanzania, Zambia and Zimbabwe, uptake remains relatively limited. The Secretariat intends to undertake an analysis of Round 10 proposals and work with partners to explore opportunities for further scaling up this intervention.

Tuberculosis

1.24 TB incidence is falling globally and in 5 of 6 WHO regions. It remains stable in South East Asia. If this trend is sustained, the MDG target for TB will be achieved. Mortality at global level fell by 35 per cent between 1990 and 2009 and the target of 50 per cent reduction in mortality by 2015 could also be achieved if the current rate of decline is maintained.

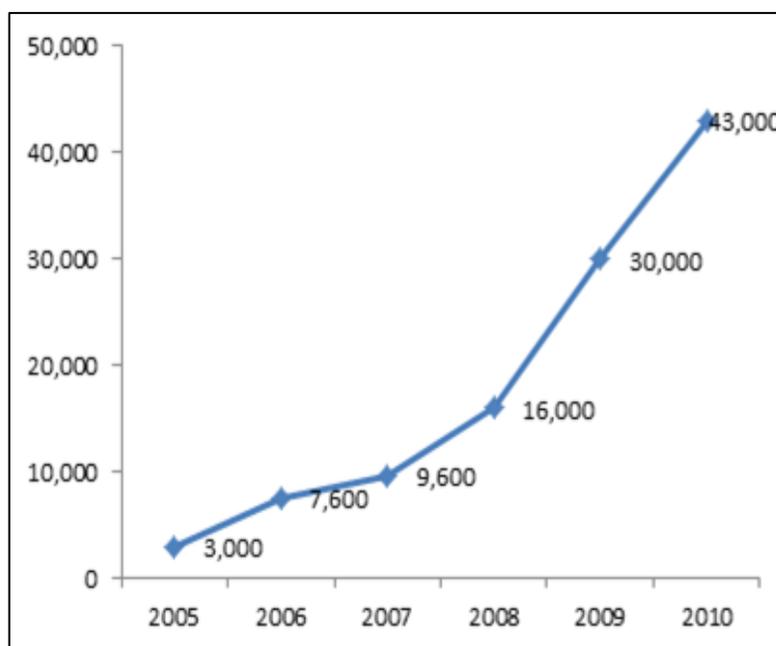
1.25 WHO recently reported that 86 per cent (2.2 million) of the 2.6 million patients with sputum smear-positive pulmonary TB in 2008 were successfully treated⁴. In 2009, there were 5.8 million notified cases of TB, equivalent to a case detection rate of 63 per cent. The Global Fund

⁴ Global Tuberculosis Control Report 2010. WHO

has helped to accelerate case detection and successful treatment in recent years, with 1.7 million additional cases of TB detected and treated by Global Fund-supported programs in 2010, compared with 1.4 million in 2009 and 1.3 million in 2008. By December 2010, the Fund had supported DOTS for a cumulative total of 7.7 million people.

1.26 Of the 5.8 million TB patients notified in 2009, 250 000 had MDR-TB. Around 30 000 (12 per cent) of these were diagnosed and notified to WHO - mostly by European countries and South Africa - and about 23,000 were enrolled for second-line treatment. Programs supported by the Global Fund provided treatment for MDR-TB to around 14 000 people in 2009 and 13 000 people in 2010, bringing the total number of MDR-cases treated with Global Fund support so far to 43 000 (Fig. 4).

Fig.4. Cumulative number of people receiving treatment for MDR-TB through Global Fund-supported programs, 2005-2010



1.27 WHO expects the overall numbers of MDR-TB patients diagnosed and started on treatment to double in 2010 and 2011 compared with 2009, with significant increases expected in China, India and Russia, the countries that have the highest estimated number of MDR-TB cases. The Global Fund currently estimates that, by 2015, it will be supporting 27,000 MDR-TB treatments per year to patients globally. However, if the trend of increased funding for MDR-TB continues, this could increase to between 65,000 and 121,000 MDR-TB treatments per year by 2015.

1.28 National data on treatment outcomes for MDR-TB among cohorts of at least 200 patients are available from nine countries. Rates of treatment success vary widely, from around 40 per cent to 80 per cent. High rates of default are a common problem. Inadequate laboratory capacity is one of the most important constraints to rapid expansion of diagnostic and treatment services for MDR-TB.

1.29 This year WHO reported new data from 15 countries showing that efforts by national TB programs to engage private care providers who deliver services at the community level in TB control (an approach known as public private mix or PPM) can be an effective way to increase case detection rates.

1.30 Up to 13 per cent of the 9.4 million TB incident cases worldwide in 2008 (around 1.4 million cases) were among people living with HIV. Nearly 80 per cent of these were in sub-Saharan Africa. Around 140 000 TB patients were enrolled on ART in 2009 and 80 000 people with HIV received isoniazid preventive therapy, an increase over previous years but still less than 1 per cent of all people living with HIV worldwide. According to WHO, in 2009 only 43 per cent of countries had isoniazid preventive treatment as intervention package, 60 per cent reported having intensified case finding for TB prevention, and 51 per cent had TB infection control policy.

Malaria

1.31 Major progress has been made in just the last few years with a massive expansion of coverage of insecticide-treated nets and effective scale up of malaria treatment. Of the nearly 350 million ITNs needed to achieve universal coverage, nearly 200 million were delivered to African countries between 2007 and 2009 alone. The mean ITN/IRS coverage rate increased from less than 10 per cent in 2002 to an estimated 70 per cent by the end of 2010 for the countries most affected by malaria. The lives of at least 750,000 children are estimated to have been saved between 2001 and 2010: 85 per cent of them in just the last five years⁵.

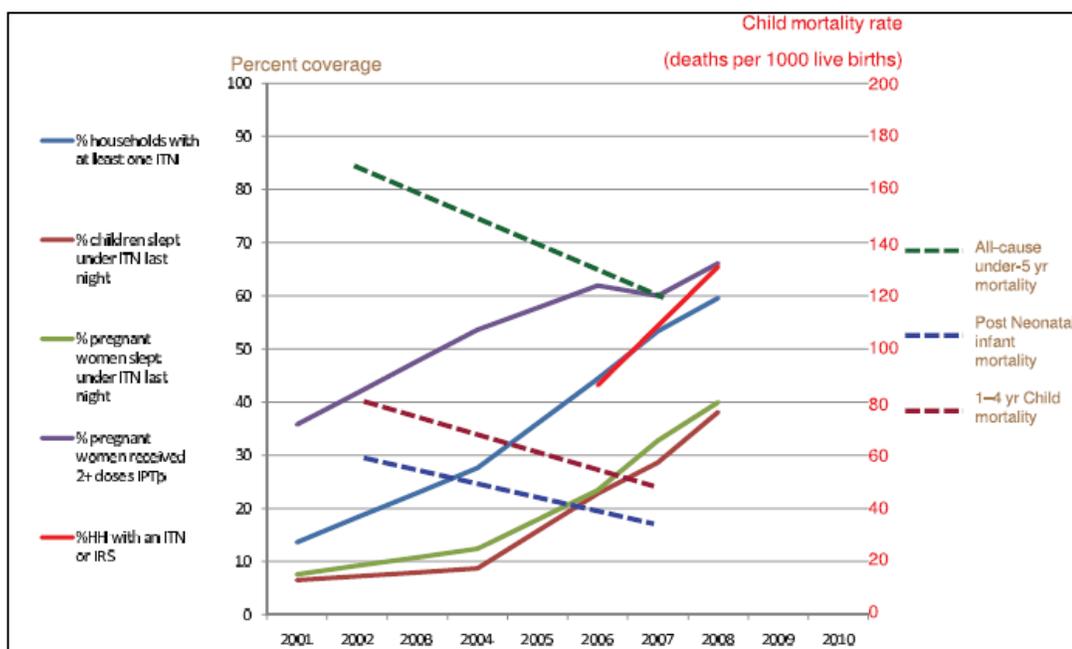
1.32 Round 8 was the largest ever Global Fund round and contained several large malaria grants. As funds in this round are now being disbursed, further substantial scale up of malaria interventions has been seen in the last year. In 2010, a remarkable 59 million insecticide-treated nets were distributed through Global Fund supported programs, compared to 34 million in 2009 and 24 million in 2009. The total number of nets distributed with Global Fund-support reached 160 million by December 2010. The number of malaria cases treated with Global Fund support nearly doubled in 2010, reaching 62 million compared to 33 million in 2009.

1.33 A recent impact evaluation of national malaria control scale-up in Africa⁶ concluded that there is substantial evidence that achieving high malaria control intervention coverage, especially with ITNs and targeted IRS, has been the leading contributor to reduced child mortality. In Zambia, for example, a significant increase in coverage and uptake of malaria interventions since 2002 has coincided with a substantial fall in all-cause child mortality (Fig. 5).

⁵Saving Lives with Malaria Control; Counting down the MDGs. Progress & Impact Series. RBM 2010.

⁶Steketee RW, Campbell CC. 2010. Impact of national malaria control scale-up programmes in Africa: magnitude and attribution of effects. *Malar J*:299.

Fig 5. Malaria intervention coverage rates per national surveys (2001-2008) and infant and child mortality rates (2001-02 and 2007) in Zambia



Steketee and Campbell 2010

1.34 Average annual international financing for malaria control has increased by 166 per cent from \$0.73 billion per annum in 2007 to \$1.94 billion per annum in 2009⁷. Between 2002 and 2009, international donor agencies had committed more than \$9.9 billion for malaria control in 81 endemic countries, of which 80 per cent has come from the Global Fund. The greatest investment in malaria since 2007 has been in Africa, followed by the Americas. There is a strong correlation between funding provided since 2002 and population at risk of stable transmission of malaria. The available funding for malaria control worldwide remains 60 per cent lower than the \$4.9 billion estimated need for comprehensive control in 2010. More than 60 per cent of countries have inadequate external funding to support malaria prevention and treatment by 2010, including ten countries in Africa and five in Asia.

MDGs 4 and 5

1.35 The G8 health experts group estimates that around 48 per cent of Global Fund disbursements benefit women and children through HIV, TB and malaria interventions across the continuum of pre-pregnancy, pregnancy, childbirth and child care, and investments in health systems strengthening. The Fund is therefore contributing beyond MDG 6 by accelerating progress towards MDGs 4 (reducing child mortality) and 5 (reducing maternal mortality).

1.36 A recent review of donor assistance to maternal, newborn and child health (MNCH)⁸ shows that in 2003, the total amount disbursed by the Global Fund and GAVI for MNCH was less than 30 per cent of the amount disbursed by other multilaterals (including the European Commission, IDA, UNAIDS, UNDP, UNFPA and Unicef). However in recent years, the Global Fund and GAVI have led

⁷ Snow RW et al (2010). Equity and adequacy of international donor assistance for global malaria control: an analysis of populations at risk and external funding. *Lancet* 376: 1409-16.

⁸ Pitt, C.; G. Greco; T. Powell-Jackson, A. Mills (2010). Countdown to 2015: assessment of official development assistance to maternal, newborn, and child health, 2003-08 *Lancet* 376: 1485-96.

the increase in aggregate ODA for MNCH, increasing their aid five-fold between 2003 and 2008 in the 68 countries that account for over 90 per cent of maternal and child deaths worldwide. The Global Fund alone has been providing more than 10 per cent of total ODA for MNCH since 2005.

1.37 The Board decision in April this year encouraged Global Fund applicants to scale up an integrated health response that includes MNCH in proposals for HIV, TB, malaria and health systems strengthening, and requested the Secretariat to explore options to further enhance the Global Fund's contributions. The Secretariat provided guidance in Round 10 to encourage linkages between disease-specific investments and broader MNCH goals. It will also systematically assess disaggregated results for women and children as part of Periodic Reviews under the new grant architecture.

Health systems strengthening

1.38 The Global Fund's Framework Document states that the Fund supports programs that "address the three diseases in ways that contribute to strengthening health systems". The Fund has been investing in health systems strengthening since its first funding round. In Rounds 1 to 4, the Fund's HSS investments were integrated in HIV, TB or malaria grants, which resulted in cumulative investments in disease-specific HSS of over \$800 million. Since Round 5, the Fund complemented its disease-specific HSS investments by cross-cutting HSS. In total, the Global Fund has now supported 96 cross-cutting HSS programs in 67 countries. Board-approved allocations for HSS have increased from \$294 million in Round 2 to \$1.015 billion in Round 9, and ranged from 26 per cent of total in Round 4 to 46 per cent of total in Round 9. The estimated amount of the total Board-approved HSS allocations during the 9 rounds is about \$7.1 billion, or 37 per cent of the Fund's nearly \$20 billion approved portfolio.

Community systems strengthening

1.39 Community systems are an integral part of the health system. The Global Fund recognizes that the presence of strong, sustainable community-based organizations and services is an essential element of ensuring program impact, sustainability, and results for HIV, TB, and malaria prevention, treatment, care and support. For this reason, starting in Round 8, the Global Fund began explicitly encouraging applicants to include measures to strengthen community systems relevant to in-country contexts on a routine basis in proposals for new and continued funding.

1.40 Prior to the launch of Round 10, the Secretariat collaborated with technical partners and NGOs to develop a community systems strengthening framework which included new Service Delivery Areas and impact indicators. In addition to this new tool, countries received support from UNAIDS, ICASO, the International HIV/AIDS Alliance and other partners to incorporate community systems strengthening activities into their proposals. In Round 10, 49 per cent of proposals included a community systems strengthening component and it is expected that the new framework and improved technical assistance will lead to stronger and better-defined community systems strengthening interventions. More than 5 per cent of funds requested in Round 10 was earmarked for community systems strengthening activities.

Progress on initiatives to accelerate access

Prevention of mother-to-child HIV transmission

1.41 Fifteen months ago, the Global Fund launched an initiative with partners to improve the quality and coverage of PMTCT programs. This strong collaboration has enabled the

reprogramming of over \$70 million in existing HIV grants in 11 of the 20 countries that account for 80 per cent of the global burden of vertical HIV transmission. Nine countries in sub-Saharan Africa plus India have switched from single dose nevirapine to the more efficacious drug regimens that are now recommended by WHO. Another 10 countries with high rates of vertical transmission are transitioning to more efficacious regimens. And ten high-burden countries in sub-Saharan Africa have committed to the target of virtual elimination of vertical HIV transmission by 2015 or earlier in the framework of their Global Fund grant.

1.42 A preliminary analysis shows that the re-programming exercise has resulted in a 65 per cent increase in budgets for PMTCT programming in Global Fund grants. This achievement is a strong example of the Global Fund partnership in action with Unicef, WHO, UNAIDS, UNFPA, the Children's Investment Fund Foundation, the Clinton HIV/AIDS Initiative and civil society partners coming together quickly and effectively to provide technical assistance, programmatic guidance and support to CCMs and principal recipients.

1.43 Several countries submitted proposals for Round 10 that included ambitious PMTCT components. This will need to continue in future rounds if further substantial scale-up of PMTCT programs is to be achieved and more comprehensive services are to be offered to prevent and treat HIV among pregnant women and their children.

Gender equality, sexual orientation and gender identities

1.44 Steady progress continues in the implementation of both the Gender Equality Strategy and the Sexual Orientation and Gender Identities (SOGI) Strategy. Proposal forms, guidelines and supportive documentation were revised for the Round 10 application process and promoted in regional briefings and roadshows. The MARPS Reserve channel - approved by the Board for Round 10 - was well subscribed. The monitoring, evaluation and performance review of programs has been strengthened through the development of a KPI on gender and key affected groups; the integration of gender issues in the Grant Performance Scorecard and at Phase 2 review, and the development of an equity assessment to be used as part of the periodic review process to be introduced with single stream funding.

1.45 A recent analysis of gender components in Round 8 and 9 HIV proposals show that more than 60 percent of approved proposals included a focus specifically targeting women, but only 13 percent of proposals included interventions to address harmful gender norms and only 7 percent addressed stigma reduction. In addition, an analysis of the \$900 million budgeted for HIV proposals in Round 8, Phase 1, showed that US\$ 79 million - 8.8 per cent - specifically set out to target men who have sex with men, sex workers and people who inject drugs.

1.46 The two strategies will be evaluated in 2011.

Affordable Medicines Facility for Malaria

1.47 The AMFm Phase 1 is now being implemented in eight of the nine pilot countries. Disbursements to finance supporting interventions have also started.

1.48 The AMFm mechanism, under which countries place orders for ACT drugs with manufacturers who in turn receive a co-payment from the Global Fund, is operational. Although it is early days, some remarkable trends have already been observed. In Accra, Ghana, for example, retail ACT prices have fallen to the equivalent of about \$0.70 from pre-AMFm levels up to \$9.00

per adult treatment, lower than the pre-AMFm end user price in the public sector (\$1.50 - \$2.00). In Kenya, early indications are that some outlets sold the ACTs for the equivalent of about \$0.60, 10 times less than the pre-AMFm average price of \$6.00. However, other outlets sold the ACTs at prices that were higher than desired. Retail prices are expected to decline as a result of several factors, including increased quantities of ACT in each country, competition among sellers at all levels, public information and marketing campaigns to increase awareness among buyers and patients of country-recommended prices and maturation of the model over time.

1.49 As of early November 2010, more than 100 first-line buyers of ACTs had signed the Buyer Undertaking, and the Secretariat has received 47 co-payment requests for 13 million treatments. The Secretariat has also completed Master Supply Agreements with all six eligible manufacturers of quality-assured ACTs agreeing to reduce manufacturer sales prices to private sector buyers to the same level as for public sector buyers. This is a tremendous example of a public-private partnership in action to expand access to life-saving medicines.

Procurement

Voluntary Pooled Procurement

1.50 During its first phase of operation between June 2009 and December 2010, demand for pooled procurement has exceeded expectations. Forty-two countries are registered to use pooled procurement and are buying products through it. By mid-November this year, principal recipients had used the mechanism to procure \$492 million worth of bed nets, antimalarial and antiretroviral medicines and related health products. The pooled procurement complementary service provided by the Global Fund focuses on capacity building activities for procurement and supply management systems.

1.51 With pooled procurement now operational, key considerations include determining how this mechanism can most effectively impact upon market dynamics and how the Global Fund partnership can best respond to increasing demand for capacity building in procurement and supply management.

Pharmaceutical and Health Product Management Country Profiles

1.52 In 2010 the Secretariat introduced a new approach for principal recipients to submit Procurement and Supply Management (PSM) plans and information related to the pharmaceutical sector at country level. Instead of asking principal recipients to submit information on local pharmaceutical systems in the narrative section of PSM Plans for each grant being implemented, this information is now maintained in a single Pharmaceutical and Health Product Management Country Profile. These profiles offer a more detailed picture of the in-country situation based on standard indicators that are updated on a periodic basis. They reduce the need for multiple reports by countries, simplify the PSM Plan review and approval process, speed up grant signing and align the Fund with partner agencies such as WHO. By the end of September 2010, 38 countries had adopted this streamlined approach.

Price and Quality Reporting system

1.53 The PQR has become an extremely valuable asset for the Global Fund. It has now captured pharmaceutical procurement transactions to the value of \$785 million reported by principal recipients in more than 130 countries.

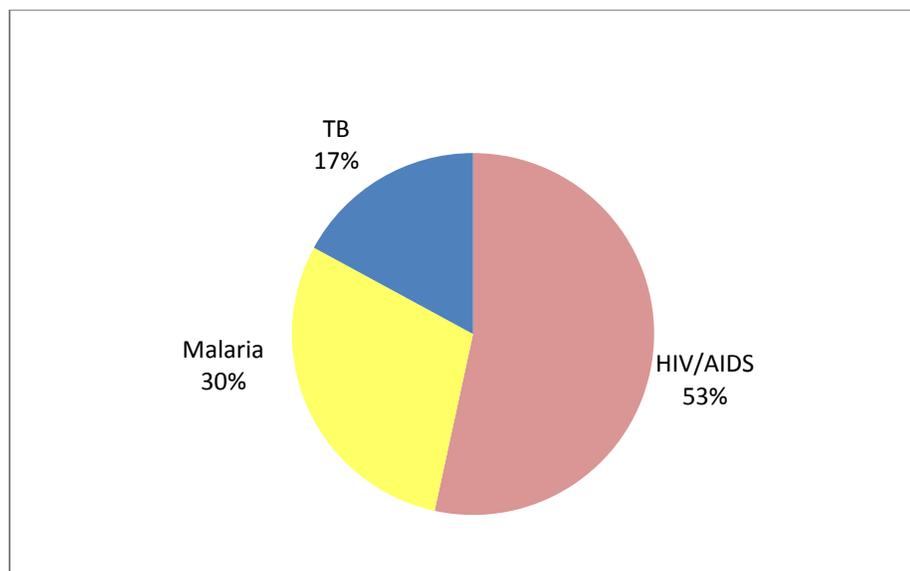
1.54 Significant work has been done in 2010 to improve the quality of PQR data and increase the use of PQR data in the Secretariat's decision-making. A new Oracle Business Intelligence Enterprise solution has greatly improved the Secretariat's ability to produce reports based on PQR data and enables the PQR to be used as a source of reference prices, to track procurement trends, and to identify grants that are consistently paying more than the estimated prices. The Secretariat has developed a methodology to benchmark grants based on attained prices that is being piloted by the Phase 2 Panel from November 2010. Compliance with PQ reporting is tracked in all Phase 2 reviews and the Secretariat actively follows up on under-reporting grants.

Overview of the Portfolio

1.55 By the end of October 2010, the Global Fund had disbursed a cumulative total of \$12.5 billion through around 825 grants in more than 140 countries. There were 479 active grants in 117 countries.

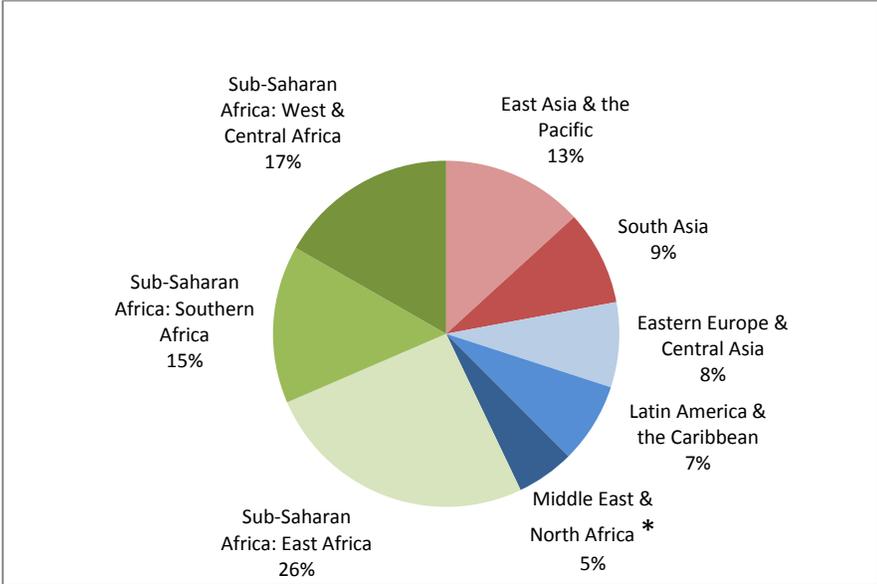
1.56 Anticipating Board approval of Round 10, 53 per cent of the portfolio has been committed to AIDS programs, 30 per cent to malaria and 17 per cent for TB (Fig. 6). The proportion for malaria has increased by 8 per cent since 2007, while the proportion for HIV has fallen from above 60 per cent and TB has increased slightly.

Fig 6. Anticipated composition of the portfolio by disease, Rounds 1 to 10



1.57 Nearly 60 per cent of the portfolio is invested in sub-Saharan Africa (Fig. 7).

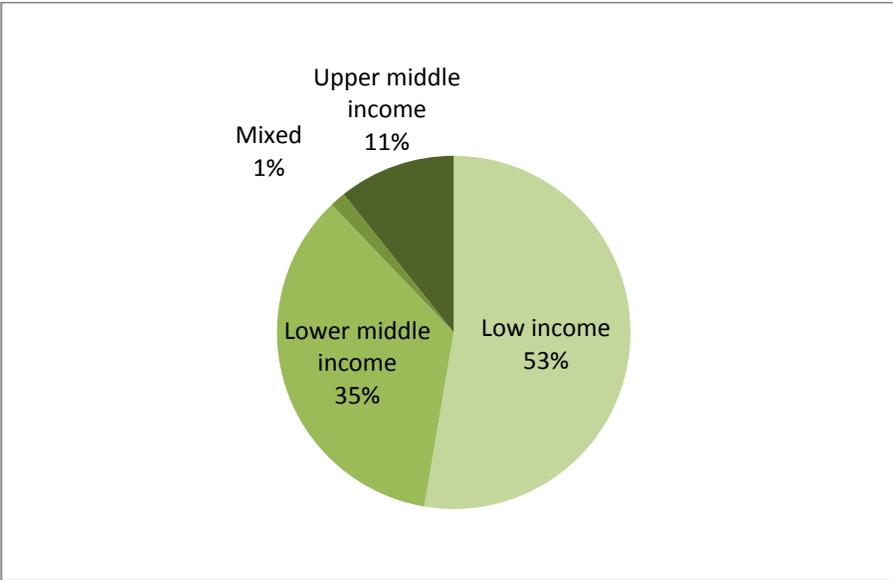
Fig. 7. Composition of the portfolio by Global Fund region (with sub-regions for Africa), Rounds 1 to 9



* The Global Fund MENA region comprises Chad, Djibouti, Egypt, Iraq, Jordan, Mali, Mauritania, Morocco, Niger, Somalia, Sudan northern zone, Sudan southern zone, Syria, West Bank & Gaza, Yemen.

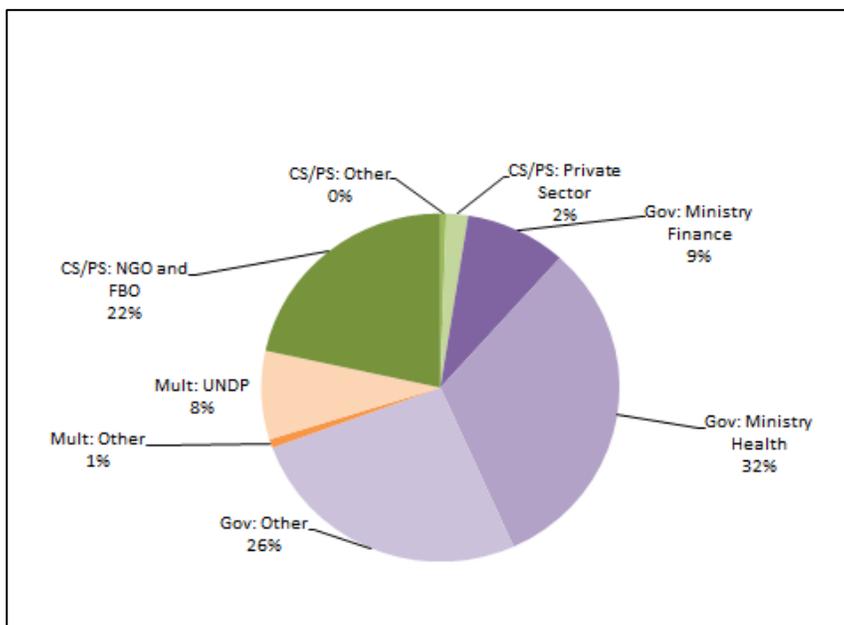
1.58 Anticipating Board approval of Round 10, nearly 90 per cent of the portfolio is invested in low-income and low-middle income countries (Fig. 8).

Fig. 8. Anticipated composition of Global Fund portfolio by income level, Rounds 1-10



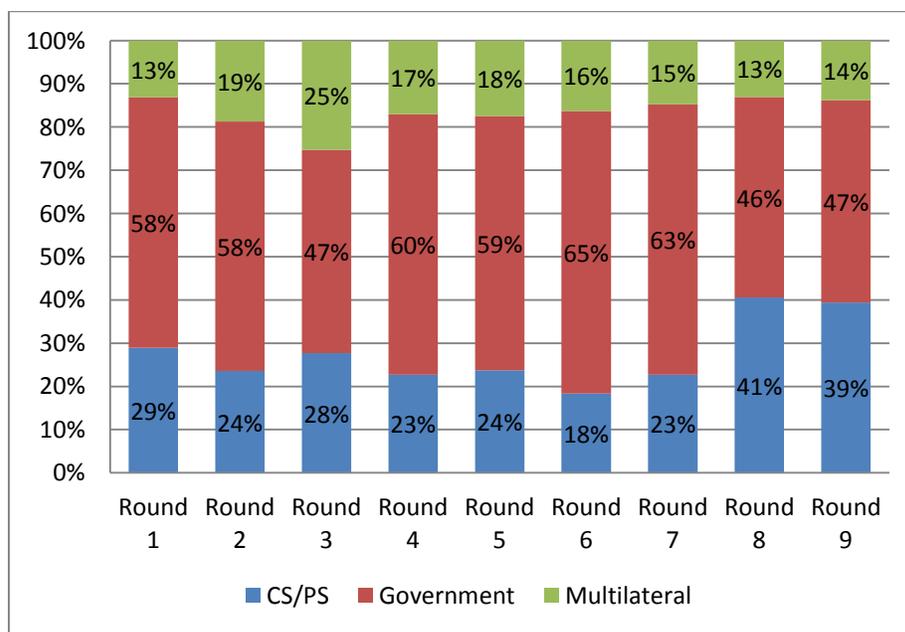
1.59 As of November 2010, governments accounted for around two-thirds of the principal recipients for currently active grants (Fig. 9). Civil society, private sector and non-government organizations were principal recipients for nearly a quarter of active grants and multilateral organizations (mainly UNDP) nearly 10 per cent.

Fig 9. Principal recipient by type for active grants, November 2010



1.60 Since the introduction of Dual Track Financing in Round 8, around 40 per cent of grants in the last two rounds have a civil society or private sector principle recipient, compared to around 20 per cent of grants in the previous few rounds (Fig. 10).

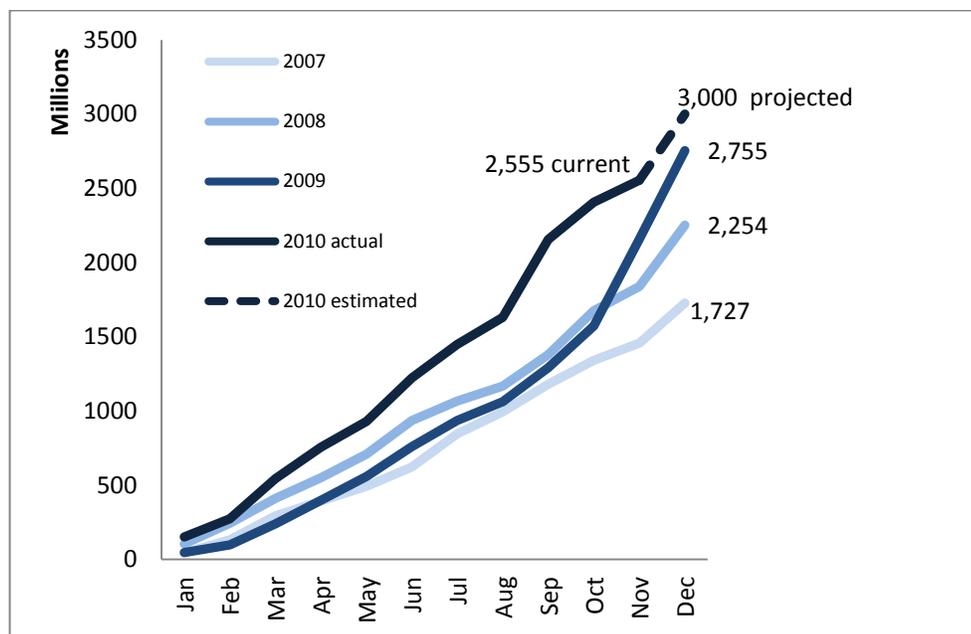
Fig 10. Percentage of grants per principal recipient type, Rounds 1-9



Disbursements

1.61 In 2009, Global Fund disbursements fell below target in the first three quarters of the calendar-year and then peaked in November and December. This year, the Secretariat has been implementing a number of measures to better monitor the disbursement process, proactively address bottlenecks to disbursement and track disbursement targets on a quarterly basis across regions (See Part 4 of this report). As a result, disbursements have been distributed much more evenly throughout the year in 2010 and stood at 96 per cent of target at the end of Q3 compared to just over 50 per cent of target at the same point in 2009 (Fig. 11).

Fig. 11. Monthly disbursements, 2007-2010

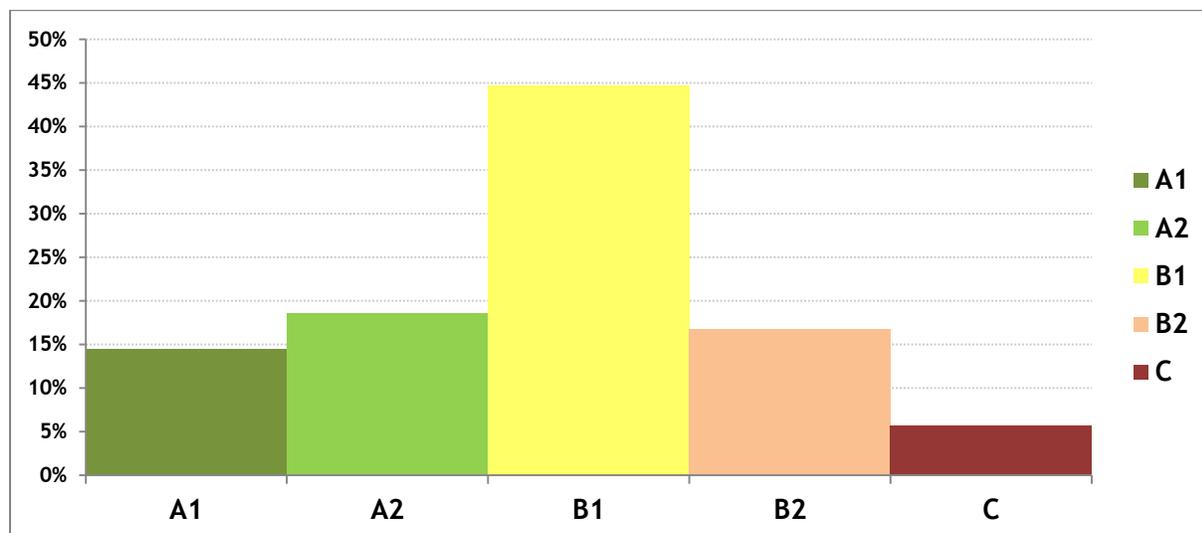


1.62 The KPI results for Q3 2010 show a median time for disbursement processing of 26 days, below the target of 21 days but a significant improvement on the 35 day median result for 2009. With total disbursements for the year currently standing at \$2.5 billion, the Fund is on track to achieve its disbursement target of \$3.05 billion for 2010.

Grant performance

1.63 The portfolio as a whole continues to perform strongly. By the end of November 2010, 22 per cent of grants were performing poorly (rated B2 or C at last disbursement) (Fig. 12). Moreover, 52 per cent of grants that were rated B2 or C at the end of 2009 had improved their performance (i.e. achieved a rating of B1 or higher).

Fig. 12. Grant rating at last disbursement, end-October 2010



1.64 Key Performance Indicator 6 (funding following performance in the case of disbursements) continues to fall short of target in 2010 (18 per cent at end of Q3, compared to a target of 30 per cent), reflecting to some extent the inherent tension between the Fund’s performance-based model and the volume of disbursements in a portfolio of this size. Improvements in this area are expected with the introduction of a number of reforms in the Secretariat that are described in Part 4, and additional actions to further strengthen performance-based funding at disbursement will be proposed when the PSC reviews the end-2010 KPI report.

Round 8 grant signing

1.65 Round 8 was the largest round in the history of the Global Fund, with 142 grants signed for a two-year value of \$2.5 billion. Nearly \$1.4 billion (56 per cent) of this round had already been disbursed by mid-November 2010. Three grants remain to be signed: two because the Inspector General is undertaking an investigation in the country and a third where an extension has been granted until February 2011. The average time from Board approval to signing for the round as a whole was 9.5 months, with an average time of 6 weeks between signing and first disbursement.

Round 9 grant signing

1.66 Round 9 was the second largest round. The Board approved \$2.6 billion for Phase 1 in 140 grants, including 8 grants based on National Strategy Applications. Governments account for around half of principal recipients, while civil society, private sector or faith-based groups account for more than a third. Nearly half of the grants (44 per cent) are for countries in sub-Saharan Africa.

1.67 By mid-November 2010, 94 grants had been signed for a total Phase 1 value of \$1.65 million and \$312 million had been disbursed. Nearly half (45) of the grants signed to date have been signed as single stream funding agreements. All grants with a November 2010 deadline have been signed except 8 grants that have received extensions. It is expected that around 40 grants with a deadline of February 2011 will be signed on schedule. Efficiency gains achieved in grant negotiations to date average 14 per cent of fully signed grant components, with a range of 8 per cent to 27 per cent.

1.68 The Q3-2010 KPI result for speed of grant signing was estimated to be around 10.6 months, compared to 10.4 months in 2009. The KPI target of 8 months has never been achieved.

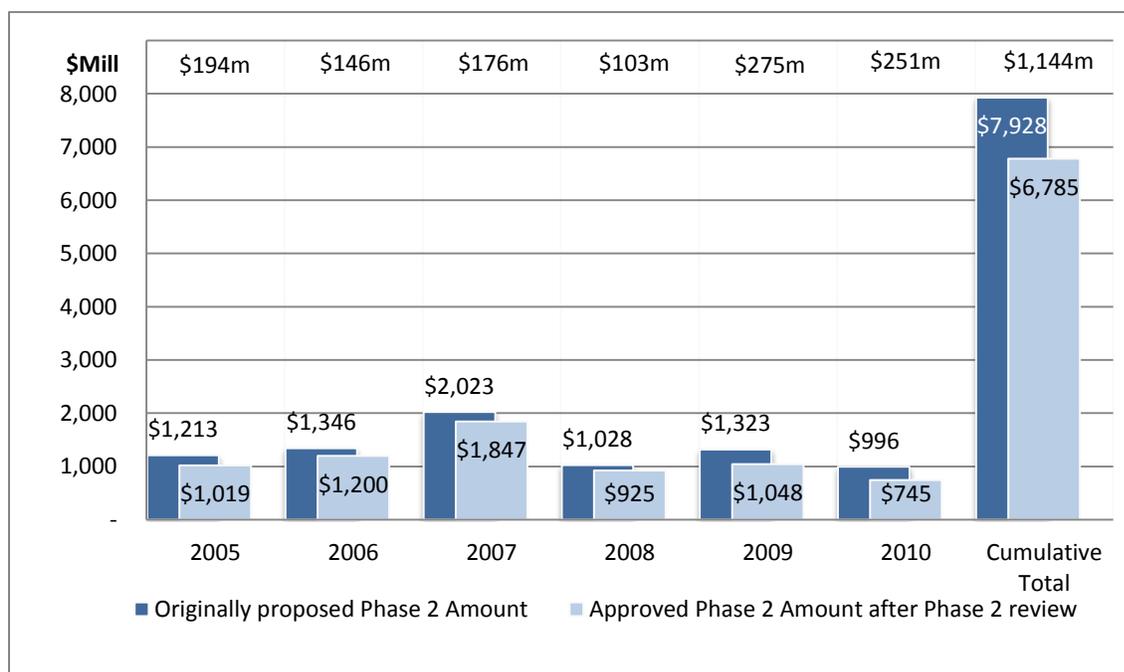
Phase 2 renewals

1.69 By the end of November, 66 Phase 2 agreements had been signed as stand-alone grants (52 grants for a total value of \$417 million) or as consolidated grants. For the 74 grants approved for Phase 2 in 2010, 44 per cent were given a “Go”; 53 per cent “Conditional Go” and 3 per cent (2 countries) “No Go”. Overall, there has been a higher proportion of “Conditional Gos” and B2 rated grants at Phase 2 review than last year.

1.70 Key Performance Indicator 7 (funding following performance at grant renewal) significantly underperformed in the first quarter of the year but has since followed a significant upward trajectory, reaching 21 per cent at the end of Q3 against a target of 30 per cent. This improvement can be attributed to several factors, including the introduction of the Country Team approach and improvements to the Phase 2 review process.

1.71 Overall, efficiency savings of around 22 per cent have been achieved at Phase 2 review since November 2008. Fig. 13 shows that since 2005, the amount actually approved after Phase 2 review is around \$1.1 billion less than the Phase 2 amount originally proposed, highlighting the stringency of the Phase 2 review process and its contribution to achieving value for money in Global Fund grants.

Fig. 13. Comparison of originally-proposed Phase 2 amount and Board-approved Phase 2 amount, 2005-2010



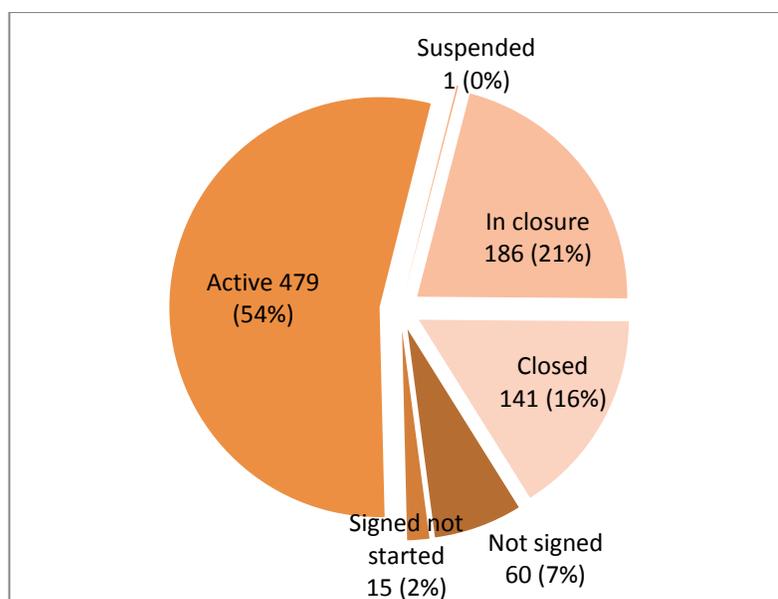
Rolling Continuation Channel

1.72 By mid-November, 21 Rolling Continuation Channel agreements had been signed in 2010, with a total value of \$693 million. Seventeen grants are still in the negotiation phase for a total value of \$796 million.

Grant closures

1.73 Nearly 100 grants have been closed, terminated or consolidated with other grants in the last 12 months, bringing the total number of closed grants to more than 140 (Fig. 14). A further 186 grants are in the process of being closed. Of the 327 grants that are closed or in closure, 214 (65 per cent) have reached their end date, 57 (17 per cent) have been consolidated into other grants and 36 (11 per cent) have changed principal recipient.

Fig 14. Status of grants, October 2010



Additional Safeguards Policy

1.74 Iran, Sudan (northern and southern sectors), Chad, Zimbabwe, North Korea and Haiti continue to be managed under the Additional Safeguards Policy while Additional Safeguards Policy measures are applied *de facto* to grants in Iraq, Syria and West Bank & Gaza. In October, I lifted the Additional Safeguards Policy measures in Cuba.

Office of the Inspector General

1.75 The Inspector General's communications to the last FAC meeting with regard to ongoing investigations included several significant instances of misuse of funds in several countries. As a result of these findings, the Secretariat has initiated an action plan to address fraud and corruption in relation to its grants. Short term actions include the suspension of two malaria grants and the termination of the TB grant in Mali. I have also decided to add Mali, Mauritania, Djibouti, Côte d'Ivoire and Papua New Guinea to the list of countries where grants are managed under the Additional Safeguards Policy.

1.76 Based on recent OIG findings in a number of countries, activities involving cash transfers for training events and associated costs, including per diems, travel, meal and expense payments, are in many cases posing a high risk of misuse. The Secretariat is taking immediate action in relation to these higher-risk activities, beginning with a two-month freeze on all training activities across the Global Fund portfolio pending the introduction of the control measures that were described in a joint Secretariat/OIG communication sent to Board members in late November.

1.77 The OIG has identified five countries where measures to protect Global Fund-financed drug shipments from theft need to be implemented. Principal recipients in these countries will be asked to submit a short term plan to secure drug supplies by mid-December and longer term plans by March 2011.

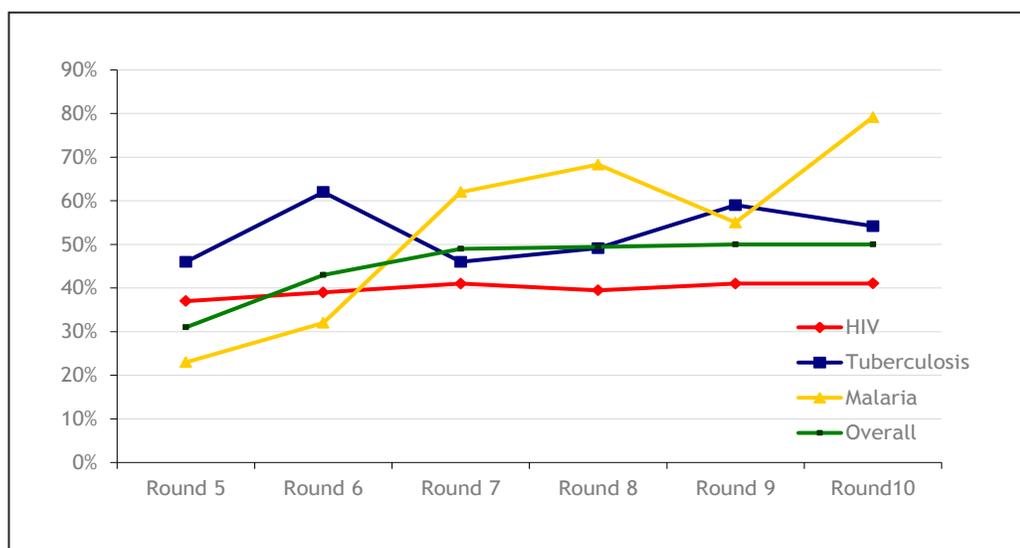
1.78 The Secretariat and OIG agree that LFAs have not been sufficiently focused on the identification of fraud risks and actual fraud in Global Fund-financed programs, and may not currently have the capacity to address these risks. A range of measures to enhance risk management and the Secretariat's responsiveness to OIG findings, including steps to strengthen the role of the LFA in preventing and detecting fraud, are described in Part 4 of this report.

Round 10

1.79 Pending approval by the Board, Round 10 will be the third largest round, both in terms of the number of proposals and the amount of funding being recommended by the TRP. In total, 79 proposals are recommended for funding by the TRP with a Phase 1 upper ceiling budget of \$1.75 billion (in Round 9 this amount was \$2.2 billion prior to TRP clarifications and efficiency gains).

1.80 The success rates in Round 10 were 41 per cent for HIV (32 of 78 proposals approved), 54 per cent for TB (26 of 48 proposals approved) and a remarkable 79 per cent for malaria (19 of 24 proposals approved). Success rates for HIV and TB have remained steady over the last three rounds, although the success rate for HIV has been consistently lower than for tuberculosis and malaria (Fig. 15). For three of the last four rounds, malaria has had the highest success rate among the three diseases.

Fig. 15. Success rates by disease, Rounds 5 to 10



PART 2 - THE THIRD VOLUNTARY REPLENISHMENT AND RESOURCE MOBILIZATION

Summary

- The Third Voluntary Replenishment of the Global Fund has been a key corporate priority for the Secretariat in 2010. \$11.7 billion has been pledged or projected, 20 per cent more than at the last replenishment in Berlin three years ago.
- The replenishment result was achieved through a huge collective effort of the entire Global Fund partnership.
- Most G8 countries continue to show strong support for the Global Fund.
- The Fund has at least nine new donors. The private sector has made a strong contribution, and the Fund has its first faith-based donor organization.
- The replenishment will enable further significant scale up, but not at the same pace as in recent years and is insufficient to meet anticipated demand. The MDGs will be more difficult to achieve.
- Further resource mobilization efforts, efficiency gains and decisions about resource prioritization will be needed to resolve tensions between demand and available resources.

- 2.1 The replenishment of the Global Fund for the period 2011 to 2013 was a key corporate priority for the Secretariat in 2010. The result of \$11.7 billion achieved at the pledging conference chaired by UN Secretary General Ban ki-Moon in New York in October came after a huge collective effort showing that the Global Fund has built a truly global network of stakeholders and supporters at the political level in the north and south, in civil society, the private sector, Friends groups, among partner agencies and in the international media.
- 2.2 The prominence of health on the development agenda and the visibility that the Fund achieved at the MDG Summit three weeks before the pledging conference showed that global political opinion and public sentiment regard health as the area of development where investments to date have achieved impressive results and consider that it should remain a priority, even in a time of global recession.
- 2.3 The replenishment result is also a strong vote of confidence in the Global Fund, its results, impact and model.
- 2.4 The amount pledged in New York is the largest single sum ever mobilized for global health and an increase of more than 20 per cent over the \$9.4 billion contributed by donors in the period 2007 to 2010 and \$6.2 billion contributed between 2005 and 2007. The replenishment result has to be seen as a remarkable achievement by donors at a time when the economic outlook remains uncertain and the public deficits of several major contributors to the Global Fund have more than quadrupled since 2007⁹.
- 2.5 There were some striking examples of leadership in this replenishment. The United States made a record pledge of \$US 4 billion, its first multi-year commitment to the Fund, showing that the Obama Administration will pursue a strong multilateral effort within its Global Health

⁹ International Monetary Fund, World Economic Outlook Database, October 2010

Initiative. President Sarkozy of France and Prime Minister Kan of Japan personally announced increased contributions to the Fund of US\$ 1.48 billion and US\$ 800 million, respectively, at the MDG Summit. Australia, Canada, the European Commission, Finland and Norway were among the other donors to announce significantly increased commitments.

- 2.6 The G8 has reaffirmed its leadership role in global health, with four G8 countries increasing their commitments to the Fund as compared with 2007, Russia becoming a net donor to the Fund with its pledge of US\$ 60 million and the United Kingdom expected to make a significant pledge in the near future. It remains unclear whether Italy will renew its commitment. The G8 countries and the European Commission together account for three-quarters of the resources pledged in New York.
- 2.7 Despite some encouraging signals received in the lead-up to the replenishment, several members of the G20 group - including the major emerging economies - do not appear ready to make a significant contribution to multilateral health efforts at this time. The same can be said of the majority of Gulf states.
- 2.8 Nine new donors were among the 40 present at the pledging conference. Because expressions of global solidarity are so essential in the fight against global epidemics, the addition of Côte d'Ivoire, Namibia, Pakistan and Tunisia to the group of implementing countries that are also donors to the Global Fund carries strong political significance.
- 2.9 Chevron Corporation continues to play a leading role on behalf of the private sector, having increased its total contribution to US\$ 55 million. The US\$ 3 million pledge by Gift from Africa, a consortium of companies led by Access Bank of Nigeria, shows that the private sector in the developing world is also mobilizing. A US\$ 28 million pledge by United Methodist Church - the first faith-based organization to contribute to the Global Fund - further expands the Fund's diverse donor base.
- 2.10 Up to US\$ 8.8 billion of the US\$ 11.7 billion pledged will provide for the continuation of programs already approved by the Global Fund Board for the period 2011 to 2013. This means far more than maintaining programs at their current scale. Rather, it will support the further significant expansion of health services in many countries. The second phase of the HIV grant in the Democratic Republic of Congo, for example, will enable an additional 33,000 people to receive antiretroviral treatment, on top of the 35,000 patients already receiving it with Global Fund support. Funding to continue the malaria grant in Sudan's southern sector will double the cumulative number of bed nets distributed there by 2013. And continuation of Global Fund TB grants will help the national TB program in India move closer to its goal of registering more than 30,000 multi drug-resistant TB cases for treatment annually by the end of 2013.
- 2.11 As a result of this replenishment, programs that have already been approved will be able to place at least a million additional people on antiretroviral therapy, distribute 300 million more bed nets and provide prophylactic drugs to prevent vertical transmission of HIV to an additional two million women by 2013, among other interventions.
- 2.12 At least \$2.9 billion from this replenishment will be available to fund entirely new programs in the coming three years. This figure will increase when savings and efficiencies are achieved in the current portfolio, additional donor contributions are received and/or the Board considers policy adjustments that alter the portfolio's balance between new investments and the funding of existing programs. Global Fund disbursements to countries are anticipated to increase from around \$ 8 billion in 2007-10 to almost \$13 billion in 2011-13: a 60 per cent

increase between the two funding periods. Contrary to some of the more pessimistic assessments of this replenishment result, the Global Fund will be helping countries to save many additional lives in the next three years.

- 2.13 Nevertheless, the total amount pledged in New York falls short of the lowest estimate of demand provided to donors by the Secretariat at The Hague in March (\$13 billion). This means that - if the replenishment result were to be the last word from donors until 2013 - the Board will face challenging decisions about which new programs to support and the rate of scale up of new programs will be significantly slower than in the preceding three years. This potential loss of momentum in the response to the pandemics is of serious concern because it means that some of the targets that until now had seemed achievable - such as reaching and maintaining universal coverage of bed nets in Africa and the elimination of vertical transmission of HIV by 2015 - will be more difficult to reach.
- 2.14 As in previous years, the Board and Secretariat will need to work together in the coming months to resolve outstanding tensions between demand and available resources. I believe that the available resources can be increased by achieving efficiencies across the portfolio and through further resource mobilization efforts. I am also encouraged by clear statements from several current donors about the possibility of additional pledges before 2013 as the economic outlook improves and the Global Fund demonstrates increased effectiveness, efficiency and value for money.
- 2.15 I have made clear to the FAC my view that, if the Global Fund is to remain truly global in nature, eligibility criteria should not be based on considerations about the resources available at any given point in time. Instead, I have suggested that consideration could be given to making eligibility for Global Fund resources contingent upon countries agreeing to co-finance programs and having an agreed "exit" strategy in place, or becoming a contributor to the Global Fund in addition to being a grant recipient.
- 2.16 Resource mobilization efforts in the Secretariat will continue, with initial priority being given to donors that are yet to announce pledges for 2011-13. An intensified effort will begin in 2011 to secure funding from new public and private donors and to further develop our work on innovative financing. A revised Resource Mobilization strategy will be developed over the coming year as an input to the new Global Fund strategy. This work will build on the experience gained during the three replenishment exercises that have been conducted to date, focusing on the valuable feedback and guidance provided by participants. While the multi-year replenishment model will remain central, it will need to be further refined and broadened to reflect the evolving economic and political environment.
- 2.17 I believe that there is still substantial potential for private sector engagement in resource mobilization, co-investment and implementation. Since the pledging conference, additional pledges have been made by Anglo-American PLC (\$3 million) and the private sector in Africa (\$2 million). These pledges show that, in a globalized world, the private sector increasingly sees the value of mobilizing in support of global health.
- 2.18 Significant groundwork was done over the last year with several of the major emerging economies regarding potential contributions to the Fund. Although these countries did not pledge in New York, I am hopeful that the intensive relationship building we have undertaken with them will soon bear fruit. In November, the government of Rwanda announced a contribution of \$1 million, joining the group of countries that are both donors to the Global

Fund and grant recipients. I hope to see the number of these countries increase in the coming years.

2.19 The Born HIV Free Campaign featuring Global Fund Ambassador Carla Bruni-Sarkozy was created to mobilize public support for the Global Fund in the replenishment year. Around 250 million people were exposed to the campaign, and 20 million people actively engaged with it. During the pledging conference, Secretary General Ban ki-Moon was presented with part of an online petition signed by 700 000 people as part of the campaign to signal to their political leaders public support for donor contributions to the Global Fund. I congratulate all those who contributed to the success of this major campaign.

2.20 Thanks are due to the many people and organizations around the world who contributed to the replenishment outcome. I warmly thank the Chair of the replenishment, Secretary General Ban ki-Moon, and Vice Chair, Richard Manning, for their remarkable work and commitment to the Global Fund. I thank all the donors for their pledges and everyone who has been working in donor governments to maintain commitment to the Global Fund and global health. I am also very grateful to the many groups and individuals that advocated on the Fund's behalf, including the seven Friends organizations around the world. And I thank the many Global Fund staff - particularly the teams led by Christoph Benn, Stefan Emblad and Chris Cannan - who worked tirelessly on the replenishment throughout the year.

PART 3: THE CHALLENGES OF SUCCESS AND GROWTH

Summary

- The Global Fund was created nearly 10 years ago as an emergency response to scale up interventions for the three diseases. Since then it has contributed to unprecedented advances in global health and represents a successful new development model.
- The Fund's rapid growth - especially in the last four years - has given rise to a range of management and operational challenges in terms of the Secretariat's structure and infrastructure; the grant architecture; grant management and operational performance, and the way the Global Fund works in countries and with partners.
- An agenda to address many of these challenges and to enhance the Global Fund's efficiency and effectiveness has been developed and is now being implemented.

3.1 This section describes a number of key challenges that have arisen for the Secretariat as a result of the rapid growth of the Global Fund, particularly in the last four years, and provides context for the agenda for a more efficient and effective Global Fund that is discussed in detail in Part 4 of this report.

Towards 10 years of the Global Fund

3.2. Ten years ago next June, the first stakeholder meetings of what was then being called a "Global Health and AIDS Fund" took place in Geneva and Brussels. A Transitional Working Group established to design the Fund's operational model met throughout the second half of 2001 and the Global Fund officially came into being at the first Global Fund Board meeting in Geneva in January 2002. Remarkably, Round 1 was launched just a few weeks later and in little more than a month 300 proposals were developed and submitted to the fledgling Secretariat. I chaired the first working meeting of the Technical Review Panel in late March 2002. At its second meeting in April the Board approved Round 1 with a two-year value of \$600 million for programs in 36 countries. Just 10 months had passed between the first formal discussions about what Fund's model should look like and the approval of the first grants.

3.3 During this rather frenetic early period, some of the characteristics that have since distinguished the Global Fund became evident, notably its sense of urgency and its reputation as a dynamic and fast-moving institution that is constantly innovating and learning by doing. In a relatively short period, these characteristics and the efforts of a very committed staff and many partners have helped the Global Fund to achieve unprecedented successes in global health.

3.4 Looking back over the nearly ten years of the Global Fund's existence, these successes can be measured in many ways: more than \$30 billion contributed or pledged; nearly \$20 billion committed by the Board and \$13 billion disbursed; rapid scale-up of prevention and treatment for the three diseases in many countries and more than 6 million lives saved. The Fund's model is seen as innovative and effective, delivering aid based on the core principles of country-ownership; transparency and accountability; decision-making based on performance and evidence, and a broad partnership that actively includes civil society and the private sector. This year, it was evident at both the MDG Summit and the replenishment

conference that the Global Fund has achieved unprecedented visibility and credibility as a leader in global health and in the broader development arena. Above all, largely because of the impact of programs that the Fund supports, goals that had once seemed idealistic - such as the elimination of malaria as a public health threat and the virtual elimination of vertical HIV transmission - are now within reach.

The challenges of growth

- 3.5 The Global Fund's growth has accelerated significantly over the last four years. Annual disbursements have more than doubled in the last four years, to around \$3 billion this year, and are anticipated to reach around \$4.5 billion in 2011. Rounds 8 and 9 were about three times the size of Round 5. The number of Global Fund staff has doubled since 2007 in response to the growth in the core business, the increasing demands on the Secretariat to contribute in the global health policy arena and the transition out of WHO administrative and human resource systems at the beginning of 2009.
- 3.6 As I look critically at the young, autonomous organization that the Global Fund is today, and at the way it operates, I believe that the Fund has on balance managed constant innovation and growth quite well, but that the speed of its growth - not surprisingly - resulted in quite piecemeal organizational development in the Fund's early years. This in turn has led to some major challenges, including considerable complexity in the grant architecture, a number of operational bottlenecks and tensions in a method of aid delivery that is based on partnership and country ownership. These challenges are discussed in the remainder of this section, while the Secretariat's actions in response to them are addressed in part 4 of this report.

The Secretariat structure

- 3.7 On becoming Executive Director in 2007, I initiated an organizational and management review to help me determine what changes might be needed to prepare the Secretariat for the coming three years. The main recommendations from the review concerned the need for a new organizational structure that has in my view broadly succeeded in its objective of accommodating growth and the increasing demands on the Secretariat, as well as the shift to being an autonomous organization.

The Secretariat's infrastructure

- 3.8 In the Global Fund's early years, the Secretariat's internal systems and infrastructure developed in a rather ad hoc fashion. For example, the information technology platform evolved as a number of separate, uncoordinated applications. Most grant management processes have been paper-based. A major effort has therefore been made over the last two years to invest in a new IT infrastructure with the objective of developing a coherent platform that effectively integrates the Fund's extensive grant, data and financial management needs. The focus in the next two years will be on implementing a new financial management system, further automation of grant management processes and improving the IT interface with countries.
- 3.9 Until 2007, the available data about the composition of the portfolio and who is implementing Global Fund grants at sub-recipient level were quite limited. This situation has improved considerably since the introduction of Enhanced Financial Reporting in 2008 and other measures to improve data quality.

- 3.10 Following the Board's decision in 2008 to terminate the Administrative Services Agreement with WHO, entirely new human resources policies and processes needed to be developed for the Global Fund Secretariat. When the Global Fund became an autonomous international financing institution on January 1, 2009, basic payroll, health insurance, pension fund, salary structure, travel office and security services were in place. Completion of the transition to full autonomy was one of my corporate priorities this year, with a focus on the information technology platform and a implementing new staff performance management framework.
- 3.11 Good progress has been made on the staff performance framework. More than 90 per cent of staff members have worked with their managers to define performance objectives in 2010 and have undergone mid-year and end-year reviews. The framework will be further developed in 2011 to include a strong performance assessment component. The improvements made in this area to date were evident in the increase in positive responses reported in the 2010 staff survey compared to 2009.
- 3.12 Overall, however, staff members are yet to feel full ownership of many of the Fund's new human resource policies and procedures, and sustaining long-term staff commitment is a challenge in an organization that continues to evolve rapidly and where half the employees were recruited less than two years ago. From 2011, the Secretariat's human resources strategy needs to focus on longer-term challenges such as career development, training and staff mobility; increasing management skills; fostering diversity; and introducing performance incentives, including a performance-based salary structure. Staff skills and development issues will need to be considered in the context of the corporate strategy that the Board will develop in 2011.

The grant architecture

- 3.13 In its first years, the Global Fund's grant architecture model was developed in a piecemeal fashion as specific needs arose over time. Many countries have multiple grants per disease, often with different reporting cycles, involving significant transaction costs for countries and the Secretariat. Initiatives such as those on health systems strengthening, community systems strengthening, gender, sexual minorities, dual track financing, National Strategy Applications and the AMFm have added important depth to the portfolio and bring new opportunities to implementers, but they have also made the process of applying for Global Fund resources more complicated. The recent picture has therefore been of quite a fragmented grant architecture, and countries have consistently expressed the view over the last few years that the Global Fund is now quite difficult to understand and complex to interact with. For these reasons, I initiated the architecture review in 2008 that has led to the Board decision to introduce single stream financing.

Grant management and operational performance

- 3.14 Significant challenges with regard to the Secretariat's management of grants and overall operational performance have become evident as the portfolio has grown. These include a rather fragmented operational policy framework and considerable inconsistency in the way grant-related policies and processes are applied across the portfolio. The capacity and skill sets of the staff that interact with implementers have also varied considerably between countries and regions. An unacceptably slow disbursement rate and lengthy periods of grant negotiation in 2009 highlighted the need to make in a number of operational areas, including the need to improve cooperation and collaboration between teams in the Secretariat and to make the processes of disbursement and grant signing more efficient.

The Global Fund's way of working in countries

- 3.15 Partnerships form the basis of the Global Fund model, and the Fund has set a new standard for inclusiveness of a broad range of stakeholders in health governance globally and in countries through the Country Coordinating Mechanism. However, challenges remain in mobilizing the partnership to its full effect at country level, notably with regard to the role of the CCM in grant oversight and in mobilizing the technical assistance and other forms of support countries need to access and implement Global Fund resources.
- 3.16 The Local Fund Agent represents an innovative way of operating and managing risks and is a crucial part of the Global Fund's risk assurance framework. LFAs provide the Secretariat with informed and independent professional advice on grants, principal recipients and the country-specific implementation environment at each stage of the grant life-cycle. In 2010, new Secretariat policies and management processes, the new grant architecture, the new Country Team Approach and findings and recommendations of the Inspector General in detecting and preventing fraud have all prompted actions to refine and improve the way LFAs work.

- 3.17 Managing the rapid growth of the Global Fund has been one of my major tasks since becoming Executive Director four years ago. Measures to address the challenges of this growth have evolved over the last two years into quite an extensive agenda of "reforms" to enhance the overall efficiency and effectiveness of the Global Fund Secretariat. When this agenda was presented at the replenishment conference in New York in October, I undertook to provide regular updates to the Board concerning its implementation. The first of these appears in Part 4 of this report.

PART 4: AN AGENDA FOR A MORE EFFICIENT AND EFFECTIVE GLOBAL FUND

Summary

- An extensive agenda of measures to improve the Global Fund's efficiency and effectiveness is currently being implemented and will be my corporate priority in 2011.
- Progress in implementing the new grant architecture in 2010 has exceeded projections. Between a third and a half of the portfolio will have transitioned to single stream financing by the end of 2011.
- The Country Team Approach has been introduced for 13 countries in 2010 and will expand to 42 countries by mid-2011. It will lead to more efficient grant management and operational performance including expedited disbursements and grant signing.
- The Country Team Approach, new CCM policies and practices and an enhanced role for LFAs will improve the way that the Global Fund works in countries.
- The Secretariat is working closely with the Office of the Inspector General to improve its responsiveness to OIG findings with special attention to areas where the fraudulent misuse of funds has been identified.
- Measures are being introduced to ensure value for money, strengthen the performance-based funding model and enhance the quality and consistency of Secretariat services.

4.1 This section provides an update on progress made in implementing measures to improve the Global Fund's effectiveness and efficiency that were presented to donors at the replenishment conference in New York in October. It focuses on those measures that I consider essential if the Secretariat is to provide a very high quality of service to countries, make the most of available resources, contribute strongly to the achievement of the health-related MDGs and move from the "emergency response" mode that has characterized the Global Fund's early years to one of longer-term sustainability. Ensuring that this agenda is fully implemented will be my corporate priority in 2011.

A streamlined grant architecture

4.2 At an Executive Management Team retreat in 2008 I noted that on my visits to implementing countries I heard frequent criticism about the growing complexity and inscrutability of the Global Fund grant-making architecture. The Secretariat then undertook a comprehensive review of the grant architecture that ultimately led to the Board's endorsement of the single stream funding model a year ago.

4.3 The Board decision marked a milestone in learning from the Fund's first seven years and clear recognition that a multiple grant model per disease was no longer sustainable. It reaffirms the Fund's commitment to an operating model that is simple and efficient for countries and represents another step in the Fund's evolution from financing "start-up" projects to providing long-term support for national programs.

4.4 Implementing the new grant architecture has been one of my top corporate priorities for 2010. The work has been undertaken by a team drawn from Units across the Secretariat under the oversight of the Deputy Executive Director.

- 4.5 Single stream funding requires the consolidation of multiple grants for each disease and principle recipient and the alignment of the periodic review and financial commitment timelines for all principal recipients in a disease with national programmatic reporting and fiscal cycles.
- 4.6 A year after the Board's approval of the single stream model, progress in implementation has exceeded initial projections. The Secretariat's internal best-case projections were to establish up to 35 single streams of funding in 2010. By early November, more than 40 single streams of funding had been established, with 60 expected to be in place by the end of the year. This will represent a 10 per cent reduction in the number of grants under management and has been made possible through the excellent work of principal recipients and CCMs with valuable support provided by Secretariat staff and partner organizations.
- 4.7 Round 10 applicants were given the option to transition to the single stream of funding by submitting a consolidated disease proposal. Twelve consolidated disease proposals were submitted, of which eight are recommended for funding. Consolidating proposals will become mandatory from Round 11.
- 4.8 Senegal provides a good example of the benefits of the single stream approach. All of the country's HIV grants were transitioned to single stream funding earlier this year. This involved consolidating multiple grants for two of the three principal recipients and aligning the review and financial commitment timings for all three principal recipients to national programmatic reporting and fiscal cycles. As a result, the required frequency of reporting has been reduced by half for the two principal recipients that had multiple grants; performance reviews will now be carried out on a program-wide basis, aligned to the national programmatic reporting cycle, and financial commitments are aligned to the country's fiscal cycle. More than €1 million in efficiencies were identified through consolidating and streamlining budgets, money that is now being reinvested to scale-up PMTCT programming.
- 4.9 The Secretariat estimates conservatively that a further 60 grants will be consolidated in 2011, meaning that between a third and a half of the portfolio will have transitioned to single stream funding by the end of next year.

More efficient grant management processes

- 4.10 In direct response to lagging Key Performance Indicators on grant signing and processing of disbursements in 2009, I brought a number of operational challenges to the Board's attention and identified making improvements to these key grant management processes as another of my corporate priorities for 2010¹⁰. Taskforces that I established early in 2010 have since worked under the oversight of the Deputy Executive Director to propose and implement a range of measures to enhance grant management. These are described below.

Country Team Approach

- 4.11 As the portfolio and staff numbers have grown, so has the tendency of people in the Secretariat to work in silos. While I have consistently promoted more "transversal" ways of working, the Country Team Approach is the first time that grant managers (Fund Portfolio Managers and Program Officers) have been brought together in teams with colleagues from the Legal, Procurement, Finance, Performance, and Monitoring & Evaluation Units and others to

¹⁰ Report of the Executive Director, November 2009 (GF/B20/3)

take shared responsibility for grant management decisions throughout the grant lifecycle. Instead of a time-consuming and at times disjointed process in which each Unit deals with a grant and with implementers sequentially, all members of the Country Team - as well as the LFA - bring their expertise together from the start, develop a joint understanding of the country and its needs, make joint decisions and interact in a coordinated way with country stakeholders.

- 4.12 The Country Team Approach was introduced in September 2010 for the management of grants in 13 “high impact countries” that have large volumes of funding, multiple grants, complex operations or other major challenges. It will be expanded to cover 42 countries during the first half of 2011. These 42 countries account for 95 per cent of those receiving ART, 81 per cent of bed nets distributed and 89 per cent of TB treatment provided with Global Fund support.
- 4.13 Moving to the Country Team Approach increases the demands on some staff, such as Finance, Procurement and Monitoring & Evaluation Officers. To accommodate these demands while maintaining a flat budget, I worked with Cluster Directors to move 27 staff positions - 5 per cent of the Secretariat workforce - to Country Teams in the middle of the year. A two-day training was delivered in October for the 65 staff members in the 13 Country Teams to reinforce team-based approaches to grant management.
- 4.14 A preliminary assessment of the Country Team Approach shows that the upfront investment of time by Secretariat staff is improving the quality and timeliness of decisions. In a recent country team visit to Zambia, feedback from partners and Principal Recipients was also positive.

Grant negotiation and signing

- 4.15 Grant negotiation - the process of translating a successful proposal into an operational grant agreement - is a very important task for the Secretariat that often shapes the course of future relations with implementers and has a major impact on the performance of programs.
- 4.16 As the portfolio has grown and grant architecture has become more complex, so too has the process of grant negotiation and signing. TRP clarifications typically add several months to the process. Round 8 grant signing was especially complex, in part due to the sheer size of the round and the need to find efficiency gains in grant budgets. However, as the KPI for grant signing has not improved with Round 9 in 2010, it is clear that more effort is needed to align the proposal development and grant negotiation processes more closely, for example through the earlier involvement of principal recipients, increased use of independent budget reviews by the TRP and designing incentives for implementers to sign grants in a timely manner. Once in place, the new grant architecture will expedite grant signing because additional funding will become the subject of amendments to existing single stream funding agreements.

Disbursements

- 4.17 In the 2009 portfolio survey, 23 per cent of principal recipients rated ‘disbursement efficiency’ as ‘poor’ or ‘fair’. The average Secretariat disbursement processing was 35 days (median) in 2009, compared to a KPI target of 21 days, and 43 per cent of the total annual disbursement was made in the last two months of the year. Recognizing these shortcomings, a number of improvements are being introduced to enhance the overall speed and quality of the disbursement process. These focus on improving quality through the introduction of new information sources for disbursement-related decision-making, including the closer

involvement of experts; LFA data verification and information from enhanced financial reporting; streamlined processes and improved automation and IT support; and reduced reporting burden as a result of new reporting forms and reduced reporting frequency. By adapting the level of sign-off to the risk-level of the grant The Country Team Approach will reduce the number of internal sign-offs required for disbursements.

- 4.18 To further reduce reporting burden, consideration is being given to introducing a semi-annual rather than quarterly default periodicity for disbursements.

More effective ways of working in countries

Partnerships

- 4.19 The Country Team approach is expected to improve interaction with country level partners. Country Teams include staff members from the Partnerships Unit to help ensure that partnership work is appropriately prioritized throughout the grant life cycle. Terms of reference for Fund Portfolio Managers working in country teams are being revised to ensure that they are accountable for achieving partnership objectives. The closer engagement of a range of other staff in support of grant management decisions will also help portfolio managers to devote more attention to partnership issues.

Country Coordinating Mechanisms

- 4.20 Over the last year, a substantial effort has been made to strengthen CCMs, including through new CCM funding guidelines that were approved by the Board last year and the new CCM guidelines that the Board is being asked to approve at this meeting. These new guidelines will provide guidance with regard to the CCM oversight function, which has not been well understood or exercised in many countries. They also offer practical guidance and tools to support a range of other CCM functions, including managing conflicts of interest and ensuring transparency and accountability, and promote aid effectiveness and alignment of CCMs with other country development mechanisms. Five CCM regional meetings have been held in 2010 to enable CCMs to share experience and best practices and to improve CCM understanding of the most relevant Global Fund policy developments.

Local Fund Agents

- 4.21 Until now the role of LFAs has focused on verification of financial and programmatic performance of programs. The Office of the Inspector General has noted that in many countries the LFA is not sufficiently focused on detecting risks associated with grant implementation, such as fraud or other misuse of funds. In response to the OIG's concerns, the Secretariat is revising LFA terms of reference to strengthen its role in detecting and preventing fraud and financial abuse. With the assistance of the OIG, issues related to fraud and financial abuse are now addressed in LFA training and an updated LFA Manual will be published in early 2011.
- 4.22 LFAs are now required to conduct an assessment of fraud and corruption risks in countries managed under the Country Team Approach; this assessment is recommended for all other countries. The risks are documented by the LFA in a new risk assessment tool that was introduced in October. By adapting the LFA's Terms of Reference in high-risk settings (and possibly reducing the scope of the role in low-risk settings) the Secretariat ensures that it is getting better value from LFA services. LFAs will also be required to report to the OIG and

Secretariat ‘red flags’ (potential high-risk situations) related to fraud encountered as part of their normal verification work.

- 4.23 Some of these measures will involve additional transaction costs in the form of increased reporting and verification requirements for principal recipients and additional staff time to communicate with the LFA and Country Team members. The increased levels of LFA verification will also mean higher LFA costs, as reflected in the LFA budget for 2011.
- 4.24 In addition to measures focused on fraud prevention, the Secretariat has implemented a number of other actions including revising the LFA role in the first group of countries that will be managed under the Country Team Approach.
- 4.25 A rigorous LFA Performance Evaluation and Feedback system has been introduced, including a formal mid-term performance review for each LFA. The system identifies strong performing LFAs and helps take early action where poor performance is identified. In 2010, LFA contracts for six countries were terminated and re-tendered in response to poor performance.
- 4.26 As part of the annual LFA procurement process, the Secretariat systematically reviews the qualifications and mix of LFA experts in each country. Where necessary, the Secretariat requests the LFA to change or expand its team and its quality assurance arrangements to ensure that the Secretariat receives consistent high-quality service.
- 4.27 Training and orientation is held periodically to ensure that LFAs understand the Secretariat’s evolving requirements. In November 2010, for example, 142 LFA finance experts attended a three-day specialized finance training event organized by the Secretariat. LFA trainings consistently receive very positive feedback from participants.
- 4.28 The Secretariat is updating and strengthening LFA in-country communication protocols. This initiative aims to provide principal recipients, CCMs and other partners with more information about the Secretariat’s decisions and important issues and challenges facing the country.

Improved responsiveness to OIG findings

- 4.29 Board members are being advised in a joint OIG/Secretariat communication about additional, longer-term policies and practices that are being developed to minimize the risk of fraud and ensure timely Secretariat responses to OIG findings. These measures, described below, are consistent with the Board decision in May 2009¹¹ on grant policy during OIG investigations and audits.
- 4.30 The Secretariat’s will move to *suspend* grants when it appears that the level of weakness of country systems is such that continued disbursements through existing entities would expose the Global Fund to an unacceptable risk, but the Secretariat believes that, with adequate action appropriately communicated to the country, the grants could be ‘reinstated’ within a reasonable timeframe. A decision to suspend a grant will be made in the context of receiving adequate assurance with regard to the continuity of services through an alternative principal recipient. The Secretariat will move to *terminate* grants when it appears that the level of fraud or the weakness of systems are such that continued disbursements through existing

¹¹ GF/B19/DP325

entities would expose the Global Fund to an unacceptable risk, and alternative arrangements are impossible.

- 4.31 To prevent systematic abuse or misappropriation of higher-risk activities such as training, travel and related expenses, procurement, payroll, and other activities involving cash transfers, a range of strengthened control measures is being implemented. These measures include requiring principal recipients to submit an annual training program for approval; spot checks by principal recipients or LFAs of attendees at and expenditures in training programs, and closer scrutiny of budgets for these activities by the TRP and Phase 2 Review Panel.
- 4.32 When risks of misappropriation of drugs or other procured health products are identified, principal recipients will be required to develop and implement plans to ensure the security of those products.
- 4.33 To ensure timely Secretariat responses to OIG findings, a rapid response protocol and process will be developed to guide Country Teams and other Secretariat staff when misuse of funds is identified. The Secretariat and OIG have also agreed to develop guidance to Country Teams and LFAs regarding specific 'red flags' to look for in their review of higher risk activities during grant negotiations for approved Round 10 funding.
- 4.34 The Secretariat is currently considering potential amendments to the Additional Safeguards Policy to specifically address situations where fraud is suspected or identified.
- 4.35 The Secretariat and OIG will continue to make every possible effort to ensure that misappropriated funds are recuperated and that those responsible for fraud are held accountable.

Value for money

- 4.36 Rarely in development has there been such direct and rapid correlation between investments and impact as in the case of AIDS, TB and malaria. That is why it is so critical to ensure that every dollar entrusted to the Global Fund represents value for money. Since the global recession began in 2008, the Secretariat has focused more intensively on ensuring value for money both in terms of operating the Secretariat as efficiently as possible and scrutinizing expenditure in Global Fund-supported programs. This needs to remain a key focus for the Secretariat.
- 4.37 Every opportunity has been taken to minimize Secretariat operating costs. For example, changes to the travel policy after the separation from WHO led to a 16 per cent reduction in the average airline ticket price in 2009 compared to 2008, and a further 10 per cent reduction in 2010. Recognizing the impact of the global recession on donor budgets in a replenishment year, the Secretariat reduced its component of the operating expense budget by 1 per cent for 2011, after several years of substantial growth.
- 4.38 Several measures have been introduced in the last two years to improve budget scrutiny through the course of the grant cycle. Since Round 8, independent budget reviews have been undertaken for large grant proposals in Round 10, the TRP was able to selectively recommend a subset of a proposal's components for the first time. Board-mandated efficiencies have been sought at the time of grant negotiation in Rounds 8 and 9. Additional budget scrutiny now occurs at the time of Phase 2 review and, in April of this year, formal unit cost evaluations

began to be piloted in the Phase 2 review process. Budget reconciliations are also undertaken at grant closure to ensure that unused funds are returned to the Global Fund.

4.39 Approximately 40 per cent of grant expenditures are used to procure medicines and other health products. All grant recipients are required to conduct procurement through a transparent and competitive process and to report price information to the Global Fund's publicly accessible Price and Quality Reporting database, which together with WHO data can help grant recipients negotiate prices and facilitate price comparisons by third parties. Based on the data on drug and health product procurement and on reported service unit costs, the Global Fund has been able to estimate the ranges of service delivery unit costs for key interventions, as summarized in Table 3. The Secretariat has worked with WHO, UNAIDS, PEPFAR and other partners to develop a joint approach to measurement of standardized unit costs at program level and provide support to countries to embed this approach in national programs.

Table 3. Estimates of unit costs for key interventions in Global Fund programs, 2008

Service and cost unit	National income level and unit cost estimate, median and interquartile range, \$US	
LLIN distributed to a person or family at risk for malaria	All incomes:	7.3 (6.7-8.0)
DOTS per TB patient	Low income:	150 (138-191)
	Lower-middle income:	173 (151-177)
	Upper-middle income:	1,023 (956-3,148)
ART per person per year (<i>first-line</i>)	Low income:	553 (538-572)
	Lower-middle income:	675 (654-708)
	Upper-middle income:	776 (729-803)
ART per person per year (<i>second-line</i>)	Low income:	1,351 (1,324-1,488)
	Lower-middle income:	1,803 (1,533-2,331)
	Upper-middle income:	3,305 (2,408-5,223)

4.40 With the launch of voluntary pooled procurement in 2009, countries have been able to access a collective purchasing facility that aims to influence market characteristics such as price, quality and supply through bulk purchasing. The Global Fund's corporate KPIs include annual targets of a 5 per cent decrease in the prices of antiretroviral drugs and long-lasting insecticide-treated bed nets purchased through pooled procurement.

4.41 For the first time, guidance on value for money was provided to applicants as part of the Round 10 application process.

4.42 Under the new grant architecture, value for money will be comprehensively assessed at periodic reviews. Existing LFA and Secretariat reviews of variances in grant financial and programmatic results will be further systematically integrated in the new periodic review.

Improved performance-based funding

- 4.43 Performance-based funding is a fundamental component of the Global Fund's innovative model. I have strongly supported a range of initiatives to strengthen performance-based decision-making including the inclusion of staff in Country Teams with the skills needed to enhance the country's performance framework.
- 4.44 Reliable data underpin the entire credibility of the performance-based funding model. The Global Fund data quality strategy that began implementation in 2010 will improve the quality of programmatic, financial and procurement data used in the Secretariat. The strategy includes activities in four areas: strengthening health information systems at country-level; reinforcing grant data verification mechanisms; streamlining the grant data architecture and strengthening data management.
- 4.45 A grant-specific review process is not adequate for determining the impact and outcome of national disease programs and therefore tends to focus on process and output indicators. The new grant architecture will enable better evaluation of outcome and impact at the time of periodic review so that the Global Fund's performance-based funding decisions are increasingly based on an assessment of the "public health impact of activities supported by the Fund", as envisaged in the Framework Document.
- 4.46 I am committed to developing a culture of performance in other aspects of the Secretariat's work. For example, as the new staff performance framework is refined in 2011, performance incentives including but not limited to performance-based pay will gradually be introduced.

Quality and consistency of services

- 4.47 The Global Fund cannot be concerned only with the volume of funds that it disburses to countries. I am equally committed to developing a stronger culture of *quality* in the Secretariat in terms of the services provided, the consistency of operational practice across the portfolio and the rigour of internal systems and processes. Many of the initiatives described earlier in this section - including the Country Team Approach, improved grant management and enhanced data quality - will directly improve the quality of Secretariat deliverables. Several other quality improvements are described below.
- 4.48 In October I announced a reorganization of the Country Programs Cluster. From 2011, revised terms of reference for the three Unit Directors will focus their work mainly on the introduction of new approaches and consistent processes. One of these three Directors will lead a new Support Services & Quality Assurance Unit to specifically provide support to Fund Portfolio Managers and Team Leaders in assuring the quality of their teams' deliverables, replacing, for example, the *post facto* compliance verifications for disbursements that are currently conducted by the Finance Cluster.
- 4.49 In the last two years, a new policy manual and Users' Guide to the Global Fund have been developed and in 2010 Standard Operating Procedures are being consolidated and updated. These documents will help to address implementers' concerns that policies and practices are applied inconsistently across the portfolio.
- 4.50 Other opportunities to enhance the quality of the Global Fund's work will be sought throughout the grant cycle, for example, by including of the Global Fund's disease advisers in the Phase 2 review process. Major investments in the Global Fund's IT platform have been

made over the last two years and further work in 2011 - such as the progressive automation of proposal, grant management and review processes - will further enhance quality and consistency.

Q1 Review of the Secretariat

- 4.51 In the first quarter of 2011 I will commission a light review of the Secretariat structure to ensure that the organigram introduced three years ago continues to meet operational needs and adequately accommodates the efficiencies and measures to improve effectiveness that are being introduced.

Measuring progress in implementing the agenda

- 4.52 The Secretariat is developing a series of internal indicators to measure progress in implementation of this agenda that I will report on in 2011. I will also report on the impact of these efficiencies and effectiveness measures in 2011 and 2012 on Key Performance Indicators that relate to matters such as disbursement processing, speed of grant signing, funding following performance, overall grant performance, aid effectiveness and value for money.

- 4.53 As we look ahead to the next three years in the life of the Global Fund we can anticipate further significant scale-up of programs to fight the three diseases, as well as a period of consolidation and strengthening of the Global Fund's successful operational model. This will also be a period in which we make strategic decisions about how best to position the Global Fund on the health landscape in the critical years leading towards the MDG deadline. For these reasons I have felt it important to focus this report on a critical assessment of the challenges we have faced and the steps we need to take to make the Global Fund the best it can possibly be.

- 4.54 I wish the Board well at its twenty-second meeting.

Michel D. Kazatchkine
Geneva, December 3, 2010