Sustaining Performance, Scaling Up Results:

THIRD PROGRESS REPORT 2005

Investing in our future

The Global Fund

To Fight AIDS, Tuberculosis and Malaria

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LIST OF TERMS AND ABBREVIATIONS USED

ACT	Artemisinin based combination therapy
ARV	Antiretroviral therapy
CCM	Country Coordinating Mechanism
DFID	Department For International Development (UK)
DOTS	Directly Observed Treatment, Short course (referring to the internationally-approved tuberculosis treatment strategy)
EARS	Early Alert and Response Systems
FPM	Fund Portfolio Manager
HBC	High-burden country (used in reference to tuberculosis disease burdens)
IEC	Information, education, communication
IRS	Indoor residual spraying
ITN	Insecticide-treated (bed) nets
LFA	Local Fund Agent (independent consultants contracted by the Global Fund to assess and verify program results as they are reported by the Principal Recipients of grants)
LLIN	Long-lasting insecticidal nets
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MDR-TB	Multidrug-resistant tuberculosis
MEFA	Monitoring and Evaluation, Finance and Audit Committee (of the Global Fund's Board)
PEPFAR	President's Emergency Plan for AIDS Relief (USA)
PMTCT	Prevention of mother-to-child transmission (HIV)

PR	Principal Recipient
RDT	Rapid diagnostic testing
SWAp	Sector-wide Approaches
TB	Tuberculosis
TERG	Technical Evaluation Reference Group
TRP	Technical Review Panel
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	UN General Assembly Special Session
UNDP	United Nations Development Programme
WHO	World Health Organization

On the Bluefields coast of Nicaragua, home visits at least once a week ensure that patients complete DOTS treatment.

EXECUTIVE SUMMARY

1. The Global Fund is on schedule to complete the implementation of a four-tier performance measurement framework covering its own operations, grant-funded programs, system effects and impact on the three diseases. Progress is on target against goals set for 2005, providing a transparent, rigorous and consistent performance measurement system.

2. By August 1, 2005, the Global Fund had signed grant agreements worth US$ 3 billion for 316 grants in 127 countries. In just over 30 months, the Global Fund has gone from having no grants to approving more than 300, and from having no resources to disbursing over US$ 1.3 billion. The average age of active grants as of this date was only 15 months.

3. Overall, disbursements are in line with the progress of the portfolio. As of August 1 2005, overall disbursements had reached US$ 1.39 billion, equal to 55 percent of the grant value[1] approved, in line with 58 percent of grant time elapsed[2].

4. Results as of June 30, 2005 show that, taken together, the entire portfolio of grants supported by the Global Fund have:

- Put 220,000 people on antiretroviral (ARV) treatment for HIV/AIDS;
- Reached 600,000 people with treatment under the DOTS strategy for tuberculosis (TB);
- Distributed or re-treated 3.1 million insecticide-treated bed nets (ITNs) to protect families from malaria;
- Reached 2.5 million people with counseling and testing for HIV;
- Provided 397,000 orphans with social, medical and educational support;
- Reached 1.1 million people with treatment for malaria (227,000 with artemisinin-based combination therapy (ACT) for drug-resistant malaria);
- Trained 304,000 additional people to fight HIV, AIDS, TB or malaria.

These figures represent significant increases in the first half of 2005 compared to 2004, showing, for example, increases of 69 percent for people on ARV treatment, 56 percent for those on TB treatment, and 130 percent in terms of distribution of ITNs.

5. To achieve its goals, the Global Fund needs not only to sustain this level of performance but to significantly - by at least a factor of five - scale up these results in the next four years. Annual targets have been set - based on grant agreements - for the scaling up of Global Fund-supported grant activities in order to reach 1.6 million with ARV treatment for AIDS and 3.5 million with TB treatment, and to distribute 108 million ITNs to protect families from malaria over the five-year lifespan of all grants approved to date. If these targets are reached, this will increase global coverage two or more times from current levels.

[1] The dollar value of signed grant agreements, as opposed to the value of Board-approved grant proposals. This calculation excludes grants with no disbursements.

[2] The average percentage elapsed of the first two years of signed grants' lifespans.

6. As of August 1, 2005, 74 grants had been recommended to the Board for Phase 2 funding as they approached the two-year mark[3], and 70 grants had been approved for Phase 2 grants worth US$ 614 million. In assessing the performance of these grants, 80 percent met (B1-graded grants) or exceeded (A-graded grants) expectations, although overall performance covers considerable variability among the grants. Seventeen percent of grants showed inadequate results but demonstrated potential (B2-graded grants), and three percent showed unacceptable performance (C-graded grants).

7. Taken as a whole, the 74 Phase 2 grants achieved overall programmatic targets set. While some of these grants fell below their individual targets, the overachievement of high-performing grants ensured that the collective performance targets of these grants were reached. In terms of key service indicators, results included 103 percent of targets reached for people receiving ARV treatment, 112 percent for people treated for TB under the DOTS strategy, 62 percent for distribution of ITNs and 156 percent for people receiving ACT for drug-resistant malaria. In addition, 102 percent of targets were reached for HIV counseling and testing, 166 percent for orphan support and 103 percent for treatment of multidrug-resistant TB.

8. Performance evaluation for Phase 2 has provided valuable lessons for accelerating the implementation of other grants. The continued strength of civil society organizations as Principal Recipients continued to be clearly demonstrated, with 41 percent of these grants being graded A and none graded C. By disease, TB grants performed best, with 44 percent of tuberculosis grants being A-graded grants. The mix of coordinated support from the Stop TB Partnership covering technical, implementation, management and procurement issues may provide models for other disease programs. While sub-Saharan Africa had the same percentage of underperforming grants as other regions, it had a lower rate of overperforming or A-graded grants. The greatest potential to accelerate implementation in sub-Saharan Africa may lie in boosting merely adequately-performing grants, rather than disproportionately focusing efforts on chronic underperformance.

9. Evaluation for Phase 2 strengthens the Global Fund's initial investments by ensuring that Phase 2 funding - or the Global Fund's "reinvestment" - goes to programs with proven performance. Eighty-seven percent of approved Phase 2 funds went to A- and B1-graded grants with documented satisfactory performance. This supports the foremost principle of performance-based funding: to match funds to program performance to ensure that funds continue to flow to effective services reaching people in urgent need.

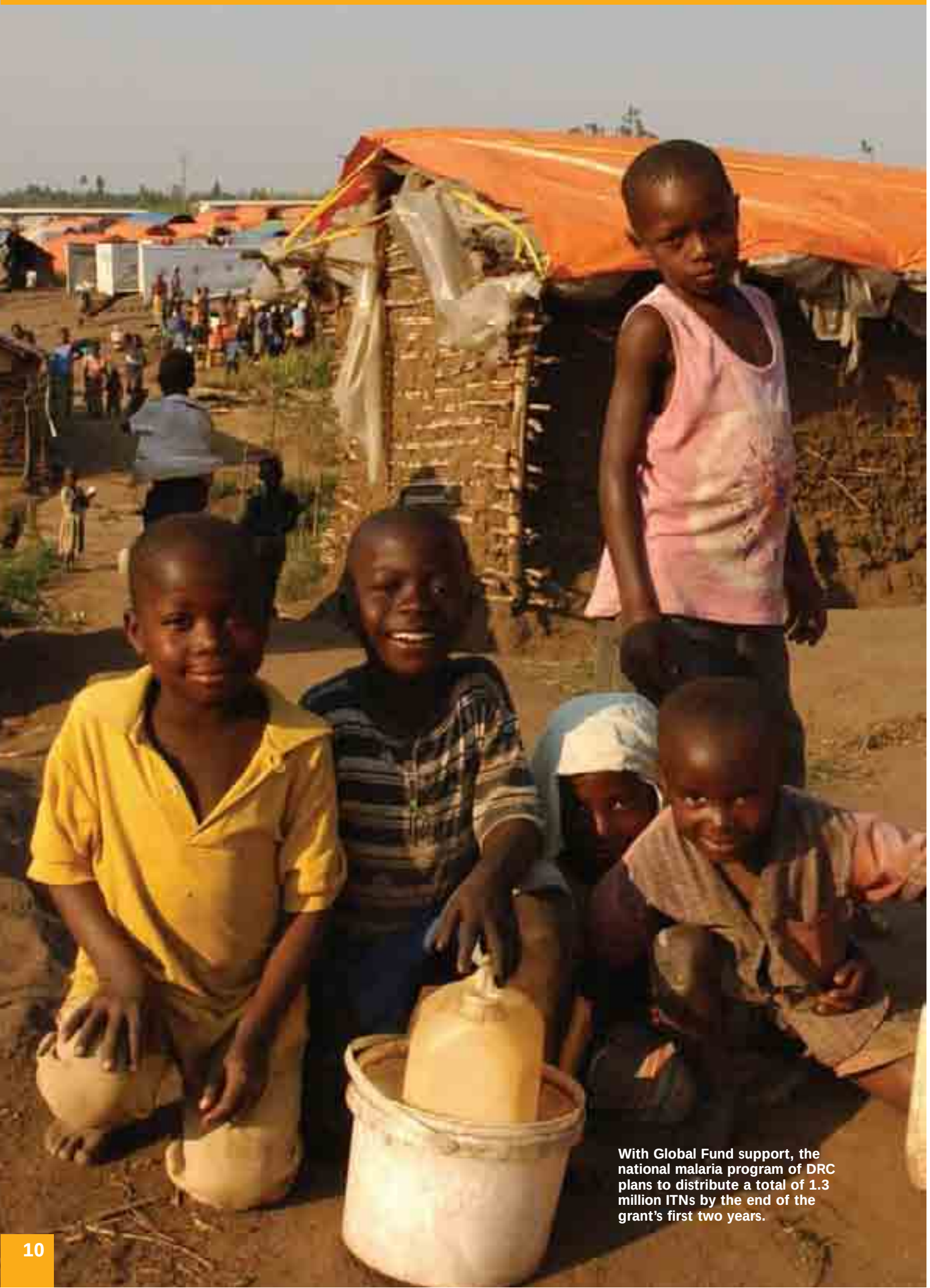
[3] Grants are approved in principle for five years, contingent on satisfactory performance over the first two years measured against targets set out in the first grant agreement. If approved, Phase 2 funding covers the remaining years of the grant's lifespan.

10. A baseline study of Country Coordinating Mechanisms (CCMs) was completed as part of an exercise in establishing baseline data for the measurement of systems effects of the Global Fund. The results show that significant progress is required for CCMs to meet the majority of Board requirements (as set out for CCMs at the Ninth Board meeting in November 2004). The data provide a transparent baseline to mark CCM progress, measured only weeks after the Board requirements were first formally communicated to recipient countries. Baseline data are also being established for the measurement of other indicators of systems effects, and impact indicators for the three diseases are being built into all Phase 2 grants.

11. The robustness of the Global Fund's performance measurement framework has been considerably strengthened with the implementation of new data quality systems and disbursement tools to provide a clear basis for and documentation of performance-based funding decisions. In implementing these tools, the Secretariat has responded to concerns about the documentation of the performance process throughout the grant lifecycle.

12. The Global Fund is working with its partners to apply the UNAIDS principles of the "Three Ones" - one national plan, one national coordinating body and one national monitoring and evaluation (M&E) system - to all three diseases. It is working particularly closely with relevant partners to simplify and harmonize M&E requirements and to support the establishment of single, national-level M&E systems in recipient countries.

13. In conclusion, the Global Fund continues to implement a robust performance measurement framework, and grant-funded programs are showing evidence of strong performance in delivering services to fight the three diseases. The challenges ahead include supporting the scaling up of services as delivered by strong performers and strengthening the performance of those whose performance has been merely adequate in order to reach the ambitious goals that are the mandate of the Global Fund and which are shared by those that supported the Global Fund's creation. This will require an exceptional and sustained effort from recipient countries, donors, technical partners and the Global Fund's Board and Secretariat.



With Global Fund support, the national malaria program of DRC plans to distribute a total of 1.3 million ITNs by the end of the grant's first two years.

INTRODUCTION

14. This report is the Global Fund's third progress report in 2005 and is based on data to August 1, 2005 (unless otherwise noted). It builds on the two previous progress reports released in March 2005 (*Investing in the Future*) and June 2005 (*Making Performance-based Funding Work*).

15. The first half of the report describes progress made to date on the implementation and further development of the Global Fund's four-tiered performance measurement framework and the steps being taken to strengthen particular aspects of its operational systems and processes. Although the Global Fund's grant portfolio is still young and evidence of significant impact is still a few years away, indicators to measure system effects and impact are being incorporated now.

16. The second half of the report gives an analysis of the performance of the 74 grants evaluated for Phase 2 funding up to August 1, 2005 and a review of the lessons learned. Performance-based funding quickly brings many of the challenges of implementation to the surface. While a minority of the grants analyzed have serious performance issues, important lessons have been learned in applying the principles of performance-based funding, demanding prompt attention by the Global Fund and its partners in donor and recipient countries.

17. The requirements of the Global Fund's performance-based funding system provide a platform for grant recipients to prove their achievements. Of the 74 grants that had reached (or nearly reached) their two-year anniversary by August 1, 2005 - and therefore a full performance assessment and the decision point on continuation of funding - most have shown that they can use scarce resources to reach millions of people with high-quality and urgently-needed services across all three diseases and on several continents. The challenge facing the Global Fund, recipient countries, donors and partners is to sustain and scale up these examples of performance with the financial, technical and managerial support that is required, even by strong performers. This is a challenge for all stakeholders to ensure that the Global Fund reaches the levels of coverage and impact it was set up to achieve.

In the maximum security women's prison in Rusca, Moldova, a Global Fund grant for HIV/AIDS supports needle exchange, psychological rehabilitation and outplacement services to 270 inmates.

SUSTAINING PERFORMANCE, SCALING UP RESULTS

18. In just over 30 months, the Global Fund has gone from having no grants to approving more than 300 grants across 127 countries, and from having no resources to disbursing over US$ 1.3 billion. Most importantly, it has gone from having no results to funding an enormous range of services and interventions, thereby impacting millions of lives.

19. The results of grant-funded programs in the first half of 2005 show a rapidly increasing delivery of services to people in need across the top three coverage indicators (see Figure 1). In the first half of 2005, the Global Fund saw a sharp increase in its contribution to the global goal outlined in the World Health Organization's "3 by 5" initiative (putting three million people on antiretroviral treatment for HIV/AIDS by the end of 2005). TB programs for treatment under DOTS continued to perform strongly, reaching 86 percent of their collective target for the end of 2005 by June 30, 2005. The increase in distribution of insecticide-treated bed nets (ITNs) by 130 percent in the first half of 2005 is particularly encouraging, as recent efforts to resolve procurement bottlenecks have clearly boosted results.

20. Beyond its top three indicators, the Global Fund finances a wide range of service delivery areas across prevention, treatment and care interventions, and further mid-year results for the entire grant portfolio included:

- 2.5 million people counseled and tested for HIV;
- 397,000 orphans reached with at least one form of basic external support (medical, emotional, school-related or other material services);
- 104,000 women reached with prophylaxis to prevent mother-to-child transmission of HIV (PMTCT);
- 131 million condoms distributed;
- 304,000 additional people trained to fight HIV/AIDS, TB or malaria;
- 1.1 million malaria treatments (227,000 with artemisinin-based combination therapy (ACT) for drug-resistant malaria).

GRANT RESULTS	JUNE 30, 2005	DEC. 31, 2004	PERCENTAGE INCREASE
HIV: People on ARV treatment	220,000	130,000	69%
TB: People treated under the DOTS strategy	600,000	385,000	56%
Malaria: Insecticide-treated nets distributed or re-treated	3,100,000	1,350,000	130%

Figure 1: Results of the entire grant portfolio supported by the Global Fund for the top three coverage indicators as of June 30, 2005

21. These "headline" coverage indicators provide a snapshot of results for the whole grant portfolio across all three diseases and all regions. However, there is still incompleteness in reporting, particularly for the last six indicators above, and therefore these results must be seen as a low estimate of grant-funded results to date in these areas. Individual grant performance reports showing the full range of service delivery areas will be published in September 2005 on the Global Fund's website for grants greater than six months of age which have progress reports. This is part of a concerted effort to strengthen the Global Fund's transparent documentation of results and show the basis for disbursement decisions. This effort is described in greater detail in the section entitled "Strengthening Performance-based Funding".

SUSTAINING GRANT PERFORMANCE

22. Results achieved by programs financed by Global Fund grants are due to the work of principal and sub-recipients in both the public and private sectors, supported by the substantial technical assistance of the Global Fund's partners, including WHO, UNAIDS, the Roll Back Malaria Partnership, the Stop TB Partnership and many other bilateral and multilateral agencies. This broad range of health and development organizations and networks forms the system that the Global Fund works within as a financing mechanism - as opposed to an implementing agency - to convert funds into results. The Global Fund provides financing and applies the principles of performance-based funding. This ensures that grant funding committed in principle is owned neither by recipient countries nor by the Global Fund itself. Rather, it belongs to successful programs that reach people with urgently needed services.

23. The results of the evaluation of the 74 Phase 2-eligible grants showed that 80 percent of these grants were performing well or adequately. The remaining 20 percent showed inadequate performance, with 17 percent of these inadequate performers showing documented evidence of potential. (See the section of the report entitled "Grant Performance: Analysis of 74 Phase 2-eligible Grants" for detailed information.) While some grants fell below targets, the overperformance of strong grants more than compensated to reach overall targets.

24. Of the 74 Phase 2 grants evaluated, results when measured against two-year targets were as follows:

- **HIV:** 103 percent of targets were met for ARV treatment, 102 percent for HIV counseling and testing and 166 percent for orphan support;
- **TB:** 112 percent of targets were met for treatment under the DOTS strategy, 117 percent for patients cured under the DOTS treatment strategy and 103 percent for multidrug-resistant TB;
- **Malaria:** 62 percent of targets were met for insecticide-treated bed nets (ITNs) and 156 percent for artemisinin-based combination therapy for drug-resistant malaria.

25. Many challenges remain in dealing with implementation problems in grants. It is critically important at this stage to tackle the problems in order to sustain the current levels of performance and financing to the majority of grants that are successfully reaching people with services in accelerating numbers - and then to move past sustaining current results to scaling them up.

SCALING UP RESULTS GOING FORWARD

26. The average age of a Global Fund grant was only 15 months as of August 1, 2005. However, grant-funded programs aim to build a long-term, sustainable effort to halt and reverse the spread of AIDS, TB and malaria. About 50 percent of total grant funds are budgeted for capacity building - including 20 percent for human resources and training, and 13 percent for physical infrastructure - enabling them to support the scale-up of results in the future.

27. Targets from grants signed have been consolidated and projected to provide annual targets for the overall grant portfolio for the top three indicators (see Figure 2). Results to date are promising but still fall short of the tens of millions that are needed globally. These results must be scaled up by at least a factor of five in the coming years. The long-term vision and sustainability of financing is crucial if these results are not only to be sustained but also scaled up to meet the ambitious goals the Global Fund was set up to achieve.

28. Results of the Global Fund's overall portfolio measured against key coverage indicators (see Figure 3) are on track for 2005 as of June 30, 2005. Sixty-three percent of the year-end target for the number of people receiving ARV treatment has been met, 86 percent of the target for TB treatment under DOTS, and 62 percent of the year-end target for ITN distribution, compared with an expected result of approximately 50 percent at the mid-year point. A full evaluation will be undertaken at the end of the year.

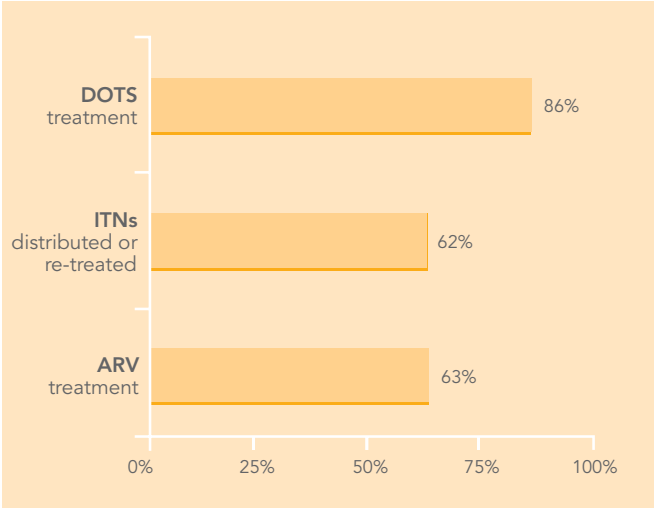


Figure 3: Percentage of 2005 targets reached by mid-year (June 30, 2005)

YEAR	2004	2005	2006	2007	2008	2009
HIV: ARV treatment	125,000	350,000	600,000	875,000	1,200,000	1,600,000
Malaria: ITNs distributed or re-treated	2,000,000	5,000,000	15,000,000	30,000,000	60,000,000	100,000,000
TB: Treatment under DOTS	300,000	700,000	1,200,000	1,800,000	2,600,000	3,500,000

Figure 2: Cumulative targets (by year) for the Global Fund's entire portfolio of approved grants

THE "THREE ONES" FOR THE THREE DISEASES

29. The Global Fund relies on a broad network of health and development partners and their systems at the global, national and community levels for support and implementation of the programs it funds. International harmonization of systems and procedures extending across the three diseases is therefore a priority in strengthening the Global Fund's performance-based funding system. The Global Fund aims to invest seven to ten percent of grant funds in supporting the establishment of common monitoring and evaluation (M&E) systems.

30. In 2005, the Global Fund worked closely with its partners to make important advances in applying the principles of the "Three Ones" established by UNAIDS (one national plan to fight HIV/AIDS, one national coordinating body and one national M&E system) and extending it to TB and malaria. Advances to date include:

- **Harmonized Reporting:** Joint partner agreement on common indicators across HIV/AIDS, TB and malaria resulted in a *Monitoring and Evaluation Toolkit*, published in 2004 and updated in September 2005 to include technical advances and health systems strengthening. The Global Fund does not have its own indicators but uses a subset of those agreed on and used by recipient countries and partners to show service delivery and impact.
- **International Data Sharing:** A meeting was held to share data and harmonize systems concerning national results with a number of international partners, including PEPFAR, WHO, UNAIDS, DFID, the World Bank and the Global Business Coalition (representing the private sector for the first time) in July 2005. On this basis, the regional ARV results published below are consistent with partner and country results.
- **Joint M&E Support:** A Joint Facility for M&E Support was launched for recipient countries. The Joint Facility matches country and grantee requests for M&E technical support with partner capabilities and supply. It is an early example of the "Three Ones" in action and supports the Global Fund's developing Early Alert and Response System (EARS) for grant-funded programs. Since June 2005, the Joint Facility has been extended to cover malaria and TB as well as AIDS. The addition of private sector involvement has provided much-needed support beyond the technical expertise of partner agencies.

31. Systems of harmonized reporting, data sharing and joint M&E technical support have expanded and developed in 2005 to support the "Three Ones" across all three diseases - not just HIV/AIDS. Many challenges remain in embedding this approach in recipient countries and reducing specific donor requirements for M&E. However, joint partner training in countries is already underway to strengthen the contribution of performance-based funding to the "Three Ones".

32. A prominent example of harmonization has been the effort of all partners to share data on people on ARV treatment and to assess overlap in order to assess the number of unique individuals treated in reaching for the goals of WHO's "3 by 5" program. On the basis of these data-sharing meetings, the Global Fund has produced regional breakdowns of its ARV figures consistent with partner figures (see Figures 4 and 5). The Global Fund only includes a grant's ARV results where:

- The grant supports an essential element of ARV treatment on a national scale;
- The grant is performing and there are no significant data quality issues;
- Financial contributions are significant and over US$ 10 million;
- Overlap with PEPFAR and "3 by 5" results is examined on a country-by-country basis to finalize consistent partner figures.

In addition, only patients currently documented as being on ARV treatment at the time of grant reporting are included according to standard indicators.

33. Grantees can use other funds to finance ARV treatment, and this is supported by the Global Fund to the extent that performance-based funding processes include procedures for operating in pooled funding and SWAp contexts. Results attributed to Global Fund grants are due to the work of grantees, regional and national programs, and a variety of local and international partners that provide additional support and technical expertise.

34. As of June 2005, the Global Fund, together with PEPFAR, had supported programs that treated a total of 350,000 unique people for HIV/AIDS, contributing significantly to global goals and to the WHO's "3 by 5" initiative.

35. ARV treatment programs require a range of activities and resources, including drug provision, human resources, treatment of opportunistic infections, laboratory and testing facilities, and health systems strengthening. A joint approach to documenting different types of partner inputs to national ARV programs will be completed by the end of 2005 for the Global Fund, PEPFAR, the World Bank, the UK's Department for International Development and the private sector.

36. Similarly, it is important that national systems provide the basic reporting and accountability around which donors can harmonize. A basic set of transparently-available national indicators (supported by WHO and UNAIDS) would help to prevent the development of parallel reporting systems within countries. The Global Fund and PEPFAR have therefore simplified the top ten indicators to track the progress of programs.

REGIONAL CLUSTER	GLOBAL FUND ARV GRANT RESULTS	WHO "3 BY 5" PEOPLE ON ARVS	PERCENTAGE
Sub-Saharan Africa	169,000	500,000	34%
Latin America and Caribbean	18,850	290,000	6%
East, South and South East Asia	29,250	155,000	19%
Europe and Central Asia	1,970	20,000	10%
North Africa and the Middle East	1,100	4,000	28%
Total	**220,170**	**969,000**	**23%**

Figure 4: Regional breakdown of people living with HIV/AIDS on ARV treatment

37. Performance-based funding is contributing to embedding accountability and performance incentives into country systems, while at the same time simplifying partner reporting, data sharing and M&E technical support. Global Fund accountability will always go beyond the internal requirements of national systems to ensure that funds are reaching those urgently in need of services.

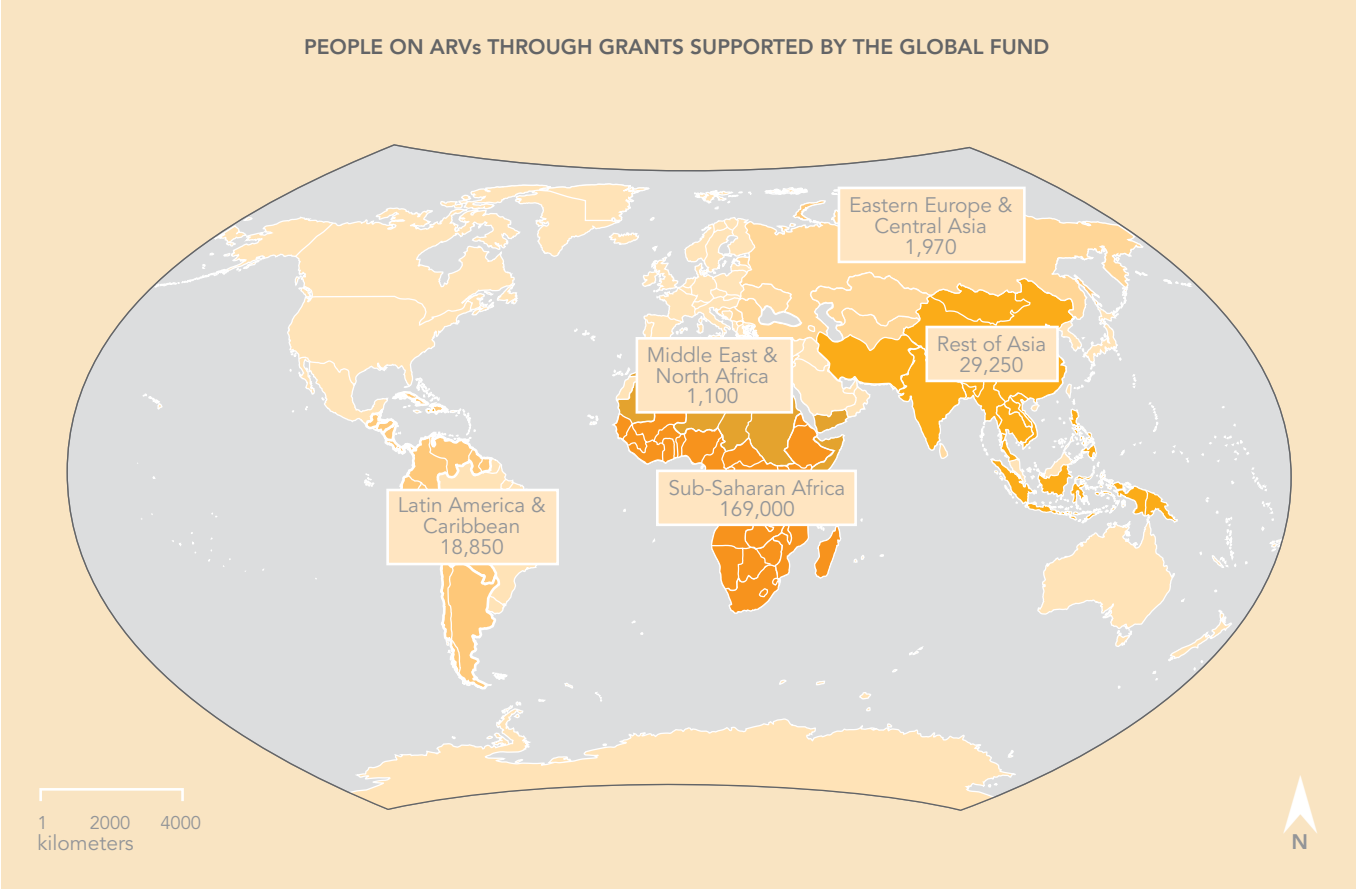


Figure 5: People on ARVs through grants supported by the Global Fund

In El Tuma, Nicaragua, vector control with insecticide smoke cannons is one element of a malaria prevention program.

STRENGTHENING PERFORMANCE-BASED FUNDING

38. In 2004, the Global Fund designed and began to implement measurement systems for its own operations and for grant performance - the first two tiers of a four-tiered performance measurement framework (see Figures 6a and 6b), to be fully implemented by the end of 2005. In building these systems, the Global Fund has incorporated accountability for results into all of its own operations as well as those of its funded programs. The final two tiers, developed with input from technical, donor and recipient partners, measure the system effects of Global Fund financing and the impact of grant-funded programs on the three diseases. This section of the report includes an initial baseline analysis of the CCMs through which the Global Fund works in countries.

39. The scaling up of results in recipient countries will require the strengthening of performance-based funding systems at all four levels of the Global Fund's performance measurement framework. In particular, the system effects and impact levels need to be well established in order to measure progress towards the goals of the Global Fund over the medium term and as more grants mature and commence Phase 2 funding.

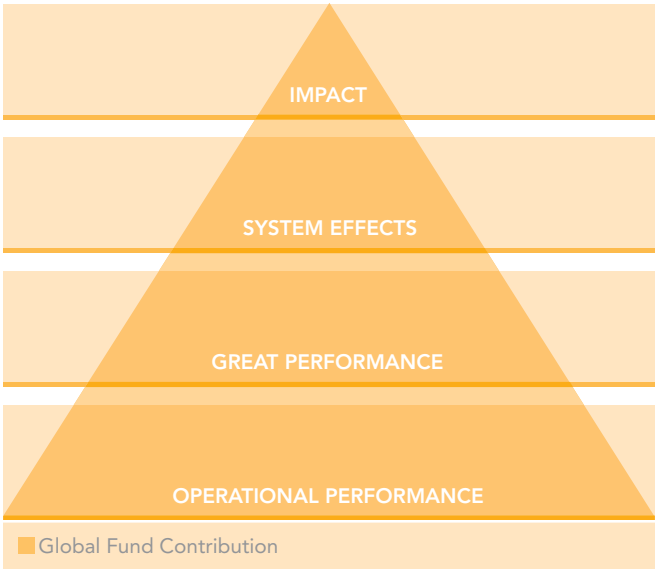


Figure 6a: People on ARVs through grants supported by the Global Fund

The four levels of the measurement framework are as follows:

1. **Operational Performance:** This level measures the performance of the core functions of the Global Fund and its Secretariat, including resource mobilization, grant management, proposal and grant signing, disbursements and Secretariat costs.

2. **Grant Performance:** This level measures the performance of grants and is the cornerstone of performance-based funding as implemented by the Global Fund. Together with its primary technical partners, the Global Fund developed a joint monitoring and evaluation toolkit which defines simplified measures across the three diseases.

3. **System Effects:** This level measures the impacts (positive and negative) that the Global Fund has on the existing systems through which it works, in particular at the country level. Under the oversight of the Technical Evaluation Reference Group (TERG) and the relevant Board committees, and in conjunction with a wide range of partners and stakeholders, a set of indicators and measurement tools has been developed and has been published in the recent guide, *Measuring the Systems Effects of the Global Fund: Resource Document and Measurement Guidelines.*

4. **Impact:** This level provides the means for measuring the impact of the Global Fund in the fight to turn the tide of the three diseases. Indicators are built into grants, and contributions are assessed at the global level; for example, contributions to the Millennium Development Goals (MDGs).

Figure 6b: Definitions of the four levels of the measurement framework

40. It is important to restate here that performance-based funding goes beyond mere accountability to enable accelerated implementation. Given scarce resources, performance-based funding ensures that funds go to successful programs which reach people in urgent need. This is a cornerstone of accelerated implementation, to ensure that incentives are in place from the moment funds are disbursed to invest in quality, sustainable performance. Performance-based funding began to prove itself as a catalyst for accelerated implementation in early 2005: Global Fund performance measurement systems were implemented, grants matured and ongoing funding decisions began to guide scarce resources to programs with proven results.

41. Performance-based funding quickly and transparently brings the challenges in development systems and grants to the surface. At the same time it provides a platform for the vast majority of grants to demonstrate that they can convert financing into results, enabling further funds to be committed in a sustainable manner. This is shown in the later sections of this report that evaluate the performance of grants over their first two years.

42. This report provides data as transparently as possible to present the successes and challenges of grant activities. This section will focus on efforts made to strengthen the performance-based system in the period leading up to August 1, 2005 in order to reach the 2005 development targets (see Figure 7, page 25). The ten most important recent developments in strengthening this system are listed below:

I. **Performance-Based Disbursements:** This standard tool to document the performance and financial basis for disbursements is being implemented in the Global Fund Secretariat. This will improve documentation and greatly strengthen the performance system prior to and after the Phase 2 evaluation. It is part of the effort to ensure that performance-based funding and documented decisions occur throughout the grant lifecycle

II. **Country Data Quality:** A data quality and audit process has been set up in coordination with WHO, Health Metrics Network and PEPFAR under the guidance of the TERG to ensure reliability in the quality of data coming from countries on which performance decisions are made. Data quality will become a material element in performance decisions.

III. **Target Setting:** An evaluation study has been initiated to review target setting as implemented in proposals and their associated funding requests. This is closely linked to an independent study commissioned on the grant proposal preparation and review process which looks at how targets are first set initially and then reviewed.

IV. **Harmonizing Country M&E Support:** The Global Joint Facility was launched in April 2005 to harmonize monitoring and evaluation support across partners (WHO, Global Fund, PEPFAR, UNAIDS, CDC, USAID, World Bank, Measure Evaluation Group), in response to demands from countries in order to be able to respond to early warnings of M&E problems. The Global Joint Facility is based with a single contact in UNAIDS (email: helpME@unaids.org), and in July was extended to cover tuberculosis and malaria as well; it also now includes the private sector.

V. **Private Sector Involvement in M&E:** Following the June replenishment meeting of the Global Fund, a number of initiatives targeting the private sector were launched: (1) The private sector was involved in the joint partner results meetings to share data on private support for ARV treatment (currently a major gap in global data); (2) The private sector was invited by the Joint M&E Facility so as to provide its skills in management and IT. This complements the efforts of technical partners in building country M&E systems. The program is being piloted in India and is currently providing support on financial systems, smart card and data management technology as tools to strengthen grant M&E.

VI. **CCM Baseline Survey Results:** the outcomes of the survey have been analyzed. These results provide a baseline for improvement, as the survey was carried out only weeks after the newly-implemented requirements had been formally communicated to countries. Early indications are that real progress is needed in these areas, and the study provides a transparent baseline against which to mark improvements.

VII. **MDGs and Impact:** Modeling has been implemented with partners to assess the joint contribution of the Global Fund over the longer term to the achievement of the Millennium Development Goals. This modeling will serve to assess the impact of Global Fund coverage on an ongoing basis as results are scaled up.

VIII. **Paris Declaration Targets on Aid Effectiveness:** The Global Fund works within these frameworks and global targets as set in July 2005. In addition, certain elements of the measurement with partners are being considered part of the "soft indicators" initiative for reporting on Global Fund progress, which relate grant activities to selected global targets.

IX. **Regional M&E clinics:** In addition to establishing a dedicated M&E support team to provide assistance to Global Fund portfolio managers, the M&E team is providing training and support to country-level participants in clinics which are held during regional meetings and which provide hands-on assistance regarding Global Fund performance policy. This occurs in parallel with Global Fund involvement in training organized by the Global Fund's partners: UNAIDS, WHO, CDC, USAID and the Measure Evaluation Group.

X. **Top ten indicators to track progress:** Through a partners' meeting in July, the Global Fund and PEPFAR defined the top 10 simplified indicators. This acknowledges that to harmonize around a common M&E system, clear results on the delivery of services beyond ARV treatment need to be available internationally from these systems. This should provide a focus to implement the "Three Ones" in AIDS treatment by simplifying and harmonizing donor requirements.

43. There are many challenges to strengthening performance-based funding and to ensuring that incentives are in place to guide funds towards well-performing grants. Perhaps the biggest challenge is to ensure that external accountability is implemented alongside country-owned objectives and targets. These two principles form the axes and tension in the Global Fund's performance-based system.

44. The figure opposite is a summary table which gives more information on the Global Fund's progress towards the implementation and further development of the measurement framework, as compared to targets, for the current year (2005).

	Level of measurement framework	Implementation targets for 2005	Implementation status as of Jan. 2005	Progress Update as of August 1, 2005
4	**Impact**	- All Phase 2 grants have impact targets as of January 2005 - Contribution to MDGs quantified by September 2005	- Impact indicators defined in *Monitoring and Evaluation Toolkit* - Suite of measurement tools implemented to capture targets for grants	- Some early grants showing impact, analyzed in this report - All Phase 2 grants include impact indicators/targets. Many grants have this as a condition for Phase 2 funding - Contribution to MDGs described in this report, quantification started in July with partners through modeling - Long-term coverage targets provided by year to 2009
3	**System**	- CCM baseline survey results in all countries by June 2005 - Baseline report on core system effects indicators by December 2005 - 100% of GF funding needs contributed for 2005	- Measurement framework and indicators agreed - Baseline implementation initiated	- CCM baseline results presented in this progress report - Background document on system effects and technical indicator appendix published. Initial case studies and baseline results presented. Gaps in national disease accounts need to be tackled with partners - Gap in Global Fund funding needs for 2005 remains a major issue
2	**Grant**	- 95% of disbursements based on evidence of performance and expenditure in 2005 - 100% of all new and Phase 2 grants have coverage indicators in 2005 - Report on portfolio "Top 10" coverage indicators by December 2005	- Standard indicators agreed with partners in *Monitoring and Evaluation Toolkit* - Key coverage indicators included in all Phase 2 and new grants - Portfolio results in for ARVs, DOTS, ITNs	- Disbursement tool designed to remove gaps in Secretariat documentation. Disbursements are based on progress updates and LFA assessment of performance and expenditure. - All Phase 2 grants and new grants have key coverage indicators. 527 high-level coverage indicators evaluated for 74 grants, 44% of all indicators, and on average 7 indicators per grant - Reporting system embedded in grants to aggregate portfolio results for key indicators. Targets finalized to 2009.
1	**Operational**	- Internet access to an Executive Dashboard that is updated continuously by March 2005	- Core indicators implemented - Executive Dashboard finalized - LFA study completed	- Internet access to the Executive Dashboard is now available and the information is updated regularly

Figure 7: Update on development and implementation of the Global Fund's four-tier measurement framework

OPERATIONAL AND GRANT LEVELS OF THE MEASUREMENT FRAMEWORK

45. At the operational and grant levels, there have been a number of areas of progress: strengthening performance-based disbursements and their documentation; implementing data quality procedures for grants; extending the Joint Facility for M&E support to malaria and tuberculosis as well as AIDS; and including the important and underutilized technical inputs of the private sector. In addition, the Global Fund has fully implemented its Executive Dashboard.

EXECUTIVE DASHBOARD

46. The Executive Dashboard is now fully launched and available on the Global Fund's website at www.theglobalfund.org. It is updated quarterly as a standardized management and reporting tool on the core activities of the Global Fund. The five core areas of the Global Fund's operational activities are captured by indicators as set by the Global Fund Board:

1. **Resource mobilization:** resources contributed as compared to pledges and internal targets
2. **Proposal management:** grants signed as a share of the total number of approved grants
3. **Grant negotiation:** median proposal handling time (from call for proposals to grant signing)
4. **Disbursement and grant management:** actual disbursements as compared to disbursement targets
5. **Business services:** operating and Secretariat costs as a percentage of total expenditure

47. The Executive Dashboard includes one top-level indicator for each of the five core areas and a number of supporting indicators for more detailed information. Investments in strengthening the Global Fund's internal data systems are ongoing in order to support the capture and analysis of real-time data concerning operations.

48. The Executive Dashboard's top-level indicators highlighted the following results as of August 1, 2005:

- US$ 1.39 billion has been disbursed to grants;
- 316 grants have been signed out of 321, with only 4 outstanding for Round 4 (due to specific reasons presented to the Board);
- In the second quarter of 2005, the median handling time from grant signing to disbursement was 5 weeks, and from Board approval to grant signing 51 weeks (as many of the last grants from round 4 were signed);
- Funds contributed to the Global Fund in 2005 as of August 1 totaled US$ 836 million with 2005 pledges totaling US$ 1.4 billion. (The target for 2005 is US$ 2.3 billion.) Significant increases in contributions, which triggered the full US contribution, have nevertheless left a funding gap;
- Operating and Secretariat costs as a percentage of total expenditure were less than 3 percent.

49. Results for grant signing show the great effort made by the Global Fund Operations team to sign outstanding grants since the last progress report, with few now remaining unsigned.

DISBURSEMENT AND GRANT MANAGEMENT

50. To evaluate whether disbursements are on track, the Global Fund compares disbursed funds as a percentage of grant value[4] with the proportion of grant time elapsed[5] since the grant agreement was signed (Figure 8). Rounds 3 and 4 grants, which are younger, have disbursed in excess of grant time elapsed because initial disbursements tended to be larger. With time, expenditures tend to track more closely with the average time elapsed. By August 1, 2005, the mean grant amount disbursed was 55 percent, compared to 58 percent of grant time elapsed for Phase 1 and 2 grants.

51. While performance-based funding of grants reaches a critical milestone at the Phase 2 funding stage, the measurement and evaluation system starts with Phase 1, when indicators and targets are agreed between the recipients and the Global Fund and are then made part of the initial grant agreement. Targets are tracked at every point in the process, from grant agreements to regular disbursement requests and performance updates, through requests for continued funding and extended grant agreements into Phase 2 (see Figure 9, on the following page).

CURRENT FINANCIAL STATUS OF THE GLOBAL FUND
US$ figures in millions, as of August 1, 2005

Current grants (including approved Phase 2 renewals)

Round	Date	Approved	Signed	Disbursed	Mean Percent Disbursed	Mean Time Elapsed
Round 1	April 2002	$ 986	$ 664	$ 486	74%	86%
Round 2	January 2003	$ 1,025	$ 837	$ 496	62%	73%
Round 3	October 2003	$ 634	$ 634	$ 240	42%	40%
Round 4	June 2004	$ 1,018	$ 933	$ 167	36%	17%
Total		**$ 3,663**	**$ 3,067**	**$ 1,389**	**55%**	**58%**

Figure 8: Financial status of the Global Fund: approvals, commitments and disbursement by funding round and total.

[4] *The dollar value of signed grant agreements, as opposed to the value of Board-approved grant proposals*

[5] *The average percentage elapsed of signed grants' lifespans*

52. By the time a grant arrives at the stage of Phase 2 evaluation, the Global Fund has reviewed grantees' implementation capacity and performance from five sources at different points in the cycle:

- Initial assessments of the Principal Recipient's financial management and systems; institutional and programmatic capacity; monitoring and evaluation systems; procurement and supply management; and background analysis;
- Three to six progress updates of results measured against targets as a basis for disbursement decisions;
- Independent review and recommendations by the Local Fund Agent (LFA) on each progress update and disbursement decision;
- Multiple country visits and coordination with the Country Coordinating Mechanism (CCM) to provide oversight;
- Review of M&E, targets and results, annual reviews and all Phase 1 data submitted by the CCM, including further data verification by the LFA.

SIMPLIFYING M&E

53. Performance-based funding provides a platform for grants to show how they are contributing to the scale-up of services. An ongoing challenge is to simplify reporting for grant recipients, and to ensure it is comparable across grants and countries. End-of-year reporting by the Global Fund has now been harmonized around ten indicators of people being reached by key services, as shown in Figure 10 below. An initial agreement with PEPFAR is also being reached to harmonize the minimum service information required from national systems around ten key indicators. Considerable reprogramming of grants is required to ensure consistent reporting around standard, simple indicators which can reflect the scaling of services. A major challenge of the "Three Ones" is to provide this basic information in national systems around which all partners can harmonize.

54. Three areas where the Secretariat has been focusing its efforts are: (1) Performance-based disbursements and their documentation; (2) Systems to ensure data quality from grants and countries; and (3) the Early Alert and Response Systems (EARS).

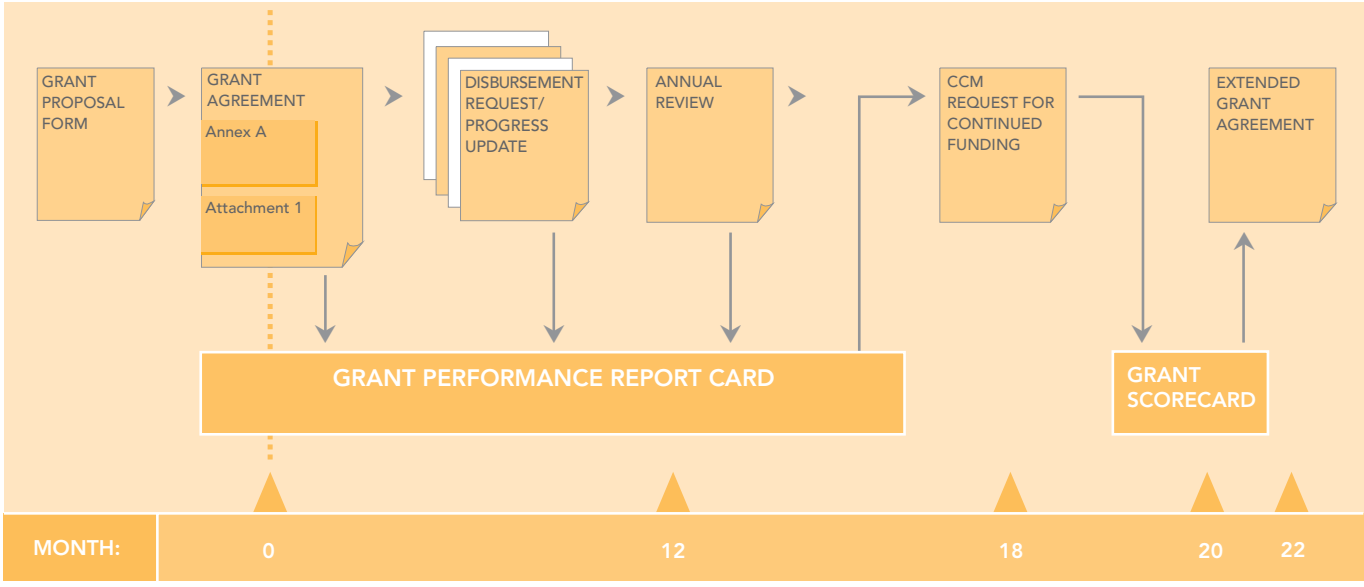


Figure 9: The Global Fund's grant performance measurement system

	TOP TEN INDICATORS OF PEOPLE REACHED BY SERVICES	DISEASE
1	Number of people currently receiving antiretroviral therapy (ARVs)	HIV
2	Number of smear-positive TB cases receiving treatment under DOTS Specify: a. new cases detected b. number successfully treated c. number on MDR-TB treatment	TB
3	Number of insecticide-treated bed nets (ITNs) distributed (or households receiving indoor residual spraying, depending on region)	Malaria
4	Number of people counseled and tested for HIV	HIV
5	Number of HIV-positive pregnant women receiving a full course of ARV prophylaxis to reduce mother to child transmission (PMTCT)	HIV
6	Number of people receiving anti-malarial treatment (specify ACT/non-ACT)	Malaria
7	Number of condoms distributed	HIV
8	Number of people benefiting from outreach community programs Specify: a. prevention b. orphan support c. home-based care and external support	HIV/TB/Malaria
9	Number of people receiving treatment for infections associated with HIV Specify: a. HIV/TB b. opportunistic infections c. STIs with counseling	HIV/TB/Malaria
10	Number of people trained Specify: a. health and related services b. peer and community prevention	HIV/TB/Malaria

Figure 10: The Global Fund's top ten indicators relating to people reached by key services

PERFORMANCE-BASED DISBURSEMENTS

55. Performance-based funding is integrated into every phase of the full lifecycle of a grant, from the proposal stage through grant agreement negotiations, successive disbursements, the decision to continue funding beyond the first two years, and until the end of the grant's life.

56. The Global Fund dedicated considerable efforts into the development of systems for the Phase 2 grant renewals. An additional key pillar of the performance-based funding architecture is the disbursement process whereby, after an initial disbursement, the Global Fund makes subsequent disbursements of funds on the basis of periodic evidence of programmatic progress and financial accountability. All disbursement decisions are made on the basis of progress updates, independent LFA review, and fund portfolio judgment of performance. However the Secretariat has been correctly criticized regarding the need to improve its documentation of disbursements.

57. Strengthening the underlying tools for disbursement decision-making has been an important response over the recent months by the Secretariat. A standard disbursement decision-making tool has been developed to ensure consistent decisions across clusters, supported and documented on the basis of performance and financial data. This tool:

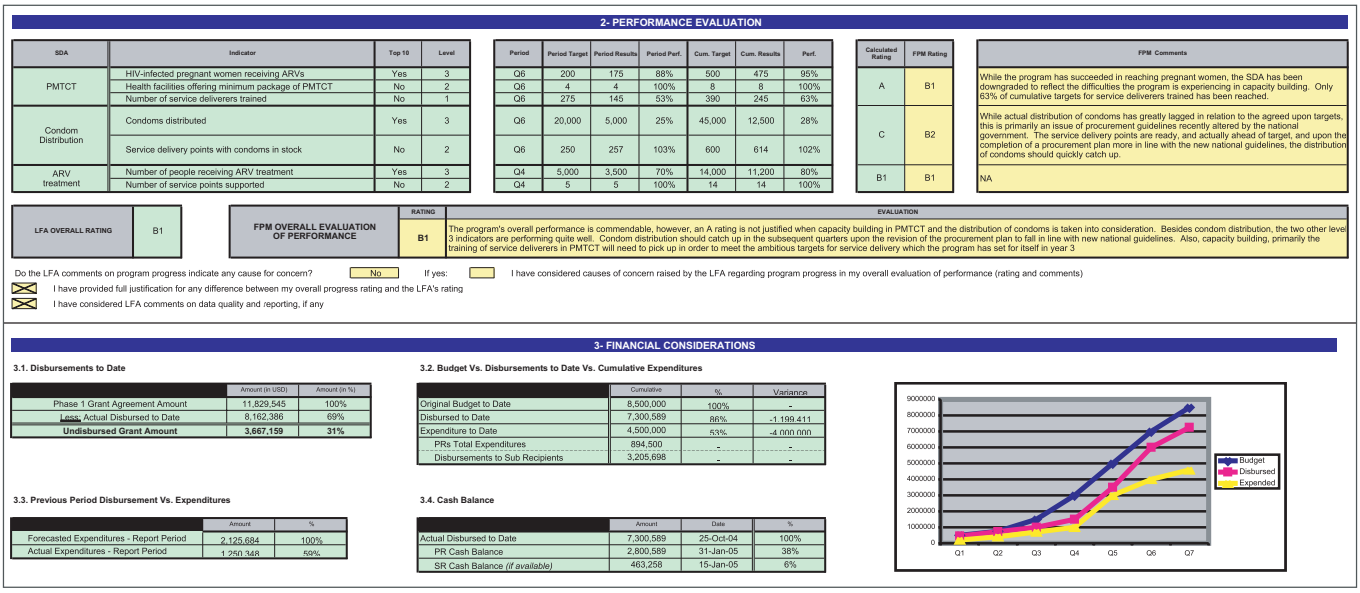
- consolidates key information for decision-making on disbursements (progress against agreed-upon targets, expenditures to date, cash balance, LFA overall rating and recommendation);
- captures the explanation and rationale for disbursement decisions within fund portfolio management.

58. The disbursement decision-making screen is divided into six sections:

- **Performance Evaluation:** This section contains results against agreed-upon targets, as well as the overall rating given by the LFA. It also captures the Fund Portfolio Manager's (FPM) evaluation of performance (including a performance rating and comments).
- **Financial Considerations:** This section contains latest information on disbursements, expenditures and cash balance. It also captures any relevant financial comments from the FPM.
- **Contextual Information:** This section captures any contextual information which has been taken into account for decision-making on disbursement (for example, completeness of reporting, data-quality problems, program management or governance issues, exchange rate considerations, etc.)
- **Outstanding Requirements (if any):** This section captures information on the compliance of the Principal Recipient (PR) regarding conditions precedent (included in the Grant Agreement) and required documentations (e.g., audit report).
- **LFA Recommendations:** This section contains the LFA recommendations linked to the disbursement request, as well as the corresponding decisions from the FPM.
- **Disbursement Decision:** This section contains the disbursement amount and the corresponding rationale from the FPM.

59. Key sections of the disbursement decision-making screen - those pertaining to performance, finance and the disbursement decision - are shown below. The full tool which is being rolled out throughout all grants is shown in Appendix 3.

60. As stated, the purposes of this disbursement tool are to improve documentation on disbursement decisions, to feed into the Early Alert and Response System and to greatly strengthen the performance system prior to Phase 2 evaluation. It is part of an overall effort to strengthen the performance-based funding architecture and to better document funding decisions throughout the grant lifecycle.



2- PERFORMANCE EVALUATION

SDA	Indicator	Top 10	Level	Period	Period Target	Period Results	Period Perf.	Cum. Target	Cum. Results	Perf.	Calculated Rating	FPM Rating	FPM Comments
PMTCT	HIV-infected pregnant women receiving ARVs	Yes	3	Q6	200	175	88%	500	475	95%	A	B1	While the program has succeeded in reaching pregnant women, the SDA has been downgraded to reflect the difficulties the program is experiencing in capacity building. Only 63% of cumulative targets for service deliverers trained has been reached.
	Health facilities offering minimum package of PMTCT	No	2	Q6	4	4	100%	8	8	100%			
	Number of service deliverers trained	No	1	Q6	275	145	53%	390	245	63%			
Condom Distribution	Condoms distributed	Yes	3	Q6	20,000	5,000	25%	45,000	12,500	28%	C	B2	While actual distribution of condoms has greatly lagged in relation to the agreed upon targets, this is primarily an issue of procurement guidelines recently altered by the national government. The service delivery points are ready, and actually ahead of target, and upon the completion of a procurement plan more in line with the new national guidelines, the distribution of condoms should quickly catch up.
	Service delivery points with condoms in stock	No	2	Q6	250	257	103%	600	614	102%			
ARV treatment	Number of people receiving ARV treatment	Yes	3	Q4	5,000	3,500	70%	14,000	11,200	80%	B1	B1	NA
	Number of service points supported	No	2	Q4	5	5	100%	14	14	100%			

LFA OVERALL RATING	B1

FPM OVERALL EVALUATION OF PERFORMANCE	RATING	EVALUATION
	B1	The program's overall performance is commendable, however, an A rating is not justified when capacity building in PMTCT and the distribution of condoms is taken into consideration. Besides condom distribution, the two other level 3 indicators are performing quite well. Condom distribution should catch up in the subsequent quarters upon the revision of the procurement plan to fall in line with new national guidelines. Also, capacity building, primarily the training of service deliverers in PMTCT will need to pick up in order to meet the ambitious targets for service delivery which the program has set for itself in year 3

Do the LFA comments on program progress indicate any cause for concern? No If yes: I have considered causes of concern raised by the LFA regarding program progress in my overall evaluation of performance (rating and comments)

I have provided full justification for any difference between my overall progress rating and the LFA's rating

I have considered LFA comments on data quality and reporting, if any

3- FINANCIAL CONSIDERATIONS

3.1. Disbursements to Date

	Amount (in USD)	Amount (in %)
Phase 1 Grant Agreement Amount	11,829,545	100%
Less: Actual Disbursed to Date	8,162,386	69%
Undisbursed Grant Amount	**3,667,159**	**31%**

3.2. Budget Vs. Disbursements to Date Vs. Cumulative Expenditures

	Cumulative	%	Variance
Original Budget to Date	8,500,000	100%	-
Disbursed to Date	7,300,589	86%	-1,199,411
Expenditure to Date	4,500,000	53%	-4,000,000
PRs Total Expenditures	894,500	-	-
Disbursements to Sub Recipients	3,205,698	-	-

3.3. Previous Period Disbursement Vs. Expenditures

	Amount	%
Forecasted Expenditures - Report Period	2,125,684	100%
Actual Expenditures - Report Period	1,250,348	59%

3.4. Cash Balance

	Amount	Date	%
Actual Disbursed to Date	7,300,589	25-Oct-04	100%
PR Cash Balance	2,800,589	31-Jan-05	38%
SR Cash Balance *(if available)*	463,258	15-Jan-05	6%

Figure 11: Screen shot of part of the new Disbursement Decision Tool

DATA QUALITY SYSTEMS

61. A critical component of performance-based funding is the quality of the programmatic data reported by grantees. These data serve as the basis for the Global Fund's decisions on disbursements and grant renewals. Local Fund Agents are employed to verify the quality of data submitted by Principal Recipients of Global Fund grants. However, the broader problem is often the inadequate M&E systems, which often produce programmatic data of variable quality.

62. To improve the quality of the data and to support recipient countries in building the capacity of their M&E systems, the Global Fund is working with WHO, Health Metrics Network and PEPFAR under the oversight of the independent Technical Evaluation Reference Group (TERG) to establish a comprehensive data quality system (see Figure 12). The system will be piloted in September 2005 and implemented by the end of the year.

63. The system will rely on two elements: self-assessments by all grantees (one before grant signing and one before Phase 2 evaluation) and data audits of a largely random sampling of grants.

A. **M&E Systems Self-Assessment Checklist:** The checklist will be used by Principal Recipients to assess the main features of their M&E systems and identify any capacity gaps and technical assistance needs. By conducting the first of these self-assessments *before* grant negotiations, the grantee can ensure that an appropriate budget for strengthening M&E systems is included in the grant agreement. The timing also gives the Global Fund the opportunity to require that specific strengthening measures be implemented as a pre-condition to disbursement. A second self-assessment will be conducted before the Phase 2 application is submitted. All self-assessments will be verified by Local Fund Agents.

B. **Data Quality Audit:** The in-country data quality audit will be based on the M&E Systems Self-Assessment Checklist. It will be performed in recipient countries on approximately ten percent of programs to verify the accuracy, completeness and consistency of reported data, and to assess the robustness and reliability of the reporting systems. Such audits would be performed on a random sampling of grants as well as on identified high-risk or problematic programs, with sampling concentrated in the second year of implementation (i.e., in the lead-up to Phase 2 renewal decisions). Such audits could also be requested by a PR or a CCM who may want to benefit from such external review.

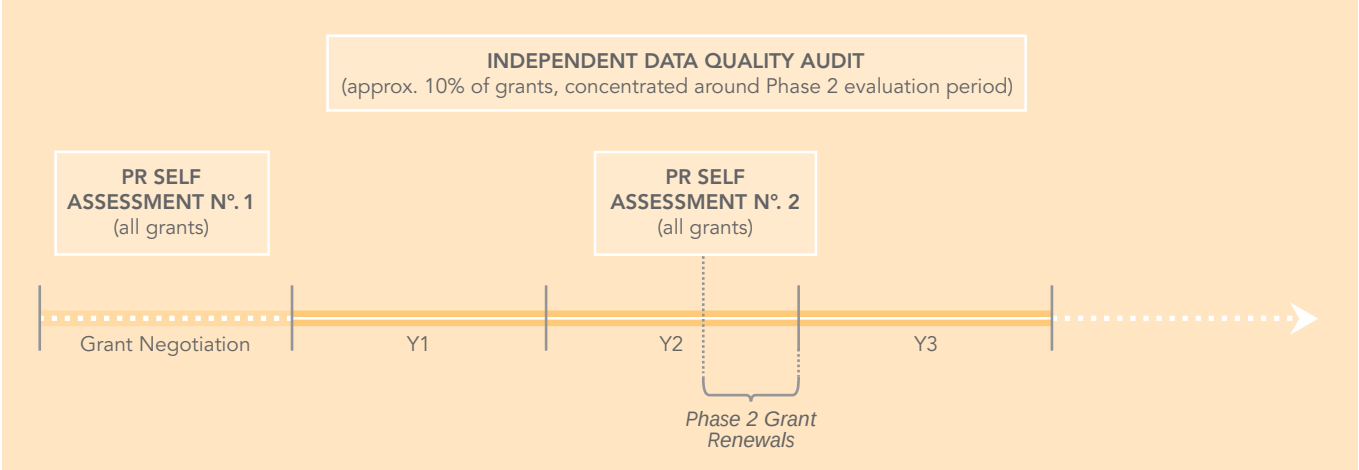


Figure 12: Components of the Data Quality Audit system of grants

64. The purpose of systems to support data quality is to enhance the quality and reliability of programmatic information reported to the Global Fund, but also to strengthen in-country M&E capacity. The checklist-based self-assessment, jointly developed with technical and donor partners, gives recipients a set of guiding norms and standards for the improvement of M&E systems. It also provides a standardizing tool for Local Fund Agents as they verify the quality of data and systems.

EARLY ALERT AND RESPONSE SYSTEM (EARS)

65. The Global Fund has made substantial progress over the past months in developing the Early Alert and Response System (EARS) as an essential part of grant support and performance management. While the Global Fund is a financing mechanism, not an implementing agency, it has an important role to play in assisting recipients to identify problems in implementation and in mobilizing support to find solutions to those problems. EARS has been developed through consultation with countries, with grant participants at regional meetings and with partners and will be refined as experience is gained in its rollout. The Secretariat is also working with partners to formalize and implement the newly formed Joint Problem Solving and Implementation Support Initiative, which will be one of the main clients of EARS.

66. Considerable early warning and support has previously been provided on a grant-by-grant basis, but the goal of EARS is to formalize this across all grants. EARS is a support mechanism designed to promote early identification of challenges to implementation by facilitating the systematic sharing of information on grant progress both within and outside the Secretariat. While Principal Recipients and Country Coordinating Mechanisms are primarily responsible for making grants work, they require - and count on - the support and expertise of technical and other partners (at country, regional, and global levels) to overcome challenges in existing capacity. The Global Fund Secretariat, through EARS, will facilitate that process.

67. Every month, the Global Fund Secretariat will compile a list of grants that appear to be experiencing problems in implementation through:

- a set of indicators related to disbursement requests and progress reports;
- communications from country stakeholders and partners which indicate implementation issues with a grant;
- information provided by the FPM and the LFA about specific problems identified during country visits, through communications with the PR, the CCM, partners or other stakeholders, or from other sources.

68. To facilitate and formalize the early identification of problems, a set of broad indicators has been developed and grouped into four categories:

1. **Contextual:** political issues, natural disasters, broad systemic problems such as weak health systems;
2. **Program Performance and Management:** capacity issues related to PRs, sub-recipients, project management, procurement and supply chain management issues, human resources, financial management, monitoring and evaluation, legal issues and conditions precedent;
3. **Governance and Oversight:** CCM, civil society, donor and partner relations, Global Fund Secretariat and LFA-related;
4. **Propriety:** poor fiscal management or potential illegal or unethical practices.

69. Some of the information, such as pace of spending captured in disbursement records, will be generated automatically through the Secretariat's regular management systems. Other information is more qualitative in nature and will be entered in designated fields as it becomes available.

70. The focus of EARS is on strengthening the implementation capacity of grants in countries. The following steps within the Secretariat form part of EARS:

1. **Special review of grants identified by the Early Alert and Response Committee**

   The system will generate internal lists of grants which seem to have problems in implementation. The Early Alert and Response Committee (EARC) within the Secretariat will review all of the grants arising on this monthly list. Together with the Fund Portfolio Manager, the EARC will identify those grants which require special review. The FPM will send a letter to the Principle Recipient notifying them that their grant is under special review, the reason for the review, and explaining what actions should be taken. This letter is confidential. The PR is given two weeks to respond to the Secretariat regarding these concerns and any corrective actions planned or underway, and the FPM will assist the PR in responding to the concerns.

2. **Consideration of PR Response and Possible Flagging of the Grant**

   The EARC will then consider the PR reply (if received), as well as any updates provided by the Fund Portfolio Management in the Secretariat and decide whether the grant should be "flagged". All flags, and the reason for the flag, will be communicated to the CCM and the PR, and posted on the Global Fund website. Posting a flag in this transparent fashion will allow partners to know where problems exist, and to work more closely with the countries to address those problems.

3. **Responding to Flags in the Early Alert and Response System**

   The purpose of EARS is to rapidly identify problems with grants, to alert PRs and CCMs transparently about serious issues in grant performance, and to mobilize timely and appropriate resources with and through partners to address the problem with a view to increasing the chances of success for the grant. The Secretariat will work with partners, in particular in countries, to track relevant action taken to overcome the issues identified.

4. **Monthly Assessment by the Secretariat**

   The EARC will review all flags every month, and decide whether or not the flag should remain. When a flag is removed by the Secretariat, the Global Fund will post an explanation of what the country has done to address the problem.

71. In August and September 2005, the Secretariat will be notifying a number of Principle Recipients for the first time that there is concern about their grants, and that they are entering the EARS process. The first flags are expected to be communicated to CCMs and PRs and posted on the Global Fund website by the beginning of September. EARS is intended to support countries in the resolution of problems by promoting a coordinated approach among partners, and, where appropriate, by assisting in identifying and mobilizing appropriate resources to ensure prompt and results-oriented technical support. Any questions or comments you have regarding EARS may be sent to EARS@theglobalfund.org.

SYSTEM EFFECTS AND IMPACT LEVELS OF THE MEASUREMENT FRAMEWORK

72. Strengthening the third and fourth tiers of the measurement framework - system effects and impact - has continued to be a priority as the Global Fund enters the second half of 2005. In terms of measuring the Global Fund's system effects, a major baseline study of CCMs has been completed and is summarized below. In addition, further progress has been made on establishing baselines for the core system effects indicators, focusing on additionality. The average age of a Global Fund grant is still only 15 months. Nevertheless, it is important to lay the foundations for measuring impact at an early stage, and global approaches together with grant examples are presented.

MEASURING SYSTEM EFFECTS

73. The Global Fund is committed to measuring the systems effects of its activities, in line with its mandate and principles (see Figure 13). The measurement of system effects means measuring both the positive and the negative impacts that the Global Fund has on the existing systems through which it works, in particular at the recipient country level. The development of commonly-agreed and time-bound measures of the Global Fund's progress towards achieving its purpose and core principles will help to focus the Fund's work strategically within the broader context of national and international efforts.

74. In 2004, under the oversight of the independent Technical Evaluation and Reference Group (TERG) and the Board's Monitoring, Evaluation, Finance and Audit Committee (MEFA), a set of core indicators was developed with a wide set of partners and stakeholders. A particular focus was placed on the additionality of resources, long-term sustainability of efforts and harmonization between technical and donor agencies, with reference to the core principles of the Global Fund. An additional central area of focus was national partnerships under the guidance of the CCM.

GUIDING PRINCIPLES OF THE GLOBAL FUND

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

The Global Fund:

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

Figure 13: Guiding principles of the Global Fund

Additionality: The Global Fund's mandate to make available and leverage additional resources means that it must provide a true net financial addition to interventions against the three diseases. At a global level, one way to assess this is to monitor donors' increased spending on identified funding gaps or "unmet need". Meanwhile, monitoring spending trends in recipient countries can help assess the extent to which Global Fund grants and other donor money is or is not substituting for domestic resources.

Sustainability: The Global Fund is committed to making a significant and sustainable contribution to the fight against AIDS, TB and malaria. This commitment means that the Global Fund itself must be sustainable. To measure the extent of this sustainability, it can monitor levels and trends in funding committed by donors as well as purchasing economy and efficiency for the key commodities it finances. Meanwhile, the Global Fund's activities should be made sustainable by contributing to prevention as well as treatment and care, strengthening the overall health systems of recipient countries and leveraging domestic as well as other donor funding.

Partnerships: Monitoring the Global Fund's recipient country, bilateral and multilateral partnerships largely depends on assessing the inclusion, participation and effectiveness of those partnerships at various levels. At a global level, the Global Fund can monitor the extent of its harmonization and alignment with other agencies; at a country level, participation by grant-funded programs in national-level strategies is important, as is the satisfactory functioning of Country Coordinating Mechanisms.

Figure 14: Core areas for measuring the system effects of the Global Fund: additionality, sustainability and partnerships.

75. In April 2005, key measurement priorities were identified in a background document entitled *Measuring the Systems Effects of the Global Fund with a Focus on Additionality, Partnerships and Sustainability: Resource Document & Measurement Guidelines* (see Figure 15). Core and supplemental indicators to measure additionality, sustainability and partnerships were developed in conjunction with partners at WHO, a wide range of Board constituencies and technical partners, with technical and financial support from the UK's Department for International Development.

Figure 15: Resource document and measurement guidelines for systems effects

76. Good progress was made in the operationalization of the systems effects indicators identified in the annex of *Measuring the Systems Effects of the Global Fund*, measurement issues, such as a lack of data, were identified as in some cases limiting indicator assessment. For example, gaps in disease accounts for AIDS, TB and malaria are an important priority if a transparent view on donor and domestic funding in measuring additionality is to be achieved. This will require concerted partner collaboration over the coming year. Progress in providing the systematic baseline of core indicators relating to systems effects is shown in Figure 16. It highlights the important international gaps in data for this area, together with areas where the Global Fund has progressed with the help of partners.

PRIORITIES	MEASUREMENT AREA	INDICATORS DEFINED	INDICATORS PUBLISHED	CASE STUDIES/PILOT PROJECTS (IF RELEVANT	PARTNER/GLOBAL FUND DATA EXISTS /INCOMPLETE/DOESN'T EXIST	BASELINE AVAILABLE	MEASUREMENT COMPLETE/ NEXT STEPS
Leverage additional financing globally; closing the gap	Levels and trends in donor assistance	✓	✓		Exists for HIV/AIDS & TB. Incomplete for malaria	✓ for HIV	✓ for HIV
	Public and private allocations for spending on development, health and the three diseases	✓	✓	Community-based study from South Africa	Exists for HIV/AIDS. Incomplete for TB & malaria	✓ for HIV	✓ for HIV
	Progress in reducing 'unmet need' for AIDS, TB, malaria spending	✓	✓		✓	✓	✓
Reducing poverty	% of Households allocating >0.25 household income to health services (catastrophic health expenditure)	✓	✓		Incomplete requires updating		
Increasing health human resources	Numbers and change in trained health professionals	✓	✓		2004 data available for most countries	Data for community health workers available December 2005	
Improve purchasing economy and efficiency for key commodities	Prices for key commodities procured with Global Fund funds (drugs, diagnostics, preventive supplies etc.) trends over time, comparison across countries.	✓	✓		Price reporting mechanism developed by Global Fund available to PRs data collection incomplete		
Improve sustainability and manage risk via growing commitment of own-government resources	Total health expenditure/GDP	✓	✓		✓	✓	✓
	Government Health/Government Total Spending	✓	✓		✓	✓	✓
	Malaria, TB, HIV spending/Total Health (if available)	✓	✓		Compilation by partners underway		
	Inter-Year change in Malaria, TB, HIV spending (all sources) > Global Fund grant spending	✓	✓		Compilation by partners underway	✓	
	Ratio of donor to local spending allocated to the 3 diseases	✓	✓		Compilation by partners underway	✓	
	Pledges and projections of Global Fund funding against estimated requirements ten years forward planning	✓	✓		Available until 2007	✓	
Improve partnerships via: ***Global partnership and harmonization*** ***Country partnership and harmonization*** ***Effective CCM Composition and Representation***	Joint activities with other agencies that produce outputs to support alignment & harmonization in support of Global Fund activities (with documentation)	✓	✓		Data collection system underway by Global Fund		
	Including Global Fund participation in OECD/MDG/UN harmonization initiatives including bilateral agencies	✓	✓		✓	✓	✓
	Countries with relevant national strategies (PRSPs, health sector etc.) that specifically refer to Global Fund funding	✓	✓		Data collection system underway by Global Fund		
	Number of CCMs which show evidence of membership of people living with and/or affected by the diseases	✓	✓		✓	Available for 68 countries. Follow up in 2006	
	Numbers of CCMs where NGO members are selected by their own constituencies based on a documented, transparent process	✓	✓		✓	Available for 68 countries. Follow up in 2006	
	Number of CCMs with a documented, transparent process to solicit & review submissions, nominate PRs, & oversee program implementation	✓	✓		✓	Available for 68 countries. Follow up in 2006	
	Number of CCMs with a documented, transparent process to ensure a broad range of stakeholders in proposal development & oversight	✓	✓		✓	Available for 68 countries. Follow up in 2006	
	Number of CCMs that have a written plan to mitigate against conflicts of interest (where the PR and chair or vice-chair are from the same entity	✓	✓		✓	Available for 68 countries. Follow up in 2006	

Figure 16: Status of systems effects baseline measurement

BASELINE CCM STUDY

77. A central element of the Global Fund's potential effect on systems is improved partnerships in terms of effective CCM composition and functioning. To accurately determine the performance of CCMs, the Secretariat oversaw an assessment of CCM processes and procedures, including the extent to which CCMs met established guidelines and determined criteria for their composition, roles and responsibilities. The assessment was carried out by the Futures Group.

78. The assessment provides a snapshot of CCMs for the period of March through July 2005, thereby suggesting areas requiring greater effort and establishing a baseline against which future progress can be gauged. For many countries, the assessment period preceded the distribution of the *Revised Guidelines on Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility,* which were based on decisions at the Ninth Board meeting in November 2004. The guidelines were formally issued in April 2005, following decisions concerning Round 5 eligibility at the Tenth Board meeting. A summary of the eligibility criteria for CCMs is shown in Figure 17, on the page opposite. It is important to note that on receipt of the checklist and of the *Revised Guidelines,* many CCMs immediately initiated procedures to comply with its recommendations and requirements. Therefore, the picture of CCM performance is known to have already changed rapidly from the baseline results.

79. The instruments and methods used in the CCM assessment were reviewed and finalized with guidance from the TERG and with inputs from the former Monitoring, Evaluation, Finance and Audit Committee and the Governance and Partnership Committee. The CCM assessment was comprised of two parts:

1. **Performance checklist:** A document-verified survey that covered issues such as composition and representation, participation and communication, and governance and management, focusing on the five Board-approved eligibility criteria for CCMs for proposals submitted from Round 5 onwards and Phase 2 Requests for Continued Funding.
2. **Satisfaction survey:** An opinion-based survey that allowed each CCM member and their respective constituencies to express their degree of satisfaction with specific aspects of CCM operation, including participation in decision-making and opportunity to voice opinions and perspectives within CCM fora.

80. The full assessment aimed to solicit responses from 109 CCMs worldwide. While all CCMs were encouraged to complete the assessment, a considerable number did not do so. By the end of July 2005, assessment data were available for 70 countries. Once the final report is issued in September, it will be made widely available to CCMs and to partners. Results reported here summarize the findings of the performance checklist and not the satisfaction survey.

CCM ELIGIBILITY CRITERIA

1. CCM members representing the non-government sectors must be selected/elected by their own sector(s) based on a documented, transparent process, developed within each sector.
2. The Global Fund requires all CCMs to show evidence of membership of people living with and/or affected by the diseases.
3. CCMs are required to put in place and maintain a transparent, documented process to:
   a. Solicit and review submissions for possible integration into the proposal;
   b. Ensure the input of a broad range of stakeholders, including CCM members and non-members, in the proposal development and grant oversight process.
4. CCMs are required to put in place and maintain a transparent, documented process to nominate the Principal Recipient(s) and oversee program implementation.
5. When the PRs and Chair or Vice Chair of the CCM are the same entity, the CCM must have a written plan in place to mitigate against this inherent conflict of interest.

Figure 17: CCM Eligibility Criteria

81. The Performance Checklist was conducted through two means:

1. In the majority of countries, a locally-hired consultant collected responses from CCM members through interviews using detailed checklists and, based on these, compiled a summary response. In many cases, the CCM then held a consensus meeting to review the completed checklist.
2. In 28 countries, CCMs were requested to complete the exercise as a self-assessment.

82. CCMs were required to provide documentation to substantiate their answers. Acceptable documentation included: existing reviews of CCMs, often funded by partners, and case studies, records, meeting minutes, membership lists, procedures manuals and member reports to constituencies. If a CCM did not have an eligibility criterion in place, they were asked about plans to improve or correct this. Assessment materials were available in English, French, Spanish, Russian, Chinese and Portuguese.

83. As seen in Figure 18, on the the following page, 74 percent of CCMs met two or more of the five Board-approved eligibility criteria, but only five percent met all five. Forty-four percent of CCMs met three or more of the five eligibility criteria. With the distribution of the revised guidelines and subsequent CCM reform processes, this distribution is likely to shift rapidly as increasing numbers of CCMs work to meet more of the requirements. Country Coordinating Mechanisms responded rapidly to gaps identified in the assessment, especially those that were preparing proposals for Round 5. For example, through partner-supported CCM strengthening efforts in Indonesia, people living with HIV/AIDS are now CCM members.

84. Throughout Round 5 proposal screening and clarification, materials substantiating the significant progress on eligibility criteria were gathered. In other cases, CCMs presented concrete and agreed-upon plans for remedying eligibility criteria, to be implemented prior to Round 5 grant signing. While criteria may not have been strictly fulfiled at this point in time, evidence was convincing that this would be solved prior to grant signing and commitment of resources.

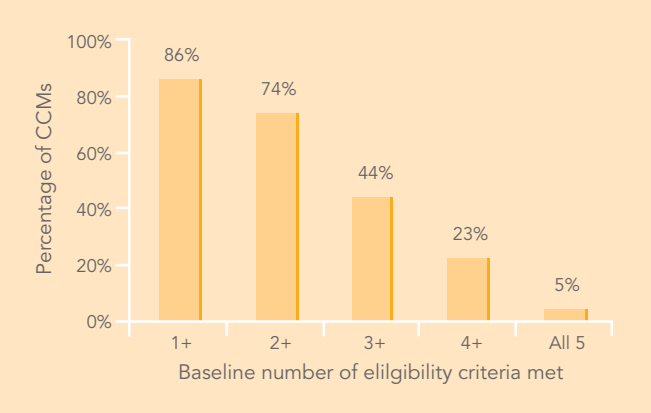


Figure 18. Baseline Performance of CCMs: number of eligibility criteria met of baseline

85. While Figure 19 shows the percentage of CCMs that met specific eligibility criteria, it is important to remember that these results are based on the most rigorous definition of the criteria. For example, reporting on the criterion related to nomination of PRs and oversight of program implementation was based on countries meeting both components of the criteria: nomination and oversight.

86. The criterion CCMs were most likely to meet was demonstrating that it included the membership of people living with or affected by the diseases (64 percent). More than half of CCMs had a transparent, documented process for nominating the PR and overseeing program implementation (52 percent).

87. Other criteria, such as non-governmental sectors having a transparent, documented process to select or elect their sector representative on the CCM were less commonly found (35 percent). This criterion was measured across all non-governmental sectors as outlined in the revised guidelines: NGOs/community-based organizations, people living with the diseases, religious/faith-based organizations, private sector and academic institutions. Over seventy percent of CCMs complied with the Board recommendation that at least 40 percent of CCM members come from non-governmental sectors.

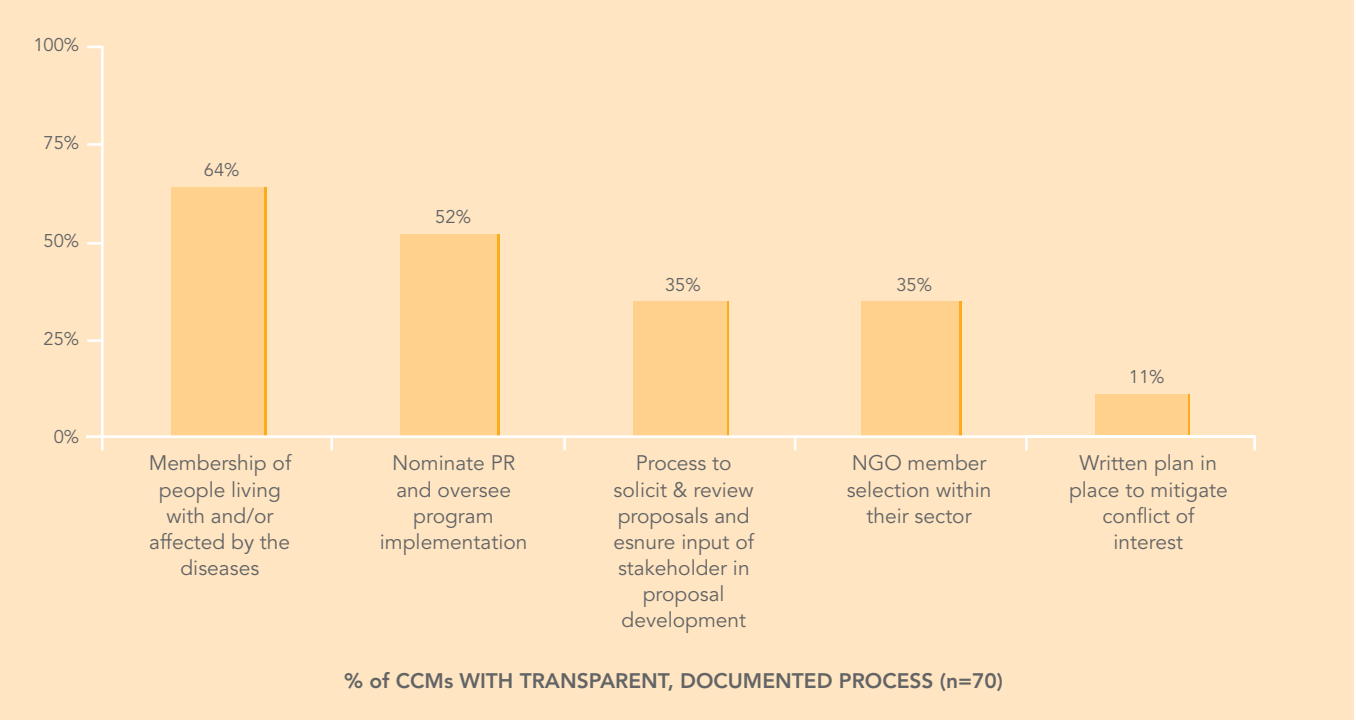


Figure 19: Baseline performance of Country Coordinating Mechanisms in meeting eligibility criteria

88. CCMs are also required to maintain a transparent and documented process for soliciting and reviewing submissions for possible integration into the overall grant proposal to the Global Fund and to ensure the input of a broad range of stakeholders in proposal development and grant oversight. As a compound measure, 35 percent of CCMs met this criterion. CCMs were most commonly able to document their process to solicit and review proposals. Fewer CCMs were able to document procedures for engaging stakeholders in proposal development and grant oversight. For those CCMs where the PR comes from the same entity as either the Chair or Vice Chair of the CCM, a written plan is required to mitigate this potential conflict of interest. Of those CCMs with this potential conflict, few (11 percent) had such a written plan at the time of the survey.

89. Based on the timing of Global Fund Board approval and dissemination of the revised guidelines and the subsequent CCM assessment, these results represent the baseline against which to measure CCM performance. Similar information, to be collected through future rounds of the CCM assessment, will undoubtedly show considerable progress against these baseline findings. In addition, these results point to specific areas where the Global Fund, working with partner organizations, will seek to strengthen and improve standard procedures and practices within CCMs.

FINANCIAL ADDITIONALITY - LEVERAGING ADDITIONAL FINANCING GLOBALLY

90. The Global Fund finances a broad range of programs which can stretch the limits of current activities in some countries. The Global Fund requires that its grants provide additional resources to fight the three diseases, and that new ways of generating absorptive capacity are utilized so that these additional funds can be put to use.

91. External resources are considered additional when they do not substitute for but supplement existing domestic and donor financing. Ensuring additionality is the responsibility of both governments and donors. The Global Fund strives to ensure additionality, globally and at the recipient country level, by building these conditions into its grant agreements. Funding aimed at country programs should not displace local or other international funding sources, but instead should provide additional funds to combat the three diseases.

92. Financial additionality can be explored at many levels: national, sectoral, health program or activity levels. Using a case study approach, the Global Fund is collaborating with the WHO to develop a generic tool to measure additionality. The results of this tool are to be made available by December 2005.

93. For HIV/AIDS, National AIDS Accounts (NAA) were established in 13 countries in 2003. These are comprehensive assessments of HIV/AIDS spending at the country level that will provide baseline estimates to assess financial additionality. In addition, another eight countries have established National AIDS Accounts. In 2005, 114 countries are expected to begin National AIDS Spending Assessments under the guidance of UNAIDS.

94. Four country case studies are presented below, documenting additionality in health spending at the country and community levels. The complexities surrounding the measurement of additionality are highlighted particularly well in the case of Honduras, where information was insufficient to show Global Fund additionality at the country level.

ADDITIONALITY CASE STUDY:
GHANA - GROWING DONOR AND DOMESTIC FUNDING

The Global Fund finances HIV/AIDS activities in Ghana through a US$ 14 million grant to the Ministry of Health. To date, a total of US$ 6 million has been disbursed to increase access and generate greater demand for both prevention and care services for groups vulnerable to HIV infection, and improve care and support for those already living with HIV. To date, over 38,000 Ghanaians have accessed counseling and testing services, close to 5,000 people have received treatment for opportunistic infections and over 2,400 people with advanced HIV infection are receiving antiretroviral combination therapy.

A National AIDS Account established for Ghana in 2002-2003 shows additionality of Global Fund funding to the country. Foreign funding represents the primary source of HIV/AIDS financing in Ghana, with the involvement of many partners, including the World Bank, USAID, the Gates Foundation and the UK's DFID, among others. In 2003, an increase in multilateral funding (which included the Global Fund grant) was noted in Ghana from 1.2 percent in 2002 to 15.2 percent in 2003, as shown in the table below. The Global Fund disbursed close to US$ 1.7 million to Ghana between December 2002 and July 2003. Corresponding increases in public contributions to the fight against HIV in Ghana also show growing commitment to increase the envelope of total funding, increasing proportionately.

SOURCE	2002		2003	
Public	17,484.73	(16.1%)	79,628.79	(33.6%)
Private	10,462.50	(9.7%)	17,460.59	(7.4%)
Foreign	80,363.37	(74.2%)	140,043.76	(59.1%)
Multilaterals	1,273.30	(1.2%)	36,004.99	(15.2%)

Table: National HIV/AIDS expenditure, Ghana, 2002, 2003 (in millions of Cedis)

(Reference: Ghana AIDS Commission, UNAIDS, FUNSALUD, SIDALAC. *National HIV/AIDS Accounts Ghana, 2002-2003 Level and Flow of Resources and Expenditures to Confront HIV/AIDS.*)

ADDITIONALITY CASE STUDY: THAILAND - NO REPLACEMENT OF GOVERNMENT ARV SPENDING

Thailand has implemented HIV/AIDS, tuberculosis and malaria programs with Global Fund financing since 2003. HIV/AIDS grants were awarded for Rounds 1, 2 and 3; tuberculosis and malaria grants were awarded for Rounds 1 and 2 respectively. Two year approved funding for the three diseases exceeds US$ 61 million, with a total of over US$ 36 million disbursed by the end of 2004. In Thailand in 2004, the Global Fund contributed a significant 14 percent of all HIV/AIDS funding from international donor sources.

Information from National AIDS Accounts (2000-2003), National Health Accounts (1994-2001), key informant interviews and data from the Bureau of Budget was mobilized and analyzed by researchers at the Ministry of Public Health and the National Economic and Social Development Board in Thailand, in collaboration with WHO.

Three indicators confirmed that monies channeled through Global Fund programs have not replaced government spending on HIV/AIDS programs, including treatment of opportunistic infections (OI) and provision of antiretroviral therapy (ART) when comparing the baseline period (2000-2002) with the year Global Fund programs began implementation (2003). Thailand saw an 80 percent increase in AIDS program expenditure from international sources in 2003 when compared with the baseline period, confirming additionality of Global Fund HIV/AIDS financing. The government also increased HIV/AIDS spending by 10 percent in 2003 compared to the baseline period, indicating that Global Fund finances are not displacing domestic resources. The Thai government increased spending on OI treatment by 10 percent and increased spending by 70 percent on ART the year Global Fund disbursements began in Thailand.

(Reference: Tangcharoensathien V, Toekul W, Vasavid C. et al. *Measuring Additionality: Thailand Country Case Studies.* Bangkok, WHO, 3 March 2005.)

ADDITIONALITY CASE STUDY: HONDURAS - EVIDENCE OF NON-FINANCIAL ADDITIONALITY BUT FINANCIAL ADDITIONALITY INCONCLUSIVE

In Honduras, additionality of Global Fund financing was measured in a study conducted by the WHO, FUNSALUD and SIDALAC reviewing National AIDS Accounts for 2002-2004. Honduras is the recipient of a Round 1 HIV grant, with total disbursements from 2003 exceeding US$ 12 million. The HIV grant aims to reduce the incidence of HIV/AIDS in Honduras by 25 percent, particularly in those groups that are most vulnerable to the epidemic. In addition, the grant addresses human rights issues of people living with HIV/AIDS and people vulnerable to the disease, undertakes outreach activities to promote healthy behaviors, and expands prevention and treatment services to people living with HIV/AIDS, including the substantial expansion of ARV therapy in the country.

Difficulty was reported in the assessment of additionality of Global Fund spending in Honduras. **While total public spending in the national AIDS program declined significantly in 2003, public spending on ARVs increased 5 times between 2002 and 2003** - in 2003, public sources contributed over US$ 900,000 and the Global Fund contributed US$ 1,025,369 towards the purchase of ARVs. A number of other indicators were assessed at baseline levels, though follow-up data was not yet available.

Despite the inconclusive nature of the financial additionality of Global Fund monies in Honduras, **non-financial additionality was clearly evidenced: a doubling of municipalities providing AIDS care, a doubling of AIDS organizations and a four-fold increase in the number of centers providing integrated AIDS care.**

(Reference: Izazola JA, Cardona RV, Sandoval EE. *Measuring the financial additionality in a Global Fund-sponsored project in HIV/AIDS.* WHO, FUNSALUD, SIDALAC, 2005)

ADDITIONALITY CASE STUDY: RECEIVING FUNDS IN COMMUNITY-BASED SETTINGS

The Global Fund seeks to support additionality at every level. The term *additionality* typically refers to true *net* financial addition at the national level. However, the broad scope of many programs financed by the Global Fund has shown additionality beyond this strict definition. A study in three South African communities funded as part of the Global Fund systems effects work identified augmentation of capacity at the local level but also identified problems. Overall, an increase in the number of organizations involved in AIDS responses was recorded and, notably, a greater increase in the number of faith- and community-based organizations as well as civil society organizations was observed. Preliminary data suggest that these organizations are heavily involved in providing complementary care and support services.

Clear non-financial additionality was evident. For example, training schemes promote community value by providing skills to the unemployed or improving the skills of those working in the HIV/AIDS field. However, training needs to be better integrated with the work of existing organizations. This would ensure that training leads to employment and application of relevant skills.

While non-financial additionality brings benefits to the community, the pressure to secure funding has led community-based organizations to cater their services to the requirements of AIDS funding bodies, potentially detracting from community needs. **In some cases, activity substitution was observed, where activities around food provision were abandoned in lieu of more lucrative HIV/AIDS activities.** It has also been suggested that financing at the local level has resulted in a decline in volunteerism, as increasingly volunteers expect to be remunerated for their activities. These legitimate concerns need to be addressed by governments and Principal Recipients at the local level as financing increases.

(Reference: Kelly K, Birdsall K, Tshose P. *The HIV/AIDS Funding Environment in South Africa: A Community-level Perspective.* 2005)

NON-FINANCIAL ADDITIONALITY - BUILDING HUMAN RESOURCE CAPACITY

95. A crucial element of non-financial additionality for the Global Fund is to increase human resource capacity in recipient countries. Financing may be only one of the challenges faced in ensuring that additional resources - in the broadest sense - can be put to work. Global Fund programming includes large capacity investments in health care personnel (human resources in general represent approximately 20 percent of most budgets). The change in health care personnel over time is a function both of training additional physicians, nurses and pharmacists as well as creating environments to retain them at country level in countries where "brain drain" is a serious problem.

96. The challenges of human resource capacity vary greatly between and within countries. The issue of low numbers of trained staff is compounded by morale problems, skills imbalance and poor geographic distribution. Sub-Saharan Africa presents a particularly formidable challenge to the provision of adequate human resources, as health needs are greatest and health sector responses have largely been insufficient to date. The aggregate training target over five years for Global Fund-financed programs is more than 650,000 people (see Figure 20 for examples). Many Global Fund grant-funded programs secure training beyond the health sector and incorporate community-based initiatives, including peer education, teacher training and training for particularly vulnerable populations such as commercial sex workers (CSWs) and men who have sex with men (MSMs).

COUNTRY	COMPONENT	PEOPLE TRAINED	DESCRIPTION OF TRAINING
Uganda	HIV	16,382	Training for health educators, youth leaders, STI management provision, PMTCT and VCT services providers, condom distributors
Peru	HIV	7,236	Teachers trained in sex education, peer educators, neighborhood youth promoters, CSWs, MSMs and prisoners trained as peer educators, PLWAs trained in integral health and as peer educators in prevention activities, volunteers trained in home care to PLWAs
El Salvador	Tuberculosis, HIV	8,934	Health workers trained in DOTS, CSWs trained in condom use, training of community leaders, health care professionals, lab workers, health specialists, statisticians
Cambodia	Tuberculosis, HIV, malaria	21,944	Community DOTS supporters, HIV trainers and educators, case management training, people trained in BCC, EDT training, net treatment training
China	Tuberculosis	13,500	Training on DOTS implementation for health workers
Croatia	HIV	9,310	Teachers trained in peer-based HIV education and young people in peer education, NGO activists trained, medical professionals trained in prevention and counseling, school board members trained, counselors trained for mobile populations, people trained in pre- and post-test counseling, professionals trained in M&E, operational research and surveillance

Figure 20: Examples of Global Fund-financed countries with large investments in training

97. WHO Department of Human Resources for Health estimates the global number of health care personnel at approximately 27 million as of October 26, 2004. Unfortunately, the geographic distribution of human resources for health is uneven, and in the lower-income regions where Global Fund-financed programs operate, only 12.9 million health workers are reported (see Figure 21). The Global Fund continues to monitor progress towards increasing this baseline estimate while recognizing that many Global Fund programs train individuals broadly and in community settings beyond the health sector.

REGION	GLOBAL FUND-FINANCED COUNTRIES
Eastern Europe and Central Asia	4,062,010
East Africa & Indian Ocean	89,990
East Asia & The Pacific	4,995,822
Latin America and Caribbean	936,122
South Asia	1,689,376
Southern Africa	277,453
Middle East & North Africa	652,670
West & Central Africa	233,302
TOTAL	**12,936,745**

Figure 21: Human resource capacity[6] in Global Fund-financed countries (WHO, 2004)

98. For HIV/AIDS, estimates of the numbers of doctors and nurses required to meet the AIDS response over and above what is currently available in the health sector have been made for 2006-2008. These suggest that for low-income countries such as South Africa and Botswana, an additional 3,070 medical students and 5,700 student nurses are required between 2006 and 2008. The first graduates will be available in 2009 for nurses and in 2012 for the medical doctors.

99. Working with partners, the Global Fund is establishing country-by-country baseline numbers in order to measure future shifts in the numbers and changes in trained health professionals. Progress in providing the systematic baseline of core indicators relating to systems effects is shown in Figure 16. It highlights the important international gaps in data for this area, together with areas where the Global Fund has progressed with the help of partners.

[6] *This includes doctors, nurses, pharmacists and dentists.*

IMPACT

100. As of August 1, 2005, Global Fund grants were an average of 15 months old. While recommendations on the stage at which one can begin to measure impact vary from one to five years, it is important to plan for impact measurement early on and to ensure that the necessary indicators and processes are in place. One key element of impact measurement is the assessment of the Global Fund's contributions to international goals, particularly the Millennium Development Goals (MDGs) and UNGASS targets. This involves working with partners to project global disease and intervention coverage alongside projected Global Fund service delivery.

101. A second key element of impact measurement is to ensure that grant agreements routinely include standardized impact indicators in order to measure progress over the five-year grant lifecycle. The Global Fund supports the principle that impact will be a collective effort and generally cannot be attributed to any individual grant. However, the Global Fund requires grants to assess changes in disease patterns and associated mortality and morbidity. This section reports on progress in these two activities with some preliminary evidence.

CORE MDG GOALS AND TARGETS SUPPORTED BY THE GLOBAL FUND

Goal 1: Eradicate extreme poverty and hunger

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

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

Goal 4: Reduce child mortality

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

Goal 5: Improve maternal health

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

Goal 6: Combat HIV/AIDS, malaria and other diseases

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

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

Goal 8: Develop a global partnership for development

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

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

Figure 22: MDG goals and targets directly and indirectly related to the Global Fund's activities

102. The MDGs, set by the countries at the Millennium Summit in 2000, are being evaluated in September 2005. Defining the contribution of the Global Fund is an important step in showing international progress. Global Fund activities are relevant for a number of goals, as shown in Figure 22, opposite. The very existence of the Global Fund is tightly connected to Goal 8: Develop a Global Partnership for Development.

103. Modeling, which is required to assess impacts at the global level, is being undertaken with relevant partners, including WHO, UNAIDS and PEPFAR. At present, the Global Fund has restricted itself to assessing interventions with clear links to impact: ITN distribution, TB treatment under DOTS, ARV treatment. Different approaches for HIV prevention, based on comparing country epidemic trajectories with partners, are being developed. The approach so far therefore assesses minimum impacts.

METHODS AND LIMITATIONS OF MODELING IMPACTS

To model the impact of Global Fund grants, mortality and infections averted will be estimated by taking the relevant service delivery targets of grant-funded programs with their estimated effects and comparing them to scenarios without these service deliveries. In other words, a "with Global Fund scenario" and a "without Global Fund scenario" are compared to estimate how many people will have been saved from death and infection because of the activities of Global Fund grant-financed programs. The target figures are translated into estimated impacts starting only with service delivery areas that have clear links and documented evidence of impact from studies - such as the effects of ITNs, progression of people with HIV treated with ARVs, mortality among people on TB treatment under DOTS - based on the relevant literature.

For example, a systematic review has shown that use of ITNs reduces episodes of uncomplicated malaria by 50 percent and that 1,000 children sleeping under ITNs results in a reduction of 5.52 child deaths per year from all causes in endemic African countries[7]. To model the impact of ITNs, additional factors such as population, household sizes, level of malaria endemicity and age of grants need to be included. On the other hand, the model for AIDS-related deaths considers the progression rates, modes of transmission and duration of ARV therapy. One exception of methodology relates to HIV infections averted. Unlike other impacts modeled in this exercise, averted HIV infections cannot be easily deduced from a few indicators that the grantees have chosen to report. There are also limitations to the evidence base in the literature. Working with PEPFAR, methods are being considered to assess epidemic trajectories in some key countries. Modeling is imperfect and is limited by data available and various assumptions. The next stage is to compare approaches with those of partners, including UNAIDS, to ensure consistency in approaches as progress towards MDGs is estimated.

[7] *Lengeler C. Insecticide-treated bed nets and curtains for preventing malaria. The Cochrane Database of Systematic Reviews 2004, Issue 2*

1. MALARIA

104. An estimated 350 to 500 million malaria episodes per year occur, resulting in over one million deaths annually and creating enormous health, social and financial burdens for the 3.2 billion people who live in affected areas[8]. In highly malarial countries, a loss of 1 percent of economic growth has been associated with malaria prevalence[9].

105. Every year from 2000 to 2005, over 30 million bed nets - 160 million in total - must be distributed in order to meet the Abuja targets of protecting 60% of populations at risk in Africa[10]. By 2003, 18 million nets had been distributed or sold in Africa and 8 million nets in Asia, while 13 million nets in Africa and 65 million nets in Asia had been treated with insecticides.

106. As of July 11, 2005, 87 Global Fund malaria grants had been signed, all including components for preventing and treating malaria. Almost all of these grants have components related to ITN distribution and relevant indicators. With current coverage of 3.1 million ITNs, and assuming appropriate timing of treatment and usage, an estimated 413,000 malaria illness episodes are estimated conservatively to be prevented by end of June 2005. These ITNs, if correctly re-treated, can continue to provide protection for mothers and children in subsequent years. Over the five-year grant periods with a goal of distributing 108 million ITNs, impacts will develop significantly. At these levels, initial methods need refining to take into account regional variations and community coverage levels, which have a greater impact when they reach 60 percent in endemic areas.

MALARIA DATA	GLOBAL	SUB-SAHARA AFRICA
Baseline information:		
Disease burden (2004)	350-500 million episodes and 1 million deaths per year	60% of the episodes and over 80% of the deaths
ITN needs	-	Over 30 million per year
ITNs distributed, sold, or nets (re)treated (by 2003)	26 million distributed or sold and 78 million (re)treated	18 million distributed or sold and 13 million (re)treated
GLOBAL FUND CONTRIBUTIONS (FROM INCEPTION TO END JUNE 2005)		
ITNs distributed or retreated	3.1 million (108 million over 5 years)	
Estimated deaths averted	2,000 children under 5	2,000 children under 5
Estimated malaria episodes averted	413,000 including 206,000 children under 5	369,000 including 190,000 children under 5

Figure 23: Projected Global Fund impact on malaria

[8] *WHO and UNICEF, 2005. World Malaria Report 2005.*

[9] *Sachs, JD. Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health. Geneva, WHO, 2001.*

[10] *Roll Back Malaria, 2002, Scaling-up insecticide-treated netting programmes in Africa: A Strategic Framework for Coordinated National Action.*

107. Grant-funded programs are aiming to achieve ambitious impacts. For example, the aim is to reduce annual parasite incidence to one-third in Cambodia and by over 80 percent in Laos and Sri Lanka in five-year programs as compared with the baseline year (Figure 24). Thus, a significant reduction in malaria illnesses is to be expected in countries with Global Fund-financed programs.

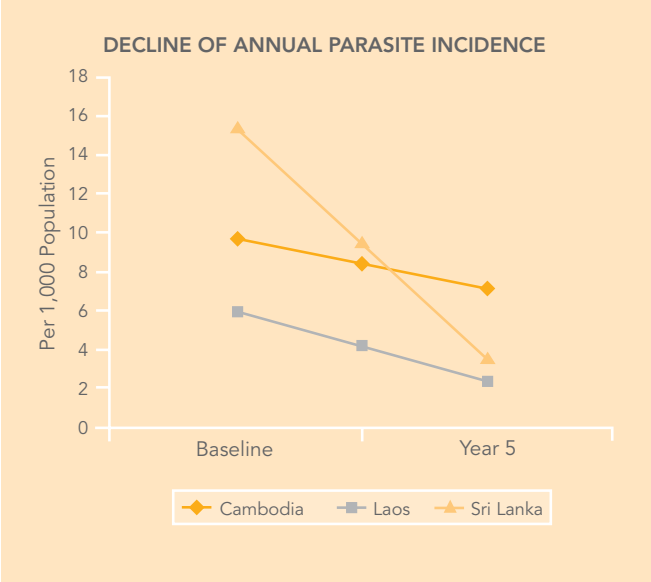


Figure 24: Grant impact goals to reduce annual parasite incidence

108. A few programs show indications of impact at this stage. These results need to be confirmed with successive malaria seasons, but particularly promising signs are apparent from the multi-country Africa malaria grant covering South Africa, Swaziland and Mozambique.

109. Use of indoor residual spraying (IRS) in appropriate situations with early effective treatment (in this case, transitioning to ACT drugs due to chloroquine resistance) is enormously effective in controlling mosquitoes and hence reducing malaria. The multi-country grant for Africa (including Mozambique, South Africa and Swaziland) has already shown, within two years of initiation of the program, evidence of declining malaria parasites (see figure 25, below), mostly exceeding the predetermined targets. The program has also shown a decrease in malaria disease burden (see below), and aims to improve economic activities and tourism. The program was building on an existing public-private partnership which was already showing strong results from a baseline in 2000. The impacts also need to be sustained over successive malaria seasons. The Global Fund provides only part of the support for the public-private program but helps it extend proven approaches throughout the region (now to over 100,000 km square in 3 countries). The grant proposal intends to at least halve malaria incidence within 5 years, and initial data support progress towards this goal.

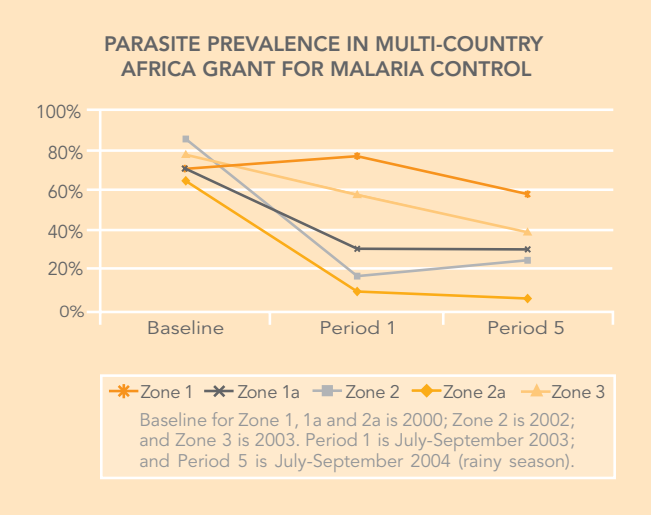


Figure 25a: Reduction in prevalence of multi-country Africa malaria grant

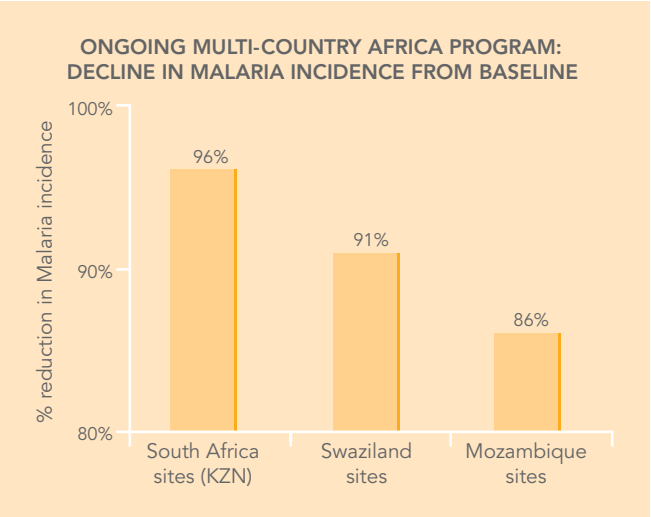


Figure 25b: Impact results of multi-country Africa malaria grant

2. TUBERCULOSIS

110. In 2003, 8.8 million new cases, including 3.9 million smear-positive cases, were estimated, and 1.7 million people died from tuberculosis during that year. To achieve the MDG concerning the reduction in global TB prevalence, an increasing number of TB cases must be detected and treated under the recommended DOTS strategy.

111. Worldwide, the average annual increment of case detection under DOTS from 2002 to 2003 was 324,000, increasing from only 134,000 in the period 1995 to 2000. The rise in case detection in 2003 was a result of worldwide awareness and increased resources to fight tuberculosis, including additional resources from the Global Fund.

TUBERCULOSIS DATA	GLOBAL	SUB-SAHARAN AFRICA
Baseline information:		
Disease burden (2003)	8.8 million new cases, including 3.9 million smear positive cases	2.4 million new cases, including 1 million smear positive cases
DOTS needs	Increment of 488,000 cases per year	
DOTS cases detected (2003)	1,753,000	503,000
GLOBAL FUND CONTRIBUTIONS (FROM INCEPTION TO END JUNE 2005)		
DOTS cases detected	600,000 (with a target of 3.5 million within 5 years)	
Estimated deaths averted	113,000	58,000
Estimated infectious TB cases averted	384,000	208,000

Figure 26: Projected Global Fund impact on tuberculosis

112. As of July 2005, 76 tuberculosis grants and seven HIV/TB grants have been approved. With expanded DOTS programs in place, countries will achieve reduced mortality but also reduced incidence of TB. For example, Haiti is aiming to reduce the incidence of TB cases by one-third within five years, while programs in Bolivia and Russia are committed to a five to ten percent reduction. Examples of impact targets built into grants in countries are shown below:

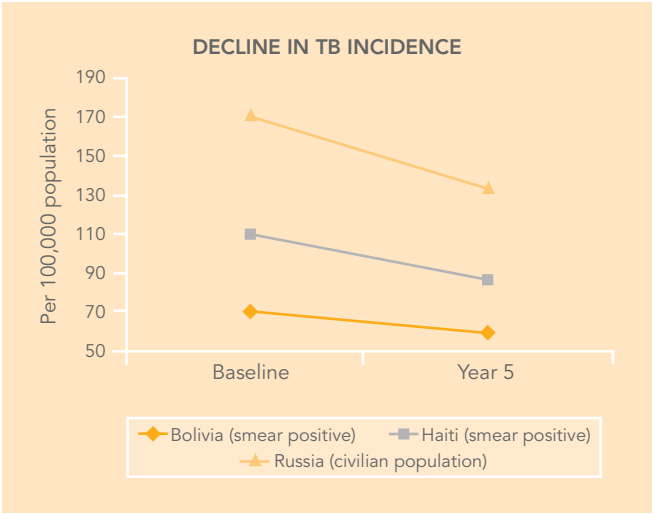


Figure 27: Grant impact goals to reduce annual TB incidence

3. HIV/AIDS

113. Over 3 million people die every year from AIDS, while 5 million people become newly infected with HIV. Global resource availability for HIV/AIDS has increased from US$ 2.1 billion in 2001 to US$ 6.1 billion in 2004, including all domestic and donor sources.

114. As of June 2005, WHO and UNAIDS estimate that 6.5 million people, including 4.7 million people in sub-Saharan Africa, require ARV treatment, and that only 970,000 people (including 500,000 in sub-Saharan Africa), are receiving this essential treatment. The Global Fund is an important source of funding for this worldwide effort. By the end of June 2005, 220,000 people, have been provided with ARV treatment through programs supported by Global Fund grants. Antiretroviral treatment prolongs lives considerably, and virtually all those who require ARV treatment but who do not receive it will die within two years of the HIV infection blossoming into full-blown AIDS. ARV treatment, however, is only one factor in measuring the impact of HIV programs, another one being the number of infections averted as a result of prevention programs. Assessing the impact of prevention programs is, of course, difficult and new methods of assessment will be developed with partners which will enable the comparison of model results to the trajectories of real country epidemics as they develop over the next few years.

HIV/AIDS DATA	GLOBAL	SUB-SAHARAN AFRICA
Baseline information:		
Disease burden (End of 2004)[11]	39.4 million	25.4 million
ARV needs (2005)[12]	6.5 million	4.7 million
ARV provided (June 2005)	970,000	500,000
GLOBAL FUND CONTRIBUTIONS (FROM INCEPTION TO END JUNE 2005)		
ARVs provided	220,000 (1.6 million target in 5 years)	
Estimated death averted due to ARVs	127,000	94,000
Estimated infections averted	0.4 million	-

Figure 28: Projected Global Fund impact on HIV/AIDS

[11] *UNAIDS 2004 AIDS Epidemic Update: December 2004.*

[12] *World Health Organization. 2005. Progress on global access to HIV antiretroviral therapy: an update on «3 by 5».*

115. A number of country grants are aiming to reduce HIV prevalence over the next five years. Many have incorporated ambitious impact targets into their grants; for example, Mozambique is aiming for a 25 percent reduction in HIV prevalence and Belize is targeting a 50 percent reduction in HIV prevalence.

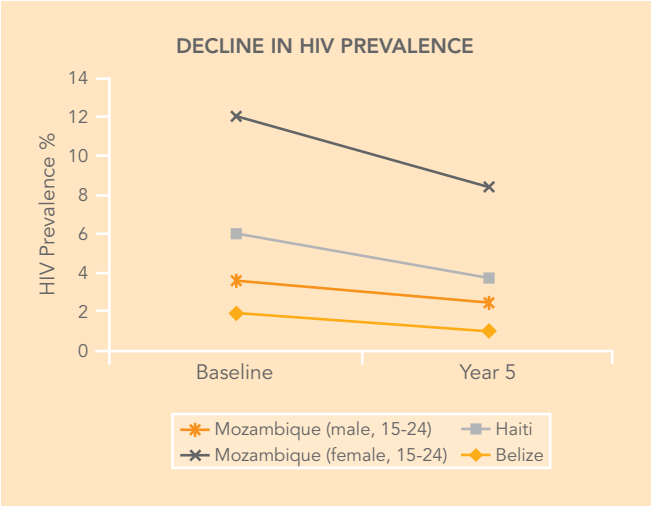


Figure 29: Grant impact goals to reduce annual HIV prevalence

116. The Global Fund is too young to show much evidence of impact as of yet. Methods of modeling impact are still at an early stage and include thus far only selected service delivery areas for which there is a documented evidence base. These methods will continue to be refined with partners, and as grants provide increasing data on coverage and impact results against targets. However, the reason that measurement systems and methods are being developed at this time is so that impact can be captured as results are scaled up.

In Pang Lao, Thailand, 12-year-old girls learn about social groups most at risk from HIV.

GRANT PERFORMANCE: ANALYSIS OF 74 PHASE 2-ELIGIBLE GRANTS

117. As of August 1, 2005, 74 grants had been recommended to the Board for Phase 2 funding (years three to five of the grant's lifespan). Analysis of these 74 grants has provided an important snapshot of the performance of the Global Fund and its grants to date. As the number of grants has increased, greater confidence has emerged in the trends observed by grant rating, region, disease and type of Principal Recipient. In addition, the results and supporting data provide a significant body of evidence on performance-based funding, highlighting progress and challenges.

118. The 74 grants represent programmatic results financed by total disbursements of US$ 463 million in 54 countries (see Figure 30). The performance reporting included 1,208 results against targets, an average of 16 indicators per grant. Forty-four percent of these indicators were the highest-level coverage indicators of people reached by services for disease prevention, treatment and care, agreed upon by numerous bilateral and multilateral donors as part of global efforts to harmonize key indicators. This demonstrates that there is a sound basis for the evaluation of the number of people reached with services.

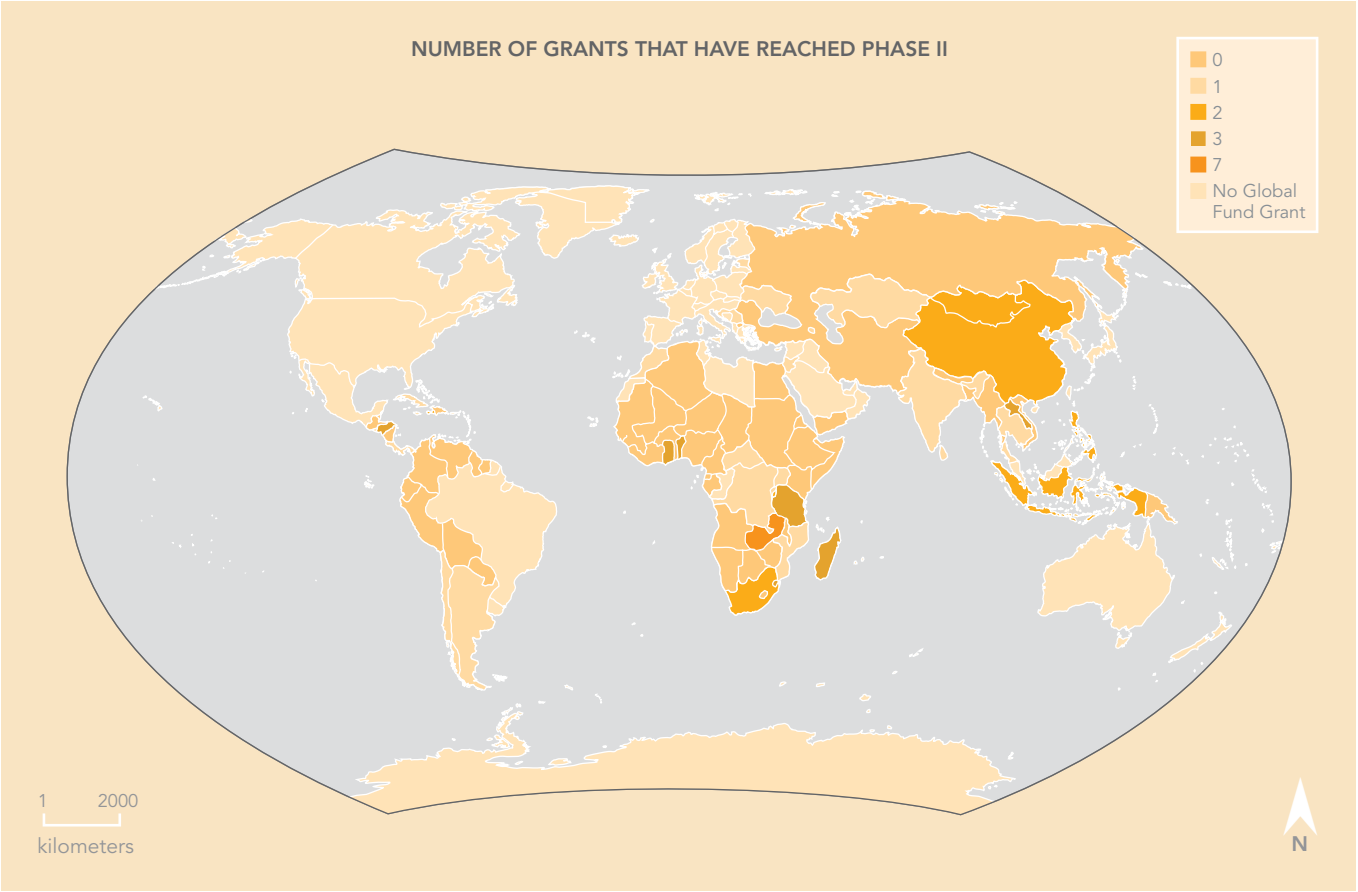


Figure 30: Distribution of countries with grants reviewed for Phase 2 funding as of August 1, 2005

119. The total Phase 2 amount in continued funding requested by CCMs for these 74 grants was US$ 743 million. By August 1, 2005, US$ 614 million in Phase 2 funding had been approved by the Board (83 percent of the total). Discontinued funding resulted in US$ 35 million being freed for other, more effective programs and interventions, and a further US$ 76 million in potential Phase 2 funding was contingent upon the resubmission of proposals or the provision of additional information to the Board.

120. Of the total amount of Phase 2 funding approved, 45 percent was approved for sub-Saharan Africa, 20 percent for South Asia, East Asia and the Pacific, 17 percent for Latin America and the Caribbean, 17 percent for Eastern Europe and Central Asia, and one percent for other regions. In terms of funding by disease, 55 percent of Phase 2 funding was allocated to HIV/AIDS grants, two percent to HIV/TB, 24 percent to tuberculosis alone and 19 percent to malaria. In looking at type of Principal Recipient, 48 percent of Phase 2 funding was approved for a governmental PR, 41 percent for civil society and 11 percent for the UNDP.

121. The data used to evaluate Phase 2-eligible grants is drawn from verified information gathered throughout the grant's first two years, including the formal request for continuation of funding sent by the CCM. Data is verified independently by a Local Fund Agent. Within the Secretariat, there is rigorous analysis of the data to review performance as well as financial and grant management. The outcome of the analysis is then passed to the Secretariat's Phase 2 Decision Panel, which develops a recommendation to the Board.

122. Performance-based funding is a continuous process that begins even before the very first disbursement as pre-grant assessments are carried out on Principal Recipients, and indicators to measure performance are built into the initial grant agreement. The Secretariat has built up an extensive basis on which to evaluate performance by the time of each Phase 2 evaluation, including:

1. Five initial assessments of the PR;
2. Three to six progress updates with financial and performance data;
3. An independent review of each update with performance recommendation by the LFA;
4. Annual reviews giving the opportunity to the PR to submit contextual information;
5. Multiple country visits;
6. A Phase 2 process where the PR and the CCM can submit full additional information reviewed by the LFA; and
7. Secretariat review of finance, performance and grant management information submitted to the Secretariat's Phase 2 Review Panel.

123. The Phase 2 evaluation is therefore only one point in a continuous performance evaluation and funding process.

OVERALL PROGRAMMATIC TARGETS ACHIEVED

124. Analysis of the 74 grants shows that, overall, results for key services have been reached (see Figure 31), varying from 62 percent of the collective target reached for the distribution of insecticide-treated bed nets (ITNs) to 166 percent of the target reached for orphan support. ARV treatment figures have improved dramatically since the analysis of the first 27 Phase 2-eligible grants in January 2005, reaching 103 percent of target compared to only 61 percent reached in January. This reflects improvements in more recent grants and the increasing influence of WHO's "3 by 5" initiative to put three million people on treatment by the end of 2005. Tuberculosis treatment under DOTS reached 112 percent of target, and artemisinin-based combination therapy (ACT) for drug-resistant malaria reached 156 percent of target. While ACT figures were high, there is still considerable work to be done to include specific ACT targets in all grant agreements providing ACT as a treatment intervention.

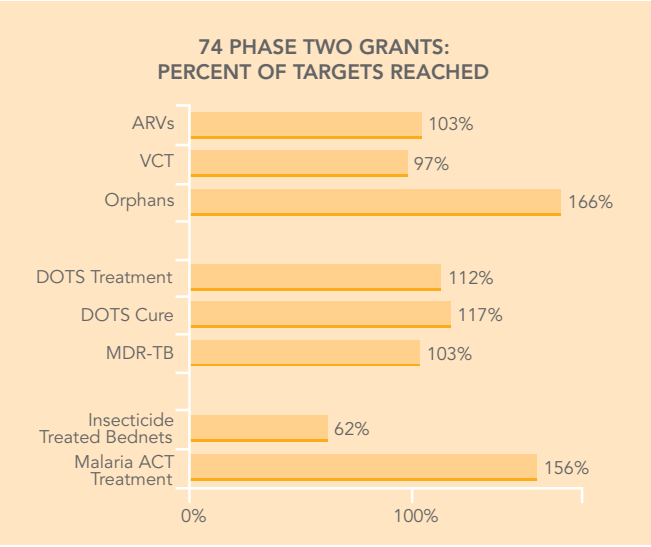


Figure 31: Phase 2 - percent of targets reached (74 grants, August 1, 2005)

125. ITN distribution results have improved across the Global Fund's portfolio of malaria grants as a whole (3.1 million distributed by June 30, 2005 as compared to the 1.35 million distributed at December 31, 2004). However, the overall ITN distribution results of this subset of Phase 2-eligible grants were poor, reaching only 62 percent of the collective target by August 1, 2005. This was largely due to a Round 2 malaria grant for Ethiopia with a large ITN distribution target that experienced serious procurement difficulties and therefore showed poor results when evaluated in June. The size of this unmet target had a disproportionate effect on overall performance of Phase 2-eligible malaria grants. A condition for Phase 2 funding for this grant was that ITNs would be distributed in September 2005.

126. Since 2004, targets in many of the 74 Phase 2-eligible grants have been strengthened so that 44 percent of the results data measured coverage indicators - people reached by prevention and treatment services. These grants, therefore, were able to report on substantial numbers of people reached (see box).

Results for key services of 74 Phase 2-eligible grants as of August 1, 2005:

- 51,267 people were reached with ARV treatment
- 1.7 million people were provided with HIV counseling and testing
- 359,000 people were treated for TB under the DOTS strategy
- 680,000 people received with malaria treatment (215,000 with ACT for drug-resistant malaria)
- 2.9 million ITNs were distributed or re-treated to protect families from malaria

127. In addition to these results, 67 million people were reached with prevention information through the mass media, 3 million were served by community outreach, 107 million condoms were distributed and 286,000 people were trained in prevention, diagnosis or treatment for AIDS, TB or malaria. This is only a selection of results from over 30 different service delivery areas supported among the 74 grants.

VARIATION IN PERFORMANCE ACROSS GRANTS

128. Eighty percent of the 74 Phase 2-eligible grants achieved an A (met or exceeded targets) or B1 (adequate performance) rating (see Figure 32). Seventeen percent received a B2 rating (inadequate performance but demonstrated potential), and three percent received a C rating (unacceptable performance).

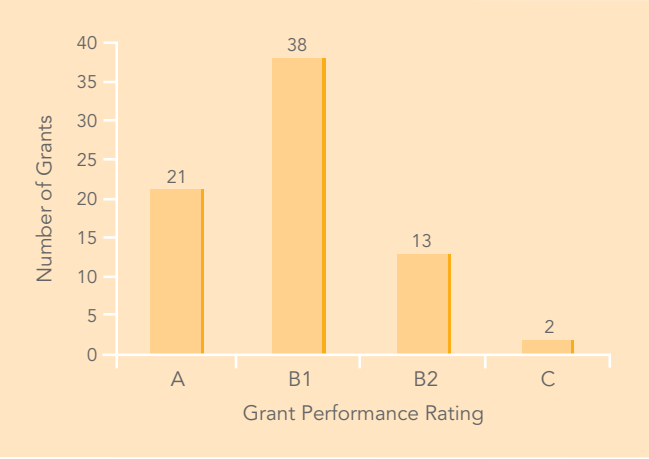


Figure 32: Performance rating of grants

129. At the two extremes of the performance scale, ninety percent of A-rated grants achieved a straightforward "Go" decision on continued funding (no conditions), while all C-rated grants were recommended to the Board as "No Go" decisions (funding discontinued). As of August 1, 2005, the Secretariat had recommended that four grants be given a "No Go" decision. One of these "No Go" recommendations was confirmed, and the Board has requested further information regarding the other three.

130. The most difficult continued funding decisions concerned the B2-rated grants. Decisions for these grants had to balance inadequate performance to date with evidence of significant potential for the future. As shown in Figure 33, below, no B2-rated grant received a straight "Go" decision. Of the B2-rated grants, those that were given Board approval received a "Conditional Go" for Phase 2 funding, meaning that continued funding would be contingent on significant change and improvement in implementation and capacity.

131. While performance provides the clear basis for most continued funding decisions, the final decision takes into account contextual and individual grant conditions. As of August 1, 2005, 59 percent of grants had received a "Go" decision, while 41 percent had received a "Conditional Go", "No Go", or are still pending a final Board decision.

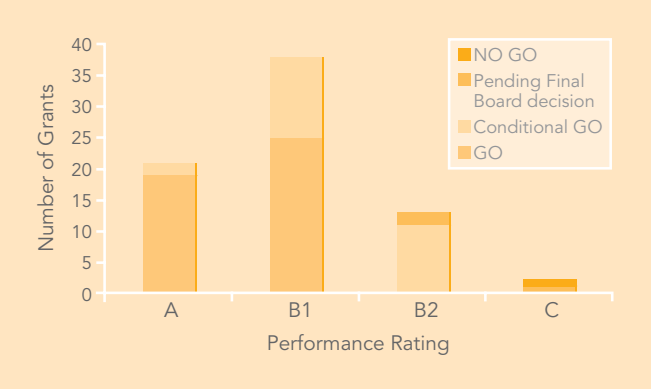


Figure 33: Phase 2 funding decisions by grant performance rating (74 grants, August 1, 2005)

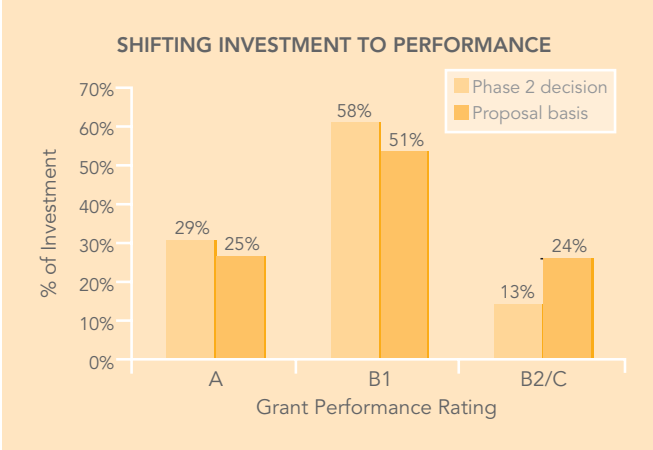


Figure 34: Phase 2 investments follow performance (74 grants, August 1, 2005)

PHASE 2 FUNDING: AN INVESTMENT IN PERFORMANCE

132. Performance-based funding aims to take into account variability in performance to ensure that funds flow to programs where people in need are reached with prevention and treatment services. Ultimately, Phase 2 strengthens the Global Fund's investment of scarce resources: 87 percent of approved Phase 2 funding went to A- and B1-graded grants (see Figure 34). Conversely, 24 percent of requested Phase 2 funding was for B2- or C-graded grants, but only 13 percent of approved Phase 2 funding went to these grants. The data suggest that, overall, Phase 2 decisions strengthen the Global Fund's investment in performance.

RELEASE OF COMMITTED FUNDS

133. Another function of the Phase 2 decision-making process is to release funds that are either committed to non-performing grants or to grants that are performing with reduced budgets. These funds can then be channeled to more effective programs in other grants through new proposal rounds. This release of funds to be used elsewhere is an important outcome of performance-based funding.

134. Discontinued funding or reduced budgets have to date resulted in US$ 35 million being freed up for other programs. Following its review of 74 grants eligible for Phase 2 renewal, the Global Fund Secretariat recommended reductions totaling 15 percent of the original Phase 2 amounts requested by CCMs. Of this, four percent related to budget reductions and 11 percent to the discontinuation of four grants due to poor performance. As of August 1, 2005, the Board had confirmed one of the discontinuation recommendations and confirmed the budget reductions (see Figure 35). The Board has requested additional information regarding three additional "No Go" recommendations.

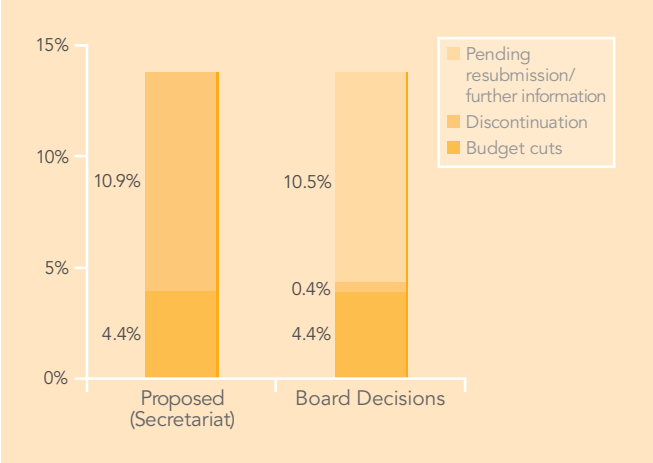


Figure 35: Percentage reductions on original Phase 2 amounts

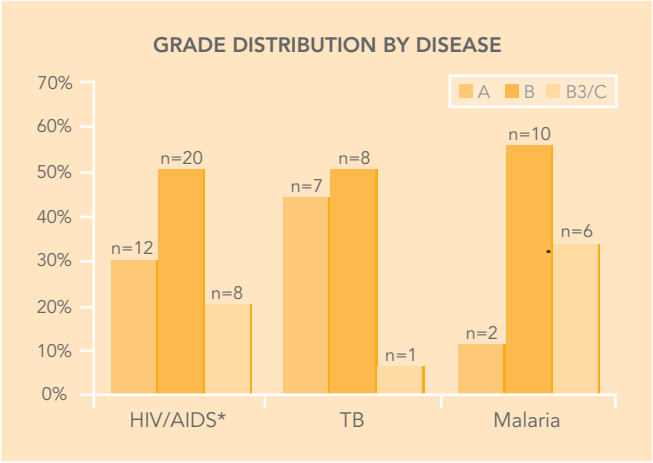


Figure 36a: Grant performance by Disease

LESSONS LEARNED FROM GRANT EVALUATION

135. The evaluation of data from the 74 Phase 2-eligible grants thus far has provided significant lessons on implementation and on the Global Fund's performance-based system, which will be incorporated as the system evolves. Patterns of grant performance made apparent by this evaluation are similar to those in the previous analyses, and confirm the earlier findings. (For those results, see *Investing in the Future: The Global Fund at Three Years, and Making Performance Based Funding Work*, both available on the website). Key lessons included the strength of civil society as implementers, the value of the Stop TB Partnership as a model for the other diseases and the potential for accelerating implementation in programs across all diseases in sub-Saharan Africa in the coming year.

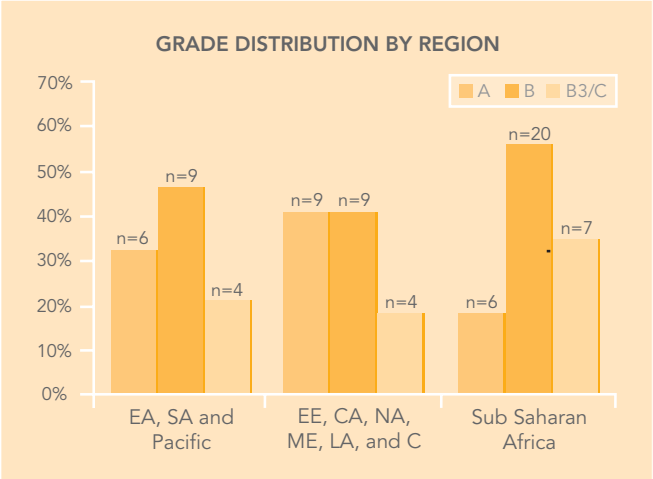


Figure 36b: Grant performance by Region

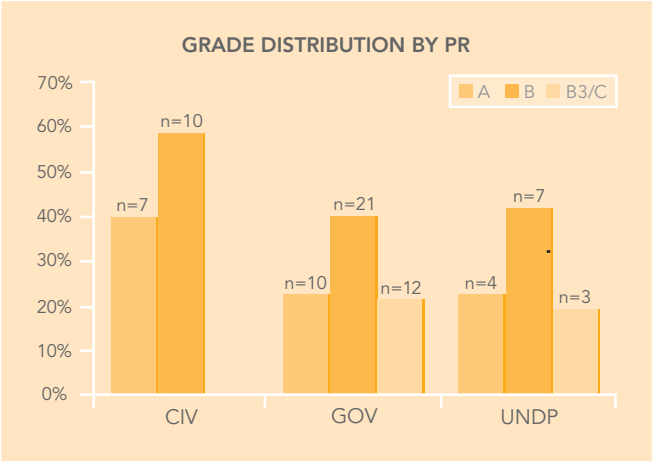


Figure 36c: Grant performance by Principal Recipient type

CONTINUED STRENGTH OF CIVIL SOCIETY AS AN IMPLEMENTER

136. The analysis of these 74 grants confirms the pattern that civil society has shown to date, that of continued strength as implementers. This is reflected in Phase 2 funding approved to date, with civil society PRs receiving over 99 percent of what their CCMs had requested, government PRs receiving 77 percent and UNDP 75 percent of amounts requested. This share of grant resources for which civil society is responsible highlights its important implementing role in the fight against the three diseases.

137. Civil society grants may not be directly comparable to public sector grants. (In particular, procurement issues are less important and the programmatic focus tends to be different). Civil society PRs have proven themselves highly efficient, however, in managing significant amounts of funds and rapidly converting money into results. The Global Fund does encourage CCMs to broaden the participation of civil society and other sectors in the selection of PRs and to use multiple principal recipients where appropriate.

138. As the performance analysis shows, progress towards fully-functioning CCMs is essential not only to improved participation, but also to effective implementation, oversight and performance of grants. Countries need to mobilize multiple implementation streams in order to extend absorptive capacity, achieve results, and reach diverse populations. A lesson learned from the performance analysis is that it is not useful to directly compare civil society and government PRs as they often play different roles. Instead, the effective role of civil society in direct implementation alongside government should be strongly supported and acknowledged.

LEARNING ACROSS DISEASES: STOP TB PROVIDES AN IMPORTANT MODEL

139. Grant performance was strongest for tuberculosis grants. Of the 74 grants evaluated for Phase 2, 44 percent of the TB grants were graded A, followed by 30 percent of HIV/AIDS grants and only 11 percent of malaria grants, indicating that lessons from strong models of implementation should be shared across the three diseases. Six percent of grants for TB were graded B2 or C, compared to 20 percent of grants for HIV/AIDS and 33 percent for malaria. Procurement problems had a greater impact on HIV/AIDS and malaria grants than on TB grants. Identifying good examples of existing partner networks, and encouraging information-sharing across diseases will provide strong strategy and implementation models for Principal Recipients and sub-recipients. In addition, special emphasis on establishing procurement capacity is necessary for HIV and malaria grants, with lessons to be learned from some countries' TB drug procurement systems which may serve as models.

140. The Stop TB Partnership may provide a useful model for harmonizing various actors, and for providing support which spans technical issues, management, procurement, human resources, monitoring, public-private and community initiatives. The range of implementation issues in Global Fund grants often requires solutions beyond just traditional technical support (for which the Stop TB Partnership has mobilized a wide range of expertise and partners). The Global TB Drug Facility also plays a significant role in ensuring that almost all high-burden countries have a secure supply of anti-TB drugs. Barriers to TB implementation remain, in staff capacity, infrastructure and laboratory services. Emergency initiatives to reach DOTS targets have been launched in Chile, India, Indonesia, Kenya, Pakistan, Romania, the Russian Federation and China in 2004-5.

141. Malaria- and HIV/AIDS-focused grants also provide important models for successful performance: HIV in wide stakeholder participation, and malaria in community participation and services. Much can be learnt from the different experiences across the three diseases (for example, DOTS expansion efforts have been underway for longer than ARV treatment program expansion and have successful models of partnership and implementation to share).

ACCELERATING GRANTS IN SUB-SAHARAN AFRICA

142. Analysis by region shows that percentage of underperforming grants in sub-Saharan Africa was no higher than that of other regions. However, sub-Saharan Africa had significantly lower rates of overperforming, or A-graded, grants; half those of other regions. These outcomes indicate that the region appears to have no greater obstacles to implementation than other regions, and has more latitude for improvement, notably in accelerating grants that are performing adequately.

143. The Global Fund must work with its partners to ensure that assistance is being provided to B-graded grants to the same degree as it is to C-graded grants. In doing so, all partners will ensure that the focus is on accelerating the performance of merely adequate grants rather than a disproportionate focus on saving underperformers.

144. This finding also has implications for the continuing development of the Global Fund's Early Alert and Response System (EARS). With partner support, the greatest potential to accelerate performance in sub-Saharan Africa may be afforded by adequately-performing grants, rather than flagged non-performing grants. The system of partner support needs to be able to identify the barriers to shift grants from adequate to excellent performance, as much as from underperforming to adequately-performing status (the point at which the flag goes down). In addition, stakeholders need to become concerned about "Go" and "Conditional Go" grants as much as about "No Go" grants at the Phase 2 point and throughout the performance-based funding process. The analysis suggests that both the hidden barriers and untapped potential to boost performance in sub-Saharan Africa lie in the category of grants evaluated as adequately-performing, or B1, grants.

ADDITIONAL PERFORMANCE CHALLENGES

145. The available data highlights the variability in converting funding into results, in terms of recipients of services, underlining the importance of the Global Fund maintaining a sharp performance focus. This process involves difficult decisions regarding where funds should be allocated, and whether grants should be continued into Phase 2. These decisions maintain the incentive system for grant recipients to demonstrate performance from the moment funds are disbursed by ensuring that funds are rapidly invested in technically sound and sustainable performance.

146. As described in this report, a major challenge to the Global Fund is to build performance-based funding into grant performance from day one. It is not only a question of evaluation at Phase 2, but of day-to-day implementation at all stages of a grant. There is a strong basis to achieve this ambition in the Global Fund through the focus placed on performance-based funding. Analysis of the 74 grants which have gone through Phase 2 evaluation to date shows that there is a correlation between the amount of funds disbursed by the Global Fund (and expended by PRs) before the Phase 2 evaluation process and the level of grant performance.

147. Typically, A-rated grants had received 85 percent of Phase 1 two-year amounts (slightly more than the 83 percent expected at month 20) and had expended most of the money received (83.5 percent). The analysis showed a parallel in lower amounts disbursed by the Global Fund and expended by PRs and lower grant performance. Grants which can use funds rapidly have high disbursements and expenditure rates; the worst-performing grants received less than 50% of their approved funds, and expended less than 50% of available resources. (The remainder is available in their accounts). However, the relationship between performance and disbursement needs to be strengthened, which is a major focus of the Secretariat with the introduction of standard disbursement tools.

148. At the same time, it is important to provide support to poorer-performing grants across a range of areas: management and governance issues, problems of financial accountability, procurement, human resources, and performance measured against numeric targets. The broad range of implementation issues is a challenge to traditional technical assistance providers, and may require inputs from the private sector, civil society, and sources of managerial and technical support. Overall, grants performed well when they filled gaps in existing national strategies or scaled up services which built on existing projects.

149. In terms of implementation, procurement remains a major issue, particularly for HIV/AIDS and malaria grants - an issue that disproportionately affects the performance of governmental Principal Recipients because they are the major procurers of drugs and commodities for the health system. Support is required to build capacity, particularly in national procurement processes and, more importantly, in establishing and managing supply chains. There are also continuing problems with broad participation and ownership by CCMs and ensuring multiple streams of implementation. This was particularly the case with HIV/AIDS grants, which require the coordination of a particularly wide range of stakeholders.

150. Finally, self-assessment still needs to be improved and better supported. In several B2- and C-graded grants, poor performance was apparent throughout the grant lifecycle, in reports from LFAs and in frequent Secretariat interactions with CCMs and PRs. Even where poor performance was clear, however, and questions had been raised over previous disbursements, few of these grantees had produced plans to revise or improve their grants. Earlier and more rigorous self-assessment by recipients, and evidence of careful budgeting in CCM applications for Phase 2 funding (for example, not consistently requesting the full amount provided as an upper limit) has been clearly linked to program success to date.

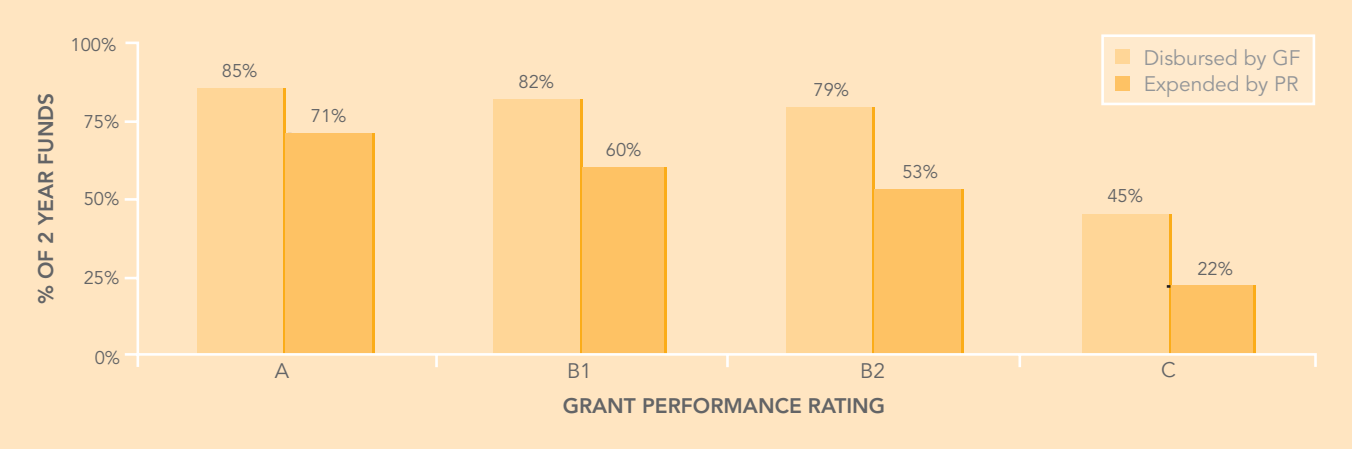


Figure 37: Funds disbursed before Phase 2 evaluation in relation to performance (74 grants, August 1, 2005)

In Bhanganoma community, Swaziland, siblings in an orphan-headed household prepare a meal from rations received from a local food distribution center.

CHALLENGES FOR PERFORMANCE-BASED FUNDING

151. With the major systems in place, the challenge is to maintain the sharp focus on performance in order to realize the benefits of accelerated implementation. The performance-based funding system has created strong incentives for grants to demonstrate performance.

152. There are many challenges in maintaining this performance focus throughout the grant lifecycle, disbursement by disbursement, as results are built up from process to service coverage and eventually to impact. In addition, it is essential that the Global Fund works with its partners to simplify M&E, and to harmonize approaches around the "Three Ones" for the three diseases, at least where reporting is concerned. The Global Fund has to continue to learn by doing, as illustrated by the CCM analysis, where urgent progress is required from baseline results, or the response to improve the basis and documentation of performance-based disbursements.

153. The three reports so far in 2005 have laid the path for investing in the future, making performance-based funding work, and sustaining this performance, while rising to the challenge of scaling these results. The challenge of performance-based funding is not to stay still or to maintain the status quo. The challenge will be to maintain the sharp focus on performance, and to scale up the level of funding and results.

154. In terms of performance-based funding, a number of challenges remain in 2005 and 2006:

- To pilot and embed data quality systems in grants and countries, while ensuring that parallel reporting systems are limited. This needs close collaboration with WHO, PEPFAR and grant Principal Recipients;
- To continually simplify M&E and embed standard measures of performance and accountability in grants. In addition, to support the agenda of harmonization of reporting systems and indicators, while extending this across the three diseases;
- To embed the early alert and response system (EARS) in countries and involve partners closely in identifying and addressing grant problems;
- To maintain the sharp focus of Global Fund financing on performance.

155. Ultimately, resources raised by the Global Fund's donors and committed in principle through two-year grants belong to no one but those in need of services for the prevention and treatment of HIV/AIDS, TB and malaria.

APPENDIX 1 - TIMETABLE OF GRANTS INCLUDING PHASE 2 DATES

Country	Component	Grant Number	2 Year Grant Amount	Program Start Date*	Request for Continued Funding Expected	Estimated Secretariat Recommendation to the Board
Sri Lanka	Tuberculosis	SRL-102-G04-T-00	$475,020	1-Mar-03	1-Sep-04	1-Nov-04
Kenya	HIV/AIDS	KEN-102-G01-H-00	$2,650,813	1-Apr-03	1-Oct-04	1-Dec-04
Kenya	HIV/AIDS	KEN-102-G02-H-00	$220,875	1-Apr-03	1-Oct-04	1-Dec-04
Benin	Malaria	BEN-102-G01-M-00	$2,973,150	1-May-03	1-Nov-04	1-Feb-05
Burundi	HIV/AIDS	BRN-102-G01-H-00	$4,877,000	31-Mar-03	1-Oct-04	1-Feb-05
China	Tuberculosis	CHN-102-G01-T-00	$48,070,000	1-Apr-03	1-Oct-04	1-Feb-05
China	Malaria	CHN-102-G02-M-00	$6,406,659	1-Apr-03	1-Oct-04	1-Feb-05
Ghana	HIV/AIDS	GHN-102-G01-H-00	$14,170,222	1-Jan-03	1-Jul-04	1-Feb-05
Ghana	Tuberculosis	GHN-102-G02-T-00	$5,687,055	1-Jan-03	1-Jul-04	1-Feb-05
Haiti	HIV/AIDS	HTI-102-G01-H-00	$24,603,680	1-Jan-03	1-Jul-04	1-Feb-05
Haiti	HIV/AIDS	HTI-102-G02-H-00	$6,754,697	1-Jan-03	1-Jul-04	1-Feb-05
Honduras	HIV/AIDS	HND-102-G01-H-00	$12,583,466	1-May-03	1-Nov-04	1-Feb-05
Honduras	Tuberculosis	HND-102-G02-T-00	$6,597,014	1-May-03	1-Nov-04	1-Feb-05
Honduras	Malaria	HND-102-G03-M-00	$7,204,140	1-May-03	1-Nov-04	1-Feb-05
India	Tuberculosis	IDA-102-G01-T-00	$8,655,033	1-Apr-03	1-Oct-04	1-Feb-05
Lao PDR	HIV/AIDS	LAO-102-G01-H-00	$3,407,664	1-May-03	1-Nov-04	1-Feb-05
Lao PDR	Malaria	LAO-102-G02-M-00	$12,709,087	1-May-03	1-Nov-04	1-Feb-05
Madagascar	Malaria	MDG-102-G01-M-00	$2,000,063	1-Feb-03	1-Aug-04	1-Feb-05
Madagascar	HIV/AIDS	MDG-202-G02-H-00	$747,199	24-Apr-03	24-Oct-04	1-Feb-05
Madagascar	HIV/AIDS	MDG-202-G03-H-00	$3,032,048	1-May-03	1-Nov-04	1-Feb-05
Moldova	HIV/TB	MOL-102-G01-C-00	$11,719,047	1-May-03	1-Nov-04	1-Feb-05
Mongolia	Tuberculosis	MON-102-G01-T-00	$1,730,000	1-May-03	1-Nov-04	1-Feb-05
Morocco	HIV/AIDS	MOR-102-G01-H-00	$9,238,754	1-Mar-03	1-Sep-04	1-Feb-05
Panama	Tuberculosis	PAN-102-G01-T-00	$570,000	1-Apr-03	1-Oct-04	1-Feb-05
Rwanda	HIV/TB	RWN-102-G01-C-00	$8,409,268	1-May-03	1-Nov-04	1-Feb-05
Senegal	HIV/AIDS	SNG-102-G01-H-00	$6,000,000	1-Apr-03	1-Oct-04	1-Feb-05
Senegal	Malaria	SNG-102-G02-M-00	$4,285,714	1-Apr-03	1-Oct-04	1-Feb-05
Tajikistan	HIV/AIDS	TAJ-102-G01-H-00	$2,425,245	1-May-03	1-Nov-04	1-Feb-05
Tanzania	Malaria	ZAN-102-G01-M-00	$781,220	14-May-03	14-Nov-04	1-Feb-05
Argentina	HIV/AIDS	ARG-102-G01-H-00	$12,177,200	1-Jul-03	1-Jan-05	1-Mar-05
Cuba	HIV/AIDS	CUB-202-G01-H-00	$11,465,129	1-Jul-03	1-Jan-05	1-Mar-05
Congo (Democratic Republic)	Tuberculosis	ZAR-202-G01-T-00	$6,408,741	1-Aug-03	1-Feb-05	1-Apr-05
El Salvador	HIV/AIDS	SLV-202-G01-H-00	$12,856,729	1-Aug-03	1-Feb-05	1-Apr-05
Ethiopia	Tuberculosis	ETH-102-G01-T-00	$10,962,600	1-Aug-03	1-Feb-05	1-Apr-05
Mongolia	HIV/AIDS	MON-202-G02-H-00	$2,997,103	1-Aug-03	1-Feb-05	1-Apr-05
Multi-country Africa(RMCC)	Malaria	MAF-202-G01-M-00	$7,090,318	1-Aug-03	1-Feb-05	1-Apr-05
Multi-country Western Pacific	HIV/AIDS	MWP-202-G01-H-00	$5,163,925	1-Jul-03	1-Jan-05	1-Apr-05
Multi-country Western Pacific	Malaria	MWP-202-G02-M-00	$4,530,300	1-Jul-03	1-Jan-05	1-Apr-05
Multi-country Western Pacific	Tuberculosis	MWP-202-G03-T-00	$2,738,806	1-Jul-03	1-Jan-05	1-Apr-05
Philippines	Malaria	PHL-202-G01-M-00	$7,244,762	1-Aug-03	1-Feb-05	1-Apr-05
Philippines	Tuberculosis	PHL-202-G02-T-00	$3,434,487	1-Aug-03	1-Feb-05	1-Apr-05
Benin	HIV/AIDS	BEN-202-G03-H-00	$11,348,000	25-Jul-03	25-Jan-05	1-May-05
Chile	HIV/AIDS	CHL-102-G01-H-00	$38,059,416	1-Aug-03	1-Feb-05	1-May-05
Ghana	Malaria	GHN-202-G03-M-00	$4,596,111	1-Sep-03	1-Mar-05	1-May-05
Indonesia	HIV/AIDS	IND-102-G03-H-00	$6,924,971	1-Jul-03	1-Jan-05	1-May-05
South Africa	HIV/TB	SAF-102-G02-C-00	$12,000,000	1-Aug-03	1-Feb-05	1-May-05
Swaziland	HIV/AIDS	SWZ-202-G01-H-00	$29,633,300	1-Aug-03	1-Feb-05	1-May-05
Zambia	HIV/AIDS	ZAM-102-G01-H-00	$21,214,271	25-Jul-03	25-Jan-05	1-May-05
Zambia	Tuberculosis	ZAM-102-G03-T-00	$12,447,294	25-Jul-03	25-Jan-05	1-May-05
Zambia	HIV/AIDS	ZAM-102-G04-H-00	$6,614,958	25-Jul-03	25-Jan-05	1-May-05
Zambia	Tuberculosis	ZAM-102-G06-T-00	$2,307,962	25-Jul-03	25-Jan-05	1-May-05
Zambia	HIV/AIDS	ZAM-102-G08-H-00	$8,073,013	25-Jul-03	25-Jan-05	1-May-05
Zambia	Malaria	ZAM-102-G05-M-00	$852,600	1-Aug-03	1-Feb-05	1-May-05
Zambia	Malaria	ZAM-102-G02-M-00	$17,039,200	15-Aug-03	15-Feb-05	1-May-05
Cambodia	HIV/AIDS	CAM-102-G01-H-00	$11,242,538	1-Sep-03	1-Mar-05	1-Jun-05
East Timor	Malaria	TMP-202-G01-M-00	$2,300,744	1-Sep-03	1-Mar-05	1-Jun-05
Estonia	HIV/AIDS	EST-202-G01-H-00	$3,908,952	1-Oct-03	1-Apr-05	1-Jun-05
Tanzania	HIV/AIDS	ZAN-202-G02-H-00	$1,116,000	1-Sep-03	1-Mar-05	1-Jun-05
Uganda	HIV/AIDS	UGD-102-G01-H-00	$36,314,892	15-Jun-03	15-Dec-04	1-Jun-05
Armenia	HIV/AIDS	ARM-202-G01-H-00	$3,166,641	1-Nov-03	1-May-05	1-Jul-05
Benin	Tuberculosis	BEN-202-G02-T-00	$2,173,404	1-Nov-03	1-May-05	1-Jul-05
Burundi	Malaria	BRN-202-G02-M-00	$13,792,126	1-Oct-03	1-Apr-05	1-Jul-05
Central African Republic	HIV/AIDS	CAF-202-G01-H-00	$8,198,921	1-Oct-03	1-Apr-05	1-Jul-05
Costa Rica	HIV/AIDS	COR-202-G01-H-00	$2,279,501	1-Oct-03	1-Apr-05	1-Jul-05
Ethiopia	Malaria	ETH-202-G02-M-00	$37,915,011	1-Oct-03	1-Apr-05	1-Jul-05
Indonesia	Tuberculosis	IND-102-G01-T-00	$21,612,265	1-Aug-03	1-Feb-05	1-Jul-05
Jordan	HIV/AIDS	JOR-202-G01-H-00	$1,778,600	1-Nov-03	1-May-05	1-Jul-05
Lao PDR	Tuberculosis	LAO-202-G03-T-00	$1,524,338	1-Oct-03	1-Apr-05	1-Jul-05
Serbia & Montenegro	HIV/AIDS	SER-102-G01-H-00	$2,718,714	1-Nov-03	1-May-05	1-Jul-05
Swaziland	Malaria	SWZ-202-G02-M-00	$978,000	1-Sep-03	1-Mar-05	1-Jul-05
Tanzania	Malaria	TNZ-102-G01-M-00	$8,790,612	1-Nov-03	1-May-05	1-Jul-05
Ukraine	HIV/AIDS	UKR-102-G04-H-00	$23,354,116	6-May-04	6-Nov-05	1-Jul-05
Tanzania	HIV/AIDS	TNZ-102-G02-H-00	$5,400,000	1-Nov-03	1-May-05	1-Jul-05
Burkina Faso	Malaria	BUR-202-G01-M-00	$7,499,988	1-Dec-03	1-Jun-05	1-Aug-05
Croatia	HIV/AIDS	HRV-202-G01-H-00	$3,363,974	1-Dec-03	1-Jun-05	1-Aug-05
Global(LWF)	HIV/AIDS	WRL-102-G01-H-00	$485,000	1-Feb-03	1-Aug-04	1-Aug-05
Kazakhstan	HIV/AIDS	KAZ-202-G01-H-00	$6,502,000	1-Dec-03	1-Jun-05	1-Aug-05
Nigeria	HIV/AIDS	NGA-102-G02-H-00	$1,687,599	1-Dec-03	1-Jun-05	1-Aug-05
Sri Lanka	Tuberculosis	SRL-102-G03-T-00	$2,384,980	1-Mar-03	1-Sep-04	1-Aug-05
Thailand	HIV/AIDS	THA-202-G03-H-00	$5,993,913	1-Oct-03	1-Apr-05	1-Aug-05
South Africa	HIV/TB	SAF-102-G01-C-00	$2,354,000	8-Dec-03	8-Jun-05	8-Aug-05
Burkina Faso	HIV/AIDS	BUR-202-G02-H-00	$7,130,400	1-Dec-03	1-Jun-05	1-Sep-05
Cote d'Ivoire	HIV/AIDS	CIV-202-G01-H-00	$18,099,398	1-Dec-03	1-Jun-05	1-Sep-05
El Salvador	Tuberculosis	SLV-202-G02-T-00	$1,918,344	1-Dec-03	1-Jun-05	1-Sep-05
Eritrea	Malaria	ERT-202-G01-M-00	$2,617,633	28-Nov-03	28-May-05	1-Sep-05
Kenya	Tuberculosis	KEN-202-G04-T-00	$4,928,733	1-Nov-03	1-May-05	1-Sep-05
Kenya	Malaria	KEN-202-G05-M-00	$10,526,880	1-Oct-03	1-Apr-05	1-Sep-05
Malawi	HIV/AIDS	MLW-102-G01-H-00	$41,751,500	1-Oct-03	1-Apr-05	1-Sep-05
Mali	Malaria	MAL-102-G01-M-00	$2,023,424	1-Dec-03	1-Jun-05	1-Sep-05
Sri Lanka	Malaria	SRL-102-G01-M-00	$730,140	1-Mar-03	1-Sep-04	1-Sep-05
Sri Lanka	Malaria	SRL-102-G02-M-00	$4,467,480	1-Mar-03	1-Sep-04	1-Sep-05
Thailand	HIV/AIDS	THA-102-G01-H-00	$30,933,204	1-Oct-03	1-Apr-05	1-Sep-05
Thailand	Tuberculosis	THA-102-G02-T-00	$6,999,350	1-Oct-03	1-Apr-05	1-Sep-05
Thailand	HIV/AIDS	THA-202-G04-H-00	$14,079,270	1-Nov-03	1-May-05	1-Sep-05

* Program start dates are not the official grant start dates

Country	Component	Grant Number	2 Year Grant Amount	Program Start Date*	Request for Continued Funding Expected	Estimated Secretariat Recommendation to the Board
Bulgaria	HIV/AIDS	BUL-202-G01-H-00	$6,894,270	1-Jan-04	1-Jul-05	1-Oct-05
Cambodia	HIV/AIDS	CAM-202-G02-H-00	$5,370,564	1-Jan-04	1-Jul-05	1-Oct-05
Cambodia	Malaria	CAM-202-G03-M-00	$5,013,262	1-Jan-04	1-Jul-05	1-Oct-05
Cambodia	Tuberculosis	CAM-202-G04-T-00	$2,505,255	1-Jan-04	1-Jul-05	1-Oct-05
Ethiopia	HIV/AIDS	ETH-202-G03-H-00	$55,383,811	1-Jan-04	1-Jul-05	1-Oct-05
Guinea	HIV/AIDS	GIN-202-G01-H-00	$4,804,696	1-Jan-04	1-Jul-05	1-Oct-05
Guinea	Malaria	GIN-202-G02-M-00	$6,893,509	1-Jan-04	1-Jul-05	1-Oct-05
Indonesia	Malaria	IND-102-G02-M-00	$8,254,947	1-Jul-03	1-Jan-05	1-Oct-05
Kenya	HIV/AIDS	KEN-202-G03-H-00	$36,721,807	1-Dec-03	1-Jun-05	1-Oct-05
Lesotho	HIV/AIDS	LSO-202-G01-H-00	$10,557,000	1-Jan-04	1-Jul-05	1-Oct-05
Lesotho	Tuberculosis	LSO-202-G02-T-00	$2,000,000	1-Jan-04	1-Jul-05	1-Oct-05
Nigeria	HIV/AIDS	NGA-102-G01-H-00	$8,708,684	1-Jan-04	1-Jul-05	1-Oct-05
Nigeria	HIV/AIDS	NGA-102-G03-H-00	$17,772,103	1-Jan-04	1-Jul-05	1-Oct-05
Pakistan	HIV/AIDS	PKS-202-G01-H-00	$3,822,700	1-Jan-04	1-Jul-05	1-Oct-05
Pakistan	Malaria	PKS-202-G02-M-00	$4,407,000	1-Jan-04	1-Jul-05	1-Oct-05
Pakistan	Tuberculosis	PKS-202-G03-T-00	$2,248,800	1-Jan-04	1-Jul-05	1-Oct-05
Peru	HIV/AIDS	PER-202-G01-H-00	$15,718,354	1-Dec-03	1-Jun-05	1-Oct-05
Peru	Tuberculosis	PER-202-G02-T-00	$20,153,818	1-Dec-03	1-Jun-05	1-Oct-05
Romania	HIV/AIDS	ROM-202-G01-H-00	$21,801,000	1-Jan-04	1-Jul-05	1-Oct-05
Romania	Tuberculosis	ROM-202-G02-T-00	$16,870,000	1-Feb-04	1-Aug-05	1-Oct-05
Sierra Leone	Tuberculosis	SLE-202-G01-T-00	$2,569,103	1-Jan-04	1-Jul-05	1-Oct-05
South Africa	HIV/TB	SAF-102-G03-C-00	$26,741,529	1-Jan-04	1-Jul-05	1-Oct-05
Togo	HIV/AIDS	TGO-202-G01-H-00	$14,185,638	1-Oct-03	1-Apr-05	1-Oct-05
Vietnam	HIV/AIDS	VTN-102-G01-H-00	$7,500,000	1-Feb-04	1-Aug-05	1-Oct-05
Zimbabwe	Malaria	ZIM-102-G02-M-00	$6,716,250	1-Sep-03	1-Mar-05	1-Oct-05
Bangladesh	HIV/AIDS	BAN-202-G01-H-00	$6,010,140	1-Mar-04	1-Sep-05	1-Nov-05
Georgia	HIV/AIDS	GEO-202-G01-H-00	$4,018,332	1-Mar-04	1-Sep-05	1-Nov-05
Kyrgyzstan	HIV/AIDS	KGZ-202-G01-H-00	$4,958,038	1-Mar-04	1-Sep-05	1-Nov-05
Kyrgyzstan	Tuberculosis	KGZ-202-G02-T-00	$1,212,835	1-Mar-04	1-Sep-05	1-Nov-05
Nicaragua	Malaria	NIC-202-G01-M-00	$3,404,671	1-Mar-04	1-Sep-05	1-Nov-05
Nicaragua	Tuberculosis	NIC-202-G02-T-00	$1,271,820	1-Mar-04	1-Sep-05	1-Nov-05
Nicaragua	HIV/AIDS	NIC-202-G03-H-00	$4,025,689	1-Mar-04	1-Sep-05	1-Nov-05
Thailand	Malaria	THA-202-G05-M-00	$2,280,000	1-Mar-04	1-Sep-05	1-Nov-05
Yemen	Malaria	YEM-202-G01-M-00	$4,159,632	1-Mar-04	1-Sep-05	1-Nov-05
Comoros	Malaria	COM-202-G01-M-00	$1,534,631	22-Mar-04	22-Sep-05	1-Dec-05
Cote d'Ivoire	HIV/AIDS	CIV-304-G02-H	$1,023,534	1-Apr-04	1-Oct-05	1-Dec-05
Cote d'Ivoire	Tuberculosis	CIV-304-G03-T	$2,870,122	1-Apr-04	1-Oct-05	1-Dec-05
India	Tuberculosis	IDA-202-G03-T-00	$7,080,000	1-Apr-04	1-Oct-05	1-Dec-05
Mauritania	Malaria	MRT-202-G02-M-00	$824,044	1-Apr-04	1-Oct-05	1-Dec-05
Nepal	HIV/AIDS	NEP-202-G01-H-00	$4,365,996	1-Apr-04	1-Oct-05	1-Dec-05
Nepal	Malaria	NEP-202-G02-M-00	$2,622,929	1-Apr-04	1-Oct-05	1-Dec-05
Uganda	Malaria	UGD-202-G02-M-00	$23,211,300	15-Mar-04	15-Sep-05	1-Dec-05
Uganda	Tuberculosis	UGD-202-G03-T-00	$4,692,021	15-Mar-04	15-Sep-05	1-Dec-05
Chad	Tuberculosis	TCD-202-G01-T-00	$1,263,963	1-May-04	1-Nov-05	1-Jan-06
India	HIV/AIDS	IDA-202-G02-H-00	$26,116,000	1-May-04	1-Nov-05	1-Jan-06
Mauritania	Tuberculosis	MRT-202-G01-T-00	$1,104,742	1-May-04	1-Nov-05	1-Jan-06
Togo	Malaria	TGO-304-G02-M	$3,479,336	1-May-04	1-Nov-05	1-Jan-06
Togo	Tuberculosis	TGO-304-G03-T	$1,752,982	1-May-04	1-Nov-05	1-Jan-06
Burundi	Tuberculosis	BRN-405-G03-T	$1,887,175	9-May-05	9-Nov-06	1-Feb-06
Dominican Republic	HIV/AIDS	DMR-202-G01-H-00	$14,698,774	1-Jun-04	1-Dec-05	1-Feb-06
Iran (Islamic Republic of)	HIV/AIDS	IRN-202-G01-H-00	$5,698,000	10-May-05	10-Nov-06	1-Feb-06
Jamaica	HIV/AIDS	JAM-304-G01-H	$7,560,365	1-Jun-04	1-Dec-05	1-Feb-06
Vietnam	Tuberculosis	VTN-102-G02-T-00	$2,500,000	1-Jun-04	1-Dec-05	1-Feb-06
Zimbabwe	HIV/AIDS	ZIM-102-G01-H-00	$10,300,000	9-May-05	9-Nov-06	1-Feb-06
Colombia	HIV/AIDS	COL-202-G01-H-00	$3,482,636	1-Jul-04	1-Jan-06	1-Mar-06
Egypt	Tuberculosis	EGY-202-G01-T-00	$2,480,219	1-Jul-04	1-Jan-06	1-Mar-06
Georgia	Malaria	GEO-304-G02-M	$645,700	1-Jul-04	1-Jan-06	1-Mar-06
Mozambique	HIV/AIDS	MOZ-202-G01-H-00	$7,732,956	1-Jul-04	1-Jan-06	1-Mar-06
Somalia	Malaria	SOM-202-G01-M-00	$8,890,497	1-Jul-04	1-Jan-06	1-Mar-06
Bangladesh	Tuberculosis	BAN-304-G02-T	$11,172,846	1-Aug-04	1-Dec-04	1-Apr-06
Bolivia	HIV/AIDS	BOL-304-G01-H	$6,019,023	26-Jul-04	1-Dec-04	1-Apr-06
Bolivia	Malaria	BOL-304-G02-M	$6,099,563	26-Jul-04	1-Dec-04	1-Apr-06
Bolivia	Tuberculosis	BOL-304-G03-T	$2,381,646	26-Jul-04	1-Dec-04	1-Apr-06
Botswana	HIV/AIDS	BOT-202-G01-H-00	$18,580,414	5-Jul-04	1-Dec-04	1-Apr-06
Chad	HIV/AIDS	TCD-304-G02-H	$7,380,156	1-Aug-04	1-Feb-06	1-Apr-06
Haiti	Malaria	HTI-304-G03-M	$7,390,556	1-Aug-04	1-Feb-06	1-Apr-06
Haiti	Tuberculosis	HTI-304-G04-T	$8,131,836	1-Aug-04	1-Feb-06	1-Apr-06
Papua New Guinea	Malaria	PNG-304-G01-M	$6,106,557	1-Aug-04	1-Feb-06	1-Apr-06
Philippines	HIV/AIDS	PHL-304-G03-H	$3,496,865	1-Aug-04	1-Feb-06	1-Apr-06
Rwanda	HIV/AIDS	RWN-304-G02-H	$14,860,735	15-Jul-04	15-Jan-06	1-Apr-06
China	HIV/AIDS	CHN-304-G03-H	$32,122,550	1-Sep-04	1-Mar-06	1-May-06
Dominican Republic	Tuberculosis	DMR-304-G02-T	$2,636,816	1-Sep-04	1-Mar-06	1-May-06
Guinea-Bissau	Tuberculosis	GNB-304-G01-T	$1,503,587	6-Aug-04	6-Feb-06	1-May-06
Niger	HIV/AIDS	NGR-304-G01-H	$8,475,297	1-Sep-04	1-Mar-06	1-May-06
Niger	Malaria	NGR-304-G02-M	$4,815,109	1-Sep-04	1-Mar-06	1-May-06
Russian Federation	HIV/AIDS	RUS-304-G01-H	$31,596,307	15-Aug-04	15-Feb-06	1-May-06
Somalia	Tuberculosis	SOM-304-G02-T	$5,601,215	16-Aug-04	16-Feb-06	1-May-06
Belize	HIV/AIDS	BEL-304-G01-H	$1,298,884	1-Oct-04	1-Dec-04	1-Jun-06
Congo (Democratic Republic)	HIV/AIDS	ZAR-304-G02-H	$34,799,786	1-Oct-04	1-Apr-06	1-Jun-06
Congo (Democratic Republic)	Malaria	ZAR-304-G03-M	$24,966,676	1-Oct-04	1-Apr-06	1-Jun-06
Gabon	HIV/AIDS	GAB-304-G01-H	$3,154,500	1-Oct-04	1-Apr-06	1-Jun-06
Gambia	HIV/AIDS	GMB-304-G01-H	$6,241,743	1-Oct-04	1-Apr-06	1-Jun-06
Gambia	Malaria	GMB-304-G02-M	$5,665,500	1-Oct-04	1-Apr-06	1-Jun-06
Sudan	Malaria	SUD-202-G01-M-00	$12,855,490	1-Oct-04	1-Apr-06	1-Jun-06
Sudan	Tuberculosis	SUD-202-G02-T-00	$5,842,932	1-Oct-04	1-Apr-06	1-Jun-06
Bangladesh	Tuberculosis	BAN-304-G03-T	$5,470,228	11-Oct-04	1-Dec-04	1-Jul-06
Eritrea	HIV/AIDS	ERT-304-G02-H	$8,124,910	11-Oct-04	11-Apr-06	1-Jul-06
Guinea-Bissau	HIV/AIDS	GNB-404-G02-H	$1,166,801	1-Nov-04	1-May-06	1-Jul-06
Macedonia, FYR	HIV/AIDS	MKD-304-G01-H	$4,348,599	1-Nov-04	1-May-06	1-Jul-06
Madagascar	HIV/AIDS	MDG-304-G04-H	$13,415,118	1-Nov-04	1-May-06	1-Jul-06
Madagascar	Malaria	MDG-304-G05-M	$5,232,448	1-Nov-04	1-May-06	1-Jul-06
Multi-country Americas (CARICOM)	HIV/AIDS	MAC-304-G01-H	$6,100,900	25-Oct-04	25-Apr-06	1-Jul-06
Nigeria	Malaria	NGA-202-G04-M-00	$20,994,149	1-Nov-04	1-May-06	1-Jul-06
Rwanda	Malaria	RWN-304-G03-M	$13,045,293	11-Oct-04	11-Apr-06	1-Jul-06

Country	Component	Grant Number	2 Year Grant Amount	Program Start Date*	Request for Continued Funding Expected	Estimated Secretariat Recommendation to the Board
South Africa	HIV/AIDS	SAF-304-G04-H	$15,521,457	19-Oct-04	19-Apr-06	1-Jul-06
Tajikistan	Tuberculosis	TAJ-304-G02-T	$1,301,485	1-Nov-04	1-May-06	1-Jul-06
Afghanistan	Integrated	AFG-202-G01-I-00	$3,125,605	30-Nov-04	1-Dec-04	1-Aug-06
Belarus	HIV/AIDS	BLR-304-G01-H	$6,818,796	1-Dec-04	1-Dec-04	1-Aug-06
Benin	Malaria	BEN-304-G04-M	$1,383,931	4-Nov-04	1-Dec-04	1-Aug-06
Guatemala	HIV/AIDS	GUA-304-G01-H	$8,423,807	1-Dec-04	1-Jun-06	1-Aug-06
Liberia	HIV/AIDS	LBR-202-G01-H-00	$7,658,187	1-Dec-04	1-Jun-06	1-Aug-06
Liberia	Tuberculosis	LBR-202-G02-T-00	$4,534,017	1-Dec-04	1-Jun-06	1-Aug-06
Liberia	Malaria	LBR-304-G03-M	$12,140,921	1-Dec-04	1-Jun-06	1-Aug-06
Paraguay	Tuberculosis	PRY-304-G01-T	$1,194,902	1-Dec-04	1-Jun-06	1-Aug-06
Russian Federation	Tuberculosis	RUS-304-G02-T	$6,306,869	1-Dec-04	1-Jun-06	1-Aug-06
Serbia & Montenegro	Tuberculosis	SER-304-G02-T	$2,428,986	1-Dec-04	1-Jun-06	1-Aug-06
Tanzania	HIV/TB	TNZ-304-G03-C	$23,951,034	11-Nov-04	11-May-06	1-Aug-06
Tanzania	Tuberculosis	ZAN-304-G03-T	$959,482	29-Nov-04	29-May-06	1-Aug-06
Thailand	HIV/AIDS	THA-304-G06-H	$911,542	3-Nov-04	3-May-06	1-Aug-06
Uzbekistan	HIV/AIDS	UZB-304-G01-H	$4,760,755	1-Dec-04	1-Jun-06	1-Aug-06
Algeria	HIV/AIDS	DZA-304-G01-H	$6,185,000	1-Jan-05	1-Dec-04	1-Sep-06
Burkina Faso	Tuberculosis	BUR-404-G03-T	$7,505,405	30-Dec-04	30-Jun-06	1-Sep-06
Cameroon	HIV/AIDS	CMR-304-G01-H	$14,641,407	1-Jan-05	1-Jul-06	1-Sep-06
Cameroon	Malaria	CMR-304-G02-M	$16,938,794	1-Jan-05	1-Jul-06	1-Sep-06
Cameroon	Tuberculosis	CMR-304-G03-T	$2,986,220	1-Jan-05	1-Jul-06	1-Sep-06
Comoros	HIV/AIDS	COM-304-G02-H	$685,600	28-Dec-04	28-Jun-06	1-Sep-06
Guinea-Bissau	Malaria	GNB-404-G03-M	$1,885,791	1-Jan-05	1-Jul-06	1-Sep-06
Guyana	HIV/AIDS	GYA-304-G01-H	$8,881,686	1-Jan-05	1-Jul-06	1-Sep-06
Guyana	Malaria	GYA-304-G02-M	$2,055,675	1-Jan-05	1-Jul-06	1-Sep-06
Mozambique	HIV/AIDS	MOZ-202-G02-H-00	$21,959,684	1-Jan-05	1-Jul-06	1-Sep-06
Mozambique	Malaria	MOZ-202-G03-M-00	$12,217,393	1-Jan-05	1-Jul-06	1-Sep-06
Mozambique	Tuberculosis	MOZ-202-G04-T-00	$9,202,140	1-Jan-05	1-Jul-06	1-Sep-06
Myanmar	Tuberculosis	MYN-202-G01-T-00	$6,997,137	1-Jan-05	1-Jul-06	1-Sep-06
Namibia	HIV/AIDS	NMB-202-G01-H-00	$26,082,802	1-Jan-05	1-Jul-06	1-Sep-06
Namibia	Tuberculosis	NMB-202-G02-T-00	$904,969	1-Jan-05	1-Jul-06	1-Sep-06
Namibia	Malaria	NMB-202-G03-M-00	$3,719,354	1-Jan-05	1-Jul-06	1-Sep-06
Pakistan	Malaria	PKS-304-G04-M	$1,548,636	1-Jan-05	1-Jul-06	1-Sep-06
Pakistan	Tuberculosis	PKS-304-G05-T	$5,605,431	1-Jan-05	1-Jul-06	1-Sep-06
Swaziland	Tuberculosis	SWZ-304-G03-T	$1,348,400	28-Dec-04	28-Jun-06	1-Sep-06
Tajikistan	HIV/AIDS	TAJ-404-G03-H	$2,508,720	1-Jan-05	1-Jul-06	1-Sep-06
Vietnam	Malaria	VTN-304-G03-M	$13,388,402	1-Jan-05	1-Jul-06	1-Sep-06
Cameroon	HIV/AIDS	CMR-404-G04-H	$6,347,296	10-Jan-05	10-Jul-06	1-Oct-06
Central African Republic	HIV/AIDS	CAF-404-G02-H	$4,695,012	3-Jan-05	3-Jul-06	1-Oct-06
Central African Republic	Tuberculosis	CAF-404-G03-T	$2,033,885	3-Jan-05	3-Jul-06	1-Oct-06
Gabon	Malaria	GAB-404-G02-M	$7,419,624	3-Jan-05	3-Jul-06	1-Oct-06
India	HIV/TB	IDA-304-G04-C	$2,667,346	10-Jan-05	10-Jul-06	1-Oct-06
Nigeria	Malaria	NGA-404-G05-M	$20,467,000	3-Jan-05	3-Jul-06	1-Oct-06
Rwanda	Tuberculosis	RWN-404-G04-T	$5,946,347	5-Jan-05	5-Jul-06	1-Oct-06
Suriname	Malaria	SUR-404-G02-M	$2,963,950	25-Jan-05	25-Jul-06	1-Oct-06
Tanzania	Malaria	ZAN-404-G04-M	$5,089,361	3-Jan-05	3-Jul-06	1-Oct-06
Djibouti	HIV/AIDS	DJB-404-G01-H	$7,271,400	1-Mar-05	1-Sep-06	1-Nov-06
Ecuador	HIV/AIDS	ECU-202-G01-H-00	$7,453,979	1-Mar-05	1-Sep-06	1-Nov-06
Madagascar	Tuberculosis	MDG-404-G08-T	$3,982,018	10-Feb-05	10-Aug-06	1-Nov-06
Suriname	HIV/AIDS	SUR-305-G01-H	$2,188,432	8-Feb-05	8-Aug-06	1-Nov-06
Zambia	HIV/AIDS	ZAM-102-G07-H-00	$6,395,758	1-Mar-05	1-Sep-06	1-Nov-06
Angola	Malaria	AGO-305-G01-M	$28,473,354	1-Apr-05	1-Dec-04	1-Dec-06
Bhutan	Malaria	BTN-405-G01-M	$1,000,957	1-Apr-05	1-Dec-04	1-Dec-06
Bhutan	Tuberculosis	BTN-405-G02-T	$560,568	1-Apr-05	1-Dec-04	1-Dec-06
East Timor	Tuberculosis	TMP-304-G02-T	$967,650	9-Mar-05	9-Sep-06	1-Dec-06
Ethiopia	HIV/AIDS	ETH-405-G04-H	$41,895,884	23-Mar-05	23-Sep-06	1-Dec-06
Georgia	Tuberculosis	GEO-405-G03-T	$1,829,218	1-Apr-05	1-Oct-06	1-Dec-06
Ghana	Malaria	GHN-405-G04-M	$18,561,367	18-Mar-05	18-Sep-06	1-Dec-06
India	Tuberculosis	IDA-405-G08-T	$6,819,000	24-Mar-05	24-Sep-06	1-Dec-06
India	HIV/AIDS	IDA-405-G05-H	$4,158,465	28-Mar-05	28-Sep-06	1-Dec-06
Madagascar	Malaria	MDG-405-G07-M	$9,261,672	18-Mar-05	18-Sep-06	1-Dec-06
Madagascar	Malaria	MDG-405-G06-M	$10,042,388	24-Mar-05	24-Sep-06	1-Dec-06
Multi-country Americas (OECS)	HIV/AIDS	MAE-305-G01-H	$2,553,861	10-Mar-05	10-Sep-06	1-Dec-06
Sao Tome & Principe	Malaria	STP-405-G01-M	$1,941,359	10-Mar-05	10-Sep-06	1-Dec-06
Sudan	HIV/AIDS	SUD-305-G04-H	$7,842,140	30-Mar-05	30-Sep-06	1-Dec-06
Uzbekistan	Malaria	UZB-405-G02-M	$1,343,466	24-Mar-05	24-Sep-06	1-Dec-06
Uzbekistan	Tuberculosis	UZB-405-G03-T	$6,056,522	31-Mar-05	1-Oct-06	1-Dec-06
Yemen	HIV/AIDS	YEM-305-G03-H	$2,715,720	1-Apr-05	1-Oct-06	1-Dec-06
Indonesia	HIV/AIDS	IND-404-G04-H	$31,129,618	27-Apr-05	27-Oct-06	1-Jan-07
Kenya	Malaria	KEN-405-G06-M	$81,749,756	1-May-05	1-Nov-06	1-Jan-07
Mongolia	Tuberculosis	MON-405-G03-T	$1,958,259	29-Apr-05	29-Oct-06	1-Jan-07
Myanmar	HIV/AIDS	MYN-305-G02-H	$19,221,525	12-Apr-05	12-Oct-06	1-Jan-07
Myanmar	Malaria	MYN-305-G03-M	$9,462,062	12-Apr-05	12-Oct-06	1-Jan-07
Sudan	Malaria	SUD-202-G03-M-00	$14,237,853	12-Apr-05	12-Oct-06	1-Jan-07
Togo	HIV/AIDS	TGO-405-G04-H	$11,517,643	21-Apr-05	21-Oct-06	1-Jan-07
Uganda	Malaria	UGD-405-G05-M	$66,432,148	1-May-05	1-Nov-06	1-Jan-07
Azerbaijan	HIV/AIDS	AZE-405-G01-H	$6,098,600	1-Jun-05	1-Dec-04	1-Feb-07
Somalia	HIV/AIDS	SOM-405-G03-H	$10,004,644	1-Jun-05	1-Dec-06	1-Feb-07
Tanzania	HIV/AIDS	TNZ-405-G04-H	$79,741,826	1-Jun-05	1-Dec-06	1-Feb-07
Tanzania	Malaria	TNZ-405-G08-M	$54,201,787	1-Jun-05	1-Dec-06	1-Feb-07
Central African Republic	Malaria	CAF-405-G04-M	$10,592,816	2-Jun-05	2-Dec-06	1-Mar-07
Sierra Leone	HIV/AIDS	SLE-405-G02-H	$8,574,255	8-Jun-05	8-Dec-06	1-Mar-07
Sierra Leone	Malaria	SLE-405-G03-M	$8,886,123	13-Jun-05	13-Dec-06	1-Mar-07
Uganda	HIV/AIDS	UGD-304-G04-H	$70,357,632	28-Jun-05	28-Dec-06	1-Mar-07

APPENDIX 2: ALL PHASE 2 GRANTS RECOMMENDED TO THE BOARD AS OF 1ST AUGUST, 2005

Board Submission Date	Country	Component	Grant Number	Global Fund Region	Principal Recipient Type	2 Year Grant Amount	Secretariat Grade	Board Decision	Board Approved Amount*
1-Feb-05	Benin	Malaria	BEN-102-G01-M-00	Sub-Saharan Africa: West & Central Africa	UNDP	2,389,185	B1	Conditional GO	583,965
1-Feb-05	Burundi	HIV/AIDS	BRN-102-G01-H-00	Sub-Saharan Africa: East Africa	Government	4,877,000	B1	GO	3,780,000
1-Feb-05	China (People's Republic)	Tuberculosis	CHN-102-G01-T-00	East Asia & the Pacific	Government	25,370,000	A	GO	22,700,000
1-Feb-05	China (People's Republic)	Malaria	CHN-102-G02-M-00	East Asia & the Pacific	Government	3,523,662	B1	GO	2,882,997
1-Feb-05	Ghana	HIV/AIDS	GHN-102-G01-H-00	Sub-Saharan Africa: West & Central Africa	Government	4,965,478	B1	Conditional GO	9,204,744
1-Feb-05	Ghana	Tuberculosis	GHN-102-G02-T-00	Sub-Saharan Africa: West & Central Africa	Government	2,336,940	B1	Conditional GO	3,350,115
1-Feb-05	Haiti	HIV/AIDS	HTI-102-G01-H-00	Latin America & the Caribbean	Civil Society	24,603,680	A	GO	35,547,100
1-Feb-05	Haiti	HIV/AIDS	HTI-102-G02-H-00	Latin America & the Caribbean	UNDP	6,754,697	B1	GO	0
1-Feb-05	Honduras	HIV/AIDS	HND-102-G01-H-00	Latin America & the Caribbean	UNDP	12,583,466	B2	Pending	Pending
1-Feb-05	Honduras	Tuberculosis	HND-102-G02-T-00	Latin America & the Caribbean	UNDP	3,790,500	B2	Conditional GO	2,806,514
1-Feb-05	Honduras	Malaria	HND-102-G03-M-00	Latin America & the Caribbean	UNDP	4,096,050	B2	Conditional GO	3,108,090
1-Feb-05	India	Tuberculosis	IDA-102-G01-T-00	South Asia	Government	5,650,999	A	GO	3,134,000
1-Feb-05	Lao PDR	HIV/AIDS	LAO-102-G01-H-00	East Asia & the Pacific	Government	1,307,664	B2	Conditional GO	2,100,000
1-Feb-05	Lao PDR	Malaria	LAO-102-G02-M-00	East Asia & the Pacific	Government	3,155,152	B2	Conditional GO	9,553,935
1-Feb-05	Madagascar	Malaria	MDG-102-G01-M-00	Sub-Saharan Africa: East Africa	Civil Society	1,750,299	B1	GO	249,764
1-Feb-05	Madagascar	HIV/AIDS	MDG-202-G02-H-00	Sub-Saharan Africa: East Africa	Civil Society	747,199	A	GO	756,425
1-Feb-05	Madagascar	HIV/AIDS	MDG-202-G03-H-00	Sub-Saharan Africa: East Africa	Civil Society	3,032,048	B1	GO	1,992,068
1-Feb-05	Moldova	HIV/TB	MOL-102-G01-C-00	Eastern Europe & Central Asia	Government	5,257,941	A	GO	6,461,106
1-Feb-05	Mongolia	Tuberculosis	MON-102-G01-T-00	East Asia & the Pacific	Government	644,000	A	GO	1,086,000
1-Feb-05	Morocco	HIV/AIDS	MOR-102-G01-H-00	North Africa & the Middle East	Government	4,738,806	A	GO	4,499,948
1-Feb-05	Panama	Tuberculosis	PAN-102-G01-T-00	Latin America & the Caribbean	UNDP	440,000	A	GO	130,000
1-Feb-05	Rwanda	HIV/TB	RWN-102-G01-C-00	Sub-Saharan Africa: East Africa	Government	8,409,268	A	GO	6,231,778
1-Feb-05	Senegal	HIV/AIDS	SNG-102-G01-H-00	Sub-Saharan Africa: West & Central Africa	Government	6,000,000	C	Pending	Pending
1-Feb-05	Senegal	Malaria	SNG-102-G02-M-00	Sub-Saharan Africa: West & Central Africa	Government	4,285,714	C	NO GO	0
1-Feb-05	Tajikistan	HIV/AIDS	TAJ-102-G01-H-00	Eastern Europe & Central Asia	UNDP	1,474,520	A	GO	950,725
1-Feb-05	United Republic of Tanzania	Malaria	ZAN-102-G01-M-00	Sub-Saharan Africa: East Africa	Government	781,220	B1	GO	371,860
1-Mar-05	Argentina	HIV/AIDS	ARG-102-G01-H-00	Latin America & the Caribbean	UNDP	12,177,200	A	Conditional GO	13,889,174
1-Mar-05	Cuba	HIV/AIDS	CUB-202-G01-H-00	Latin America & the Caribbean	UNDP	11,465,129	A	Conditional GO	14,687,698
1-Apr-05	Democratic Republic of Congo	Tuberculosis	ZAR-202-G01-T-00	Sub-Saharan Africa: West & Central Africa	UNDP	6,408,741	B1	Conditional GO	1,231,426
1-Apr-05	El Salvador	HIV/AIDS	SLV-202-G01-H-00	Latin America & the Caribbean	UNDP	12,856,729	B1	Conditional GO	6,682,235
1-Apr-05	Ethiopia	Tuberculosis	ETH-102-G01-T-00	Sub-Saharan Africa: East Africa	Government	10,962,600	B1	Conditional GO	16,018,049
1-Apr-05	Mongolia	HIV/AIDS	MON-202-G02-H-00	East Asia & the Pacific	Government	1,271,623	A	GO	1,725,480
1-Apr-05	Multi-country Africa(RMCC)	Malaria	MAF-202-G01-M-00	Sub-Saharan Africa: Southern Africa	Civil Society	7,090,318	A	GO	14,342,025
1-Apr-05	Multi-country Western Pacific	HIV/AIDS	MWP-202-G01-H-00	East Asia & the Pacific	Government	3,036,000	B2	Conditional GO	2,127,925
1-Apr-05	Multi-country Western Pacific	Malaria	MWP-202-G02-M-00	East Asia & the Pacific	Government	2,416,850	B1	GO	2,113,450
1-Apr-05	Multi-country Western Pacific	Tuberculosis	MWP-202-G03-T-00	East Asia & the Pacific	Government	1,699,100	B1	GO	1,039,706
1-Apr-05	Philippines	Malaria	PHL-202-G01-M-00	East Asia & the Pacific	Civil Society	7,244,762	B1	GO	4,584,783
1-Apr-05	Philippines	Tuberculosis	PHL-202-G02-T-00	East Asia & the Pacific	Civil Society	3,434,487	A	GO	8,003,577
1-May-05	Benin	HIV/AIDS	BEN-202-G03-H-00	Sub-Saharan Africa: West & Central Africa	UNDP	11,348,000	B1	GO	5,976,228
1-May-05	Chile	HIV/AIDS	CHL-102-G01-H-00	Latin America & the Caribbean	Civil Society	13,574,098	B1	GO	24,485,318
1-May-05	Ghana	Malaria	GHN-202-G03-M-00	Sub-Saharan Africa: West & Central Africa	Government	4,596,111	A	GO	4,253,380
1-May-05	Indonesia	HIV/AIDS	IND-102-G03-H-00	East Asia & the Pacific	Government	6,924,971	B2	Conditional GO	904,793
1-May-05	South Africa	HIV/TB	SAF-102-G02-C-00	Sub-Saharan Africa: Southern Africa	Government	12,000,000	B2	Pending	Pending
1-May-05	Swaziland	HIV/AIDS	SWZ-202-G01-H-00	Sub-Saharan Africa: Southern Africa	Government	29,633,300	B1	Conditional GO	22,910,845

Board Submission Date	Country	Component	Grant Number	Global Fund Region	Principal Recipient Type	2 Year Grant Amount	Secretariat Grade	Board Decision	Board Approved Amount*
1-May-05	Zambia	HIV/AIDS	ZAM-102-G01-H-00	Sub-Saharan Africa: Southern Africa	Government	21,214,271	B1	GO	na
1-May-05	Zambia	Malaria	ZAM-102-G02-M-00	Sub-Saharan Africa: Southern Africa	Government	17,039,200	B1	GO	21,382,000
1-May-05	Zambia	Tuberculosis	ZAM-102-G03-T-00	Sub-Saharan Africa: Southern Africa	Government	12,447,294	B1	GO	na
1-May-05	Zambia	HIV/AIDS	ZAM-102-G04-H-00	Sub-Saharan Africa: Southern Africa	Civil Society	6,614,958	A	GO	na
1-May-05	Zambia	Malaria	ZAM-102-G05-M-00	Sub-Saharan Africa: Southern Africa	Civil Society	852,600	B1	GO	na
1-May-05	Zambia	Tuberculosis	ZAM-102-G06-T-00	Sub-Saharan Africa: Southern Africa	Civil Society	2,307,962	A	GO	32,582,000
1-May-05	Zambia	HIV/AIDS	ZAM-102-G08-H-00	Sub-Saharan Africa: Southern Africa	Civil Society	8,073,013	B1	GO	48,027,778
1-Jun-05	Cambodia	HIV/AIDS	CAM-102-G01-H-00	East Asia & the Pacific	Government	11,242,538	B1	Conditional GO	4,472,091
1-Jun-05	Timor-Leste	Malaria	TMP-202-G01-M-00	East Asia & the Pacific	Government	2,300,744	B1	Conditional GO	618,727
1-Jun-05	Estonia	HIV/AIDS	EST-202-G01-H-00	Eastern Europe & Central Asia	Government	3,908,952	B1	GO	6,337,628
1-Jun-05	United Republic of Tanzania	HIV/AIDS	ZAN-202-G02-H-00	Sub-Saharan Africa: East Africa	Government	1,116,000	B1	GO	1,186,637
1-Jun-05	Uganda	HIV/AIDS	UGD-102-G01-H-00	Sub-Saharan Africa: East Africa	Government	36,314,892	B2	Conditional GO	12,563,525
1-Jul-05	Armenia	HIV/AIDS	ARM-202-G01-H-00	Eastern Europe & Central Asia	Civil Society	3,166,641	A	GO	4,083,250
1-Jul-05	Benin	Tuberculosis	BEN-202-G02-T-00	Sub-Saharan Africa: West & Central Africa	UNDP	2,173,404	B1	GO	930,700
1-Jul-05	Burundi	Malaria	BRN-202-G02-M-00	Sub-Saharan Africa: East Africa	Government	13,792,126	B1	Conditional GO	3,973,999
1-Jul-05	Central African Republic	HIV/AIDS	CAF-202-G01-H-00	Sub-Saharan Africa: West & Central Africa	UNDP	8,198,921	B1	GO	16,705,731
1-Jul-05	Costa Rica	HIV/AIDS	COR-202-G01-H-00	Latin America & the Caribbean	Government	2,279,501	B2	Conditional GO	1,304,370
1-Jul-05	Ethiopia	Malaria	ETH-202-G02-M-00	Sub-Saharan Africa: East Africa	Government	37,915,011	B2	Conditional GO	35,960,200
1-Jul-05	Indonesia	Tuberculosis	IND-102-G01-T-00	East Asia & the Pacific	Government	21,612,265	B1	GO	47,156,959
1-Jul-05	Jordan	HIV/AIDS	JOR-202-G01-H-00	North Africa & the Middle East	Government	1,778,600	A	GO	705,300
1-Jul-05	Lao PDR	Tuberculosis	LAO-202-G03-T-00	East Asia & the Pacific	Government	1,524,338	A	GO	2,006,053
1-Jul-05	Serbia & Montenegro	HIV/AIDS	SER-102-G01-H-00	Eastern Europe & Central Asia	Civil Society	2,718,714	B1	Conditional GO	856,798
1-Jul-05	Swaziland	Malaria	SWZ-202-G02-M-00	Sub-Saharan Africa: Southern Africa	Government	978,000	B2	Conditional GO	842,500
1-Jul-05	United Republic of Tanzania	Malaria	TNZ-102-G01-M-00	Sub-Saharan Africa: East Africa	Government	8,790,612	B2	Conditional GO	11,037,104
1-Jul-05	Ukraine	HIV/AIDS	UKR-102-G04-H-00	Eastern Europe & Central Asia	Civil Society	23,354,116	B1	Conditional GO	67,192,109
1-Aug-05	Croatia	HIV/AIDS	HRV-202-G01-H-00	Eastern Europe & Central Asia	Government	3,363,974	B1	GO	1,581,218
1-Aug-05	Global (LWF)	HIV/AIDS	WRL-102-G01-H-00	Eastern Europe & Central Asia	Civil Society	485,000	B1	GO	215,000
1-Aug-05	Kazakhstan	HIV/AIDS	KAZ-202-G01-H-00	Eastern Europe & Central Asia	Government	6,502,000	B1	GO	15,583,999
1-Aug-05	Sri Lanka	Tuberculosis	SRL-102-G03-T-00	South Asia	Government	2,384,980	B1	Conditional GO	2,605,034
1-Aug-05	Thailand	HIV/AIDS	THA-202-G03-H-00	East Asia & the Pacific	Civil Society	5,993,913	B1	GO	7,468,345

Portfolio Cluster	Cluster H
FPM	William H Smith

FPM Requirement to Complete
To be filled in via IT backbone

Proposal | Grant Agreement | TRP Clarifications | Attachments

Grant Performance Report | Progress Update / Disbursement Requests | Implementation Letters | Grant Score Card

Previous Disbursement Forms

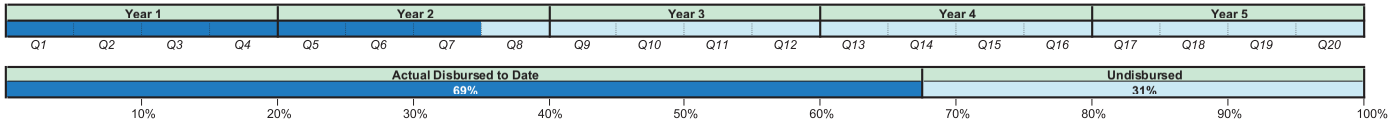
1- GENERAL GRANT INFORMATION

Country:	Country X
Disease:	HIV/AIDS
Principal Recipient:	Country X National AIDS PR
Grant Number:	XXX-202-G02-H

Program Start Date:	01-Aug-03
Proposal Lifetime:	2 Years
2-Year Budget:	$11,829,545
Life-time Budget	$11,829,545

Report Period Beginning Date:	1-Nov-04
Report Period End Date	31-Jan-05
Disbursment Request Number:	3

% of Time Elapse	88%
% of Grant Budget	69%



2- PERFORMANCE EVALUATION

SDA	Indicator	Top 10	Level	Period	Period Target	Period Results	Period Perf.	Cum. Target	Cum. Results	Perf.	Calculated Rating	FPM Rating	FPM Comments
PMTCT	HIV-infected pregnant women receiving ARVs	Yes	3	Q6	200	175	88%	500	475	95%	A	B1	While the program has succeeded in reaching pregnant women, the SDA has been downgraded to reflect the difficulties the program is experiencing in capacity building. Only 63% of cumulative targets for service deliverers trained has been reached.
	Health facilities offering minimum package of PMTCT	No	2	Q6	4	4	100%	8	8	100%			
	Number of service deliverers trained	No	1	Q6	275	145	53%	390	245	63%			
Condom Distribution	Condoms distributed	Yes	3	Q6	20,000	5,000	25%	45,000	12,500	28%	C	B2	While actual distribution of condoms has greatly lagged in relation to the agreed upon targets, this is primarily an issue of procurement guidelines recently altered by the national government. The service delivery points are ready, and actually ahead of target, and upon the completion of a procurement plan more in line with the new national guidelines, the distribution of condoms should quickly catch up.
	Service delivery points with condoms in stock	No	2	Q6	250	257	103%	600	614	102%			
ARV treatment	Number of people receiving ARV treatment	Yes	3	Q4	5,000	3,500	70%	14,000	11,200	80%	B1	B1	NA
	Number of service points supported	No	2	Q4	5	5	100%	14	14	100%			

LFA OVERALL RATING	B1

FPM OVERALL EVALUATION OF PERFORMANCE	RATING	EVALUATION
	B1	The program's overall performance is commendable, however, an A rating is not justified when capacity building in PMTCT and the distribution of condoms is taken into consideration. Besides condom distribution, the two other level 3 indicators are performing quite well. Condom distribution should catch up in the subsequent quarters upon the revision of the procurement plan to fall in line with new national guidelines. Also, capacity building, primarily the training of service deliverers in PMTCT will need to pick up in order to meet the ambitious targets for service delivery which the program has set for itself in year 3

Do the LFA comments on program progress indicate any cause for concern? No If yes: I have considered causes of concern raised by the LFA regarding program progress in my overall evaluation of performance (rating and comments)

☒ I have provided full justification for any difference between my overall progress rating and the LFA's rating

☒ I have considered LFA comments on data quality and reporting, if any

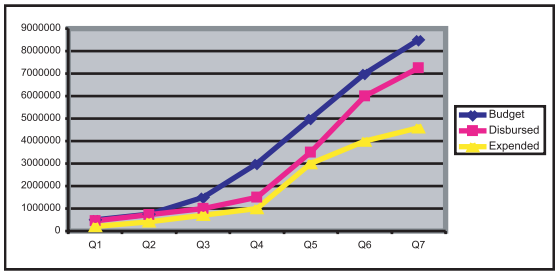
3- FINANCIAL CONSIDERATIONS

3.1. Disbursements to Date

	Amount (in USD)	Amount (in %)
Phase 1 Grant Agreement Amount	11,829,545	100%
Less: Actual Disbursed to Date	8,162,386	69%
Undisbursed Grant Amount	**3,667,159**	**31%**

3.2. Budget Vs. Disbursements to Date Vs. Cumulative Expenditures

	Cumulative	%	Variance
Original Budget to Date	8,500,000	100%	-
Disbursed to Date	7,300,589	86%	-1,199,411
Expenditure to Date	4,500,000	53%	-4,000,000
PRs Total Expenditures	894,500	-	-
Disbursements to Sub Recipients	3,205,698	-	-



3.3. Previous Period Disbursement Vs. Expenditures

	Amount	%
Forecasted Expenditures - Report Period	2,125,684	100%
Actual Expenditures - Report Period	1,250,348	59%

3.4. Cash Balance

	Amount	Date	%
Actual Disbursed to Date	7,300,589	25-Oct-04	100%
PR Cash Balance	2,800,589	31-Jan-05	38%
SR Cash Balance *(if available)*	463,258	15-Jan-05	6%

3.5. Comments on disbursements to date, expenditures and cash balance, if any

The PR has received 69% of its 2 year budget, while having elapsed nearly 90% of the two year time frame; however, they have still only spent 53% of what has been disbursed. Considering this as well continuous spending below what is forecast, a budget cut in the second phase of the program may be justified. The PR cash balance is alsc quite high at the moment further contributing to the belief that a budget cut could be in order as funding is not necessarily being fully used to reach people with services. Over time, it is further clear that the variance between the expenditures and the actual amount disbursed is growing. The sub-recipients do seem to be burning through their cash at a much better rate though, with only around $450K remaining in their account

Do the LFA comments on program expenditure indicate any cause for concern? Yes/No If yes: I have considered causes of concern raised by the LFA regarding program expenditures in the comment box above

I have provided clear explanation in the comment box above in cases where cumulative expenditures significantly deviate from budget (eg. +/- 15%)

4- CONTEXTUAL INFORMATION CRITICAL TO DISBURSEMENT DECISION

Governance (CCM, Civil Society, Donor and Partner Relations, GF Related - LFA, Secretariat, etc.-, etc.)	NO	NA
General Management (PR and Project Management, SR, Procurement, HR, Health Systems, M&E, etc.)	YES	The national government recently changed procurement guidelines which affected the procurement and distribution of condoms. While the service delivery points have been successfully established ahead of targets, the actual distribution has greatly lagged. The PR is revising its procurement plan to be in line with the new national guidelines
External Factors (Political Environment, Currency Fluctuations, Natural Disaster, etc.)	NO	NA
Other (National Programs, SWAPS, Corruptive Environment, etc.)	NO	NA

5- FUTURE AND OUTSTANDING REQUIREMENTS

Condition Precedent and/or special Conditions	DUE DATE	FULFILLED	COMMENTS (if Outstanding)
Revision of procurement plan	3/31/05	NO	The national procurement guidelines were recently revised which affects solely the procurement of the condoms. The PR is revising its procurement plan to be in line with the new national guidelines

☒ I confirm that the LFA and the PR have provided sufficient comments on all applicable condition precedent to this disbursement(s)

☒ I have reviewed and assessed LFA comments in relation to satisfaction of all applicable CPs and have ensured that they are consistent with CPs provided in the Grant Agreement

REQUIRED DOCUMENTATION	PERIOD COVERED	DUE DATE	OUTSTANDING	COMMENTS (if Outstanding)
Attachment to Annex A	Aug 1, 2003 - Aug 1, 2006	NA	NO	Attachments 1, 2, and 3 covering the first three years of the grant have already been completed
Audit Report	Jan 1, 2004 - Dec 31, 2004	30-Jun-05	YES	There was a delay by the audit firm and this audit report is expected in the next few weeks
Annual Review	Aug 1, 2003 - July 31, 2004	NA	NO	The second annual review will be due October 31, 2005

6- LFA RECOMMENDATION(S)

LFA Recommendation(s)	Global Fund Decision
No additional disbursements should be made for the procurement of condoms until the procurement plan has been revised to be in line with the new national procurement guidelines	GF has decided to follow the LFA recommendation and reduce the disbursement amount by what is intended for the procurement of condoms until the PR submits their revised procurement plan

☐ I have provided decisions for each LFA Recommendation

7- DISBURSEMENT DECISION

Subsequent period - Beginning date	1-Jan-05	End Date	30-Jun-05
Additional Quarter - Beginning date	1-Jul-05	End Date	30-Sep-05

	Amount	% of Cash Request
Cash Request (from the PR)	$2,246,553	100%
LFA Recommended	$1,765,003	79%

Disbursement Amount	$1,765,003

Rationale and Performance Basis for Disbursement Decision	The LFA assessment of disbursing only 79% of what has been requested by the PR is justified, as the 21% proposed to be cut for this disbursement take into account the difficulty the PR has had with procurement of condoms, the sustantial cash balance remaining in the PR's account, and the overall commendable performance of the program. A further cut may be justified in the PMTCT SDA as capacity building there has been quite difficult; however, considering the great performance in actually reaching people, as well as the importance and necessity to further capacity building to meet the ambitious targets for reaching people in the 3rd year, it may not be prudent to give a further cut reflecting difficulties with training at this point in time.

Has the LFA concluded that the forecasts included in the disbursement calculation is reasonable? YES If no: ☐ I have concluded that the disbursement amount is still appropriate based on the rationale outlined in the comment box above.

☒ I have provided full justification for any difference between my disbursement decision and the LFA's Recommendation and/or PR Request

☒ I have provided full justification for disbursement in case of under-performance of the program (e.g., B2 or C Rating)

Extra Comment Page

Upload relevant documentation of the period (e-mail, ...)

8- DOCUMENTATION SUPPORTING THE DISBURSEMENT

Supporting Documentation	Date
PR Disbursement Request	3/5/05
LFA On-going Progress Review and Disbursement Recommendation	3/5/05
Other:	NA
Other:	NA

☒	PR Request	PR has provided an authorized signature and date on the report
☒		Report period dates are correct and follow exactly sequentially from PR's previous report
☒		The expenditure is reported to a date not more than six months ago Date: 1/31/05
☒		Calculation of Disbursement Request is correct (from Cash Reconciliation and supporting statements)
☒		Periods for which cash is requested are reasonable and follow directly after report period
☒	LFA Report	LFA report has been properly signed and dated
☒		LFA has properly verified the PR's bank / bank account details (LFA has referenced the grant agreement face page containing the correct PR bank details for this disbursement)
☒		LFA report period dates are correct and follow directly after the report period in the previous report
☒		LFA has properly conducted all (seven) required verifications (Section 1.B.)
☒	Other	I have updated the Grant Performance Report (GPR)
☒		An LFA implementation work order is currently in place for this grant agreement and will expire not later than one month from today Expiry date: 6/30/05

9- RECOMMENDATION OF DISBURSEMENT

Statement by Fund Portfolio Manager

I have carefully reviewed the PR disbursement request and the associated LFA report and have taken account of all contextual information in my knowledge as portfolio manager for this grant as the basis for my answers and comments on this form and the acco

---------- ----------/----------/ 200 ----------
Signature Date Name (print)

Statement by Cluster Leader

I have reviewed this disbursement worksheet and the supporting documentation as listed above and have taken account of any matters brought to my attention therein. Based on my review, I recommend payment of this disbursement.

---------- ----------/----------/ 200 ----------
Signature Date Name (print)

Statement by Additional Reviewer (for disbursements in excess of)

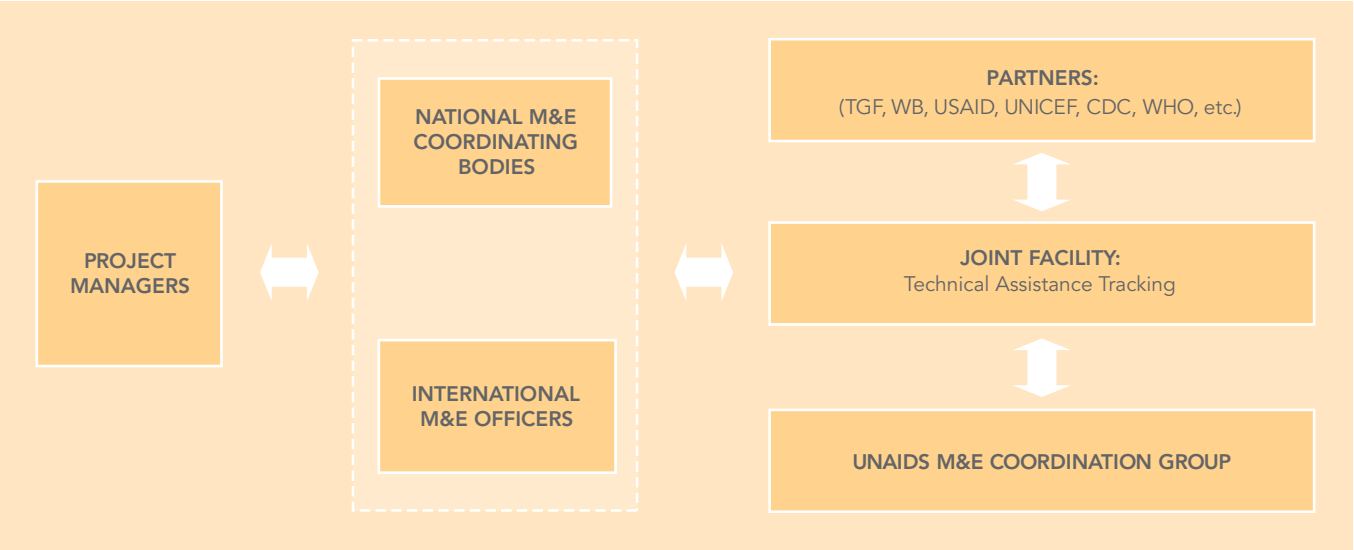
I have reviewed this disbursement worksheet and the supporting documentation as listed above and have taken account of any matters brought to my attention therein. Based on my review, I recommend payment of this disbursement.

---------- ----------/----------/ 200 ----------
Signature Date Name (print)

APPENDIX 4: JOINT PARTNER FACILITY FOR M&E SUPPORT

A major area of development in 2005 was the continued work with partners to coordinate M&E support to countries. The Global Joint Monitoring and Evaluation Facility was launched in April 2005 to broker timely responses to requests from recipient countries or partners for M&E technical assistance and training, and to track and follow up these requests. The Joint Facility can also be used by the Global Fund Secretariat's Fund Portfolio Managers to mobilize partner support when early warning signs of M&E weakness are apparent in funded countries. The Joint Facility has catalyzed partner coordination around M&E technical support, involving the partners as shown in the figure below. Since July the Joint Facility has been extended to include private sector support and support not only AIDS but also to malaria and tuberculosis.

The Global Fund has provided financing for this effort (together with the US government and UNAIDS), and UNAIDS is coordinating responses to requests for support. UNAIDS is also working closely with the WHO to continue to extend this facility across the three diseases. Early warning and technical assistance requests for M&E can be made by telephone, or for registered users, via email at helpME@unaids.org.



Joint Facility for coordinating and tracking M&E support: partner coordination and input

GOAL OF THE GLOBAL JOINT MONITORING AND EVALUATION FACILITY

To provide timely, effective and inexpensive response to M&E technical assistance (TA) and training requests from countries.

Objectives

1. To establish a system to help broker, coordinate and follow-up M&E technical assistance and training requests from countries and projects with different sources of technical support.
2. To set up and maintain a simple tracking tool to ensure that all TA requests are responded to effectively and in a timely manner.
3. To set up and maintain a web-based library of key M&E information (including a directory of local experts, agencies, M&E standards and indicators, current projects and national and international reports).
4. To ensure that all electronic information is available to requesters from developing countries in various formats (e-files, CDs, diskettes and printed materials) and through different channels (web, email, telephone, fax, mail and SMS), without adding to the workload of TA providers (namely national M&E coordinating bodies, M&E officers and partners).

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