

The Global Fund to Fight AIDS, Tuberculosis and Malaria
Fourth Replenishment (2014-2016)

Update on Results and Impact



Executive Summary

Over the last five years, the results of Global Fund-supported programs have increased dramatically. The most recent results to end 2012 show continued increases in the last year in HIV, TB and malaria prevention and treatment:

- **4.2 million people currently receiving antiretroviral (ARV) therapy** to treat HIV, an increase from 1.4 million five years ago. An additional 900,000 people received ARV therapy in 2012.
- **9.7 million new smear-positive TB cases detected and treated**, an increase from 2.9 million five years ago. 1.1 million TB cases were detected and treated in 2012.
- **310 million insecticide treated nets were distributed to protect families from malaria**, an increase from 46 million five years ago. An additional 80 million insecticide-treated nets were distributed in 2012.

The continued increase in results has been supported by countries, partners and the Global Fund, with **two important financing trends**.

- First, the strong leverage and increases in domestic financing for HIV, TB and malaria. Domestic financing has doubled in the last five years.
- Secondly, the declines in unit costs in key commodities, particularly first-line HIV treatment and insecticide-treated nets to fight malaria. Declines in unit costs of commodities in these areas of 30 to 40 percent over the past five years have made interventions more accessible.

From numbers and outputs to coverage: the continued increase in program delivery means that coverage of key interventions is reaching levels where **transformative improvements** in mortality and morbidity are within reach. When 80 percent coverage for key interventions is reached in key populations, significant returns in terms of impact on incidence, morbidity and mortality are observed, e.g. malaria in Tanzania, TB in Cambodia and HIV treatment in South Africa. Significant scale-up and progress have not only allowed individual countries to reach this threshold but more importantly put the coverage target within reach globally:

- **HIV: 56 percent of people eligible for ARV therapy** to treat HIV are estimated to receive it in sub-Saharan Africa, an increase from less than 5 percent in 2000.
- **TB: 67 percent of the estimated 8.7 million people who fall ill with TB** are now diagnosed and 85 percent successfully treated, an increase from 43 percent and 67 percent, respectively, ten years ago.
- **Malaria: 53 percent of households at risk of malaria in sub-Saharan Africa** are estimated to own at least one insecticide-treated net, an increase from 3 percent in 2000. Surveys suggest that approximately 90 percent of persons with access to an insecticide-treated net use them.

This level of achievement in such a short space of time is noteworthy and presents the global health community with a challenge and a major opportunity:

- The **challenge is to maintain coverage** to continue to protect populations from HIV, TB and malaria and prevent resurgence and drug resistance. When gaps in malaria interventions (e.g. expired nets not replaced) in Zambia and Rwanda have increased the observed number of new cases rise quite suddenly. A similar acceleration in new cases has been seen following increased gaps in HIV prevention in Uganda and Thailand in key groups in recent years.
- The current level of coverage globally is a **major opportunity** in that coverage can be extended towards the 80 percent threshold (universal access) **through incremental investments**. Countries which have extended access to this level of coverage have shown documented impact on MDG 4,5 and 6 (e.g. in Rwanda and Ethiopia), as well as the potential to control HIV, TB and malaria epidemics. When coverage has reached this threshold, countries have also been able to tackle major challenges of the gaps in health systems, focus on high-impact interventions, and access to most-at-risk populations at the community level, all of which can have a multiplier effect on impact.

Increasing investments to achieve 80 percent coverage of high-impact interventions in most-at-risk populations provides the opportunity to **invest for impact** - the basis of the Global Fund Strategy 2012-2016. There is increasing evidence of impact on HIV incidence, TB prevalence and mortality and malaria cases globally and in an increasing number of countries, where coverage of prevention and treatment is high and populations most at risk are reached as described in Part 1 of this report. Part 2 describes the evaluation strategy which is underway to support the Global Fund partnership in measuring impact and focus on coverage and the impact of its investments.

Part 1: Update on Results to End 2012

1. In 2000, there were just 50,000 people receiving HIV treatment in Africa, and less than 5 percent of families were protected against malaria with insecticide-treated nets. There was a huge gap, financial and technical, between the identified strategies to tackle HIV, TB and malaria and the resources for countries to deliver them on the ground.

2. Since then, there has been an unprecedented partner movement, led by countries, technical agencies and civil society, with the support of the Global Fund and partners, to deliver services to fight HIV, TB and malaria.

3. This is reflected in the outputs of Global Fund-supported programs over the last ten years, which have increased from tens of thousands to millions, and now tens of millions receiving key HIV, TB, malaria and health services through the programs supported by the Global Fund.

4. Over the last five years, the results of Global Fund-supported programs have increased significantly. The most recent outcome figures show continued increases in 2012:

- **4.2 million people are currently receiving ARV therapy** to treat HIV, an increase from 1.4 million five years ago. In 2012, 900,000 new patients began receiving ARV therapy. The bulk of this increase was driven by a steady scale-up of access to lifesaving ARV medication in sub-Saharan countries such as Zimbabwe and Zambia.
- **9.7 million new smear-positive TB cases were detected and treated** (an increase from 2.9 million five years ago). Of these, 1.1 million TB cases were detected and treated in 2012.
- **310 million insecticide-treated nets have been distributed to protect families from malaria** (an increase from 46 million five years ago). Of these, 80 million insecticide-treated nets were distributed in 2012.

2. Table 1, below, shows the results of Global Fund-supported programs in prevention, treatment and care over the last year and five years, showing the continued growth in results throughout 2012.

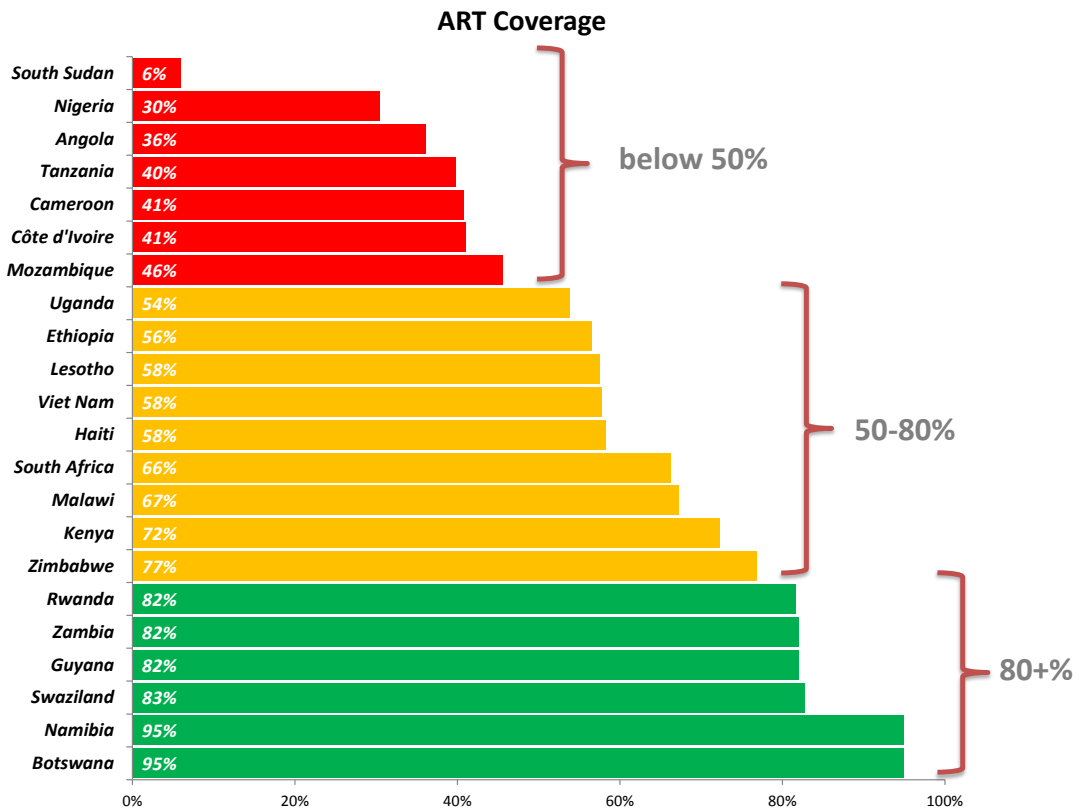
Table 1: Results from Global Fund-supported Programs at End 2012

HIV results	End 2012	1 year ago (end 2011)	5 years ago (end 2007)
HIV- People currently on ARV therapy	4,200,000	3,300,000	1,400,000
HIV – People reached with PMTCT	1,700,000	1,300,000	147,000
HIV – People reached with HIV counseling and testing	250,000,000	188,000,000	34,000,000
HIV – people receiving care and support	19,000,000	14,000,000	3,000,000
HIV – Outreach to high-risk groups	29,000,000	23,000,000	7,000,000
HIV/TB – Services provided	6,000,000	4,000,000	350,000
TB results	End 2012	1 year ago (end 2011)	5 years ago (end 2007)
TB - New smear-positive TB cases detected and treated	9,700,000	8,600,000	2,900,000
TB – Community-based prevention activities	15,000,000	12,000,000	3,000,000
TB – People treated for MDR-TB	69,000	57,000	10,000
Malaria results	End 2012	1 year ago (end 2011)	5 years ago (end 2007)
Malaria - Nets distributed (insecticide-treated nets and long-lasting insecticidal nets)	310,000,000	230,000,000	46,000,000
Malaria – Cases treated	234,000,000	187,000,000	44,000,000
Malaria – Indoor residual spraying	46,000,000	43,000,000	6,000,000

5. The continued increase in program delivery means that coverage of key interventions is reaching levels where transformative improvements in mortality and morbidity are within reach:

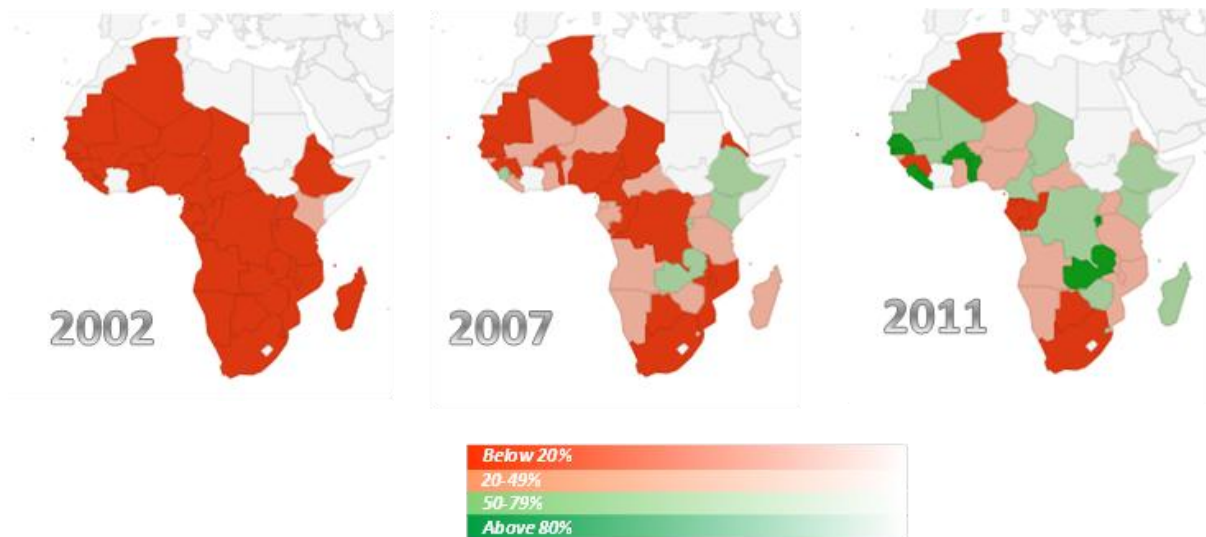
- **HIV:** 56 percent of people eligible for ARV therapy to treat HIV are estimated to receive it in sub-Saharan Africa, an increase from less than 5 percent in 2000. Coverage remains higher at 68 percent for women, compared to 47 percent for men in low- and middle-income countries, and global coverage is only 28 percent for children. Figure 1 shows the coverage of ARV therapy now achieved by country in Africa.
- **TB:** 67 percent of the estimated 8.7 million people who fell ill with TB are now diagnosed and 85 percent are successfully treated, an increase from 43 percent and 67 percent, respectively, ten years ago. Although there are continued gaps, 69 percent of TB patients in the Africa region were tested for HIV, an increase from 3 percent in 2004.
- **Malaria:** 53 percent of households at risk of malaria in sub-Saharan Africa are estimated to own at least one insecticide-treated net, increased from 3 percent in 2000. Surveys suggest that approximately 90 percent of persons with access to an insecticide-treated net use them. Figure 2 shows the transformation in coverage of insecticide-treated nets in Africa.

Figure 1: Coverage of ARV Therapy by Country



(Source: UNAIDS, 2012)

Figure 2: Insecticide-treated Net Coverage in Sub-Saharan Africa, 2002-2011



(Source: WHO, 2012)

6. This is a major achievement of countries, with the support of partners. It presents a major global challenge and opportunity:

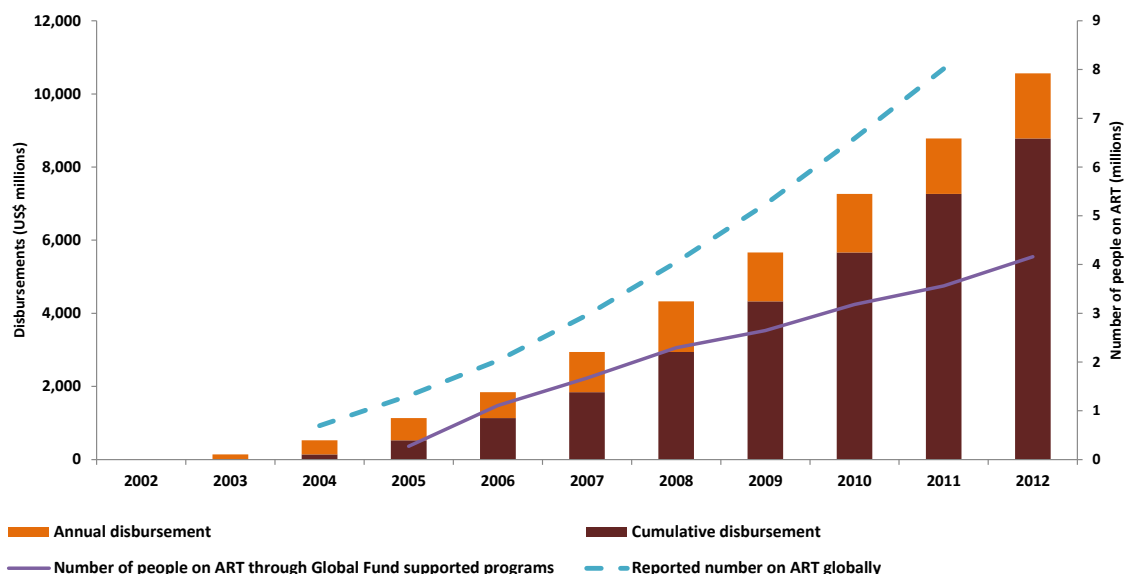
- There is a **major challenge and moral imperative to maintain coverage of key interventions**, to protect populations from HIV, TB and malaria and maintain the gains towards the Millennium Development Goals, which will otherwise be lost. This includes the recruitment and retention of people on ARV therapy, the replacement of insecticide-treated nets every three years to fight malaria, and the coverage of TB diagnostics and treatment. It has been seen in countries such as Zambia and Rwanda that if insecticide-treated net coverage is not maintained and nets replaced there is a rapid resurgence in malaria cases. If ARV therapy and TB treatment are not sustained, drug resistance increases and more expensive second-line treatments are required.
- There is a **major opportunity for incremental investments** to extend coverage towards 80 percent (“universal access”), where the returns in impact are greatest. Where 80 percent and more of the most-at-risk populations are protected, declines in child mortality, maternal mortality and HIV, TB and malaria prevalence can be observed - as has been seen in an increasing number of countries. In South Africa, as treatment coverage is extended, adult mortality of people of working age is decreasing and life expectancy increasing for the first time in a generation. Nine countries in Africa with sufficient coverage of prevention and treatment interventions are now on track to reduce malaria case incidence by 75 percent by 2015.

7. This provides the opportunity to invest for impact as per the Global Fund Strategy 2012-2016. It involves improved measurement on impact as shown in Part 2 of this update, working with countries to identify gaps in coverage, and helping them shape their investments most effectively to fill them. It includes a focus on most-at-risk populations, regions, districts, those difficult to reach, and on equity to ensure access to interventions among women, men, children and marginalized populations to achieve impact. It also requires the Global Fund to address key health systems and human rights issues, and areas of underperformance and risk in its global portfolio: for example HIV/TB, artemisinin resistance to malaria treatments, and more effective approaches to combine prevention and treatment.

HIV Financing and Results

8. Since 2002, US\$ 10.6 billion has been disbursed to support HIV interventions. In 2012, through Global Fund-supported programs, an additional 900,000 people living with HIV/AIDS were put on ARV therapy, roughly three times more than in 2011. More than three-quarters of those receiving ARV therapy live in sub-Saharan Africa.

Figure 3: Growth of Global Fund Investments in HIV Interventions

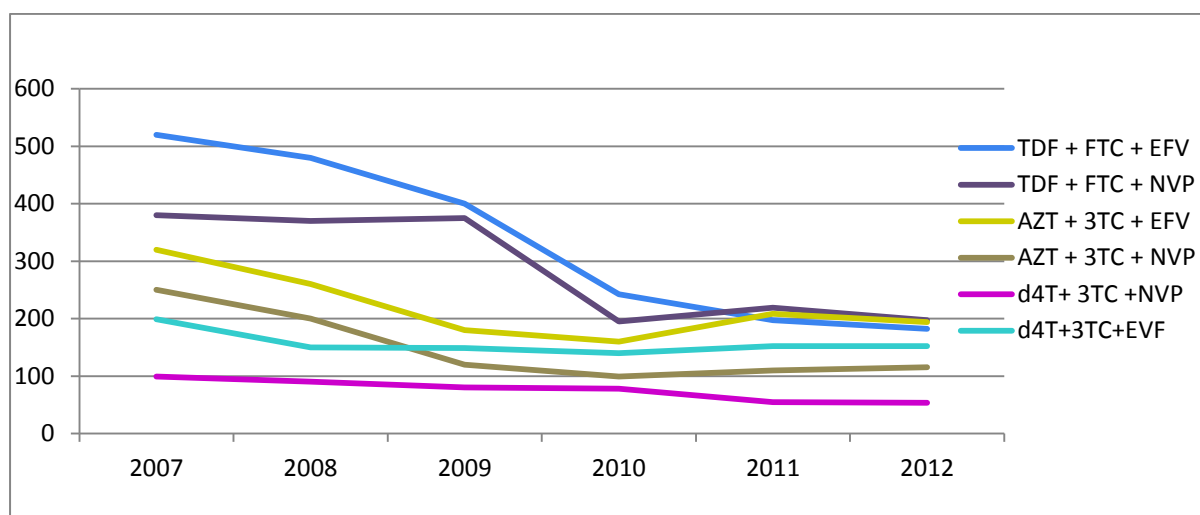


9. The Global Fund has a strong commitment to the global elimination plan to halt the transmission of HIV from mother to child. In collaboration with key partners, including the World Health Organization (WHO), the United Nations Children’s Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Fund Secretariat has been making a concerted effort to allocate and reprogram resources to further scale up all four prongs of prevention of mother-to-child transmission (PMTCT) implementation among the countries where risks of mother-to-child transmission of HIV are the highest. By the end of 2012, Global Fund-supported PMTCT programs had reached 1.7 million people in 84 countries. Almost 90 percent of these women were from sub-Saharan Africa, particularly the 22 high-burden countries. However, there remains a major challenge to scale up PMTCT to achieve global targets, associated antenatal coverage and to maximize linkages to reproductive health services.

10. The Global Fund has been the single-largest funder of harm reduction activities globally. The number of countries with intervention programs targeted to the key affected populations, including people who inject drugs, men who have sex with men, and sex workers, has been increasing over the years, from 64 countries in 2006 to 102 countries in 2012. Close to 30 million activities targeted specifically to key affected populations through Global Fund-supported programs have been reported since 2002, of which more than 6 million in 2012 alone. This figure has been steadily increasing since 2006, primarily in Asia and Eastern Europe, regions where countries mostly have HIV prevalence exceeding 5 percent among specific at-risk populations. Only 4 percent were from sub-Saharan Africa where communities could benefit from additional resources in this area.

11. A major driver of the extension of ARV coverage has been increasing domestic financing (with domestic investment in HIV doubling from 2007-2011), and the decline in the unit costs of first-line drugs that have become more affordable for national programs. The median price paid for common first-line ARV regimens was US\$ 127 in the Global Fund price reporting mechanism.

Figure 4 – Estimates of Costs for Common First-line Adult Antiretroviral Regimens



12. **Impact on HIV.** While the number of new infections remains significant, HIV incidence and mortality are declining across the world. More than half the countries are on track to meet internationally agreed targets to reduce HIV incidence and mortality. Across 105 Global Fund-supported countries with sufficient data, 41 percent have met, or are on track to meet, the international target of universal access to ARV therapy by 2015. For PMTCT prophylaxis, 32 percent of countries have met, or on track to meet, the target by 2015. There is progress across countries, but this is a critical period to extend coverage to 80 percent if global targets are to be met by 2015. To achieve this level of coverage, several health system and gender challenges need to be addressed, in particular combining increases in antenatal care coverage with the delivery of PMTCT. The Global Fund and its partners are targeting its resources under existing grants and reprogramming funds to boost this effort, as described below, but it remains a major challenge to achieve global targets of 80 percent coverage.

13. As a result of the scale-up in efforts to fight the disease in the past decade, many sub-Saharan countries have seen significant progress in ARV therapy coverage during the past several years. In Ethiopia, Ghana, and Zimbabwe, the ARV therapy coverage has at least doubled from 2007 to 2011. So far, ten countries globally have reported reaching universal ARV access, (defined as ARV therapy coverage as 80 percent or above). Between 2009 and 2011, the average ARV therapy coverage among the twenty Global Fund “high-impact” countries rose from 39 percent to 56 percent. There is therefore a challenge to maintain these people on treatment, and a major opportunity to extend coverage from 56 percent to 80 percent where the greatest returns in terms of HIV control, morbidity and mortality occur.

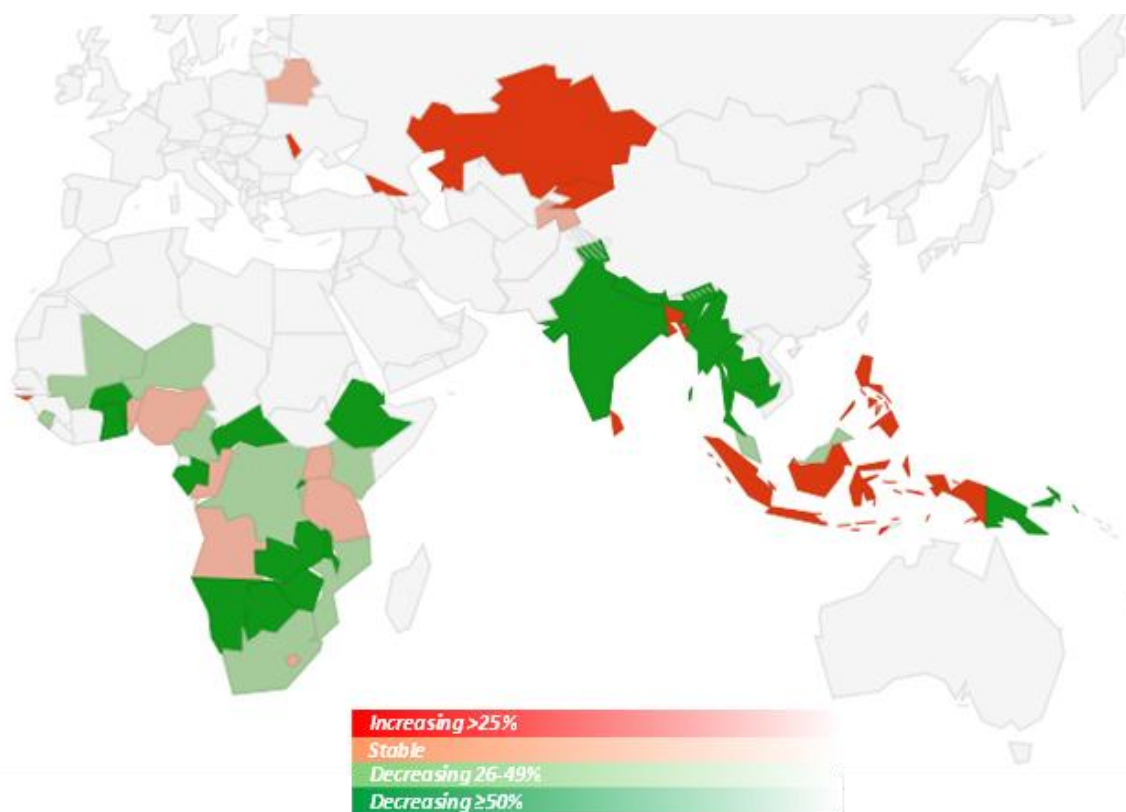
14. Seven of the ten countries with ARV coverage above 80 percent have also reported reduction in AIDS-related deaths by 50 percent or more, from 2005-2011. Nine of the ten countries achieving universal access have ARV therapy retention of at least 80 percent, while one country did not have adequate data to assess ARV therapy retention. On the other hand, for 29 out of 33 countries where ARV coverage was below 40 percent, a decrease of less than 25 percent or no change in AIDS-related deaths was recorded. In 17 of these countries, retention was below 80 percent in 2011. This highlights the operational challenges of maintaining and improving the quality of care in those already reached with treatment, and the opportunities to extend this coverage towards 80 percent.

15. By the end of 2012, Global Fund-supported PMTCT programs had reached 1.7 million people in 84 countries. Almost 90 percent of these women were from sub-Saharan Africa, particularly the 22 high-burden countries. Four countries accounted for about 50 percent of these services: Mozambique, Tanzania, Zambia, and Zimbabwe. These countries reported coverage of ARV therapy for PMTCT of 51 percent, 74 percent, 86 percent, and 54 percent, respectively. Among the eight countries (Chad, Ethiopia, Ghana, Nigeria, South Africa, Swaziland, Zambia, and Zimbabwe) underwent PMTCT reprogramming in collaboration with partners, the average increase in PMTCT coverage, specifically ARV therapy for preventing mother-to-child transmission, was 45 percent from 2010 to 2011. As of 2011, five out of the 22 high-burden countries have achieved at least 80 percent PMTCT coverage – Botswana, Namibia, South Africa, Swaziland, and Zambia. With the exception of South Africa, these countries have also achieved 80 percent coverage of ARV therapy. There is therefore a basis of significant progress in coverage in countries; nevertheless major challenges of reaching 80 percent coverage remain.

16. A major health systems challenge is low antenatal care coverage, which continues to limit the scale-up of PMTCT, and access to HIV testing and counseling services for pregnant women remains a challenge. The proportion of HIV-infected women who received ARV therapy for PMTCT in 2011 was below half in 22 sub-Saharan Africa countries and only thirteen of them had coverage for one visit of antenatal care of 80 percent or higher, pointing to missed opportunities for PMTCT service delivery. On the other hand, the five above-mentioned countries that achieved PMTCT coverage of at least 80 percent in the African region have universal antenatal coverage above 90 percent in all but South Africa, where 56 percent of pregnant women had at least four antenatal care visits. At least 80 percent of pregnant women were also tested in these countries.

17. The figure shows the estimated declines in HIV incidence by country showing impact, and declines greater than 50 percent in a significant number of countries. There is a major opportunity and challenge to build on these global trends, to implement high-impact interventions at high coverage among most-at-risk populations across countries.

Figure 5: Impact of Antiretroviral Therapy on Mortality Rates



(Source: UNAIDS Global Report, 2012)

Tuberculosis Financing and Results

18. ***TB results.*** In 2012, detection and treatment of 1.1 million TB cases were reported under Global Fund-supported TB programs, an increase of 32 percent from the previous year. This makes the total number of TB cases reported 9.7 million. A cumulative total of US\$ 2.9 billion has been disbursed to support TB diagnosis and treatment activities, making the Global Fund the leading external financier of TB programs globally.

19. Among all the new smear-positive cases reported to the Global Fund, 83 percent were from the 22 high-burden countries. Since 2002, 70 percent of all cases were reported from the East and South Asia regions. The top ten countries with the highest number of case notifications in 2011 accounted for 60 percent of the global new smear-positive cases. Of these top ten countries, seven were in Asia. However, the sub-Saharan Africa region has seen a faster rate of increase in recent years, particularly in Nigeria, the Democratic Republic of Congo, Angola, Cameroon, and Mozambique. These five countries accounted for one-third of all new smear-positive cases notified in sub-Saharan Africa as reported by WHO in 2012. They show the need for investments in TB control and HIV/TB interventions, particularly in Africa.

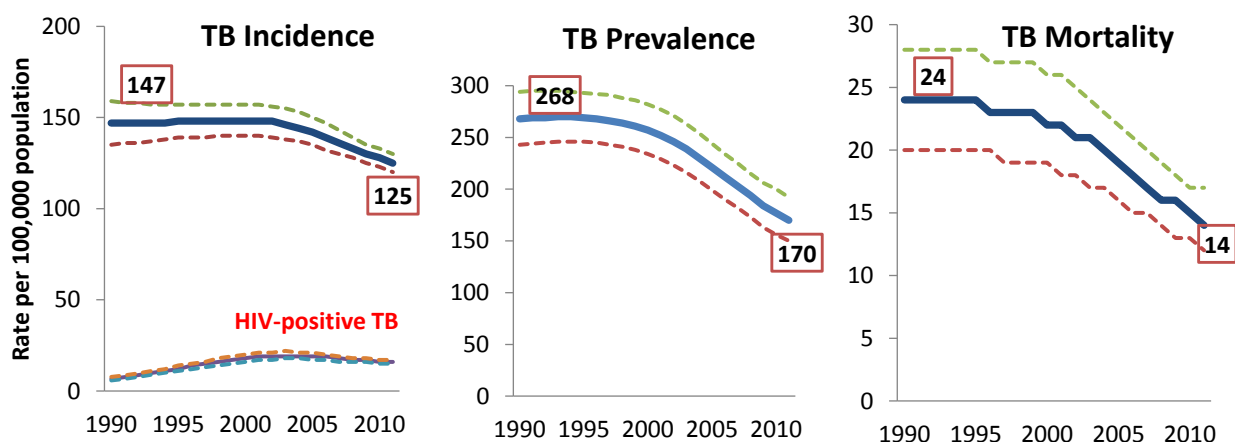
20. Multidrug-resistant TB remains a critical threat, especially in the 27 high-risk/burden TB countries accounting for 86 percent of the global multidrug-resistant TB burden, of which 23 received funding from the Global Fund. Overall, a cumulative total of 69,000 multidrug-resistant TB cases were treated through Global Fund-supported programs, an increase of more than 12,000 cases, or 22 percent, from the end of last year. However this remains insufficient to face the challenge of multidrug-resistant TB and will require additional strategic efforts in the Global Fund portfolio, to tackle health systems issues, reduce the price and increase the health systems' capacity to provide multidrug-resistant TB treatment. WHO reported that 56,000 patients were enrolled in treatment of multidrug-resistant TB in 2011, of which Global Fund-supported programs accounted for about 23 percent. However, patients with multidrug-resistant TB are still grossly underserved as an estimated 250,000 cases annually are still left untreated. The main challenges in many countries have been inadequate funds to expand diagnosis and treatment of multidrug-resistant TB patients, limited technical capacity and weak health systems to respond to the challenge of multidrug-resistant TB.

21. ***Impact on TB.*** TB mortality has decreased significantly since 2000, and treatment success rates have shown steady improvement. More than half of the countries that have received Global Fund support are on track to meet the international targets for case detection, treatment success, and TB disease incidence.

22. Global trends in estimated TB incidence, prevalence and mortality suggest the Millennium Development Goals will be achieved in this area, and there is a major potential for investments to further reduce TB, in particular with the emergence of new diagnostic tools. However the regional trends highlight the challenges of TB control in Africa, where

there are high HIV levels. There is a major opportunity for strategic investments in joint HIV/TB control in this region.

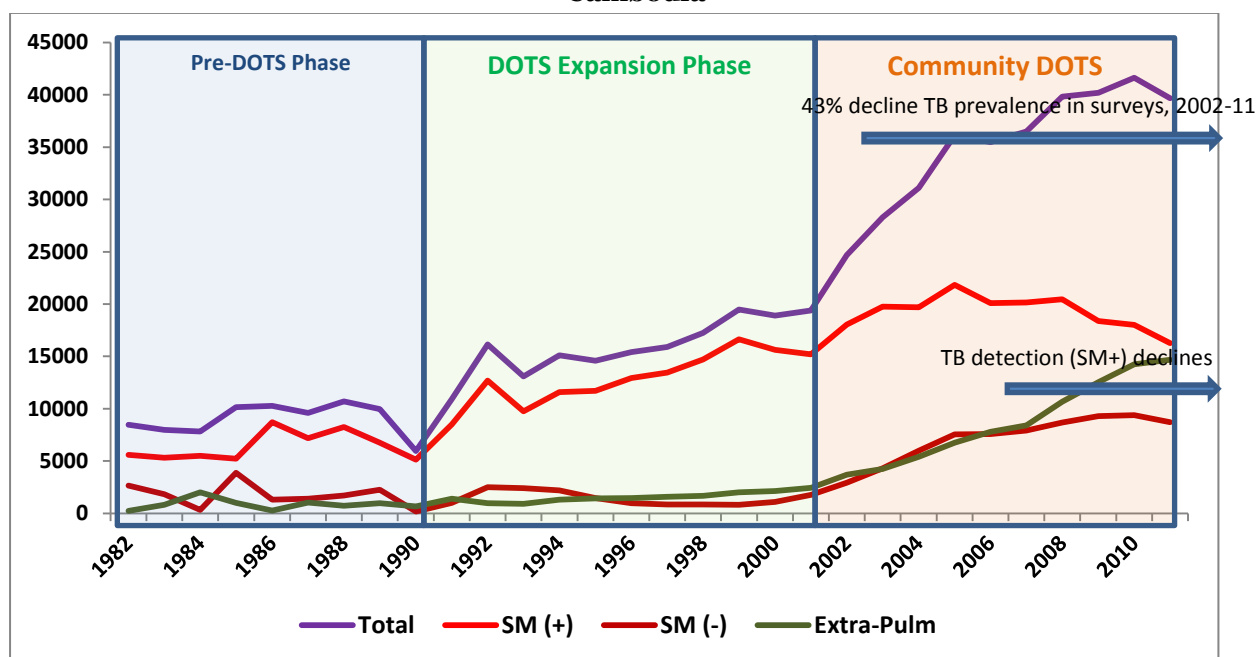
Figure 6: Declining Global Trends in TB Prevalence, Mortality and Incidence



(Source: WHO, 2012)

23. Increasingly data from TB prevalence surveys is becoming available, and are reviewed as part of Global Fund impact reviews (described in Part 2). The figure below shows how (1) Global Fund funding was used to support community DOTS, which increased the coverage of the program to over 80 percent and led to a decline in TB cases detected from 2004; and (2) this high coverage was associated with documented impact of a 43 percent decline in TB prevalence, 2002-2011, shown from two TB prevalence surveys. This shows the importance of expanding community access to achieve high coverage, and the returns in terms of declining notifications and reduction in TB prevalence which occur once high coverage is reached.

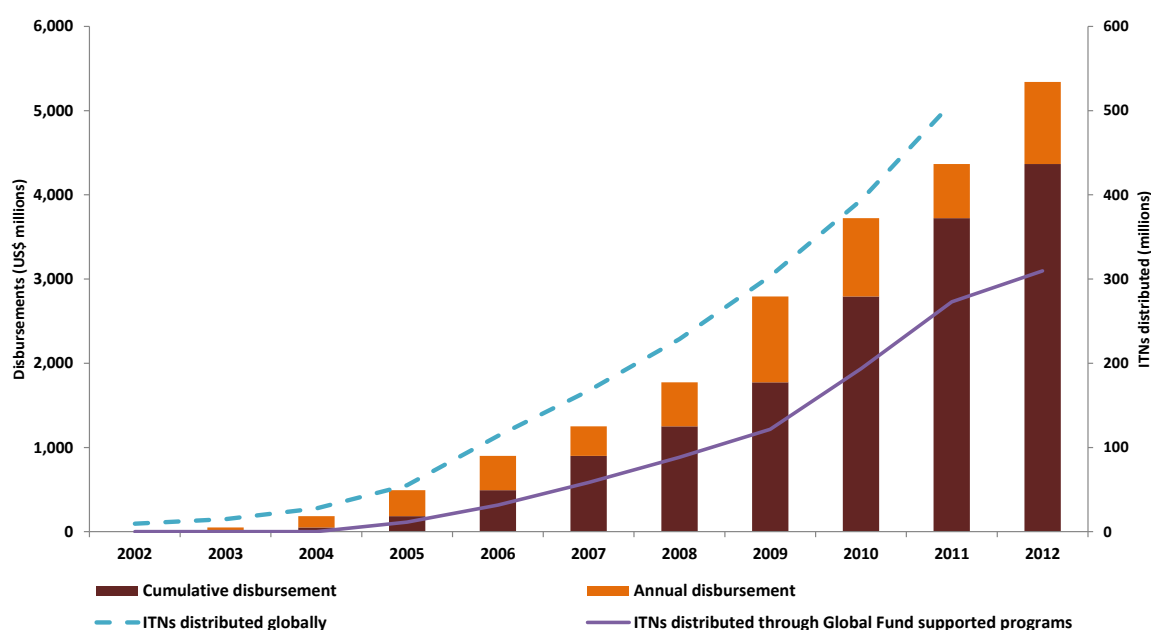
Figure 7: Reduction in Tuberculosis Prevalence Demonstrated by Surveys, Cambodia



Malaria Financing and Results

24. Through Global Fund-supported programs, 80 million insecticide-treated nets were distributed in 2012, an increase of 32 percent from the previous year. The majority (73 percent) of these nets were distributed in sub-Saharan African countries, with Cameroon, Côte d'Ivoire, the Democratic Republic of the Congo, Kenya, Malawi, and Nigeria being the top recipients. Sixteen million nets were distributed in the Asia region in 2012, of which about 50 percent went to three countries – India, Afghanistan, and Indonesia. The Latin America and Caribbean region has seen the highest increase in insecticide-treated net distribution, with a total of 2.4 million nets in 2012 alone, an increase of 133 percent from the previous year. Most of this increase was due to the significant scale-up of implementation activities in Haiti. Since 2002, US\$ 5.2 billion has been disbursed to support malaria interventions.

Figure 8: Growth of Global Fund Investments in Malaria Interventions



25. The Global Fund promotes the use of artemisinin-based combination treatment (ACT) courses over monotherapies, a practice threatening the long-term effectiveness of ACTs. By the end of 2012, a cumulative total of 290 million malaria cases had been treated through Global Fund-supported grants, a 26 percent increase from the 2011 year-end figure, with 85 percent being in sub-Saharan Africa.

26. The impact on malaria has also been supported by decreasing unit costs of prevention and treatment. This has made these interventions more affordable for national programs and domestic financing. The figure below shows the declines in unit prices for insecticide-treated nets from the Global Fund price reporting mechanism. However, the extent to which this will continue in the future is unclear.

Figure 9: Unit Costs for Long-lasting Insecticidal Nets Purchased Through Global Fund-Supported Programs

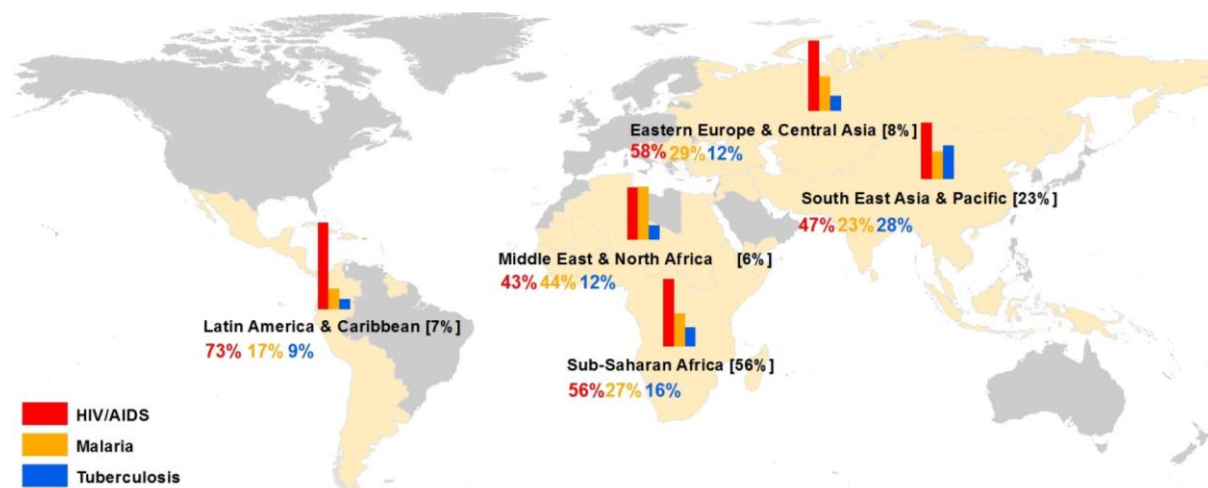


27. **Impact on malaria.** WHO estimates that 150 million insecticide-treated nets are needed annually to protect all populations at risk of malaria in sub-Saharan Africa. Only 92 million insecticide-treated nets were delivered in 2011 and 66 million (estimated) in 2012, less than the estimated need of 150 million. Overall, coverage has not changed from 2011 to 2012 and may decrease in the sub-Saharan region in the near future unless there is a substantial increase in insecticide-treated net availability in 2013. This highlights the need to sustain coverage of key interventions like insecticide-treated nets, which need to be replaced every three years. If they aren't and gaps emerge, increases in malaria cases and deaths will follow.

28. It is estimated that half of countries with ongoing malaria transmission are on track to meet the international targets of a 75 percent reduction in malaria cases by 2015. Further progress relies on achieving higher coverage of prevention and treatment in high-burden countries. Eighty per cent of malaria cases occur in 14 countries. These include Nigeria and the Democratic Republic of Congo, where coverage is more limited which is holding back progress both at the country and the global levels. There are eight countries in Africa that have achieved a 75 percent reduction in malaria cases: Swaziland, South Africa, Rwanda, Botswana, Namibia, Cape Verde, Algeria and Sao Tome and Principe, while Eritrea is on track to achieve a 75 percent reduction and Madagascar and Zambia are on track for a 50 to 75 percent reduction. These tend to have been smaller countries where service coverage has been scaled up rapidly to 80 percent and resulted in impact. However, where this high-level coverage has been reached in larger countries like Tanzania (as shown in section 2), malaria prevalence has also declined.

29. **Increasing domestic spending:** Between 2002 and the end of 2012, the Global Fund committed a total of US\$ 22.9 billion in funding for programs in 151 countries. As of December 2012, the Global Fund had disbursed a total of US\$ 19 billion, distributed by geographic region and disease as shown below. Using the Global Fund's current regional categorization, High-impact Africa accounted for 37 percent, Africa and Middle East 25 percent, Asia, Eastern Europe, and Latin America and Caribbean together made up 23 percent, and High-impact Asia 15 percent. Grant renewal decisions worth up to US\$ 4.3 billion were made in 2012. This amount is expected to be about US\$ 3.7 billion in 2013.

Figure 10: Breakdown of Global Fund Financing By Region and By Disease



30. The shift in focus from numbers/outputs to national coverage of services has been made possible by declining unit costs and, most importantly, increasing domestic expenditures. The global results were only achieved through the combination of external, Global Fund and domestic financing. Domestic financing of HIV, TB and malaria in Global Fund-eligible countries has more than doubled during the five-year period, principally thanks to the large increases in domestic HIV investment.

Table 2: Amount of Domestic Financing for the Three Pandemics, 2006-2011

Summary of 3 Diseases	2006	2007	2008	2009	2010	2011
Domestic Investment, Total	4.35	4.80	6.00	6.24	7.04	8.10
HIV	2.30	2.66	3.61	3.86	4.68	5.42
TB	1.83	1.90	2.14	2.11	2.06	2.35
Malaria	0.22	0.24	0.24	0.26	0.30	0.33

(Figures in US\$ billion)

Part 2: Evaluation Plan and Progress

31. The Global Fund Board has approved an evaluation plan to accompany its Global Fund Strategy 2012-2106 “Investing for Impact”. This has four key components:

- A system of program reviews with partners in all high-impact countries to assess impact, invest in analysis and evaluations, and provide practical recommendations to improve grants
- Independent data quality assessments as a basis to improve data systems and monitoring and evaluation capacity to support countries in analyzing and assessing their disease impact. The Technical Evaluation Reference Group stressed the importance of these investments and the major limitations of data quality in countries.
- Thematic reviews to address key cross-cutting issues and provide strategic options to the Global Fund, for example on fragile states and portfolio risks like resistance to artemisinin malaria treatments
- An independent synthesis report of the Global Fund based on results for the mid-term and end-term of its strategy (end 2014 and end 2016 results)

32. In addition the Technical Evaluation Reference Group, the Global Fund has agreed on the importance of contribution and assessing causation and competing explanations rather than narrow attribution to one source of financing or single intervention: *“Impact evaluation assesses the overall impact on the burden of cases and deaths due to the three diseases. It will assess causation and the contribution of the Global Fund and other explanations along the results chain from inputs to outcomes”*

33. The Technical Evaluation Reference Group stressed the importance of assessing positive and negative impacts and outcomes, including risks in the portfolio and individual countries. The definition of impact evaluation combined two components, assessing final disease outcomes and impact, and assessing contribution and causation along the results chain. They also stressed that the evaluations need to be practical, build on country reviews (including the WHO country-led platform for health and accountability) and should be used as inputs to grant decisions.

34. The following five principles for its evaluations were defined (Five Ps):

- **Partner** approach - build on, collaborate and synchronize evaluations with partners, maintaining rigor and objectivity;
- **Periodic** – planned, regular evaluations rather than one-off evaluations (“Five Year Evaluation is a poor substitute for five years of evaluations”);
- **Plausibility** design – provide evidence of program impact, positive and negative, also considering other non-program influences along the agreed monitoring and evaluation chain of change;
- Country **Platform** – build on national systems, including program reviews and strengthening of country monitoring and evaluation capacity;

- **Practical** for grants – reviews should provide limited, practical recommendations for grant management, grant renewal and re-programming.

35. Thematic reviews are distinguished from impact evaluations, as they provide analysis for strategic options and are defined as “Reviews of specific issues or themes which assess past evidence and selected cases, with a primary focus on providing forward looking strategic options”.

36. The Global Fund meets on a monthly basis with partners to coordinate the timing of country reviews and evaluations with partners, and with the schedule of country HIV, TB, malaria and health reviews, and to fund independent consultants, team leaders and analysis. The aim is to cover all high impact countries to assess 70 percent of the disease burden during the present Global Fund strategy period. The following table shows the schedule of country reviews which are underway and on track to 2014 (bright yellow) and countries which have agreed country timings (light yellow)

Table 3: Schedule of Country Reviews

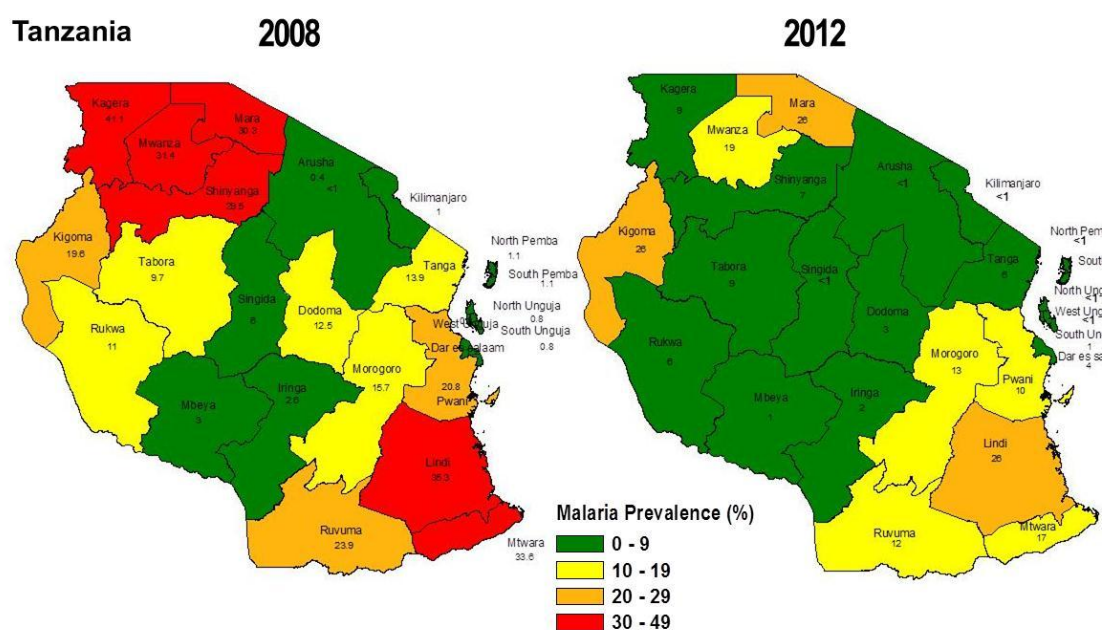
2012 Q3-4	2013 Q1-2	2013 Q3-4	2014
Cambodia (malaria, TB)	Nigeria (HIV, TB)	Kenya (HIV)	Cote d'Ivoire (NTP review)
Cambodia (TB)	Malawi (HIV)	Zimbabwe (HIV, TB, malaria)	South Africa (NTP review)
Myanmar (malaria)	Tanzania (TB)	Uganda (HIV TB,)	Zimbabwe (NTP review)
Bangladesh (malaria)	Zambia (malaria)	Haiti (HIV, malaria)	Bangladesh (Malaria)
Rwanda (HIV, malaria)	China (MPR)	DRC (HIV, TB)	South Africa (TB)
Namibia (HIV)	Cambodia (HIV)	Nigeria (TB)	North Sudan (malaria)
DRC (MPR)	Ukraine (HIV)	Ethiopia (TB)	PNG (Malaria)
Tanzania (malaria)	Thailand (HIV)	Mozambique (HIV, TB)	Kenya (TB, malaria)
Malawi (malaria)	Ethiopia (HIV)	Zambia (HIV, TB)	Zambia (TB)
India (TB & MPR)	India (HIV)	Myanmar (HIV, TB)	Malawi (TB)
South Africa (HIV)	Uganda (NTP review)	Bangladesh (TB)	Philippines (HIV, TB)
Nigeria (MPR)	Kenya (NTP review)	Tanzania incl. Zanzibar (TB)	Indonesia (HIV)

37. In addition, the timing of country reviews has been scheduled (where this fits with country schedules) to provide practical recommendations to grant reviews and the new funding model (consistent with Technical Evaluation Reference Group guidance on the new strategy of “Investing for Impact”)

38. Initial country impact reviews have showed demonstrated impact on the burden of cases and deaths, as well as gaps which have catalyzed reallocation or reprogramming of grant funding to improve future impact. They have also highlighted data-quality issues in some countries, which will require investments in the capacity of countries to measure and analyze impact. The initial results have included:

- **Bangladesh malaria** – high degree of documented impact, with 92 percent reduction in malaria deaths, the findings were included as inputs to Phase 2 to radically refocus investments to hill areas and improve surveillance to respond to the changing epidemic and geographic distribution of remaining cases.
- **Cambodia TB and malaria** – TB prevalence has declined by a full 43 percent between two national prevalence surveys, and malaria deaths decreased by 80 percent (with a greater impact in districts with advance interventions).
- **Myanmar malaria** – progress towards impact with declines in reported malaria deaths. However a major risk of artemisinin resistance, which guided the creation of the regional grant under the new funding model.
- **South Africa HIV** – impact of 75 percent ARV therapy coverage on adult mortality and life expectancy, the latter increasing for the first time in a decade from 51 years in 2005 to 60 years in 2010, and declines in mother-to-child-transmission of HIV from 3.5 percent to 2.7 percent. The program review led to the development of a five-year sustainability plan to guide Phase 2 funding, and reprogramming to interventions to address continued high HIV incidence.
- **Thailand and Uganda HIV** – limited impact of previous prevention activities, high HIV prevalence among men who have sex with men and people who inject drugs, and increasing HIV prevalence among pregnant women in Uganda. This led to reprogramming of Global Fund, national and partner funding at the district and local levels with more strategic targeting to ensure greater impact.
- **Tanzania malaria** – with other partners, declining malaria prevalence by region from 2007-2008 to 2011-2012 (as shown in the figure below)
- In addition, a **thematic review on artemisinin resistance** and country reviews in Zimbabwe, Myanmar and participation in the JANS in Mozambique have been carried out to better inform future investments under the new funding model.

Figure 11 – Malaria Prevalence by Region in Tanzania



(Source: Tanzania National Program)

39. The Technical Evaluation Reference Group has also stressed issues of data quality in its initial country assessments and the need to invest in data systems to strengthen the ability of countries to measure impact over the period of the evaluation, and in some countries as a basis for impact evaluation beyond 2016

40. The Technical Evaluation Reference Group has also launched a schedule of thematic reviews to contribute to strategic decisions. These have included monitoring and evaluation systems strengthening, which has contributed to a Board decision on investments in this area, AMFM (in support of recent Board decisions), artemisinin resistance to inform grants under the new funding model, and a planned impact review of the new funding model itself. It has reviewed terms of reference for thematic reviews on fragile states, human rights, and MDGs 4 and 5, which will contribute to strategic review and decisions over the 2014-2016 of the Replenishment and current Global Fund strategy. This aims to ensure a planned, regular cycle of evaluations to inform future Global Fund support to countries.

Annex A - Summary of the Evaluation Plan

1. The Technical Evaluation Reference Group agreed on four key components for the evaluation of the Global Fund: (1) country evaluations; (2) data quality assessments; (3) thematic reviews, and (4) an independent synthesis study and report.

2. The Technical Evaluation Reference Group agreed on supporting a “country platform” of evaluations developed with its technical and funding partners. This focuses on disease impact, capacity building and practical recommendations for countries and grants, supporting the framework of country ownership and sustainability. The following principles for its evaluations were defined (Five Ps):

- **Partner** approach - build on, collaborate and synchronize evaluations with partners, maintaining rigor and objectivity;
- **Periodic** – planned, regular reviews rather than one-off evaluations (“Five Year Evaluation is a poor substitute for five years of evaluations”);
- **Plausibility** design – provide evidence of program impact, positive and negative, also considering other non-program influences along the agreed monitoring and evaluation chain;
- **Country Platform** – build on national systems including program reviews and strengthening of country monitoring and evaluation capacity;
- **Practical** for grants – reviews should provide few, practical recommendations for grant management, grant renewal and for re-programming.

3. The country evaluations will have a primary focus on country impact, and answers to the two following two questions:

- Has there been a change in disease mortality/morbidity and/or incidence and prevalence, positive or negative?
- Has there been a change in outcomes and behaviors, positive or negative?

4. In addition, it will assess causation along the monitoring and evaluation chain but with a starting point and focus on impact. The following questions will be included, to assess contribution and causation along the results chain:

- Has there been an increase in **coverage** of key intervention services, and have these reached groups at risk?
- Has **access by age, sex, equity and quality of key intervention services** improved?
- Have **finances** been disbursed for key services and contributors?
- Was there sufficient **quality data** to detect the effect of increase in service coverage and quality on disease burden? What were sources of bias?

- What was the Global Fund’s **contribution** in scale-up of resources, increase of coverage of key intervention services, improvement of service quality and outcome? What were the other competing explanations and hypotheses of changes in outcomes and impacts, positive and negative?
- How can contributions of the Global Fund be improved to better contribute to outcomes and impact? What are the management recommendations?

5. The Technical Evaluation Reference Group agreed on its position and the importance of contribution and assessing causation and competing explanations rather than narrow attribution to one source of financing and single intervention: *“Impact evaluation assesses the overall impact on the burden of cases and deaths due to the three diseases. It will assess causation and the contribution of the Global Fund and other explanations along the results chain from inputs to outcomes”*.

Annex B – Summary of the Evaluation of the Transition Period of the New Funding Model

1. The transition phase of the new funding model (February 2013 – January 2014) focuses on monitoring and learning for the operationalization of the Board decision points (GF/B27/DP7 and GF/B28/DP4). The monitoring and learning of the transition phase will be facilitated through a process evaluation. The lessons learned and adjustments made during the transition phase will enable greater effectiveness and success during the full implementation of the new funding model in 2014. This is the Phase 1 learning phase for the transition, and additional evaluation will be conducted on full rollout of the new funding model in future.
2. In order to identify strengths and weaknesses of the new funding model and “lessons learned” and make appropriate improvements, the process evaluation requires regular data collection and analysis and close collaboration between the evaluation team and Grant Management staff under the guidance of the Technical Evaluation Reference Group. The key aim will be to assess the strengths and weaknesses of the new funding model implementation, and identify how it can be improved.
3. Information and data will be collected using qualitative and quantitative methods and the approach will focus on (1) structured country team debriefing on priority issues to improve rapidly (grant management reviews); (2) stakeholder feedback on strengths, weaknesses and areas of improvement (questionnaires); and (3) country visits (including program reviews) including a review of a limited number of metrics for delivery. Due to the limited number of countries and the time frame of the transition phase, there will be limitations to the generalization of the findings.
4. There are two phases for the evaluation of the new funding model – Phase 1 for a process evaluation of the new funding model elements during the transition phase to improve the model. Additional evaluation will be conducted on full new funding model rollout as of 2014.

Learning through the Transition – A Process Evaluation

5. The monitoring and learning of the transition phase will be facilitated through a process evaluation. The process evaluation aims to evaluate the process of operationalization of each element of the new funding model.
6. The process evaluation will aim to answer the following three key overarching questions:
 - What are the strengths and weaknesses of the new funding model implementation?
 - How can the new funding model be improved compared with the previous funding model?

- Are the key new funding model elements clearly defined in the guidance provided, and what is needed to make them work better?
7. The following questions can also be addressed during the process evaluation:
- What are the priority issues during the transition phase received from countries and country teams?
 - How well are the new funding model elements and process communicated and understood at the country level?
 - What are deviations from the defined scope of the new funding model elements during the implementation?
8. There will be linkages to thematic reviews on fragile states and human rights to enhance learning and develop strategic options.

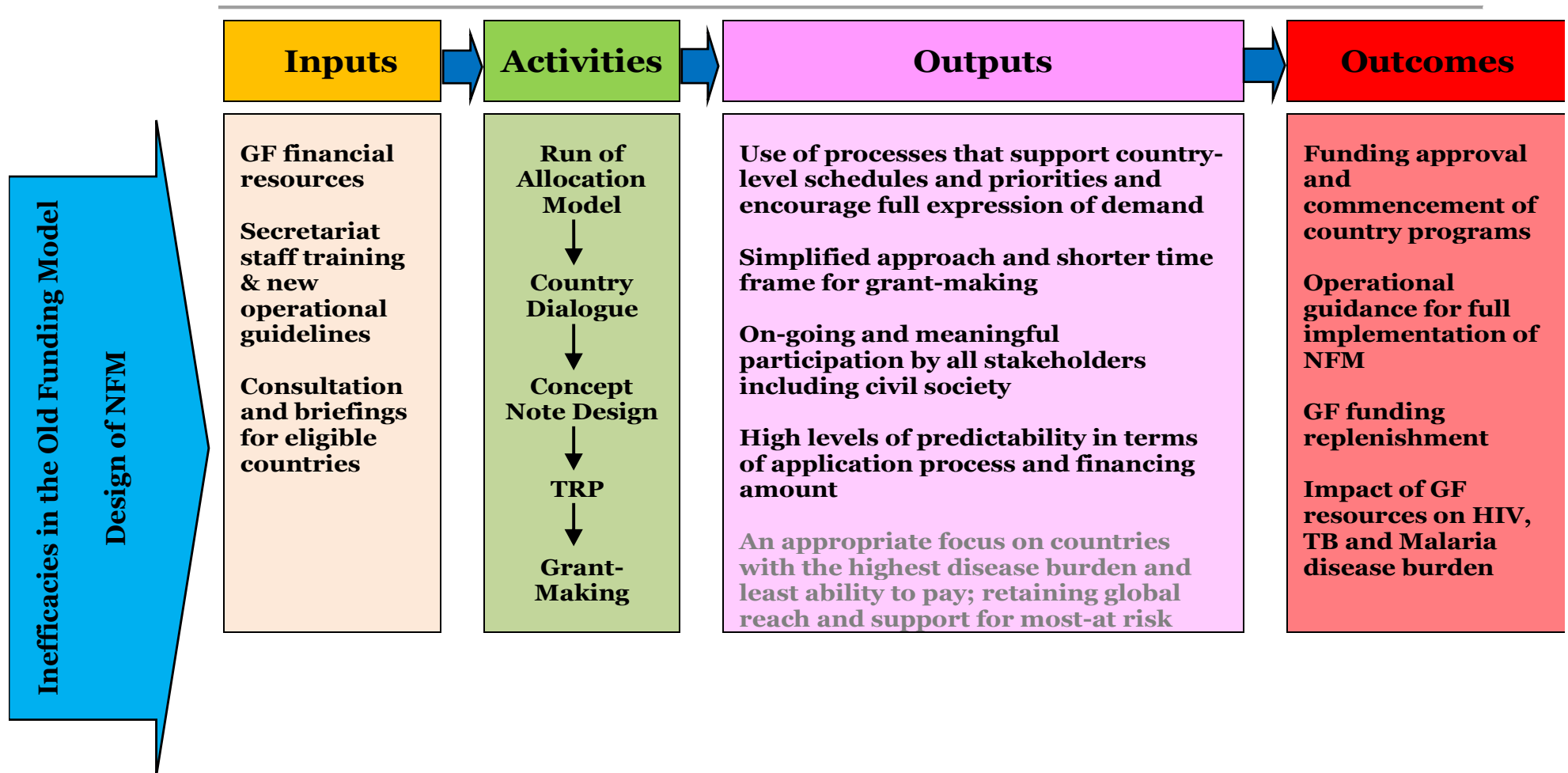
Logic Model

9. There are various issues in the previous funding model, as identified, for example, in the High-Level Panel report, and the Global Fund board decided on the new funding model to address such issues with a number of principles. Weaknesses in the previous funding model to be addressed include a slow grant-making process (e.g. Principal Recipient capacity assessment done much after the proposal approval), unpredictable timing of funding opportunities, acceptance rate of proposals (all or nothing), and significant transaction cost of developing proposals, project mode proposals, etc.

10. The process evaluation will aim to monitor and learn for improvement on the following new funding model principles:
- Greater alignment with country schedules, context, and priorities;
 - Improved country dialogue and involvement of partners
 - Simplicity for both implementers and the Global Fund;
 - Predictability of process and financing levels;

The Logic Model depicts the process and interrelationship of new funding model elements during the transition phase. The output marked in gray in the figure will be achieved during the full rollout phase of the new funding model.

New Funding Model Transition Phase – Logic Model



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