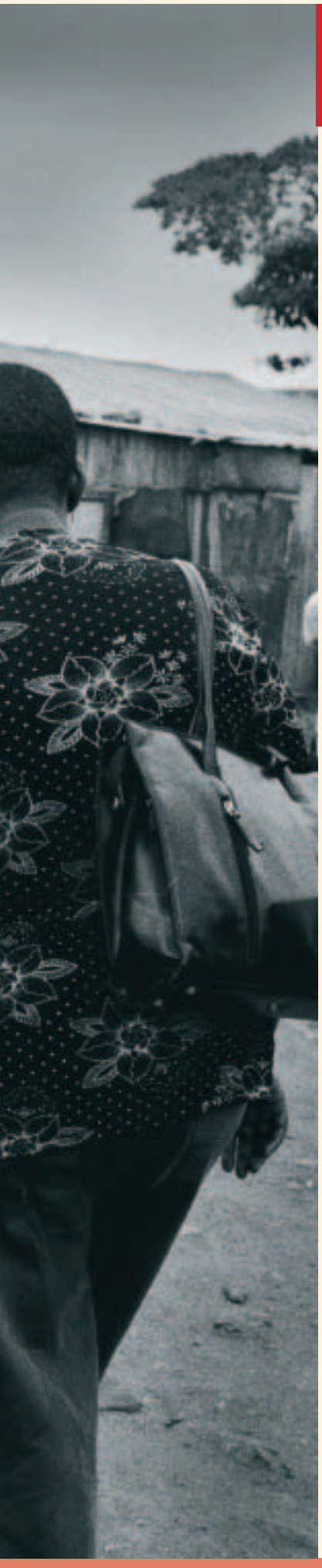

# Index

# List of terms and abbreviations used

| | |
|---|---|
| **ACT** | Artemisinin combination therapy |
| **ARV** | Antiretroviral therapy |
| **CCM** | Country Coordinating Mechanism |
| **DOTS** | Directly observed treatment, short course (referring to the internationally approved tuberculosis treatment strategy) |
| **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, outside consultants contracted by the Global Fund to assess program results as they are reported by the principal recipients of grants |
| **LLIN** | Long-lasting insecticidal nets |
| **MDGs** | Millennium Development Goals |
| **MRD-TB** | Multi-drug resistant tuberculosis |
| **MEFA** | Monitoring and Evaluation, Finance and Audit Committee |
| **PEPFAR** | President's Emergency Plan for AIDS Relief (USA) |
| **PR** | Principal Recipient |
| **RDT** | Rapid diagnostic testing |
| **TB** | Tuberculosis |
| **TERG** | Technical Evaluation Reference Group |
| **TRP** | Technical Review Panel |

This report forms part of a set of documents created specifically for the first replenishment meeting:

***HIV/AIDS, Tuberculosis and Malaria: The Status and Impact of the Three Diseases*** — contains essential background information such as disease burdens, impact on societies and economies, global response and interventions.

***Investing in The Future: The Global Fund at Three Years*** — a review of the Global Fund's challenges, progress and achievements to date, with focus on the first Phase 2-eligible grants.

***Addressing HIV/AIDS, Malaria and Tuberculosis: the Resource Needs of the Global Fund, 2005–2007*** — calculation of resource needs based on current operational projections for the Global Fund, complemented by calculations of the total global resource needs for AIDS, tuberculosis and malaria.

***Replenishing the Global Fund: An Independent Assessment*** — an external assessment of the Global Fund, focusing on issues, strengths, weaknesses, opportunities and problems.

***A Technical Note on Financial Management of the Global Fund*** — an overview of fiduciary arrangements including fiscal management, funding policy, and financing options.

All numbers used in the documents are estimates based on best available information at 31 January, 2005.

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# Investing in the Future: The Global Fund at Three Years

**"The purpose of the Global Fund is to attract, manage and disburse resources through a new public-private foundation that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals established by the United Nations."**

(Global Fund By-laws, Article 2, January 2002).

## EXECUTIVE SUMMARY

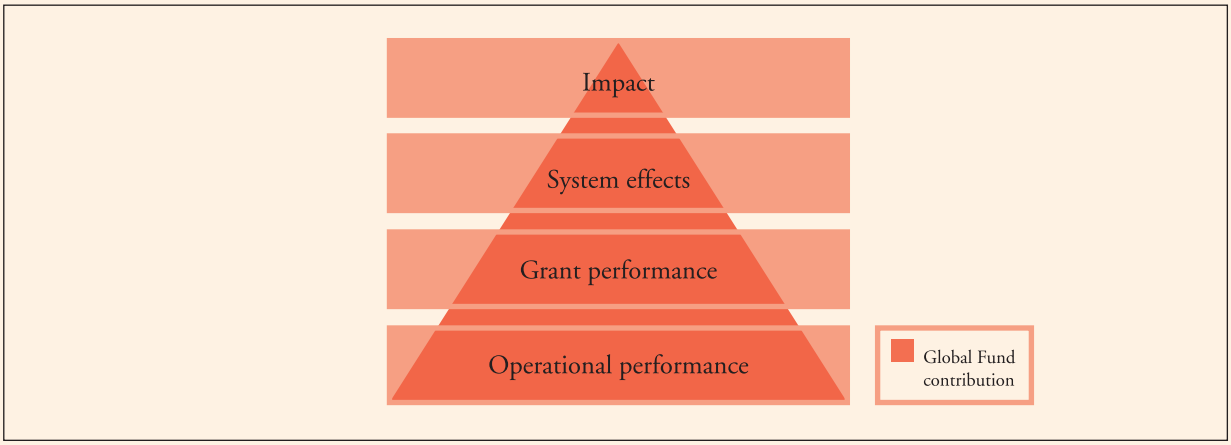
**1. The Global Fund finances programs through five-year grants, with funding initially committed for a two-year period.** After a performance assessment at the two-year mark, funds may be committed for a second phase to cover the remaining three years of the total approved grant period.

**2. Since its creation in 2002, the Global Fund's Board has approved US$ 3.1 billion to 310 grants in 127 countries for the first two years of grant funding.** As of 31 January 2005, the Global Fund had signed grant agreements worth US$ 1,884 million and disbursed US$ 873 million.

**3. The Global Fund provides initial grant funding solely on the basis of the technical quality of applications, and it provides continued funding to programs on the basis of performance.** Countries request funding based on their own identified priorities and needs, and an independent panel assesses grant applications on their technical quality. The Global Fund then sets only one overriding requirement on its grants: demonstrable progress measured against agreed indicators and targets. By insisting on broad representation in the Country Coordinating Mechanisms that submit grant applications for each country, the Global Fund has accelerated civil society involvement in the development of comprehensive national disease strategies and priority-setting in several countries.

**4. The Global Fund has designed and begun to implement transparent, rigorous and consistent performance measurement systems for its own operations as well as for grant progress in recipient countries.** The roll-out of these two systems in 2004 marked the completion of the major portion of a four-level measurement framework covering operational performance, grant performance, system effects and impact. Indicators for the third level – measuring the system effects of the Global Fund – have been approved by the Board and will be rolled out in 2005. The initial system for measuring a fourth level – the impact of the Global Fund – will be designed and initiated in the first quarter of 2005 while its bearing on the Millennium Development Goals will be defined by September 2005.

**5. The Global Fund's architecture permits and encourages constant improvement and adaptation.** The urgency of its mission meant that the Global Fund's early architecture was developed in parallel with the management of the first rounds of grants, rather than before the first grant agreements were signed. This has meant that Global Fund guidelines and operational policies have been "field tested" during the execution of its early grants, allowing for evaluation and improve-




*The Global Fund's four-level measurement framework*

ment. While this process has posed challenges for both recipients and partners, Global Fund structures have proven to be flexible and responsive to initial challenges. Problems related to Country Coordinating Mechanisms, grant application procedures, harmonization with other donors and program implementation are being addressed through dialogue with recipient countries, appropriate changes in Global Fund process or policy, and actions by recipients.

**6. The Global Fund's grant portfolio is young.** The average age of Global Fund-financed programs is 11 months, and as of 1 February 2005, only 27 of 310 grants were approaching the two-year mark at which program performance is evaluated for continued funding to cover the remaining years of the grant's life. Over the course of 2005, 136 grants will reach this stage, while the addition of grants approved in Round Five at the end of September 2005 will add an anticipated 50 to 70 new grants to the portfolio.

**7. Overall, disbursements are in line with the progress of the portfolio.** The rate at which the Global Fund disbursed money to grant recipients increased in 2004 and reached a cumulative total disbursed of US$ 873 million by 31 January 2005 out of a total commitment in signed grant agreements of US$ 1.89 billion. Overall, disbursements are roughly in line with the time elapsed for signed grants.

**8. Despite its young age, the overall grant portfolio has achieved substantial numbers of people on treatment for HIV/AIDS and TB but has shown disappointing results for the distribution of insecticide-treated mosquito nets.** While the numbers are not high relative to global need, they reveal the increasing acceleration of Global Fund-financed interventions by public and private sectors. At the end of 2004, Global Fund financing had provided:

- 130,000 people with antiretroviral treatment for AIDS;
- more than one million people with voluntary HIV testing;
- 385,000 patients with treatment under the DOTS strategy for tuberculosis control;
- more than 300,000 people with highly effective artemisinin combination treatments (ACTs) for malaria; and
- more than 1.35 million families with insecticide-treated mosquito nets.

**9. In addition, Global Fund financing has enabled grant-funded recipients to reach tens of millions of people through a wide range of prevention programs.** These include behavior change campaigns, community outreach, condom distribution, targeted support for people at highest risk for HIV infection (such as injecting drug users, sex workers and mobile populations), school programs for children and young people, and community and media awareness-raising campaigns.

**10. The foundations are being laid to accelerate scale-up of interventions.** Global Fund grants have enabled important investments in country capacity as the basis for the future increase of prevention and treatment activities. One-fifth of Global Fund expenditure is on human resources and 13 percent is on physical infrastructure for health services. Over 350,000 people were trained to fight HIV, tuberculosis and malaria in 2004. These people will work to scale up treatment to hundreds of thousands in 2005 – and millions over the life of their grants. The numbers of people receiving treatment and other services are therefore expected to increase greatly in 2005 and have already begun to accelerate noticeably since July 2004.

**11. Analysis of the first 27 grants to approach their two-year mark shows that 70 percent are progressing satisfactorily, 22 percent are underperforming but demonstrate potential and 8 percent have inadequate performance.** Grants are evaluated for Phase 2 funding as they near the end of their initial two-year funding period out of a total approved grant period of (usually) five years. The 27 grants that had applied for Phase 2 funding as of 1 February 2005 represented US$ 139 million worth of disbursements – US$ 88 million to HIV/AIDS grants, US$ 35 million for TB

and US$ 16 million for malaria. Taken together, these 27 grants have reached just over 60 percent of their targets for people on antiretroviral treatment, nearly 80 percent of targets for malaria treatment and more than 100 percent of targets for mosquito net distribution. All TB grants reached their targets for TB treatment under DOTS. The eight grants with the lowest performance account for most of the shortfall in targets that were not reached.

**12. Among the 27 grants, disbursements largely follow grant performance.** The Global Fund's grant structure was established to disburse money incrementally based on proven performance. An analysis of the first 27 grants to approach the two-year mark indicates that this system works in practice, as high-performing grants had received 92 percent of their expected disbursements after 18 months, while underperforming grants had received only 45 percent.

**13. Three years after its creation, the Global Fund has put in place most of the systems and processes necessary for implementing the full spectrum of performance-based funding.** A comprehensive measurement system is being put in place for all aspects of the Global Fund's operations and financed programs. The foundations for future scale-up are being laid through training and the improvement of physical infrastructure in funded countries. Grant performance is set to accelerate, and results are growing. However, a small but significant number of grants show persistent problems which need to be addressed at a broader level. These issues will require the further efforts of the Global Fund, its donor and technical partners, and recipient countries to solve. While the shortfall on some key targets set out in grant agreements does not leave room for complacency, the low levels of absolute failure show that the calculated risks taken by the Global Fund in funding a very broad range of recipients are paying off.

# The Global Fund Three Years On

Investing in the Future


## THE GLOBAL FUND IN AN INTERNATIONAL CONTEXT

**14.** The purpose of the Global Fund is to attract, manage and disburse resources through a new public-private foundation that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals established by the United Nations (By-laws Article 2, January 2002).

**15.** AIDS, tuberculosis (TB) and malaria are not only the world's biggest infectious disease killers, causing more than six million deaths per year; they have also resulted in the reversal of decades of health and development progress in many countries and the continuing devastation of families and communities around the world.

**16.** Over the past five years, there has been a substantial increase in resources to fight AIDS and malaria, and a moderate increase in resources for TB. Donor countries have dedicated more resources to the fight, and affected countries have begun to increase their domestic budgets for health. A number of significant new bilateral initiatives have been established, primarily to fight AIDS (most importantly the U.S. President's Emergency Plan for AIDS Relief, or PEPFAR) and two major new multilateral funding sources were created: the World Bank's Multi-Country HIV/AIDS Program (MAP) and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Numerous partnerships and initiatives have also been launched to improve the flow, coordination and effective use of resources for all three diseases.

**17.** With approximately US$ 5.9 billion pledged through 2008, the Global Fund has been a major contributor to the overall increase in resources to fight AIDS, TB and malaria. In terms of funds disbursed to

programs fighting the three diseases, the Global Fund now contributes 20 percent of the total international investment disbursed to programs fighting HIV/AIDS, 50 percent of the total disbursed to fight TB and 45 percent of the total disbursed for malaria. In some countries – for example, Haiti and Swaziland – overall health spending per capita has risen substantially due to Global Fund grants.

**18.** In addition, the Global Fund has emerged as a symbol of action against the three diseases far beyond its financial significance. As vocal supporters for its creation, nongovernmental organizations and representatives of communities living with the diseases have shown a strong sense of ownership of the Global Fund. Strong advocacy efforts at all levels have helped to increase the profile of the fight against HIV/AIDS, TB and malaria. Expectations are high, and the creation of the Global Fund has raised hopes that resources will increasingly be available to fight the three diseases.

**19.** Beyond the financial and advocacy aspects, the Global Fund's structure has led to the creation of multi-sectoral Country Coordinating Mechanisms (CCMs) in more than 120 countries. Although some countries already had well developed public-private collaborations for specific health efforts, most countries did not. The idea of bringing together representatives from health and other sectors of government, civil society (including communities of people living with the diseases), the private sector, donor countries and international organizations to formulate grant applications and oversee implementation of major health programs is a new one for most countries, north or south.

**20.** The Global Fund has also contributed to national and donor-driven processes to create baselines, set outcome-related targets and measure performance. Although the desire for results is shared among all development partners and health authorities, the performance-based funding principle of the Global Fund has produced a particularly rigorous system for setting targets and measuring outcomes for its own signed grant agreements. The development of shared tools for harmonized performance measurement has been a collaborative effort among a wide range of technical and donor partners and has brought a stronger and more unified approach to monitoring and evaluation across the spectrum of health-related development assistance.

**21.** The Global Fund was established so that donors could achieve collectively what none could achieve separately: the rapid scale-up of large amounts of new resources to fight AIDS, TB and malaria. Within this context, the Global Fund is becoming an integral part of a growing number of donor and recipient countries' strategies to fight the three diseases. It adds a multilateral element to national donor strategies, leverages the domestic health budgets of recipient countries through its complementarity and adds clout to international efforts through its large geographic reach and sharp focus on three diseases.

**22.** However, in this crowded environment of initiatives and agencies, where resource needs far outstrip availability, the Global Fund's role and usefulness needs to be constantly tested. It must continually prove that it adds value to other initiatives if it is to have a legitimate claim to new resources. As it enters its fourth year, the Global Fund has implemented the important first half of a comprehensive four-level performance measurement system and will complete implementation of all aspects by the end of 2005. This report provides data to contribute to an evaluation of whether and how the Global Fund is succeeding in its mandate.

# Measuring Performance

Investing in the Future

**This chapter describes the performance measurement systems of the Global Fund. For the results of assessments of Global Fund operations and grant performance, turn to the following chapter, entitled "Global Fund Results to Date".**

## BUILDING A PERFORMANCE-BASED FUNDING SYSTEM

**23.** Like other development financing mechanisms, the Global Fund is concerned with translating its investments into results. The Global Fund provides continued financing to grant-funded programs solely on the basis of their performance, measured against targets set out in grant agreements. In addition, performance measurement systems have been created for all aspects of the Global Fund's own operations, and these are now being implemented.

**24.** While performance measurement has been among the core principles of the Global Fund from its creation, building a functional system to measure performance and to provide the basis for funding decisions has been a gradual process. Due to the urgency of its mission, the Global Fund approved its first round of grants only three months after its creation and before any detailed architecture for managing these grants and measuring performance had been designed. The development of all aspects of its functional architecture has therefore taken place in parallel with the ongoing management of existing grants.

**25.** As a result of this parallel process, the complete system for measuring grant performance based on key indicators has been put into operation over the past nine months. Objective performance measurement systems for Global Fund operations are currently being rolled out – including systems for its Secretariat, Executive Director and Board – and the whole structure will be operational in the course of 2005. This process has undeniably presented a challenge for recipients who did not have a complete picture of the performance measurement architecture from the beginning and for donors who want objective criteria against which to measure the progress of the Global Fund and its grants. However, the process has resulted in a system tailored to the specific needs and requirements of the Global Fund's grant structure as well as field-tested components.

## WHAT THE GLOBAL FUND MEASURES – AND HOW

**26.** In 2004, the Global Fund established a measurement framework which measures its performance at all levels and addresses the seven principles spelled out in the founding documents of the Global Fund (see box below). The measurement framework with its four levels – operational performance, grant performance, system effects and impact – was developed under the oversight of the Technical Evaluation Reference Group (TERG) and the Monitoring and Evaluation, Finance and Audit (MEFA) Committee and approved by the Board. The full implementation and roll-out of this system follows a phased approach, as the Fund moves from grant signing and management towards broader systems effects and ultimately impact on the three diseases. The operational and grant performance measurement systems were implemented in 2004. While the indicators for the measurement of system effects and impact were also developed in 2004, their full implementation and roll-out are priorities for 2005, together with the preparation of a thorough five-year evaluation of the Global Fund in 2006.

### GUIDING PRINCIPLES OF THE GLOBAL FUND

Seven principles guide the policies and operations of the Global Fund from its governance to its grant-making. These principles reflect a consensus by the many stakeholders whose consultations in 2001 laid the foundation for 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 prevention, treatment, care and support.
6. Evaluates proposals through an independent review process.
7. Operates transparently and accountably and employs a simplified, rapid and innovative grant-making process.

| Level of measurement framework | Implementation status | Sample areas of measurement | Implementation targets |
|---|---|---|---|
| **4** Impact | • Impact indicators defined in M&E toolkit<br>• Suite of tools implemented to capture targets for grants | • Declining HIV, TB and malaria mortality<br>• Reduced incidence of HIV, TB and malaria<br>• Contribution with partners to MDGs and other international targets | • All Phase 2 grants have impact targets as of January 2005<br>• Contribution to MDGs quantified by Sept 2005 |
| **3** System Effects | • Measurement framework and indicators agreed<br>• Baseline implementation initiated | • Progress in reducing unmet need for AIDS, TB and malaria spending<br>• Inter-Year change in malaria, TB, HIV spending (all sources) > Global Fund grant spending<br>• Ratio of donor to local spending allocated to the 3 diseases<br>• Countries with relevant national strategies which specifically integrate Global Fund funding<br>• CCM checklist at country level | • CCM baseline survey results in all countries by June 2005<br>• Baseline report on core system effects indicators by December 2005<br>• 100% of Global Fund funding needs contributed for 2005 |
| **2** Grant performance | • Standard indicators agreed with partners in M&E toolkit<br>• Implemented into all Phase 2 and new grants<br>• Portfolio results for ARVs, DOTS, ITNs | • Coverage: people reached by services<br>• Top 10 coverage indicators: people on ARVs, DOTS, ITNs distributed, VCT, PTMC, malaria treatment (ACT/non-ACT), condoms, community/peer educators active, people exposed to behavior-change programs, people trained overall<br>• Phase 2 performance grading and evaluations | • 95 % of disbursements based on evidence of performance and expenditure in 2005<br>• 100 % of all new and Phase 2 grants have coverage indicators in 2005<br>• Report on portfolio "Top 10" coverage indicators by December 2005 |
| **1** Operational performance | • Core indicators implemented<br>• Executive Dashboard agreed<br>• LFA study completed | • Actual against target funds disbursed<br>• Funds contributed to amounts pledged<br>• Average time between grant approval and first disbursement<br>• Number of grants signed and approved<br>• Secretariat cost base as percent of expenditure | • Internet access to Executive Dashboard that is updated continuously by March 2005 |

*Figure 1: The Global Fund's measurement framework – current status, sample areas of measurement and implementation targets*

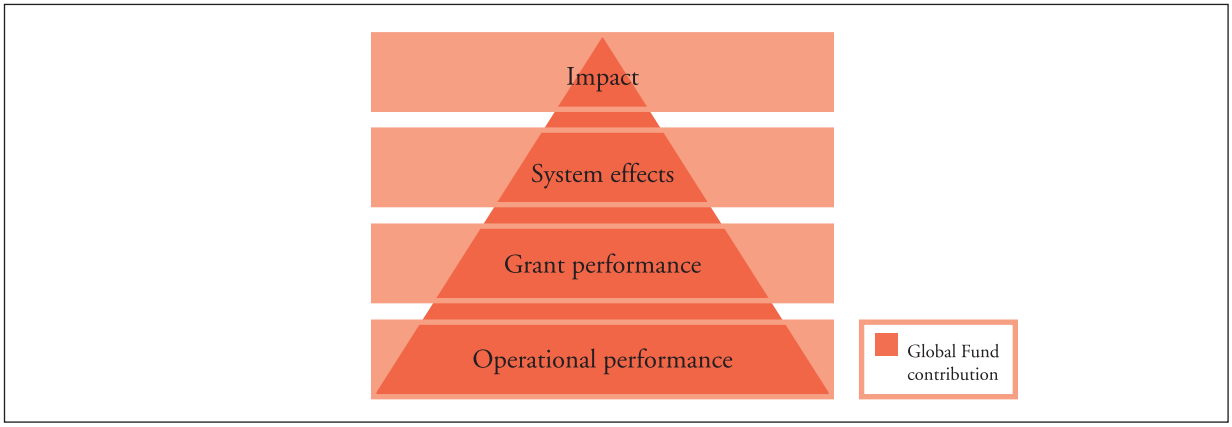



*Figure 2: The Global Fund's four-level measurement framework*

The four levels of the measurement framework (see Figure 2, above) 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. In 2004, key performance indicators for these areas were shown in a new management tool called the "Executive Dashboard". In addition, specific evaluation studies are undertaken to assess particular areas in greater detail, including the different elements of the Global Fund's basic architecture.

**2. Grant performance:** This level measures the performance of grants and is the cornerstone of performance-based funding by the Global Fund. The system was defined and implemented in 2004 and covers all aspects of the Global Fund grant process, including proposal development, grant agreements, regular disbursements and Phase 2 evaluations. Together with its primary technical partners, the Global Fund developed a joint Monitoring and Evaluation Toolkit which defines simplified evaluation frameworks and indicators at all levels for the three diseases. The Toolkit is designed to be of assistance to those applying for Global Fund grants in establishing universally-accepted targets and indicators for measuring proposed program performance. In using the Toolkit, applicants can simplify their grant designs by focusing on outputs rather than on processes. There has been a strong effort to improve performance indicators in early-round grants because these grant agreements were signed before the full grant performance system was in place and some contained weaker performance indicators. These efforts will be ongoing in 2005.

**3. System effects:** This level measures the impact (positive and negative) that the Global Fund has on the existing systems through which it works, in particular at the country level. In 2004, under the oversight of the TERG and the MEFA Committee of the Board and in conjunction with a wide set of partners and stakeholders, a set of indicators and measurement tools was developed to measure these effects with a particular focus on additionality of resources, long-term sustainability of efforts and harmonization between technical and donor agencies, as well as national partnerships under the guidance of CCMs. Measurement of these indicators will be a priority in 2005[1].

**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 for impact measurement have been developed as part of the grant management systems, as it will ultimately be the impact that Global Fund-financed programs have on the three diseases that will determine its success. While the basic indicators have been included in the joint Monitoring and Evaluation Toolkit, it will be a priority for 2005 to fully embed these in the grant management systems. The first step will be to build *impact* indicators (in addition to *coverage* indicators) into all grant extensions as grants reach the Phase 2 funding stage.

[1] *On March 9, 2005, UNAIDS and the governments of the United Kingdom, France and the United States will come together for a high-level meeting proposing further steps to achieve targets for harmonization.*

# Operational performance: level one of the measurement framework

**27.** The Secretariat operates under the same principles of performance as those demanded of its grant recipients. Measurement of the operational performance of the Global Fund is conducted through the measurement of formal sets of performance indicators against predetermined targets and also through periodic studies and reviews which are conducted both internally and externally.

## The Executive Dashboard

**28.** The Executive Dashboard (see Figure 4, below) is a standardized reporting tool providing key performance management information that is critical for senior-level decisionmaking. It provides a good overview of the Global Fund's operational performance by assessing the five core processes: resource mobilization, proposal management, grant negotiation, disbursement and grant management, and business services. In 2004, the Secretariat established indicators for each of these five areas.

**29.** Each core process has one top-level indicator to provide a snapshot of progress, and five to six supporting indicators for more detailed information. Top-level indicators for the five core processes are as follows:

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

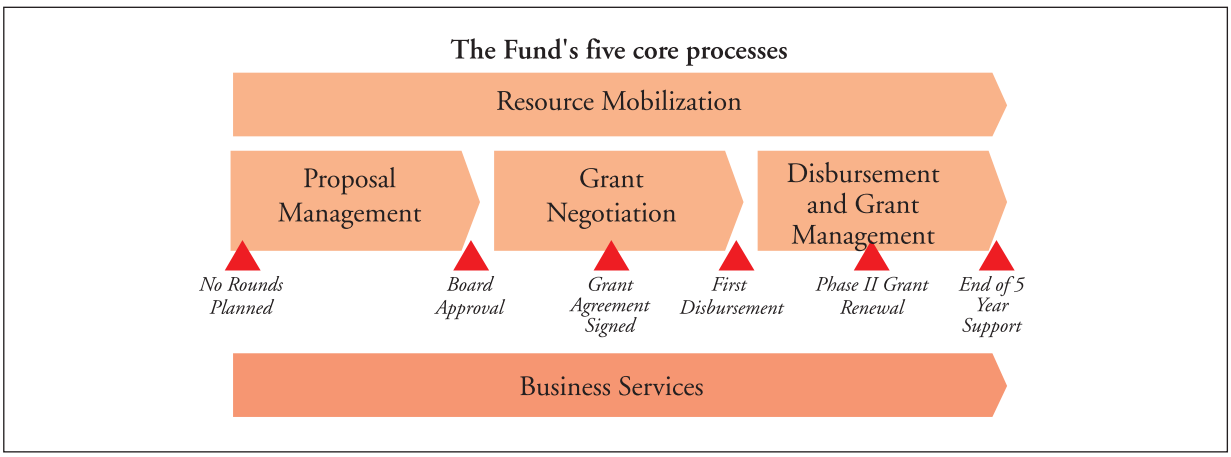



*Figure 3: The Global Fund's five core operational processes*

*Figure 4: The Executive Dashboard at a glance*

**30.** The Executive Dashboard will be fully implemented as a management tool in March 2005. It will be updated monthly and will be accessible on the Global Fund website.

**31.** In November 2004, the Board approved a set of performance measurement indicators for the Executive Director. These are being rolled into the Executive Dashboard and will be reported on in 2005 (see Appendix 3).

## Other areas of operational performance measurement

### Local Fund Agents

**32.** The decision not to have a Global Fund presence outside Geneva and instead to buy services as they are needed commercially by hiring Local Fund Agents (LFAs) is among the most innovative elements of the Global Fund's structure. Although the idea behind the LFA model is not unique, no other major development finance mechanism has so far made use of outside assessment and verification of the type and scale of the Global Fund's LFA system. LFAs are contracted by the Secretariat to assess the capacity of nominated Principal Recipients (PRs) to administer grant monies, assess the implementation of funded programs, report on financial and programmatic progress and ensure product procurement consistent with the policies of the Global Fund. LFAs also verify the Principal Recipient's periodic disbursement requests, progress updates and annual audit reports, and they advise the Secretariat regarding program implementation.

**33.** LFAs are selected through a global competitive tender. At the date of this report, seven entities were contracted as LFAs (see LFA map, figure 5, below), with the three most-used being PricewaterhouseCoopers, KPMG, and Deloitte Emerging Markets.

**34.** A thorough external review of the effectiveness, benefits and weaknesses of individual LFAs in particular and the system of outsourced oversight in general was commissioned by the Secretariat and carried out in 2004. The review included 13 in-depth case studies of LFA performance and an independent overall report on the effectiveness and value-for-money of existing LFA contracts and working arrangements. From this review came a number of recommendations, which now are being implemented through updated work procedures and revised terms for future contracts.

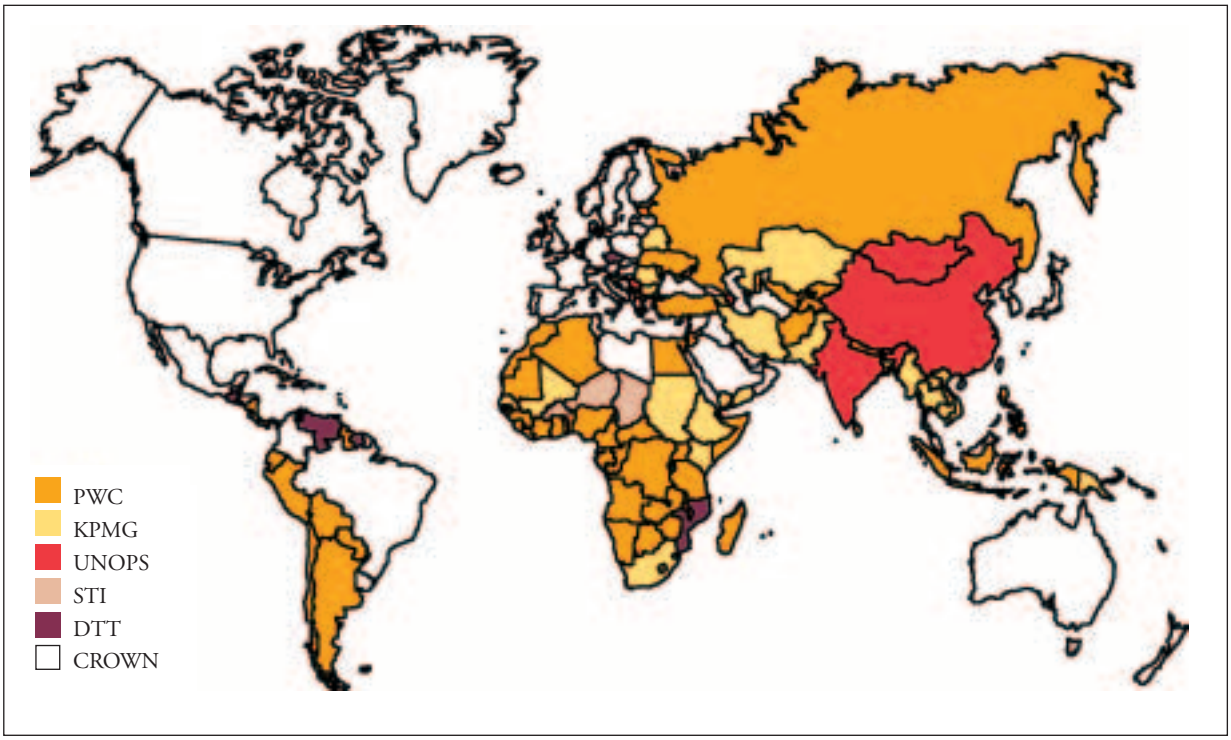



*Figure 5: Distribution of LFAs*

# Grant performance: level two of the measurement framework

**36.** Over the past year, the Global Fund has designed a transparent, rigorous and consistent performance measurement system for its grants. Each grant agreement sets out clear performance indicators and targets central to its stated aims. These indicators vary widely according to which of the diseases is being targeted by funded interventions and the nature of the approved proposals, which may include some or many different elements of prevention, diagnosis, care and treatment.

**37.** Quarterly disbursement requests from grant recipients include externally verified reports on the progress recipients have made towards their targets. Incremental disbursements continue to flow from the Global Fund to grant recipients only as long as quarterly performance targets are met.

**38.** Grants are approved in principle by the Board for up to five years, but grant agreements are signed for an initial two-year period only. Continuation of funding for the remainder of a grant's life – Phase 2 funding – is dependent on program performance over the course of the first two years. Towards the end of each grant's initial two-year funding period, a "Grant Scorecard" is compiled by the Global Fund, combining the aggregate results of the grant with independent verification and assessment data on the grant's performance and this becomes the basis for the Phase 2 funding decision taken by the Board.

**39.** The Global Fund has developed a suite of tools in collaboration with technical partners to facilitate grant management and performance-based funding decisions. These tools track relevant performance targets and achievements by using a clear set of indicators and targets taken from the original grant proposal, negotiated and approved by the Secretariat and included in the grant agreement. These indicators are tracked at every point in the process: from grant agreements through regular disbursement requests and performance updates through to the requests for continued funding and the extended grant agreements for Phase 2 funding. As grants approach their eighteenth month, all performance-related information is compiled in a "Grant Performance Report".

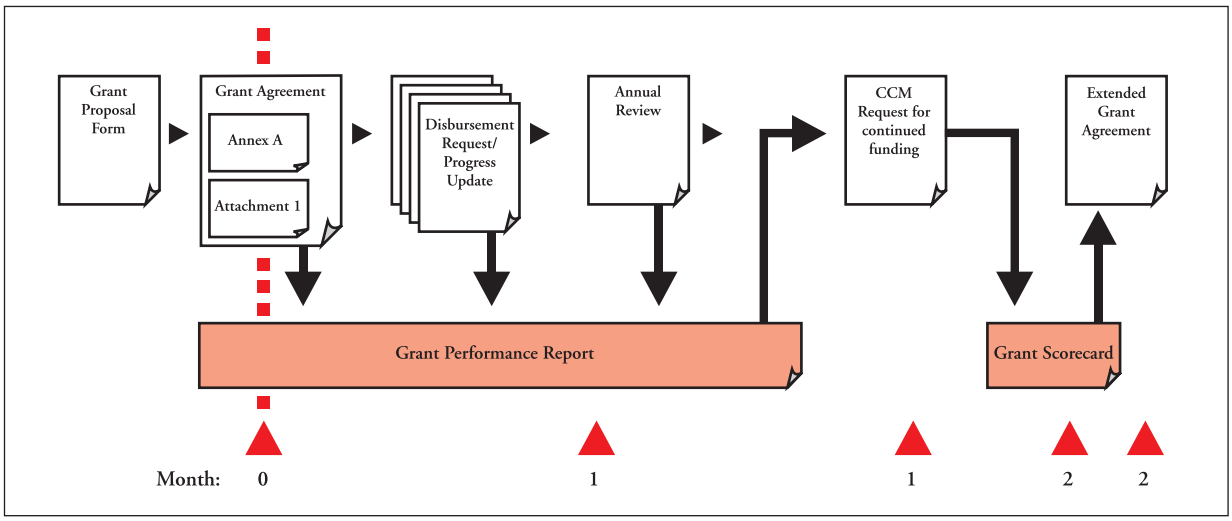



*Figure 6: The Global Fund's grant performance measurement system*

**40.** The complete performance management system was put in place in 2004, and the first 27 Phase 2 funding recommendations were made by the Secretariat to the Board on 1 February 2005. No grant will receive Phase 2 funding without having been thoroughly evaluated based on a clear set of performance indicators, and no grant will be signed without such performance indicators.

**41.** Given the urgency to begin funding, the Global Fund had not set up criteria for indicator and target development in the guidelines for the first rounds of proposals. Most of the grants currently in the Phase 2 process therefore did not at the outset have a unified set of quantified targets aligned with the grants' core activities. Many targets set for Rounds One and Two grants were related to processes rather than program achievements towards reaching more people with services. In many grants, reliable baseline data were also missing.

**42.** A major effort has been made over the past year to retrofit these early grants with key performance targets and to develop baseline data. The Phase 2 assessment of the earliest Global Fund grants will nonetheless involve a greater degree of qualitative judgment on the feasibility and future potential of the funded programs than will be the case for grants from Round Three onwards. As the clarity of indicators and targets is now improved and quarterly or six-monthly milestones have been set, the management of grants has become more objective and can be more easily assessed.

## HARMONIZING INDICATOR DEVELOPMENT

The Global Fund works in close partnership with funded countries and with other funding and technical agencies to build a "culture" of performance measurement. One key product the Global Fund helped to initiate was the *Monitoring and Evaluation Toolkit for HIV/AIDS, Tuberculosis and Malaria,* which was launched in 2004. The *Toolkit* brought together a full range of international partners (the Centers for Disease Control, the Department of State (USA), the Department of Health and Human Services (USA), the Global Fund, UNAIDS, UNICEF, USAID, the World Health Organization and the World Bank), to agree on a common, minimum set of global indicators for reporting on HIV/AIDS, TB and malaria for the first time. This is important since there is such a large number of potential indicators to measure the many and varied elements of program coverage for the three diseases.

The *Toolkit* helps to simplify the challenge of reporting at recipient-country level to multiple donors by contributing to harmonized reporting requirements, and it ensures that a common set of indicators are used to measure interventions throughout the country, which will result in harmonized data at the national level and ultimately contribute to showing measurable global progress. Challenges in monitoring and evaluation systems remain in many countries, and the support of donor and technical partners will remain critical in the coming years.

The creation of the *Toolkit* was followed up by joint training of the field staff of all involved partners, including the Global Fund, in August 2004.


Continued regional training will be conducted throughout 2005. These developments have been important in harmonizing monitoring and evaluation approaches among partners at national and international levels. The *Toolkit* aims to simplify reporting to donors by focusing on coverage (people reached, service points supported, people trained).

The *Toolkit* assists applicants for Global Fund grants to design their applications around a universally-agreed set of performance indicators and helps focus their proposals on output rather than process. This simplifies the processes of assessing grant applications, agreeing on program targets and indicators for the grant agreement, and measuring progress.

# System effects: level three of the measurement framework

**43.** 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. In 2004, under the oversight of the TERG and the Board's MEFA Committee, a set of core indicators and measurement tools was developed, in conjunction with a wide set of partners and stakeholders, to measure such effects. A particular focus was placed on additionality of resources, long-term sustainability of efforts and harmonization between technical and donor agencies. Measurement of these indicators will be a priority in 2005. An additional area of focus was national partnerships under the guidance of CCMs. A baseline study of the composition and level of functioning of CCMs is currently underway for 120 CCMs, with results expected in June 2005.

**44.** Many of the measures selected as core indicators for additionality, sustainability and harmonization build on recent work and research done by the Global Fund's partners, and information is not regularly available for the majority of funded countries. As a result, the developed measurement systems for this area will also serve as guidance for future measurement activities by partners and stakeholders in funded countries. The Global Fund is working with its key technical partners such as WHO, UNAIDS, OECD and others to establish baselines for these indicators for as many countries as possible. A full report will be given to the Board of the Global Fund at its December 2005 meeting. The Secretariat, with support from the TERG, is also planning to prepare an interim report for review before the second replenishment meeting in September 2005.

## The Role of the Country Coordinating Mechanism (CCM)

The Country Coordinating Mechanism (CCM) is one element of Global Fund architecture that will be examined more closely in 2005, in terms of its effects on harmonization with national-level processes and partnerships related to the three diseases and broader health systems in funded countries.

The CCM is one of the major mechanisms of the Global Fund to achieve broad participation and coordination in funded countries. By requiring grant proposals to be submitted by CCMs, the Global Fund has catalyzed a process with several far-reaching consequences. In many countries, it has provided legitimacy for previously marginalized groups, especially representatives of people living with HIV. For many of these groups, as well as for many nongovernmental and faith-based organizations, the CCM has been their first opportunity to become part of national decision-making and priority-setting for health issues. The CCMs also include international partners operating in funded countries, which is essential for the harmonization of external technical and other support.

In a number of countries, however, the CCM model is an idea somewhat ahead of its time and has not worked as well as hoped. Some of the problems facing CCMs are due to practical limitations: travel costs, language barriers, lack of organization among constituencies and scarce resources for administration have all hindered the smooth functioning of some CCMs. In others, the government has not been willing to fully include nongovernmental groups in decision-making processes and oversight functions, and this has reduced genuine multi-sectoral participation. In addition, in many countries, the role of the CCM vis-à-vis other fora for health planning and coordination needs to be clarified in order to align CCMs with the UNAIDS principle of "The Three Ones": **one** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; one National AIDS Coordinating Authority with a broad-based multi-sectoral mandate; **one** agreed national-level Monitoring and Evaluation System. The CCM is a mechanism which is flexible enough to incorporate other decision-making bodies where appropriate.

Improving CCMs is among the most central priorities of the Global Fund. However, while CCMs in many countries are in need of reform, not even their critics are in favor of scrapping what is a cornerstone of the Global Fund structure and process. CCMs have taken inclusiveness and multi-sectoral collaboration a step forward in the health sectors of many developing countries.

Over the past 18 months, the Global Fund Secretariat has undertaken a comprehensive analysis of the early experiences of CCMs based on case studies from 17 countries, an in-depth tracking study of CCMs in four countries, two multi-country studies of NGO involvement in CCMs, a multi-country study on the involvement of People Living with HIV/AIDS, an International Labour Organization review of private sector participation, and two studies of faith-based organizations' integration into Global Fund processes, as well as feedback from regional meetings, Secretariat staff and the Global Fund's Partnership Forum, held in July 2004.

In November 2004, the conclusions of this analysis led the Board to approve a set of revised requirements and recommendations for CCMs (outlined in the new *Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms*) covering areas such as membership, representation and process. Other results of the analysis include a series of workshops to be carried out in 2005 to build capacity in common areas of weakness, including project management and basic business skills, and an expansion of the Global Fund's mailing list for CCM communications to include all CCM members.

As part of the development of measurements for system effects, the Global Fund has developed a simple CCM checklist (see Appendix 2), which will serve as a tool for yearly self-assessments of CCM composition and functioning and as a basis for regular sample audits. The Global Fund has initiated a study that will develop a set of baseline data for all CCMs by June 2005. Results from the pilot phase, which began in January 2005, will be presented to the TERG and the Board's MEFA Committee in March 2005.

# Impact: level four of the measurement framework

**45.** In the end, of course, it is the impact on the ground that is most important. The Global Fund was set up to halt and begin to reverse the spread of the three diseases, and it should be assessed on the extent to which it succeeds in doing so. However, impact on infection rates and lives saved takes considerably more time to measure than the twenty months any of the Global Fund grants were in operation when this report was written, let alone the average 11-month age of the entire grant portfolio. The focus of this report is therefore largely on the operational performance, the grant performance and early indications of the wider (or indirect) systems effects of the Global Fund's activities to date.

**46.** Including clearly-identified impact targets in each grant is important to ensure that coverage indicators support the overall impact goals and objectives for funded programs and countries. Measuring the impact of funded programs is also critical for measuring the impact of the Global Fund as a financing mechanism. In addition to coverage indicators (the numbers of people reached or service points established, for example), impact indicators are included in the joint Monitoring and Evaluation Toolkit, which provides recipients with a common sourcebook for a broad range of measurement indicators. An important part of grant management in 2005 will be the wider inclusion of impact indicators in grant agreements. Already, the grant proposal form for Round Five has been strengthened to include clearly-defined goals (impact targets) and measures. As older grants start move into their second phase, they are required to include impact goals and indicators in their extended grant agreements, and this will start with the first tranche of Phase 2 grant agreements approved in February 2005.

# Global Fund results to date

Investing in the Future


**This chapter reports on the performance of the Global Fund's operations and grants to date. For an explanation of the Global Fund's measurement systems for assessing operations and grant performance, turn to the previous chapter, entitled "Measuring Performance".**

## A DEMAND-DRIVEN GRANT PORTFOLIO

**47.** The Global Fund finances grants through rounds of grant applications. To date, four rounds have been approved and a fifth has been launched and will come up for approval at the Eleventh Board Meeting in September 2005.

**48.** Through its first four rounds, the Global Fund has approved a total of US$ 3.1 billion over two years to 310 programs in 127 countries. The four proposal rounds were approved in April 2002, January and October 2003, and June 2004. With a few exceptions, the countries benefiting from these grants comprise all those that are currently experiencing the most severe burdens of disease or are at risk for future disaster due to rapidly-growing infection rates. Nearly two-thirds are countries classified by the World Bank as low-income countries, while one-third are lower-middle-income countries with severe disease burdens or very high infection growth rates. Three percent of the port-

folio goes to ten upper-middle-income countries with very high disease burdens or infection growth rates.[2]

**49.** Despite the fact that there are no criteria for grant approval other than the technical quality of proposals, a persistent distribution pattern has emerged for grants over the four rounds. Sixty percent of the approved funding is going to sub-Saharan Africa, while 23 percent is spent in Asia, the Middle East and North Africa, and the remaining 17 percent is shared between Latin America, the Caribbean and Eastern Europe. Just over 56 percent of funding goes to fight HIV/AIDS, 31 percent goes to malaria and 13 percent is allocated to TB programs.

**50.** Reflecting the breadth of Global Fund recipient partners at the country level, half of the principal recipients are governments, while one quarter are non-governmental organizations, and the remaining quarter are faith-based organizations, private sector companies, academic institutions or communities living with the diseases.

**51.** One of the major changes in development assistance for health over the past few years has been the acceptance by donors of the necessity of financing drugs and health-related commodities with an open-ended timeframe. As the need for a drastic expansion in the use of these products – such as antiretrovirals and other drugs, condoms, diagnostic equipment and insecticide-treated bed nets – became apparent, it also became clear that developing countries would not be able to finance the full cost of large-scale purchasing in the short- or medium-term. The Global Fund was set up in part to finance these purchases, and approximately 50 percent of committed funds are for the purchase of drugs and other commodities. The rest is being used to strengthen infrastructure and expand the training of healthcare and other supporting personnel.

[2] *The ten upper middle-income countries currently receiving Global Fund grants are: Argentina, Belize, Botswana, Chile, Costa Rica, Croatia, Dominica, Estonia, Gabon and Panama. Based on stricter eligibility criteria established for future funding rounds, only Botswana and Gabon will be eligible for future funding.*

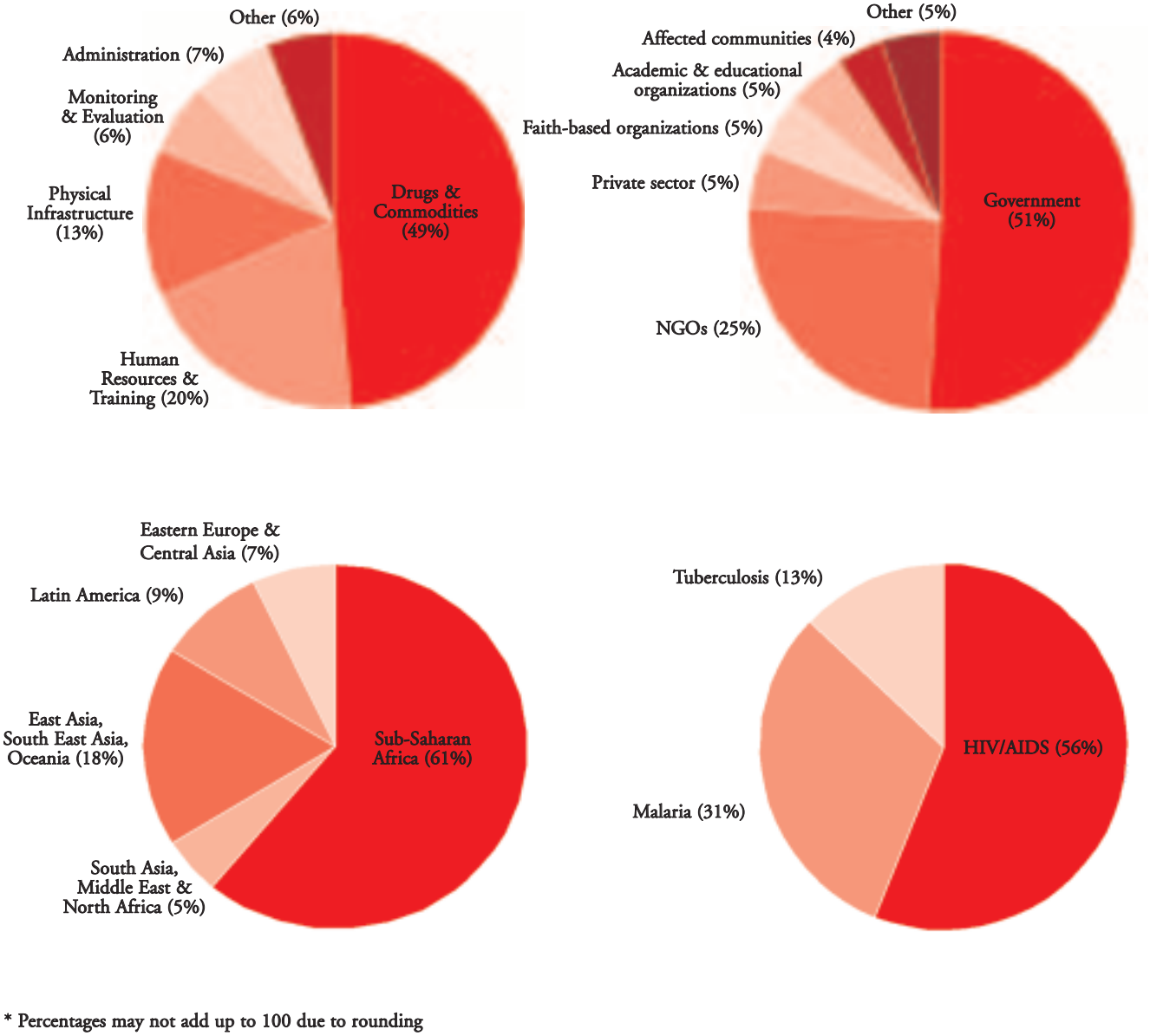



*Figure 7: Breakdown of Global Fund grants by type of expenditure, sector of recipient, by region and by disease*

**52.** Although the Global Fund is dedicated to the fight against the three diseases, it was designed and operates with a view to strengthening overall healthcare delivery systems in funded countries. Wherever possible, it emphasizes the need for integration and synergy with general health services and the importance of avoiding duplication or unnecessary "vertical" programming within the health sector. In a number of countries – in particular in sub-Saharan Africa – HIV/AIDS, TB as an opportunistic co-infection with HIV/AIDS, and malaria constitute an overwhelming burden on existing health services. A strengthening of health system capacity to deal with these diseases will strongly improve overall health system performance.

**53.** Most grants are at an early stage, building the capacity to reach more people in the near future. The average age of a Global Fund grant at the end of 2004 was eleven months. Looking across the portfolio, 57 percent of grants had used less than half of their initial two-year grant amount, 26 percent had used 50 to 75 percent, and only 16 percent of grants had reached the stage of receiving 75 to 100 percent of their two-year grant amount. This disbursement rate corresponds roughly to the age of the grants. The following is an analysis of the Global Fund's grant portfolio to show the degree to which both grant performance and the Global Fund's operations are living up to expectations, three years into the Global Fund's existence and at a point where the 27 first grants have reached the two-year mark in their lifecycle.

## OPERATIONAL PERFORMANCE – RESULTS

**54.** As described above, the Global Fund measures operational performance against indicators and targets relative to five core processes: resource mobilization, proposal management, grant negotiation, disbursement and grant management, and business services. Results as of the end of January 2005 for each of these areas are described below.

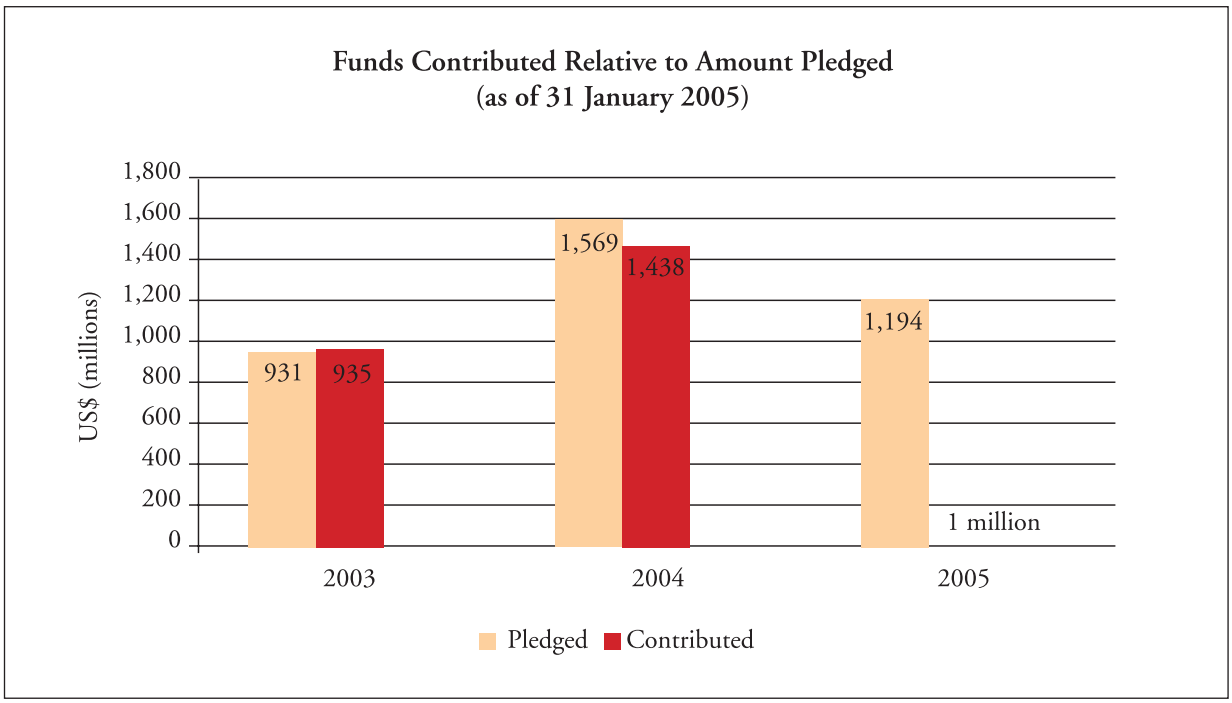



*Figure 8: Donor contributions versus donor pledges and Global Fund targets*

## Resource Mobilization

**55.** In 2004, new pledges were made by five governments and additional pledges were made by 13 governments and others. This resulted in a 2004 pledge amount of US$ 1,569 million.

**56.** As of 31 January 2005, US$ 1,438 million had been paid to the Global Fund, which represents a slight shortfall compared to pledges made. As of 31 January 2005, two outstanding payments were in the process of being paid and two had been delayed for administrative reasons.

## Business Services

**57.** A key consideration for the Global Fund is to keep its operations lean. There is no Global Fund presence outside its offices in Geneva, Switzerland, and it makes extensive use of consultants to carry out time-limited tasks and develop new operational procedures or policy options. For example, LFAs are contracted to verify grant performance in funded countries.

**58.** The operating expenses of the Global Fund comprise the expenses of the Secretariat, Board and Technical Review Panel, and fees paid to Local Fund Agents for oversight of the fund's grants in recipient countries. An indicator used to measure the efficiency of this operating overhead is the ratio of operating expenses to total expenditure. Total expenditure reflects both grant expenditure — the amount of grant commitments entered into during the year — and operating expenses (see Figure 9, below). As the size of the Global Fund's grant portfolio increases substantially over the coming years, operating expenses are expected to become a diminishing part of total expenses, reaching less than two percent by end of 2006.

**59.** The Global Fund has received a wide array of critical support from the private sector on a pro bono basis (see Figure 10, below). These contributions, valued at over $10 million in 2004, ranged from consulting services to advertising and marketing support and from staff secondments to celebrity engagements. The donation of *pro bono* services is becoming an important way for the private sector to demonstrate its support for the Global Fund, and many of these services will be ongoing in 2005.

| Areas of expenditure | Total spent (in millions US$) in 2004 | Percentage of total expenditure in 2004 |
|---|---|---|
| **Grants** | 878.0 | 95.4 % |
| **LFA fees** | 13.8 | 1.5 % |
| **Secretariat** | 26.4 | 2.9 % |
| **Board & Technical Review Panel** | 2.3 | 0.2 % |

*Figure 9: Secretariat expenses as a percentage of total expenditure in 2004*

| NAME OF PROVIDER | BRIEF DESCRIPTION OF GOODS/SERVICES RECEIVED FREE OF CHARGE |
|---|---|
| Booz Allen Hamilton | Review Board & Committee structures |
| Celebrity: India Arie | Time and creative services in producing Global Fund documentary in Africa in partnership with VH1 |
| Celebrity: Rupert Everett | Time and creative services in producing Global Fund documentary in Asia |
| Celebrity: Emma Thompson | Creative services in providing voice-over for Global Fund video (European version) |
| McKinsey | Develop Executive Director's performance criteria |
| Piper Rudnick | Legal advice and staff expertise on various issues to develop the Global Fund's risk management system in 2005 and beyond |
| Publicis Group and media partners | Advertising services and airtime/print space for Global Fund advertising campaign in France |
| Sidley, Austin, Brown & Wood | Legal advice and preparatory work on registering the Global Fund name and logo internationally. |
| Sterling Group | Marketing strategy consulting services to refine the external positioning for the Global Fund and help the Fund better communicate with the key target audiences |
| The Bill and Melinda Gates Foundation | Cost of secondment of Al Nimocks from FHI to organize Partnership Forum |
| UN Foundation | Sponsorship of Global Fund consumer website development |
| UN Foundation | Management of private donor contributions to the Global Fund and dedicated staff to mobilize partnerships and resources for the Global Fund |
| Viacom (VH1) | Advertising services and airtime for Global Fund advertising campaign |

*Figure 10: List of pro bono services contributed by the private sector in 2004*

**60.** While a lean Secretariat will continue to be the norm, the Global Fund is still adjusting its staffing levels to an optimal size with which to manage its grant portfolio effectively. Experience has shown that too little capacity in the Secretariat slows down grant management and increases risk. After an external review of staffing levels, the Global Fund is following recommendations to increase staffing from 118 fixed-term positions by the end of 2004 to a maximum of 150 positions in 2005. According to the staffing review, the Global Fund should be able to effectively manage the volume of grants foreseen by 2007 with no more than 200 staff.

## Grant management

### Pace of grant management

**61.** As mentioned above, Rounds One and Two grants were approved and signed at the same time as the Global Fund was developing its operational procedures and guidelines. One of the consequences of this parallel process was that early grant agreements were signed before necessary assessments of principal recipients' financial and procurement capacities had been completed. This often slowed down grant implementation, since weaknesses were discovered and had to be rectified before any substantial grant activities could begin. Another consequence was that early grants were signed without targets that measured core activities of funded programs, instead often including targets that measured related but not core activities.

**62.** From Round Three onwards, the Global Fund's Secretariat has given particular attention to improving the quality of the grant agreements signed. It is working with its partners to ensure that all grants have clear performance targets that show the coverage of their grant activities – in other words, targets that reflect people reached, service points supported and people trained within defined service delivery areas. The Secretariat also now requires that all PR assessments are completed before the grants are signed, in order to reduce the number of conditions precedent to grant signing. This will lead to faster disbursement. Finally, proposal formats for future rounds have been improved to ensure all critical information required for TRP review is included in the proposal and to make them more user-friendly.

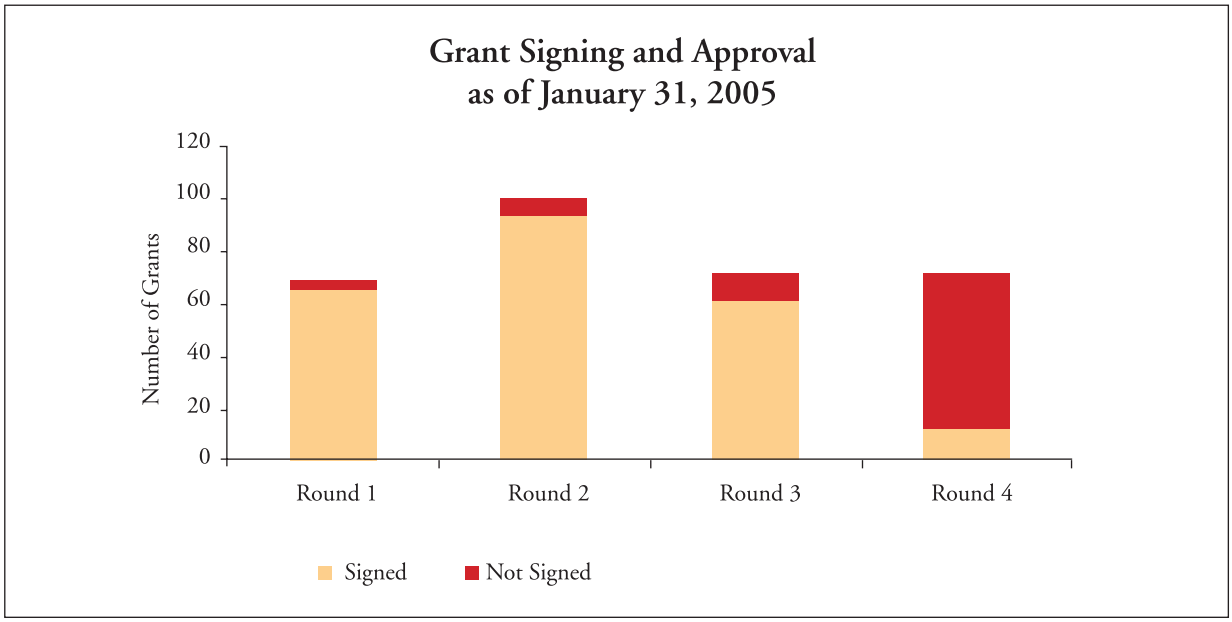



*Figure 11: Grant agreements signed as a proportion of total grants approved by the Board*

**63.** As of 15 February 2005, the Global Fund had signed 67 grant agreements for Round One out of a total of 69. One grant (to the Democratic People's Republic of Korea) had been cancelled and one grant to Zimbabwe was being negotiated. For Round Two, 97 grant agreements had been signed out of a total of 100 (the three outstanding agreements are still under negotiation). As of early February, 69 grant agreements had been signed out of a total of 71 for Round 3. Of the remaining Round 3 grants, a grant for the Democratic People's Republic of Korea was cancelled, as was a grant for Iran, and negotiations were in progress for a Multi-Country Americas grant and a grant for Yemen. Round 4 was approved at the end of June 2004 and as of early February, 20 grant agreements out of a total of 72 had been signed. Grant signing for remaining Round 4 grants will increase rapidly over the coming months, with a target of having 100% of Round 3 and 80 percent of Round 4 grants signed by the end of March 2005.

### Disbursement

**64.** The rate at which the Global Fund disbursed money to grant recipients accelerated in 2004 and reached a cumulative total amount disbursed of US$ 873 million by 31 January 2005, out of a total commitment in signed grant agreements of US$ 1.89 billion. Of funds disbursed to that time, 52.4 percent was disbursed to sub-Saharan Africa, 17.3 percent to East Asia and the Pacific, 13.3 percent to Latin America and the Caribbean, 9 percent to Eastern Europe and Central Asia, 3.5 percent to North Africa and the Middle East, and 4 percent to South Asia.

**65.** To evaluate whether disbursements are on track, the Global Fund compares disbursed funds as a percentage of all committed funds with the proportion of time elapsed since the grant agreements were signed. Applying this technique, the disbursement record is described in Figure 12, below, for each funding round and for the portfolio as a whole.

**66.** Of the total amount of disbursements to 31 January 2005, 82 percent was disbursed to Rounds 1 and 2 grants, 16 percent to Round 3 grants and only 2 percent to Round 4 grants. Round 3 and 4 grants, which are younger, have disbursed in excess of grant time elapsed because the first disbursement to recipients is usually larger than average. Over time, expenditure lines up more closely with time elapsed. From 2005, Rounds 3 and 4 grants will receive increasing disbursements and therefore contribute much more significantly to results. Overall, disbursements are roughly on track relative to the time elapsed for signed grants.

**DISBURSEMENTS BY FUNDING ROUND** $ figures in millions, as of 20 January 2005

| Round | Approved | 2-year approved[1] | 2-year signed[2] | 2-year disbursed[3] | Mean percent of 2-year amount disbursed[4] | Mean time elapsed[4] |
|---|---|---|---|---|---|---|
| Round 1 | Apr-02 | $ 558 | $ 545 | $ 372 | 70 % | 80.6 % |
| Round 2 | Jan-03 | $ 859 | $ 794 | $ 479 | 48 % | 52.3 % |
| Round 3 | Oct-03 | $ 639 | $ 477 | $ 141 | 33 % | 20.6 % |
| Round 4 | Jun-04 | $ 1,039 | $ 70 | $ 19 | 28 % | 5.6 % |
| **Total** | | **$ 3,094** | **$ 1,884** | **$ 871** | **49 %** | **48.9 %** |

[1] Proposals approved by the Board (5-year terms, with initial approval covering years 1-2)
[2] Grant agreement signed by the Secretariat, committing funds for 2-year term of grant
[3] Amount transferred to recipients – disbursed incrementally based on performance
[4] Calculations based on grants which have received one or more disbursements

*Figure 12: Approvals, commitments and disbursements by funding round*

**Performance-based funding in action**

**67.** While comparing the rate of disbursement with time elapsed since grant agreement signing is an important way to evaluate whether or not disbursements are on track overall, the disbursement rate for any single grant is never constant. Disbursement rates may vary for a number of reasons:

- some grants absorb money more slowly than others due to limited capacity; with many, absorption capacity will grow over time as grant funding, partner involvement or a broadened sub-recipient base result in an increase in absorptive capacity;
- the first disbursement after grant signing is often significantly larger than many later disbursements in order to allow recipients to make contract commitments and other initial expenditures;
- the level of verifiable programmatic performance – a lack of progress on the part of the PR or evidence that the PR is not disbursing to sub-recipients causes recipients to receive money at a slower rate; and
- the amounts of disbursement requests vary according to the types of activities planned for the disbursement period – for example, drug procurement requires more money than the training of staff.

**68.** Non-governmental PRs have performed well in absorbing funds, with an average disbursement rate of 91 percent of expected disbursement, as compared to an average of 79 percent for governmental PRs.

**Grant management response to under-performing grants**

**69.** Internal analysis of under-performing grants shows three main causes for delays or slow progress. The first cause is a lack of capacity to execute the often sizeable programs, which frequently involve significant scale-up of new services with little in-country experience. In these cases, the Global Fund's role has been to assist in identifying weaknesses or bottlenecks and encourage appropriate assistance from a wide spectrum of partners. Most frequent among the bottlenecks are procurement delays. A number of recipients have time-consuming procurement rules, and for some grants, activities have been held up while waiting for drugs and other commodities to arrive. For most of these, activities have greatly accelerated once supplies arrived, and in most cases these grants are likely to catch up with their projected targets before the end of the first two years.

**70.** In some cases, it has been the Global Fund's procedures or lack of clarity regarding these procedures that have caused delays, particularly where Global Fund grants have been integrated into existing donor harmonization efforts, such as with Sector Wide Approaches (SWAps) and basket arrangements. The Global Fund's Secretariat has revised its operational and monitoring guidelines to integrate its grant procedures with donor harmonization efforts so that it can operate flexibly in a variety of partnership and funding situations. One country where such streamlining has taken place after first having caused delays is Mozambique, where Global Fund grants are now part of the country's health sector basket arrangement.

**71.** Finally, slowdowns in implementation can be due to a variety of internal issues within funded countries, ranging from repeated changes of political leadership or senior management to conflicts between national actors. In these situations, there is little the Global Fund and its partners can do, beyond identifying the cause of delays and propose solutions where they can be found.

**72.** Over the first 18 months of the Global Fund's existence, a portfolio manager handled all of the issues associated with each of their grants. As the implementation of some grants faced more obstacles than others, portfolio managers quickly found that a few grants took up most of their time, leaving little time to support their remaining grants. In May 2004, the Global Fund created a support unit, Operational Partnerships and Country Support, whose responsibility is to assist slow-moving grants, leaving the portfolio managers free to continue routine support of higher-functioning grants. This process has enabled the Secretariat to simultaneously serve recipients better by devoting more resources to particular issues before they turn into serious problems and to better manage the Global Fund's risk exposure.

## GRANT PERFORMANCE: OVERALL PORTFOLIO RESULTS

### Overall Targets and Results

**73.** Each Global Fund grant sets a target for the numbers of people it aims to reach with key interventions over the five-year lifetime of the grant. When the targets for all grants in the first four funding rounds are tallied, a cumulative set of global targets is reached for what can be called the "return on the Global Fund's investments":

HIV/AIDS
- 1.6 million people on antiretroviral treatment
- 52 million people reached with voluntary counseling and testing for HIV
- More than one million orphans supported through medical services, education and community care

TUBERCULOSIS
- 3.5 million additional TB cases treated successfully under the DOTS treatment strategy
- More than 12,000 new treatments for multidrug-resistant tuberculosis, quadrupling current numbers on treatment

MALARIA
- 108 million bed nets to protect families from transmission of malaria
- 145 million artemisinin-based combination treatments for drug-resistant malaria

**74.** These are rolling targets, since they will increase as new rounds are included and since the five-year target refers to the lifetime of each grant and not to a fixed calendar period. Since they include Round Four grants which have yet to start implementation, the first batch of grants contributing to these targets will reach their targets by 2007 and the last batch by early 2010. Long before then, however, there will be more grants approved in successive funding rounds, so these targets will increase with each new round.

**75.** By the end of 2004, the average age of Global Fund grants was 11 months. Cumulative results for the grant portfolio as of 31 December 2004 were as follows*:

HIV/AIDS
- 130,000 people on antiretroviral treatment
- More than 1 million people reached with voluntary counseling and testing services for HIV

TUBERCULOSIS
- 385,000 TB cases treated under the DOTS strategy**

MALARIA
- More than 1.35 million families with insecticide-treated bed nets to prevent malaria
- More than 300,000 people with highly effective artemisinin combination treatment for malaria

*No significant results for HIV orphans and multi-drug-resistant tuberculosis cases have been recorded yet, as these targets predominantly stem from grants that are too young to show results.
**Some of these treatments are not yet completed and can therefore not yet be proven "successful"

**76.** In addition, an estimated tens of millions have been reached through a wide range of prevention programs, including behavior-change campaigns, community outreach programs, condom distribution, targeted support for injecting drug users, sex workers and mobile populations, school programs, and awareness-raising for communities and the media.

**77.** Given the young age of the Global Fund portfolio, it is impossible to draw any authoritative conclusions concerning the extent to which these results indicate that the cumulative five-year targets will be reached. Some indications on the pace of progress can be drawn from the analysis of the 27 grants in the following chapter, but 27 grants is too small a sample to draw conclusions for the overall grant portfolio.

**78.** Another indication of the pace of progress is to look at the growth and acceleration of grant achievements between their one-year mark and their 18-month mark. Of the 27 grants analyzed below, fifteen were also analyzed in June 2004. In comparing the June and December 2004 results of these 15 grants, a steady growth and in some cases an acceleration of results is apparent during the first half of the second year. The number of people reached with TB treat-

ment under DOTS increased by 70 percent between June and December 2004, and the distribution of insecticide-treated bed nets increased by 103 percent during the same time period. The acceleration of TB and malaria programs is not surprising, given that the first year of a grant is predominantly spent on logistical issues, physical infrastructure, procurement and training, and that these lay the ground for an acceleration of services in the grants' second year. Antiretroviral treatment numbers show steady growth rates, with results increasing by 52 percent between the 12-month and 18-month marks. These results reflect the challenges faced in scaling up ARV treatment access in settings where training, testing, and diagnostic facilities are inadequate and where capacity-building issues are more complex.

**Capacity-building**

**79.** As important as the Global Fund's "headline" results is the way grants are building human resource capacity and physical infrastructure in order to accelerate the scale-up of prevention and treatment services in the near future and to ensure that the quality of services provided is high. The grants have made important investments in country capacity as the basis for future scale-up. Over 350,000 people were trained to fight HIV, TB and malaria in 2004 – from ministries of health to community organizations and peer educators. Of Global Fund grants approved to date, 20 percent will be spent on human resources and 13 percent on physical infrastructure.

**80.** In many countries, Global Fund grants are being used to scale-up existing efforts and to pilot new or expanding programs; in other countries with little capacity or infrastructure, national governments, NGOs and other program implementers are working hard with the assistance of bilateral and multilateral partners to improve procurements systems, train staff and build clinics.

**81.** The results of Global Fund financing are the results of the work of a broad range of implementing partners. The Global Fund disburses grant funding to a wide selection of principal recipients, including government ministries, non-governmental organizations, private sector businesses, faith-based organizations, academic institutions and organizations representing people living with or affected by the diseases.

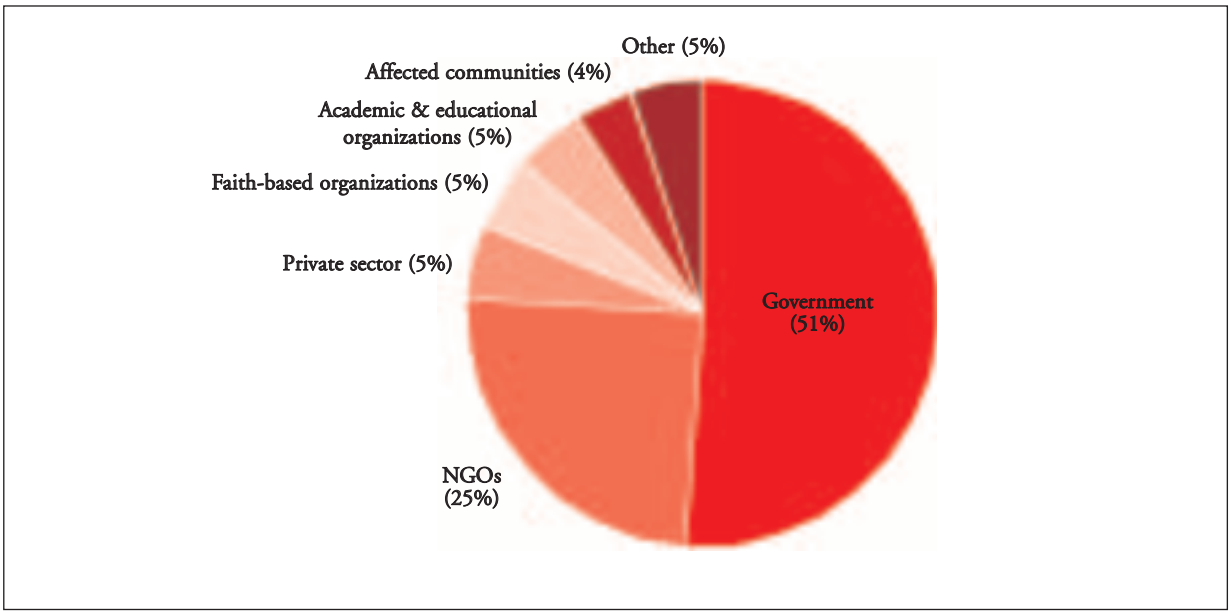



*Figure 13: Distribution of Global Fund grants by sector of recipient*

**BUILDING CAPACITY – FIGHTING DISEASE ON MANY LEVELS.**

With its grants, the Global Fund aims to build long-term capacity to fight the three diseases in recipient countries. The number of performance indicators is therefore large, including training, capacity-building, integration of targeted programs into wider settings and fighting stigma. Three country examples reflect this variety of indicators.

In addition to setting a target of getting 650 people on ARV therapy during its first 18 months, Morocco's HIV/AIDS grant included a component to train 1,000 educators in prevention work for young people and women during that same time frame. In general, achievement of anything over 80% of targets is considered substantial progress. In the grant's first six quarters, Morocco had trained 900 educators and put 706 people on ARV therapy, reaching 90% and 108% of targets, respectively.

In Burundi, the grant had set a target of reaching 3,280 people with ARV therapy and providing psychosocial treatment to every person who was reached with ARVs in order to improve their quality of life. Over 18 months, 58 percent of the 18-month target was reached, both for ARV therapy and psychosocial treatment.

The TB grant in India trained 73 laboratory technicians to diagnose TB (the target was 18) and has established and supported 475 microscopy centers (against a target of 334).

**82.** However, it is important to remember that these PRs further distribute funds to sub-recipients. In Zambia, for example, sub-recipients include health districts, faith-based organizations and non-governmental organizations; in China, there are several thousand sub-recipients at every level of government right down to district level. Results to date are the culmination of their efforts in the fight against HIV/AIDS, TB and malaria. It is the people at all of these levels – principal recipients, sub-recipients and sub-sub-recipients – and from the entire spectrum of public and private sectors that carry out the implementation of funded programs to fight the three diseases.

### Receiving Global Fund money at recipient country level – a range of experiences within one sub-region

In the **Western Cape, South Africa,** pilot programs run by NGOs were already in place treating hundreds of people for HIV/AIDS. Global Fund financing enabled these pilots to be rapidly scaled up, with local governments building on the successful NGO model to treat over 5,000 people – meeting their five-year treatment target in only one year. Global Fund financing was only one piece of the success amongst the concerted efforts of multiple players, but once all the elements were in place, treatment scale-up was very rapid. The Principal Recipient was amazed at the speed of the results and is now focused on scaling up prevention efforts as well as maintaining ongoing treatments.

In **Swaziland,** Global Fund financing has contributed significantly to a national response to HIV/AIDS that involves communities in the fight against the disease. Funding is being distributed to the Ministry of Health for some aspects of the response but also to hundreds of small, community-based organizations that work on the front line with people living with or affected by HIV/AIDS. The World Bank and other partners have provided technical support to fill some of the country's capacity gaps, for example, building the country's capacity for monitoring and evaluation of programs. The involvement of communities and partners has enabled the country to begin to scale the barriers to successful implementation, and funds are being quickly converted into measurable results, contributing to 5,453 people receiving ARV treatment in 2004.

In the **Southern African multi-country** malaria program, Global Fund financing was provided to an experienced academic institution, the Medical Research Council (MRC) of South Africa. MRC was the grant's principal recipient of a public-private partnership to scale up a well-developed malaria program, which had been successfully started and run by a private sector company to prevent and treat malaria among its employees and surrounding communities in Mozambique. The Global Fund grant has supported the expansion of the project in the Lubombo region, which stretches across three countries – Mozambique, South Africa and Swaziland – using technical input and expertise from private and public sectors. The funding has enabled a successful working model to be extended far beyond its original reach. In the first year, the program has resulted in early signs of declining parasite prevalence in the region, and malaria incidence has been reduced by up to 50 percent in some areas.

**Working with partners to maximize performance**

**83.** The Global Fund has no presence in the countries it funds, and as a funding mechanism, it plays no part in program implementation or providing technical assistance. However, as part of a dynamic network of development partners working to achieve greater combined results towards common goals, the Global Fund relies on its partners to provide technical expertise to grant recipients. The Global Fund's network includes a large and varied group of technical partners that carry out invaluable work to provide input to and build recipient-country capacity for proposal writing, program implementation, problem-solving, harmonization with existing systems and performance evaluation.

**84.** Over the past two years, much effort has been made both to strengthen and systematize the Global Fund's collaboration with technical partners, and to broaden its partner network for country-level technical support throughout the life cycle of each grant. UNAIDS is central within this network, and over the past year, the Global Fund's collaboration with UNAIDS has intensified in various areas. UNAIDS is

providing critical support to CCMs in preparing grant performance reports for Phase 2 renewals, leveraging about 30 new monitoring and evaluation officers who are being posted in various countries. In addition, UNAIDS is scaling up its involvement and staffing levels to intensify its capacity-building support.

**85.** Another central partner is the World Health Organization (WHO), and the Global Fund is working closely to expand and intensify its collaboration with WHO at all levels. In 2004, the Stop TB Department, in collaboration with the Global Stop TB Partnership, increased its provision of the technical support required by countries during the development of applications to the Global Fund and is providing significant support to countries that were approved for Round 4 TB grants pending clarifications on their proposals. WHO's Intensified Support and Action Countries initiative is supporting 17 Global Fund recipients in order to achieve more rapid and more effective program implementation. Stop TB is also supporting about 50 countries, including previously unsuccessful applicants in Round Four, in developing their applications for Round Five, which the Global Fund will approve in September 2005. Finally, the Global TB Drug Facility is working with recipients in eight priority countries to identify bottlenecks in their procurement and supply management systems and to implement solutions.

**86.** Similarly, close collaboration is taking place with the WHO's HIV/AIDS Department and the "3 by 5" initiative (to put three million people on antiretroviral treatment by 2005). A joint effort is underway to develop comprehensive technical support plans for accelerating the scale-up of antiretroviral therapy and prevention services in 15 to 20 priority countries. The support of the "3 by 5" initiative team in speeding up proposal clarifications on approved Round Four grants, like that of the Stop TB Department, has also been invaluable. In addition, WHO is strengthening its capacity to provide assistance to countries in procurement and supply-chain management.

**87.** In 2004, the collaboration with WHO's Roll Back Malaria (RBM) Department was close and complementary, specifically with regards to the ongoing effort to reprogram existing Global Fund grants to use new, more effective malaria treatments that use an artemisinin-based combination therapy (ACT). So far 26 countries have been directly assisted in this process, and a number of other countries will be assisted in producing grant proposals for the next funding round that cover the cost of changing national drug protocols to include ACT. RBM has provided valuable support to assist funded countries in accelerating implementation where progress on malaria programs has proven too slow. The Global Fund and RBM are also working to accelerate the roll-out of a new generation of long-lasting mosquito nets, which have proven highly effective.

**88.** The Global Fund has intensified dialogue on coordination, information exchange and assistance in program countries with bilateral partners. It draws on substantial support from Canadian, British, German, Swedish, American and French bilaterals and others that are providing training and technical support for the Global Fund application and implementation processes in recipient countries, and improving participation in CCMs.

**89.** The Global Fund is broadening and deepening its collaboration with NGO partners and the private sector based on lessons learned over the past two years. In a number of countries, the French-led ESTHER initiative supports Global Fund processes through technical assistance on high-quality treatment and care for people living with HIV/AIDS. The International Council of AIDS Service Organizations (ICASO) is providing support in translating CCM guidelines and working to increase civil society and community involvement in CCMs. A constructive dialogue is maintained with Médecins sans Frontières on important in-country issues, in particular concerning malaria and TB drugs. The Global Fund has also developed a plan for collaboration on drug prices and other areas of support with the Clinton Foundation for a number of sub-Saharan African countries. In working with the private sector, the Global Fund is making substantial effort to accelerate engagement through discussions on co-investment opportunities with corporations that have operations and expertise in developing countries.

### Scaling up global antiretroviral treatment coverage: a joint effort

Scaling up the numbers of people receiving ARV treatment for HIV/AIDS, and supporting the World Health Organization's global "3 by 5" initiative requires many partners to provide both financing and technical support. Treatment scale-up involves more than the procurement of drugs, which represents about one-third of the total cost. Other critical areas to enable treatment include: human resource training, preparing appropriately-supplied treatment sites, developing national drug protocols, and building referrals and comprehensive links with testing centers and organizations for community support. Some partners focus on one area and others play multiple roles.

In **Zambia**, several partners, including DFID, USAID and the Dutch are together contributing to the national ARV treatment program, which is coordinated by the Ministry of Health. The Global Fund has provided grants to the NGOs and the Churches Health Association of Zambia (CHAZ) and is supporting gaps in treatment and prevention where its funds can complement existing finance.

In **Haiti**, the Global Fund was the major initial financier in a treatment program that reached 2,308 people with ARVs in 2004. Coordination meetings are now ongoing to plan how best to allocate additional sources of finance emerging from the US PEPFAR initiative to fight HIV/AIDS, and to collaborate on procurement and drug regimes. Program work plans are being shared to ensure that funding is used in a complementary manner and to fill gaps rather than duplicating existing efforts.

In January 2005, the World Health Organization announced that a global total of 700,000 people were getting antiretroviral treatment, as compared with 440,000 in June 2004. Reaching these numbers involved sharing the data analysis among major partners in ARV scale-up, including PEPFAR, to ensure that the numbers were consistent. Global Fund grants supported treatment for 130,000 people of the 700,000 now on treatment.

## GRANT PERFORMANCE: ANALYSIS OF 27 PHASE 2-ELIGIBLE GRANTS

**90.** Performance-based funding occurs throughout the full lifecycle of a grant, from the proposal stage through grant agreement negotiations, successive disbursements and the annual review through to the decision to continue funding beyond the first two years, and to the end of the grant's life. The previous section outlined the Global Fund's overall portfolio results in terms of coverage, which are accompanied by the significant building of country capacity to scale up results in the future. At the foundation of the Global Fund's system to achieve results and to build capacity in recipient countries is a grant-by-grant process of performance evaluation.

**91.** Periodic performance evaluation in the first two years of a grant's life builds to a formal assessment at the two-year mark as to whether grants will receive Phase 2 funding to cover the remaining years of the approved grant period. This section of the report provides detailed analysis of the Global Fund's first tranche of 27 grants to reach formal Phase 2 evaluation. The first group of 27 grants reached this decision point on 1 February, 2005.

**Basis for grant evaluation: performance and contextual data**

**92.** Performance and contextual factors contribute to a broad range of information that is used to make the Phase 2 funding decision. This includes:

1. **General grant information and program objectives** – this captures the major elements of the proposal, goals, impact indicators and key dates.

2. **Program results compared to country-set targets** – these measure the services that were delivered and the progress made over time against the targets that were set out in the grant agreement. Indicators measure the numbers of people reached, the growth in capacity and the supporting environment of the grant.

3. **In-country assessments of Global Fund grants by Local Fund Agents** – this includes assessments made through the grant's first two years of procurement, monitoring and evaluation, and progress achieved at each disbursement period.

4. **Key performance and country contextual information** – this summarizes the performance data by showing the percentage of targets met for key service delivery areas. Contextual information of relevance to the interpretation of grant progress and performance is also included, such as levels of conflict in a country, natural disasters, etc.

**93.** All of this information is put into a "Grant Performance Report" which is posted on the Global Fund's website as a public document.

**94.** It is important to stress that the Phase 2 evaluation process is more than a mechanical system of measuring results against targets. The analysis combines grant performance with contextual considerations and leads to a classification of grants into the following categories: "A", "B1", "B2" or "C" (see Figure 14), with "A" meeting or exceeding expectations, "B1" being adequate, "B2" being inadequate but with potential demonstrated, and "C" being unacceptable.

**95.** Based on these categories, the Phase 2 evaluation results in one of a number of possible decisions:

- A ***Go*** decision, as shown by the green light in Table 15, below;
- A ***Conditional Go*** based on time-bound conditions, or a ***Revised Go*** based on a revision of the grant's original proposal, shown by the yellow light, or;
- A ***No Go***, which results in a discontinuation of funding, as shown by the red light.

**96.** There are many innovations in this approach to managing grants. Lessons learned by the Secretariat and grant recipients will be reviewed in 2005 and incorporated in the performance-based funding system going forward.

| | Grant Performance Rating System | | | |
|---|---|---|---|---|
| | **A** | **B1** | **B2** | **C** |
| *Actual results as compared to targets for key coverage indicators* | Meeting or exceeding expectations | Adequate | Inadequate but potential demonstrated | Unacceptable |
| i. Number of persons reached with services | Targets met or exceeding 80% | Significant improvements made (50-80%) | Some improvements made (30-50%) | Marginal or no improvements made (<30%) |
| ii. Number of service centers established/ strengthened | If the program has achieved at least significant improvements in terms of numbers of persons reached, the Global Fund does not need to consider lower-level indicators for the Phase 2 decision. | | Significant improvements made (>30%) | Marginal or no improvements made (<30%) |
| iii. Number of persons trained to deliver services | | | Significant improvements made (>30%) | Marginal or no improvements made (<30%) |

*Figure 14: The Global Fund's grant performance rating for Phase 2 funding evaluation*

| Decision category | Grant Performance rating | | Contextual considerations |
|---|---|---|---|
| "Go"<br>Phase 2 grant committed for the remaining proposal period (years 3-5) | A<br>expected or exceeding expectations | and | No or minor contextual issues |
| "Conditional go"<br>Phase 2 grant committed conditional upon time-bound actions to be taken | B1<br>adequate | and/or | Major contextual issues that can be addressed |
| "Revised go"<br>Reprogramming of grant (targets and Budget substantially revised for Phase 2) subject to Global Fund approval | B2<br>inadequate but potential demonstrated | and/or | Major recent improvements in program supporting environment |
| "No go"<br>Phase 2 grant not committed requires Board Decision | C<br>unacceptable | or | Critical contextual risks |

*Figure 15: Decision categories for Phase 2 funding*

## ACCELERATING IMPLEMENTATION: GREATER DISBURSEMENTS AND RESULTS

**97.** The 27 grants that were eligible for a decision on continued Phase 2 funding in February 2005 represent the first wave of over one hundred grants that will pass through this formal process in 2005. They provide some advance insight into the implementation of performance-based funding, and opportunities to improve this system as it is rolled out in 2005.

**98.** US$ 139 million has been disbursed to these 27 grants to date (as of January 31, 2005); US$ 88 million to AIDS grants, US$ 35 million for TB and US$ 16 million for malaria. They are the first wave of Global Fund grants and are dominated by grants from earlier rounds (25 from Round 1 and two from Round 2 grants). They represent the largest set of grant performance and financial data analyzed to date. This provides a strong performance data set for analysis. Although the grants analyzed here and the 15 one-year-old grants analyzed in June 2004 do not overlap completely, there are signs of accelerated programmatic progress in the last six months, as grants approach their two-year mark.

### Results against targets: 70 percent of the first 27 grants to approach Phase 2 funding have performed well or adequately

**99.** Overall results against targets for the 27 grants eligible for Phase 2 funding are shown below. Grants have overperformed against targets in areas such as TB treatment under DOTS, distribution of bed nets, and numbers reached by voluntary counseling and testing, and testing for the prevention of mother-to-child transmission of HIV. However, results are behind targets for the 27 grants for ARV prophylaxis treatment for pregnant women who have tested positive for HIV and for ARV therapy in general. ARV treatment figures are low largely due to procurement issues, particularly in Uganda and Senegal. Overall the results in these early grants are better for TB and Malaria.

| HIV/AIDS | % OF TARGETS MET |
|---|---|
| ARVs | 61% |
| PMTCT Prophylaxis | 72% |
| PMTCT Testing | 121% |
| VCTs | 122% |
| Orphans | 116% |
| People Reached – HIV/AIDS | 60% |
| People Trained – HIV/AIDS | 62% |
| **TB** | **% OF TARGETS MET** |
| DOTS | 101% |
| People Reached | 112% |
| People Trained | 105% |
| **MALARIA** | **% OF TARGETS MET** |
| Bed nets | 107% |
| Malaria Treatment | 79% |
| People Reached – Malaria | 91% |
| People Trained – Malaria | 79% |

*Figure 16: Overall Results of the first 27 Phase 2-eligible grants measured against their collective targets*

**100.** Many grants are now accelerating to achieve results (70 percent are rated A (10 grants) or B1 (9 grants). Twenty-two percent of grants have inadequate results (rated B2) but show potential, while eight percent of grants have unacceptable performance.

**101.** Grants rated A and B1 have received 92 percent and 86 percent, respectively, of their expected disbursements, and are successfully transforming finance into results at an accelerating rate. Furthermore the ten A grants account for over 50 percent of total results in key service areas such as ARVs, VCT and DOTs.

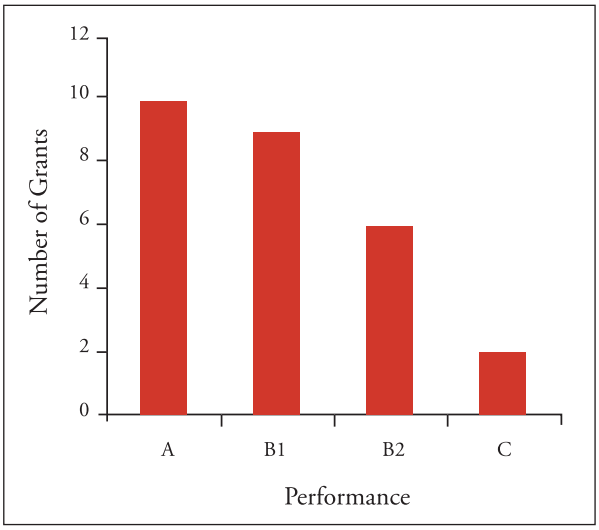



*Figure 17: Number of grants by performance category*

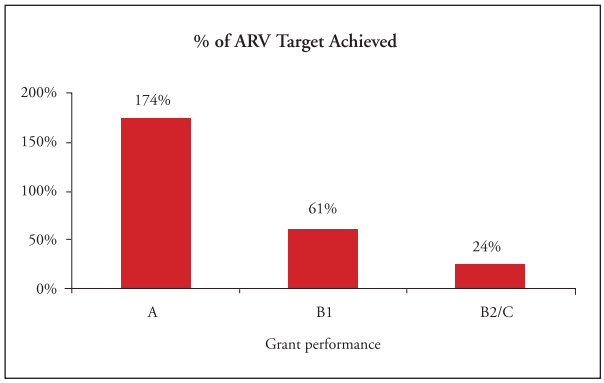



*Figure 18: Variation in ARV performance by grant category*

**Overperformance against targets in some grants**

**102.** While grants graded A and B1 have met their agreed targets for people reached and trained, B2 and C-graded grants are lagging significantly behind their targets with only 27 percent of their agreed targets met for people reached and 57 percent of their agreed targets met for people trained. Results for the numbers of people reached with ARV therapy reinforce this performance pattern. Figure 17 shows that A-graded grants outperformed their targets once implementation was underway, reaching 174 percent of their targets as they approached the end of two years. B1-graded grants reached 61 percent of their targets for people on ARVs, while B2 and C-graded grants reached only 24 percent of their ARV targets. Unfortunately, several grants with high ARV targets were in the B2 and C categories, bringing down overall performance of the 27 grants when their performance is measured against their combined targets.

**A subset of poorly performing grants need attention**

**103.** There are six grants with B2 ratings and two grants with C ratings among the Global Fund's first 27 Phase 2-eligible grants. The C grants represent a total of only US$ 4.6 million worth of disbursements to date, as opposed to their anticipated disbursement total of US$ 10.3 million (based on time elapsed). Looked at as a group, B2 and C-graded grants contributed significantly to the shortfall in the overall results of the 27 Phase 2-eligible grants compared to the combined targets of these grants. One hundred percent of the ARV treatment shortfall, 100 percent of the malaria treatment shortfall, 95 percent of the shortfall in people reached with HIV/AIDS interventions and 54 percent of the shortfall in people reached with malaria interventions are due to the underperformance of these eight grants.

**104.** Efforts therefore need to be taken to allow well-performing grants the opportunity for acceleration to perform beyond their targets. Significant attention must also be paid to underperforming grants, which, if not identified, can drag down overall grant performance significantly across the portfolio.

**Lessons learned from grant evaluation**

**105.** The data from these grants provides initial testimony to the value of the performance-based funding system. Grants that performed well received full and regular disbursements. Those that underperformed did not get their full anticipated disbursements either because they had underspent early disbursements due to slow implementation or they had not met the milestones set for their early disbursement periods. Lessons from all 27 grants will be incorporated to strengthen the system throughout 2005 as many more grants are formally evaluated as they approach the two-year mark.

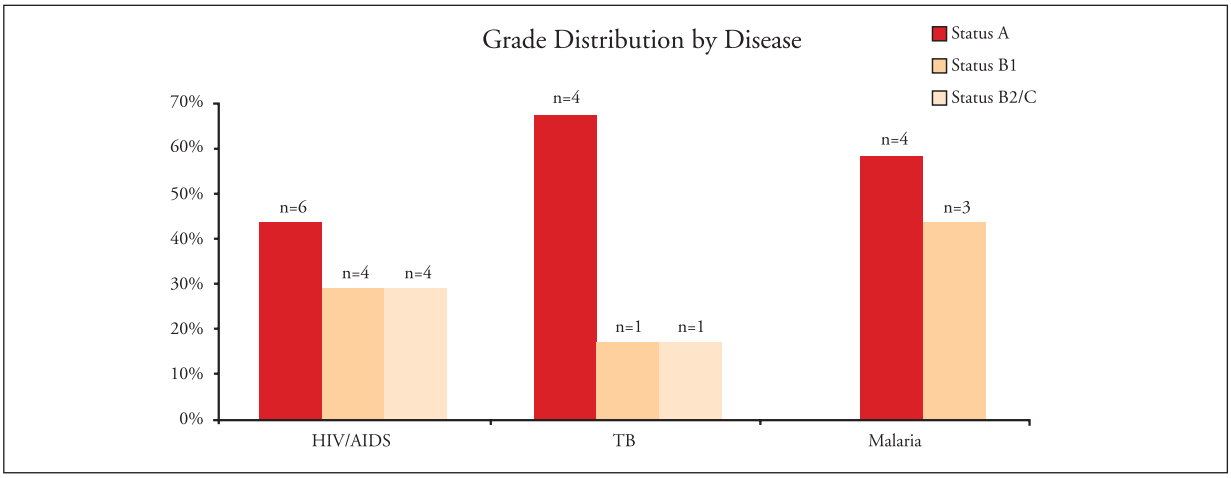
**Performance by disease, region and principal recipient**

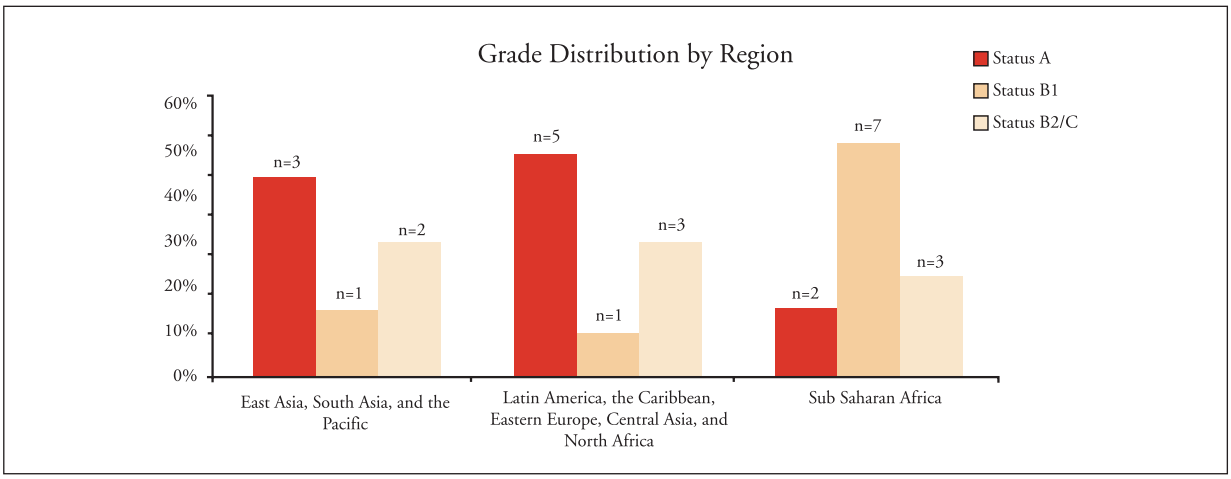
**106.** Of this first tranche of 27 Phase 2-eligible grants, analysis is limited because the number of grants is small when broken down by disease, region and principal recipient. However, some early patterns are apparent. Performance among these grants was particularly strong for those implemented by civil society – most notably for TB, followed by HIV and then malaria. Analysis by region shows that grants from sub-Saharan Africa have a slightly lower percentage of underperforming grants than other regions. They also have fewer overperforming, or A-graded, grants.

**107.** TB had the best performance profile among the 27 grants, with only 17 percent of TB grants falling into the B2 and C categories, followed by HIV with 29 percent and malaria with 43 percent. The disappointing results for the latter two were due largely to procurement problems in early grants in terms of HIV/AIDS-related drugs, malaria drugs and insecticide-treated bed nets. The Global Fund expects this profile to improve as the portfolio progresses because significant work is underway with technical partners and recipients to identify and solve procurement problems before procurement begins. While the HIV/AIDS grants among these 27 grants have met only 61 percent of their targets for delivery of ARVs, the results for the Global Fund's overall portfolio currently exceed their combined targets. The 27 early grants do not therefore reflect the overall performance results by disease as they are emerging in the overall portfolio.

**108.** By region, sub-Saharan Africa has a slightly higher percentage of grants in the B2 and C categories (33 percent) compared to 25 percent for other regions. Sub-Saharan Africa also has fewer A-graded grants – only 17 percent compared to 50 percent and 56 percent for other regions. While grants to sub-Saharan Africa are at no greater risk of underperformance than others, the stronger performers (B1 grants) from this region need support in order to start exceeding their targets and reach an A grade. In other regions the "bipolar pattern" of performance is marked. The majority of grants have now accelerated to an A grade, with a tail of B2 and C grants showing continued underperformance.

**109.** When broken down by type of sub-recipient, civil society has the strongest performance record with two A, two B1 and no B2 or C-graded grants. Principal recipients who are governmental or UNDP have a more even distribution of grants across performance categories, with 40 percent of government and 25 percent of UNDP grants in the A category (UNDP tends to manage grants in the most difficult country and grant situations).



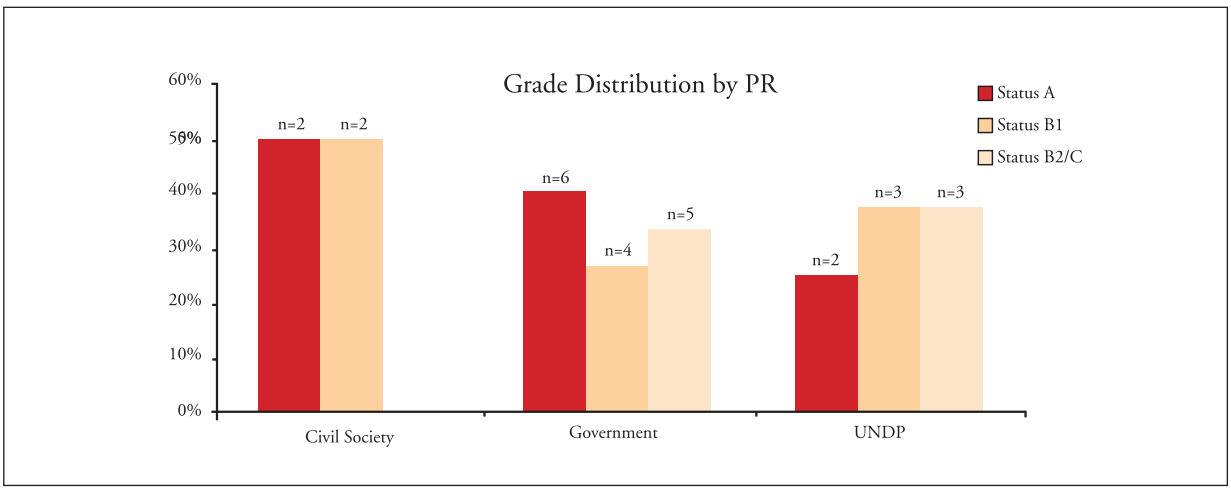




*Figure 19: Grant Performance by Disease, Region, and Principal Recipient Type*

### Evidence that performance-based funding is occurring

**110.** Overall, the analysis of grants shows a more bipolar distribution than seen the last in-depth progress analysis of a subset of grants in June 2004. Many grants have now accelerated their programs to achieve results, and disbursements are considerably higher. There is a subset of eight percent of grants in which underperformance is now critical, and 22 percent where performance is unsatisfactory but potential has been shown. Those grants with potential may require significant conditions, restructuring or shifting of resources if the overall Global Fund portfolio is to continue to reach its targets and build on its results to date.

**111.** There is additional evidence that performance-based funding is working as a system, with funds flowing well to high-performing grants and grants with low disbursement being flagged for further attention. While A and B1 grants have received most of their expected disbursements (92 percent and 86 percent respectively), B2 grants have received only 71 percent of expected disbursements and C grants only 45 percent, showing that continuing disbursements are indeed going to grants with satisfactory performance.

**112.** Since June 2004, disbursement rates have accelerated across the portfolio. The graph below (Figure 20) is probably closer to the natural portfolio curve, where lower-performing grants still receive around 50 percent of disbursements (and achieve some programmatic results), while full disbursements are distributed to A and B1 grants.

### Lessons learned from high-performing grants

**113.** Many of the 27 Phase 2-eligible grants benefited from building on existing infrastructure to scale up their services. This included the management capacities of the principal recipient, full levels of participation by the CCM and the existence of pilot structures or strong sources of technical support. In some countries, the Global Fund's finances were used to fill gaps in the national control programs for TB and malaria in poorer districts. These grants performed strongly in scaling up efforts and extending the scope of their countries' national TB and malaria control programs.

**114.** Building the management capacity of grants was also crucial, and grants that included civil society and private foundations with clear lines of responsibility (as in Haiti) tended to be more successful. Investment in the

| DISBURSEMENTS BY FUNDING ROUND<br>$ FIGURES IN MILLIONS, AS OF 20 JANUARY 2005 | | | | | | Mean time elapsed[4] |
|---|---|---|---|---|---|---|
| **Round** | **Approved** | **2-year approved[1]** | **2-year signed[2]** | **2-year disbursed[3]** | **Mean percent of 2-year amount disbursed[4]** | 80.6% |
| Round 1 | Apr-02 | $558 | $545 | $372 | 70% | 52.3% |
| Round 2 | Jan-03 | $859 | $794 | $479 | 48% | 20.6% |
| Round 3 | Oct-03 | $639 | $477 | $141 | 33% | 5.6% |
| Round 4 | Jun-04 | $1,039 | $70 | $19 | 28% | **48.9%** |
| **Total** | | **$3,094** | **$1,884** | **$871** | **49%** | |

*Figure 20: Percentage of disbursements by grant performance*

[1] Proposals approved by the Board (5-year terms, with initial approval covering years 1-2)
[2] Grant agreement signed by the Secretariat, committing funds for 2-year term of grant
[3] Amount transferred to recipients - disbursed incrementally based on performance
[4] Calculations based on grants which have received one or more disbursements

capacity-building of principal recipients with regards to finance control, and monitoring of funds and programmatic progress was beneficial within the performance-based funding system.

**Lessons learned from low-performing grants**

**115.** There were several key problems that held back grants and led to poor performance. First, low levels of participation and ownership at the CCM level, divisions between players and narrow channels of control were found to hinder implementation of the full scope of a proposal. This was particularly the case for HIV grants, which typically required coordinating a wide range of participants, including civil society organizations that may not typically work with governmental agencies or ministries.

**116.** With regards to implementation, procurement became a major problem, particularly for ARV drugs and insecticidal bed nets. To some extent, this explains why TB grants showed a better performance level overall, as procurement issues for TB drugs are being addressed through the various initiatives and technical partners in TB control. Procurement issues are gradually being solved, but they slowed down early grants. Other issues included the integration of very different grant components, including prevention and treatment, and government programs with civil society activities.

**117.** In several of the C-graded grants, poor performance was apparent over the grant lifecycle. Not enough grants, even where poor performance was clear, produced plans to restructure and improve their grants as part of their applications for Phase 2 funding. Self-assessment is considered by the Global Fund to be a key element and is an area for further improvement.

**Systems Effects and Impact**

**118.** No systematic data exists yet on the extent to which the Global Fund interacts with and affects its immediate environment. The Global Fund is in the process of developing the indicators for systems effects and impact and putting them into operation over the course of 2005.

**119.** However, despite the lack of numerical data, events over the past three years suggest that the Global Fund has influenced and adapted to the existing environment in which it operates. One clear example is with CCMs, which have now been established in more than 120 countries and which have, in many cases, increased civil society involvement in the planning and decisionmaking processes for national programs to fight AIDS, TB and malaria (see box on page 26).

**120.** Another example of the catalytic nature of Global Fund activities is the *Monitoring and Evaluation Toolkit* and the collaborative work that has followed in its wake (see box on page 24).

**121.** A third example is the increasingly close collaboration and informal work sharing taking place between the Global Fund and other donors, in particular the United States' President's Emergency Plan for AIDS Relief (PEPFAR) in program countries. An example of this kind of collaboration was the joint calculation and announcement of antiretroviral treatment figures in January 2005 by the Global Fund and PEPFAR, reflecting the fact that the two mechanisms often finance different elements within the same national treatment programs.

**122.** Finally, it will be the impact Global Fund financing has in reducing the burden of the three diseases which will determine its ultimate success or failure. Until now, one can only infer a very modest global impact against the three diseases from the results achieved to date. From Round Five onwards, all grants will have a set of impact indicators as part of their overall set of results measurement built into their Phase One grant agreements, and all Phase Two grant extensions will have impact indicators as they begin to be negotiated and signed in early 2005. The data gathered through these processes will make an important contribution to the measurement of Global Fund impact. By September 2005, the Global Fund will also have calculated the potential contribution its grant portfolio will make towards the Millennium Development Goals and assessed the extent to which actual results have made that contribution.

# Conclusion:
# Scaling results in the future

Investing in the Future

## SCALING RESULTS IN THE FUTURE

**123.** From one perspective, it may be argued that the Global Fund has achieved a great deal in only three years. It has raised US$ 6 billion and approved US$ 3.1 billion in grants; it has designed a performance-based funding architecture founded on the lessons learned and examples of best practice from the public and private sectors and a wide range of other experienced stakeholders; it has adapted a new and untried system to the complex realities of health development assistance; and it has supported programs that have already reached hundreds of thousands of people despite its grants' average age of less than one year.

**124.** However, it is also true that the Global Fund has yet to prove its added value in the complex field of development financing. There are, as this report shows, a number of elements to its performance measurement systems that require further development. The Global Fund's principles and operating procedures tie its success to the strength of its grants, many of them supporting programs in some of the most difficult environments in the world. The success of these programs often depends on the technical assistance of multilateral or bilateral non-governmental organizations with limited resources to fix complex problems. The future success of the Global Fund, in large part, depends on the extent to which it works with its partners and maximizes its own structures to ensure that its grants do achieve the expected results.

**125.** Some key elements of the Global Fund's structures are already showing their value. The Global Fund's insistence on being flexible on process while rigid in its demand for results has provided an added freedom and authority to grant recipients. Its wide set of recipients – both public and private – have ensured a greater breadth of stakeholders in the fight against the three diseases in many countries. Finally, its continuing ability to respond quickly to lessons learned from experience is invaluable in the face of changing implementing environments and advancements in medical science.

# Appendix 1:
## Summary table of Service Delivery Areas and Indicators

The following tables of service delivery areas and coverage indicators are taken from *The Monitoring and Evaluation Toolkit*, which provides recipient countries with key indicators for major prevention and treatment interventions for AIDS, TB and malaria.

# HIV/AIDS

| | SERVICE DELIVERY AREA | COVERAGE INDICATORS | |
|---|---|---|---|
| PREVENTION | • Behavioral Change Communication (BCC)<br>- Mass media<br>• Behavioral Change Communication<br>- Community outreach | • HIV/AIDS radio/television programs/newspapers produced and distributed*<br>• Number of peer/community educators active* | • Knowledge about HIV prevention among young people (number* and percentage) (HIV-PI1) |
| | • Youth Education | • Provision of life-based HIV/AIDS education in schools (HIV-PI2)<br>• Young people exposed to HIV/AIDS education in school settings* | • Delayed sexual debut, reduced number of sexual partners*** |
| | • Condom distribution | • Retail outlets and service delivery points with condoms in stock (HIV-PI3)<br>• Condoms sold through public sector*<br>• Condoms sold through private outlets* | • Young people's condom use with non-regular partners (number* and percentage) (HIV-PI6) |
| | • Programs for specific groups | • Sex workers & clients exposed to outreach programs* (number and percentage**)<br>• MSM exposed to outreach programs* (number and percentage**)<br>• Mobile populations exposed to outreach programs* (number and percentage**) | |
| | | • IDUs reached by prevention services (number* and percentage) (HIV-PI4) | • IDUs: safe injecting and sexual practices (number* and percentage) (HIV-PI5) |
| | • Counseling and Testing | • Prevention and care service points * (HIV-PI7) | • Women completing the testing and counseling process (HIV-PI8)* |
| | • PMTCT | • Health facilities offering minimum package of PMTCT* (HIV-PI9) | • HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT (number* and percentage) (HIV-PI10) |
| | • STI diagnosis and treatment | | • STIs: comprehensive case management (HIV-PI11) |
| | • Post-exposure prophylaxis (PEP) | • People receiving post-exposure prophylaxis* | |

# HIV/AIDS

| | SERVICE DELIVERY AREA | COVERAGE INDICATORS | |
|---|---|---|---|
| PREVENTION | • Blood safety and universal precautions | | • Districts with access to donor recruitment and blood transfusion (HIV-PI12)<br>• Transfused blood units screened for HIV (HIV-PI13) |
| TREATMENT | • Antiretroviral treatment (ART) and monitoring | • Health facilities capable of providing advanced interventions for prevention and medical treatment for HIV-infected persons (HIV-TI2) | • People with advanced HIV infection receiving antiretroviral combination therapy (number* and percentage) (HIV-TI1) |
| | • Prophylaxis and treatment for opportunistic infections (OIs) | • Health facilities with capacity to deliver basic level counseling and medical services for HIV/AIDS (number* and percentage) (HIV-TI3) | |
| CARE AND SUPPORT | • Support for orphans | • Families exposed to succession planning programs (number and percentage*)<br>• Number of HIV+ parents counseled*<br>• Number of meals provided at schools*<br>• Number of community organizations that received support to assist OVC* | • Orphans and other children made vulnerable by HIV/AIDS whose households received free basic external support (number* and percentage) (HIV-CS1)<br>• OVC receiving meals (number and percentage**)<br>• Orphans' school attendance (HIV-CS2) |
| | • Support for the chronically ill | • Number of community organizations that received support to assist PLWHA* | • Chronically ill adults whose households received free basic external support (number* and percentage) |
| SUPPORTIVE ENVIRONMENT | • Workplace | • Large enterprises/companies that have HIV/AIDS workplace policies and programs (number* and percentage) (HIV-SE1) | |
| | • Strengthening of civil society | • Number of NGOs dealing with HIV/AIDS services* | |
| | • Adult support of youth education on condom use | • Adult support of education about condom use to prevent HIV/AIDS among young people (HIV-SE2) | |
| | • Stigma | • Number of PLWHA support groups fighting against discrimination* | |

*See Monitoring and Evaluation Toolkit for full description of indicators and methods of measurement*

# Tuberculosis and HIV/TB

| | SERVICE DELIVERY AREA | COVERAGE INDICATORS | |
|---|---|---|---|
| PREVENTION | • Identification of infectious cases | | • New smear-positive TB cases detected under DOTS (number* and percentage) (TB-PI 1) |
| TREATMENT | • Timely detection and quality treatment of cases<br>• Control of drug resistance | • Population covered by DOTS (number* and proportion) (TB-TI 1) | • Smear-positive TB cases registered under DOTS who are successfully treated (TB-TI 2) (number* and percentage)<br>• New smear-positive cases registered under DOTS who fail treatment (number* and percentage) (TB-TI 3) |
| SUPPORTIVE ENVIRONMENT | • Sufficient drug and laboratory supplies<br>• Capacity building | • Number of health facilities involved in DOTS with sufficient drug and laboratory supplies<br>• Number of health facilities and laboratories involved in DOTS with sufficient capacity for DOTS | |

| | OUTPUT | OUTCOME |
|---|---|---|
| PREVENTION | • HIV seroprevalence among all TB patients (TB/HIV-PI 1) | • Treatment of latent TB infection for PLWHA (number* and percentage**) (TB/HIV-PI 2) |
| TREATMENT | • Intensified TB case finding among PLWHA (TB/HIV-TI 1)<br>• Counseling and testing for TB patients (TB/HIV-TI 2) | • Provision of CPD preventive therapy for TB patients (TB/HIV-TI 3)<br>• Provision of ART for TB patients during TB treatment (TB/HIV-TI 4) |
| SUPPORTIVE ENVIRONMENT | • Sufficient drug and laboratory supplies<br>• Capacity building<br>• TB/HIV coordinating body at national level and all sub-national levels where HIV and TB are both prevalent<br>• Joint planning between HIV and TB services<br>• HIV policy that addresses TB<br>• TB policy that addresses HIV | • Number of health facilities involved in DOTS with sufficient drug and laboratory supplies<br>• Number of health facilities and laboratories involved in DOTS with sufficient capacity for DOTS<br>• Number of health facilities where TB and HIV services are both available |

# Malaria

| | SERVICE DELIVERY AREA | COVERAGE INDICATORS | |
|---|---|---|---|
| PREVENTION | • Insecticide-treated nets (ITNs) | • Number of nets, LLNs, pretreated nets or re-treatment kits distributed*<br>• Number of nets retreated*<br>• Number of sentinel sites established for monitoring insecticide resistance* | • Households owning ITN (Malaria-PI1)<br>• Children under 5 using ITN (Malaria-PI 2) |
| | • Malaria in pregnancy | • Number of nets, LLNs, pretreated nets or re-treatment kits distributed*<br>• Number of nets retreated*<br>• Number of pregnant women receiving correct IPT* | • Pregnant women using ITNs (Malaria-PI 3)<br>• Pregnant women receiving intermittent preventive therapy (IPT) as (Malaria-PI 4) |
| | • Prediction and containment of epidemics | | • Malaria epidemics detected and properly controlled (Malaria-PI 5) |
| | • Indoor Residual Spraying | • Number of homes and areas sprayed with insecticide* | |
| | • Behavioral Change Communication (BCC) | • Number of targeted areas with BCC services* | |
| TREATMENT | • Prompt, effective anti-malarial treatment | • Number of patients with uncomplicated and severe malaria receiving correct diagnosis and treatment*<br>• Health facilities with no reported stock-outs of anti-malarial drugs (Malaria-TI 2) | • Children under 5 years of age with access to prompt effective treatment (Malaria-TI1)<br>• Patients with severe malaria receiving correct treatment (Malaria-TI 3) |
| | • Monitoring drug resistance | • Number of patients with uncomplicated and severe malaria receiving correct diagnosis and treatment*<br>• Health facilities with no reported stock outs of anti-malarial drugs (Malaria-TI 2) | |
| | • Home-based management of malaria | • Number of caretakers recognizing signs and symptoms of malaria* | |

# Appendix 2:
## CCM Performance Checklist

| COMPOSITION AND REPRESENTATION | |
|---|---|
| Are all constituencies represented in the CCM?<br>- Academic/Educational Sector<br>- Government<br>- NGOs/Community-Based Organizations<br>- People living with and/or affected by HIV/AIDS, TB and/or Malaria<br>- Private Sector<br>- Religious/Faith-Based Organizations<br>- Multilateral and Bilateral Development Partners in-country<br><br>Attach list of members (including constituency)<br>- If no, what is planned to address this situation? | Yes/No<br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No |
| What proportion of CCM members are women? | Proportion |
| What proportion of CCM members represents the non-government sector? | Proportion |
| Are CCM members representing the non-government sectors selected by their own constituencies following a documented transparent process (please attach)?<br>- Academic/Educational Sector<br>- NGOs/Community-Based Organizations<br>- People living with and/or affected by HIV/AIDS, TB and/or Malaria<br>- Private Sector<br>- Religious/Faith-Based Organizations<br><br>If no, are there plans to change the selection process? | <br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No |
| Does the CCM include representation from state/province/districts?<br>- If yes, attach list<br>- If no, what is planned to address this situation? | Yes/No |
| Has a list of CCM members been<br>- made public in country?<br>- submitted to the Global Fund Secretariat?<br>If no, what will be done to address this situation? | <br>Yes/No<br>Yes/No |
| Are constituencies represented at the highest level of each constituency?<br>- Academic/Educational Sector<br>- Government<br>- NGOs/Community-Based Organizations<br>- People living with and/or affected by HIV/AIDS, TB and/or Malaria<br>- Private Sector<br>- Religious/Faith-Based Organizations<br>- Multilateral and Bilateral Development Partners in-country<br>If no, what will be done to address this situation? | <br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No |
| Have senior officers regularly attended CCM meetings over the last 12 months (more than half of all meetings)<br>- Academic/Educational Sector<br>- Government<br>- NGOs/Community-Based Organizations<br>- People living with and/or affected by HIV/AIDS, TB and/or Malaria<br>- Private Sector<br>- Religious/Faith-Based Organizations<br>- Multilateral and Bilateral Development Partners in-country<br>If no, what will be done to address this situation? | <br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No |

| PARTICIPATION AND COMMUNICATION | |
|---|---|
| Does the CCM have regular meetings?<br>If yes, please tick:<br>- once per year<br>- Up to twice per year<br>- Up to four times per year<br>- More than four times per year<br>If no, what is planned to address this situation? | Yes/No |
| Do all the CCM members have access to key documents (minutes, PR disbursement reports, LFA reviews, disbursement decisions)?<br>- If yes, how is this assured?<br>- If no, what is planned to address this situation? | Yes/No |
| Can all the constituencies in the CCM document a consultation process with their members?<br>- If yes, how is it assessed and documented?<br>- If no, what is planned to address this situation? | Yes/No |
| Is relevant information related to the Global Fund made available to all interested parties in the country?<br>- call for proposals<br>- decisions taken by CCM<br>- information on approved proposals<br><br>If yes, how is information made available?<br>If no, what is planned to address this situation? | Yes/No<br>Yes/No<br>Yes/No |
| Are CCM constituencies satisfied with their level of participation<br>(in proposal development and implementation oversight)?<br>- Academic/Educational Sector<br>- Government<br>- NGOs/Community-Based Organizations<br>- People living with and/or affected by HIV/AIDS, TB and/or Malaria<br>- Private Sector<br>- Religious/Faith-Based Organizations<br>- Multilateral and Bilateral Development Partners in-country<br><br>If yes, how is it assessed and documented?<br>If no, what is planned to address this situation? | Yes/No<br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No<br>Yes/No |
| **GOVERNANCE AND MANAGEMENT** | |
| Are the Chair and Vice-Chair from different constituencies?<br>- If no, what is planned to address this situation? | |
| Is the PR from the same entity as the Chair or Vice-Chair?<br><br>- If yes, is there a written plan to mitigate against inherent conflict of interest (please attach)? | |
| Is the CCM secretariat supported by designated staff?<br>- If yes, please explain how.<br>- If no, what is planned to address this situation? | |

| GOVERNANCE AND MANAGEMENT | |
|---|---|
| Are the Chair and Vice-Chair from different constituencies?<br>- If no, what is planned to address this situation? | Yes/No |
| Is the PR from the same entity as the Chair or Vice-Chair?<br><br>- If yes, is there a written plan to mitigate against inherent conflict of interest (please attach)? | Yes/No<br><br>Yes/No |
| Is the CCM secretariat supported by designated staff?<br>- If yes, please explain how.<br>- If no, what is planned to address this situation? | Yes/No |
| Does the CCM have written TOR/bylaws/operating procedures?<br>- If yes, do they include (please tick and attach)<br>• procedure for selection of Chair/Vice-Chair,<br>• mechanism for decisionmaking,<br>• defined roles and responsibilities vis-a-vis other relevant coordinating bodies,<br>• conflict of interest policy,<br>• equal voting rights of all members/constituencies,<br>• guidelines for ethical behavior<br>- If no, what is planned to address this situation? | Yes/No |
| Does the CCM have a documented transparent process to (please attach)<br>• solicit and review submissions for possible integration into the proposal,<br>• nominate the Principle Recipient<br>• oversee program implementation<br>- If no, what is planned to address this situation? | <br>Yes/No<br>Yes/No<br>Yes/No |
| Does the CCM have a documented transparent process to ensure the input of a broad range of stakeholders (please attach)<br>- in the proposal development, including<br>• CCM members<br>• Non-CCM members<br>- in the oversight process, including<br>• CCM members<br>• Non-CCM members<br>- If no, what is planned to address this situation? | <br><br><br>Yes/No<br>Yes/No<br><br>Yes/No<br>Yes/No |
| Does the CCM have a written conflict of interest policy?<br>- If yes, please attach<br>- If no, what is planned to address this situation? | Yes/No |

# Appendix 3:
## Key Performance Indicators for Executive Director of the Global Fund

| | Objective | Metric (KPI) | Target 2005 | Weighting |
|---|---|---|---|---|
| **Results and impact** | • Finance the rapid scale-up of effective means to prevent and treat the three pandemics | • % of agreed targets reached by grants in Phase I (based on 18 months performance evaluation) | • 65% across the portfolio | 20% |
| **Core business** | • Raise it: Mobilize sufficient resources to implement GF mission and meet country needs | • % of '05 funding needs contributed<br>• % of '06 needs for current and next rounds pledged | • 100%<br>• 70% | 40% |
| | • Spend it: Scale-up disbursement to well-performing grants through effective grant management | • Amount $ disbursed to Rounds 1-4 grants<br>• Average time between grant approval and first disbursement | • $1.1 billion ('05 only)<br>• < 6 months | |
| | • Prove it: Make performance-based funding a reality | • Second and subsequent disbursements based on evidence of performance and expenditure (including disbursement to sub-recipients) | • 95% | |
| | • Communicate it: Drive consistent external communications | • All major reports, including periodic grant progress updates, produced and available on website in a timely manner* | • 80% on time | |
| **Development & Innovation** | • Develop strategy for sustainable success | • Completion of well defined 3- year strategy, including future rounds, with targets and milestones | • Strategy document completed for Board review by July 2005 | 20% |
| **Organization & Talent** | • Facilitate best-practice corporate governance | • Regular review of quality of Secretariat support to Board and committees | • 70% rating "satisfactory" or "very satisfactory" | 20% |
| | • Develop organizational capacity and people to benefit mission | • Completion of plan for transition to a fully independent entity following signature of headquarters agreement<br>• % of staff with defined objectives and annual reviews of results, competencies and development<br>• Internal staff survey on professional satisfaction and motivation<br>• Operating expenses as % of grants under management and as a % of total expenditures<br>• Performance against 3 agreed diversity targets (gender, ethnicity, communities)* | • Complete plan by Nov '05<br>• 90%<br>• 70% rating "high" or "very high"<br>• < 3%, <10%<br>• 80% of targets met | |

Shared responsibility with the Board of the Global Fund

* Detailed targets are available

# Appendix 4:
## Key Performance Indicators for the Board of the Global Fund

| | Objective | Key performance indicator | Target 2005 |
|---|---|---|---|
| **Results and impact** | Finance the rapid scale-up of effective means to prevent and treat the three pandemics | % of agreed targets reached by grants in Phase I (based on 18 months performance evaluation) | 65% across the portfolio |
| **Core business** | Mobilize sufficient resources to implement Global Fund mission and meet country needs | % of 2005 funding needs contributed | 100% |
| | | % of 2006 needs for current and next rounds pledged | 70% |
| | Support implementation at country-level | % of CCMs meeting agreed standards of performance | 75% |
| **Development & Innovation** | Approve 3- year strategy for Global Fund (based on draft proposal from the Secretariat) | Approval of well-defined and agreed 3-year strategy, including future rounds, with targets and milestones | Board-approved strategy by November 2005 |
| **Organization & Talent** | Achieve best-practice governance through rigorous oversight and efficient decision-making | Annual internal Board survey of effectiveness of Board and Committee mechanisms | 80% rating "effective" or "very effective" |

# Appendix 5:
## Sample Grant Performance Report* – Ghana

### General Grant Information

| | |
|---|---|
| **Grant Number:** | GHN-102-G01-H-00 |
| **Grant Title:** | Accelerating access to prevention, care, support and treatment of all persons affected by HIV/AIDS. |
| **Component:** | HIV/AIDS |
| **Round:** | 1 |
| **Principal Recipient:** | Ministry of Health/Ghana Health Service |
| **Lifetime Budget:** | 14,170,222 |
| **2-Year:** | 4,965,478 |
| **Program Start Date:** | 01-Jan-2003 |

## PROGRAM DESCRIPTION, OBJECTIVES, TARGETS AND RESULTS

### Program Description Summary

The 2000 national HIV prevalence rate in Ghana was estimated to be 3.0%, up from 2.7% in 1994. Heterosexual transmission accounts for 75-80% of infection with Mother to Child (MTCT) accounting for 15%. The increase in the number of AIDS cases expected, this will dramatically increase the workload for health workers. It also reinforces the need for Home Based Care and community involvement. In 2002 only a negligible number of People Living with HIV/AIDS (PLWHAs) can afford or have access to treatment of Opportunistic infections (Ois) and Antiretroviral Drugs (ARVs).

The purpose of the program's HIV/AIDS component financed by the Global Fund is to increase access to prevention services for the groups most vulnerable to HIV infection, and improve care and support to those already living with the virus. Prevention of MTCT will increase through the expansion of pilot programmes from 2 sites to 24 sites, and Voluntary Counselling and Testing (VCT) operational in 4 sites will be increased to 24 service points. The program targets youth, women of reproductive age, those who are sexually active and PLWHA nation-wide.

### Program Goals and Impact Indicators

| | | Baseline | | Target | | | | |
|---|---|---|---|---|---|---|---|---|
| Goal 1 | To increase access and generate greater demand for both prevention and care services for the groups vulnerable to HIV infection, and improve care and support for those already living with the virus. | Value | Year | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Impact Indicator | Proportion of persons adhering to drug regimens | n/a | | 40% | 90% | 95% | 98% | 98% |
| Impact Indicator | Percentage of people remaining on treatment at 6,12,24 months | n/a | | 50% | 90% | 96% | 96% | 96% |
| Impact Indicator | Percentage of Adults on ARV treatment who gain weight by at least 10% at 6 months after initiation of treatment | n/a | | 50% | 90% | 90% | 95% | 95% |
| Impact Indicator | Reduce percentage of HIV infected infants born to HIV infected mothers | n/a | | 40% | 60% | 80% | 80% | 80% |
| Impact Indicator | Mitigate anticipated growth in adult HIV prevalence rate | 2.9% | 2000 | 3.4% | 3.6% | 3.8% | 3.9% | 3.9% |

## Program Objectives, Service Delivery Areas, Indicators and Targets

| Objective 1 | To increase VCT service points from 4 to 24 points in the country, with at least one in each region. |
|---|---|
| Service Delivery Area 1 | Prevention: Counseling and testing |

| Indicator Category | Indicator | Baseline | | | Period 1 | Period 2 | Period 3 | Period 4 | Period 5 | Period 6 | Year 2 Target |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Value | Year | | | | | | | | |
| 3 | People completing the testing and counselling process | | | Target | 160 | 480 | 800 | 1400 | 3200 | 4960 | 5560 |
| | | | | Result | 0 | 0 | 745 | 1745 | 4937 | 6698 | |
| 2 | Number of districts with operational counselling and testing sites | 4 | 2002 | Target | 2 | 4 | 6 | 8 | 10 | 12 | 16 |
| | | | | Result | 0 | 1 | 8 | 8 | 8 | 8 | |
| 1 | Number of service deliverers trained | | | Target | 12 | 24 | 36 | 48 | 60 | 72 | 96 |
| | | | | Result | 12 | 24 | 77 | 104 | 104 | 104 | |

| Objective 2 | To expand PMTCT pilot programme |
|---|---|
| Service Delivery Area 2 | Prevention: PMTCT |

| Indicator Category | Indicator | Baseline | | | Period 1 | Period 2 | Period 3 | Period 4 | Period 5 | Period 6 | Year 2 Target |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Value | Year | | | | | | | | |
| 3 | Women completing the testing and counselling process | | | Target | 253 | 353 | 500 | 1000 | 3000 | 4000 | 6000 |
| | | | | Result | 406 | 804 | 1459 | 3765 | 4067 | 4399 | |
| 3 | HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT (number and percentage) | | | Target | 150 | 300 | 450 | 600 | 750 | 900 | 1200 |
| | | | | Result | 0 | 0 | 119 | 250 | 552 | 884 | |
| 1 | Number of service deliverers trained | | | Target | 10 | 20 | 30 | 40 | 55 | 85 | 100 |
| | | | | Result | 10 | 23 | 77 | 104 | 104 | 104 | |

## Program Objectives, Service Delivery Areas, Indicators and Targets

| Objective 3 | To make operational at least 2 centres providing comprehensive care including Ols and ART |
|---|---|
| Service Delivery Area 3 | Treatment: Prophylaxis and treatment for opportunistic infections |

| Indicator Category | Indicator | Baseline | | | Period 1 | Period 2 | Period 3 | Period 4 | Period 5 | Period 6 | Year 2 Target |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Value | Year | | | | | | | | |
| 3 | People receiving prophylaxis and treatment for opportunistic infections (number and %) | | | Target | 300 | 900 | 1800 | 3000 | 4500 | 6300 | 10300 |
| | | | | Result | 0 | 0 | 366 | 1178 | 3616 | 6404 | |
| 2 | Health facilities with capacities to deliver basic level counseling and medical services for HIV/AIDS | | | Target | 0 | 1 | 2 | 2 | 5 | 8 | 14 |
| | | | | Result | 0 | 0 | 2 | 2 | 4 | 4 | |

| Service Delivery Area 4 | Treatment: Antiretroviral treatment and monitoring |
|---|---|

| Indicator Category | Indicator | Baseline | | | Period 1 | Period 2 | Period 3 | Period 4 | Period 5 | Period 6 | Year 2 Target |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Value | Year | | | | | | | | |
| 3 | People with advanced HIV infection receiving antiretroviral combination therapy (number and %) | | | Target | 300 | 600 | 900 | 1200 | 1500 | 1900 | 3200 |
| | | | | Result | 0 | 0 | 229 | 595 | 1032 | 1173 | |
| 2 | Health facilities capable of providing advanced interventions for prevention and medical treatment for HIV infected persons | | | Target | 0 | 1 | 2 | 2 | 4 | 6 | 10 |
| | | | | Result | 0 | 0 | 2 | 2 | 4 | 4 | |
| 1 | Number of service deliverers trained | | | Target | | 50 | 50 | 100 | 130 | 130 | 130 |
| | | | | Result | | 50 | 88 | 140 | 140 | 140 | |

| Service Delivery Area 5 | Care and Support: Care and support for the chronically ill and families |
|---|---|

| Indicator Category | Indicator | Baseline | | | Period 1 | Period 2 | Period 3 | Period 4 | Period 5 | Period 6 | Year 2 Target |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Value | Year | | | | | | | | |
| 3 | Number of people receiving HBC | | | Target | 0 | 300 | 450 | 500 | 750 | 1000 | 2000 |
| | | | | Result | 0 | 200 | 529 | 894 | 894 | 894 | |
| 2 | Number of districts with home based care | | | Target | 6 | 12 | 20 | 28 | 38 | 48 | 70 |
| | | | | Result | 6 | 10 | 34 | 34 | 34 | 44 | |
| 1 | Number of people trained in home based care of PLWHA | | | Target | 90 | 90 | 120 | 120 | 170 | 170 | 240 |
| | | | | Result | 24 | 153 | 153 | 153 | 153 | 153 | |