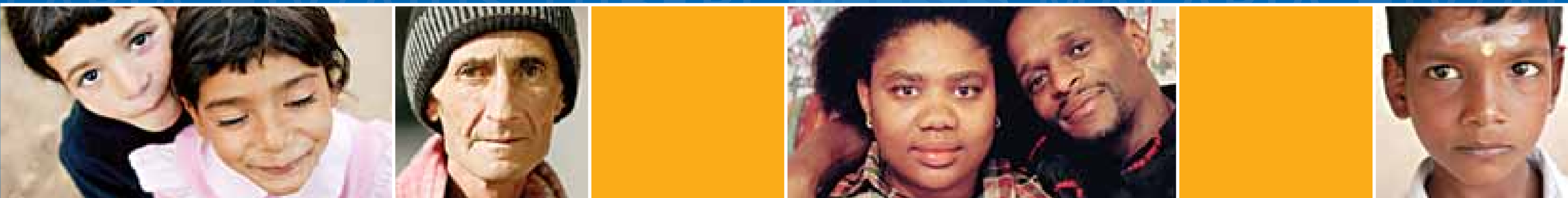
# GLOBAL FUND INVESTMENTS IN FRAGILE STATES: Early Results



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The Global Fund

To Fight AIDS, Tuberculosis and Malaria

Acknowledgements:

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ISBN 92-9224-027-7

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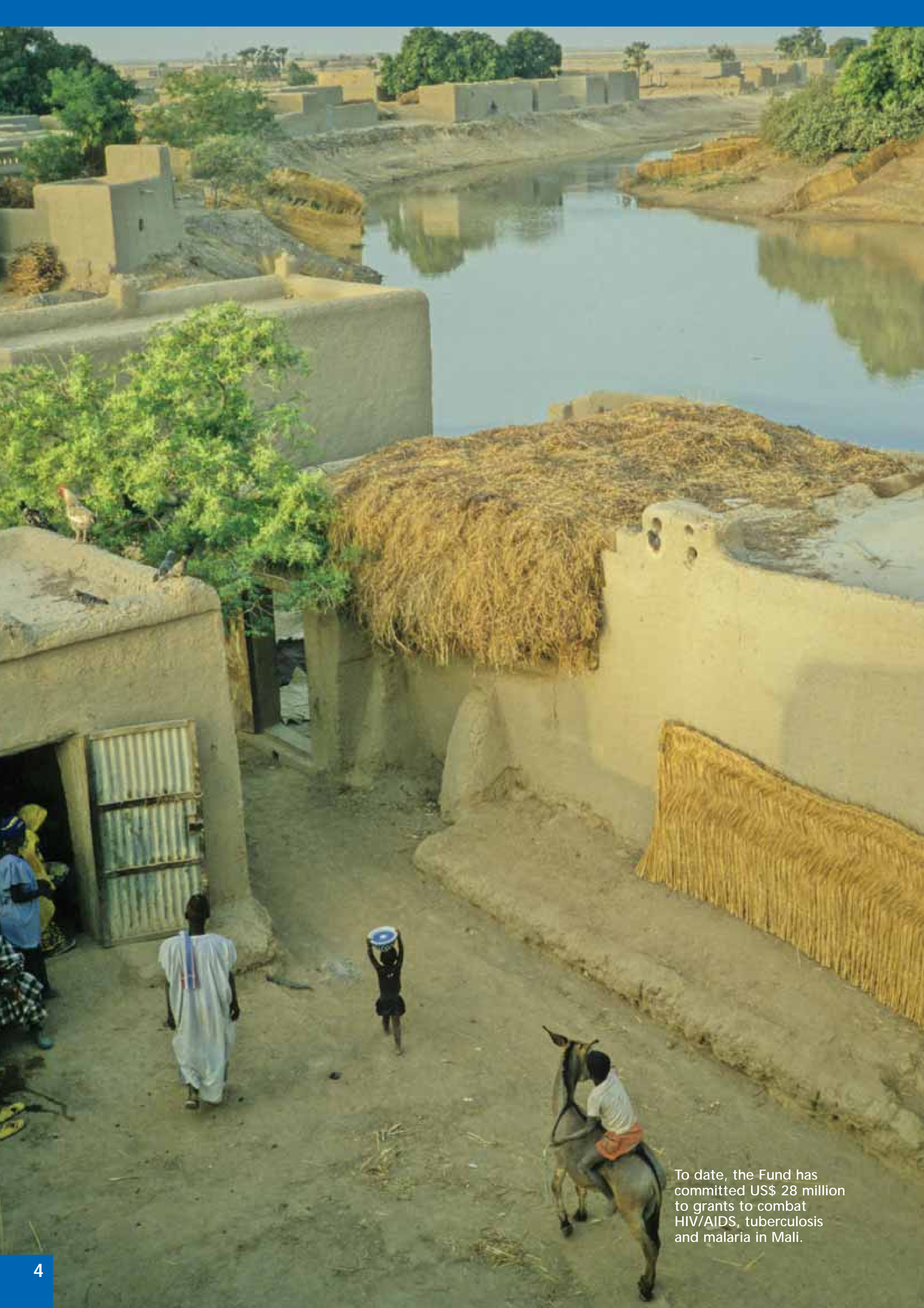

To date, the Fund has committed US$ 28 million to grants to combat HIV/AIDS, tuberculosis and malaria in Mali.

# LIST OF TERMS AND ABBREVIATIONS USED

LIST OF TERMS AND ABBREVIATIONS USED

| | |
|---|---|
| ACT | Artemisinin-based combination therapy |
| ARV | Antiretroviral therapy |
| CCM | Country Coordinating Mechanism |
| DFID | Department for International Development (UK) |
| FPM | Fund Portfolio Manager |
| GSC | Grant Score Cards<br>(internal Global Fund documents outlining grant progress and results) |
| HBC | High-burden country<br>(used in reference to tuberculosis disease burdens) |
| HIPC | Heavily indebted poor countries |
| LFA | Local Fund Agent<br>(independent consultants contracted by The Global Fund to assess and verify program results as they are reported by the Principal Recipients of grants) |
| LICUS | Low-income countries under stress |
| M&E | Monitoring and Evaluation |
| MDGs | Millennium Development Goals |
| PR | Principal Recipient |
| SIE | Strategic Information & Evaluation<br>(unit within the Global Fund Secretariat) |
| TB | Tuberculosis |
| TERG | Technical Evaluation Reference Group |
| TRP | Technical Review Panel |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| WHO | World Health Organization |

Correct diagnosis of tuberculosis is an essential part of combating this epidemic. Over two years, a Global Fund grant to Uzbekistan will support training of more than 3400 health care providers in TB detection.

# EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

**1.** In its first four rounds of funding, the Global Fund has invested one-third of committed funds in 45 fragile states, financing a total of 123 programs. This report presents initial results from an ongoing study on the performance of grants in fragile states. The report is based on a comparative analysis of the performance of the 19 grants from fragile states and the 55 grants from stable states that had been assessed for Phase 2 funding. (Global Fund grant funding is contingent on satisfactory performance. A full assessment of all grants is made 15 to 18 months from the start date of implementation to determine whether funding should continue for the remainder of the grant's lifespan). All 19 grants performed well: 14 grants were graded A or B1 (measures of excellent or satisfactory performance, respectively), and five grants achieved grade B2 (targets not met but demonstrated potential). None of the 19 grants was discontinued.

**2.** The performance by grants in fragile states was comparable to that of the 55 grants implemented in stable states. Most of the grants in fragile states (14 out of 19) were managed by Principal Recipients (PRs) from the government sector, and these grants performed equally well as those managed by non-government PRs. A well-performing grant in a fragile state was more likely to have a proactive Country Coordinating Mechanism (CCM) that met regularly with the PR and sub-recipients to review work plans and progress, and which had regular communications with the PR and sub-recipients on the one hand and the Fund Portfolio Manager at the Global Fund on the other hand. Site visits by the CCM were important for encouraging program implementers and for verifying implementation activities and results. Coordinating the input by development partners into one coherent plan of action was critical, as was the inclusion of the non-governmental sector in implementation. Other important factors of success included the creativity and initiative of the PR, timely disbursements and verification of progress reports.

An important component of a grant to the Democratic Republic of Congo to combat and prevent tuberculosis is social mobilization throughout all layers of society with information, education and communication activities.

# INTRODUCTION

**3.** State fragility has come to the fore in high-level discussions within donor circles, as evidenced by the development of several working papers on the subject in the last two years (1-5, 7-12, 14). The key concern is how development assistance can best be delivered in these constrained environments in order to achieve the Millennium Development Goals (MDGs). Despite this increased attention, there is no agreed definition of state fragility - most states can be considered to be fragile in one aspect or another. Moreover, state fragility is not constant: a country can move in and out of fragility, making it difficult to draw up a definitive list of fragile states (6, 7). Not to mention that there is substantial stigma attached to being described as a fragile state.

**4.** The UK's Department for International Development (DFID) has put forward a working definition of a fragile state as one that "cannot or will not deliver core functions to the majority of its people, including the poor." The core functions listed include territorial control, safety and security, capacity to manage public resources, delivery of basic services, and the ability to protect and support the ways in which the poorest people can sustain themselves (1).

**5.** DFID's working definition is based on the World Bank's Country Policy and Institutional Assessment (CPIA) scores, which divide low-income countries into quintiles, or five categories of performance (8). The lowest 40 percent (lowest two quintiles) comprises a list of countries that the World Bank describes as "low-income countries under stress" (LICUS), and which serves as a proxy for fragility. There is, in addition, another group of countries which by the DFID definition can be considered fragile. Together, this comprises a list of 46 countries with a total population of 870 million people or 14 percent of the world's population that can be described as fragile states. (The list of the 46 states regarded as fragile is given in Appendix 1).

**6.** State fragility presents a challenging environment for delivering development assistance. From the early 1990s onwards, donors have tended to reward low-income countries with relatively effective governments and stable macroeconomic policies. The poorly-performing states, i.e. the fragile states, have been confined to receiving mostly limited, short-term humanitarian aid (1, 9, 10). This trend is also discernible in a recent decision by the G8 to provide conditional cancellation of debt to heavily indebted poor countries (HIPCs). Only four of the 18 countries thus granted debt relief are fragile states, namely Ethiopia, Niger, Guyana and Mali.

**7.** There are compelling reasons for investing in people in fragile states. First, a large proportion of the world's poorest citizens lives in fragile states. Failure to engage with these states will maintain and may even increase levels of poverty and insecurity which could in turn again exacerbate the degree of state fragility (1, 2, 11, 12).

**8.** Second, fragile states have a higher disease burden than other low-income countries. For instance, the malaria death rate is nearly 13 times higher in fragile states than elsewhere in the developing world. The proportion of people living with HIV is four times higher, and maternal mortality is more than two and a half times higher. Nearly half of the children who die before the age of five are born in fragile states, and child mortality is two and a half times higher than in other poor countries. To ignore the states with high disease burden will only aggravate the burden, undermine poverty reduction efforts, and imperil achievement of the Millennium Development Goals.

**9.** Third, the people in these states are less likely to go to school or access essential healthcare. Denying the populations in fragile states access to two of the most fundamental tools for poverty reduction is to cast a long shadow over the lives and livelihoods of the millions living in these states and their future generations.

**10.** Fourth, given the risk of export of disease across borders, of political and military instability engendering subsequent refugee flows, failure to implement effective action in fragile states undermines the investments made in neighboring states.

The Global Fund has provided US$ 35.6 million dollars to the Democratic Republic of Congo for grants to combat HIV/ AIDS, tuberculosis and malaria.

# THE GLOBAL FUND AND FRAGILE STATES

**11.** The mandate of the Global Fund is to mobilize resources on a large scale and to disburse these resources to countries in need so that they can accelerate and scale up the fight against these three diseases of poverty. The countries in need of the Global Fund's resources are primarily the low- and middle-income countries with a high disease burden. This focus on low-income status and high disease burden, free from any other policy constraints and conditionalities, has led the Global Fund to invest large sums of resources in fragile states. This contrasts with the general current of development assistance from most other sources.

**12.** The performance and results of the grants in fragile states will, to a large extent, influence the overall success of the Global Fund and is thus of major interest. The Global Fund's large portfolio of grants in both fragile states and stable, low-income countries provides an opportunity to compare the performance of these grants within radically different environments. This is all the more important in that the disbursement of funds to the grantees, as well as continued funding decisions after the first two years of programs (Phase 2), are conditional on performance regardless of state fragility (although the Phase 2 evaluation allows for contextual information to be considered in making continued funding decisions). All its grantees are required to demonstrate good performance in managing and implementing their grants to assure continued funding.

**13.** Can this system work in fragile states? These states have, by definition, a low capacity to manage public resources, low absorptive capacity, inadequate infrastructure, and a low human resource base. In some cases, states may have few or no other donors providing significant funds for the fight against the three diseases, as was the scenario in Togo when the Global Fund first awarded that country a grant. A key question therefore is: given that the Global Fund does not run a differential system for performance-based disbursements according to political stability, can fragile states be expected to perform at the same level as stable states?

## STUDY OBJECTIVES

**14.** This report presents the first information drawn from an ongoing Global Fund study on the performance of fragile states. It is based on a study of 19 grants to fragile states which have reached 18 months or more of program activities. The study had two objectives. First, it aimed to evaluate the suitability of the Global Fund model for fragile states, looking into areas for potential improvement. Then the study also aimed to draw lessons that can be used in other areas of health development assistance, including the non-health sectors, to advance the effectiveness of development aid to fragile states. It should be noted that even within the category of "fragile states" there are substantial differences between individual countries in ability and level of commitment concerning the delivery of public services. Some of the results of the study may be attributed partly to these differences.

**15.** The key questions asked included: what are the key factors that underlie well-performing grants in fragile states? What factors are associated with poorly-performing grants? The study examined the size of grants; the characteristics of each state's Country Coordinating Mechanism; the number and type of sub-recipients per grant; the management characteristics of managers at implementation level; the reporting and functional relationships between Principal Recipient and sub-recipients; the relative demand for support visits from Fund Portfolio Managers; and the roles played by technical partners or other donor agencies.

## STUDY DESIGN

**16.** The study looks at grant performance in fragile states, based on grants assessed for Phase 2 funding. These were five-year grants that had reached the end of Phase 1 (the first two years) and had passed through Phase 2 assessment to determine whether funding should be continued for years 3 to 5 (Phase 2). The Global Fund policy is that when a grant is approved by the Board, approval is, in principle, to fund the proposal for up to five years, since most of the proposals cover this time range. However, to ensure that financing is applied on a performance basis, the funds committed by the Board are for the first two years only. Before committing to the extension of funding beyond the first two years, the Global Fund Secretariat critically reviews performance of the grant as at 18 months to assess whether funding should be approved for Phase 2.

**17.** The decision is based on critical assessment of financial and programmatic performance as well as the management and governance of the grant. There are several points during the lifecycle of a grant at which evaluation is carried out; however, the assessment at the Phase 2 stage is a critical point involving a greater level of depth in the analysis of results. The stakeholders responsible for grant performance are the Principal Recipient (who carries accountability for the grant), the Country Coordinating Mechanism (a stakeholder body responsible for submitting grant proposals and overseeing implementation), and the sub-recipients (as implementers of all or part of the program activities). Information on grant performance submitted by the CCM is, in addition, verified by a Local Fund Agent (an independent entity contracted by the Global Fund for that purpose).

**18.** All the grants that had gone through their Phase 2 assessments by the end of July 2005 were included in the study. They included grants implemented in both stable and fragile states during the same time period. As of this date, 74 grants had completed this process and so were included. Of the 74 grants assessed, 19 were from fragile states. This compares to 316 grants signed overall, of which 123 are in fragile states. The relatively small number of grants from fragile states which could be included in this initial study places substantial limitations on the weight of the conclusions of this analysis. However, the analysis is continuing as more grants continue to come up for Phase 2 review.

## STUDY LIMITATIONS

**19.** Based on the definition of Phase 2 (i.e., having a minimum of 15 months of implementation) this study reviews *only* the grants with a lifespan *longer* than two years. Any grant awarded for a maximum of two years was not part of this analysis, such as the well-performing grants to two NGOs (SANAA and KENWA) in Kenya (one of the fragile states). Likewise, five-year grants that were still in Phase 1 (i.e., less than 15 months' functioning) were not included. Other aspects not addressed in this study are: the conditions precedent that were required prior to grant agreement signature; time to completion of negotiations; and time to commencement of implementation after receipt of first disbursement. This is the subject of a separate study.

## STUDY METHODOLOGY

**20.** All information relevant to the Phase 2 evaluation is contained in Grant Score Cards (GSC), which are compiled by the Global Fund's Strategic Information & Evaluation (SIE) unit at the Secretariat. This study reviewed the Grant Score Cards for all grants that had completed the Phase 2 process. The researchers and authors of this study have not been part of the Secretariat's Phase 2 decision-making process.

**21.** The Grant Score Cards rate the overall performance of grants according to one of four categories: A, B1, B2 or C, based on the proportion of program targets achieved and the rate of resource utilization (defined as the proportion of funds disbursed against the expenditure budgets agreed at the start of implementation). Relevant contextual information is also taken into consideration. Category A represents grants reaching or exceeding expectations and which have no or minor contextual issues; B1 covers grants that have adequate performance and/or have substantial contextual issues, but which issues are likely to be solved over time; B2 covers grants that show inadequate performance but have demonstrated potential and/or major recent improvements in the program-supporting environment; and C is for grants whose performance is unacceptably low or have critical contextual risks (13). Grants falling into categories A and B1 are generally recommended for continued funding. Category B2 grants are generally recommended for continuation, subject to certain conditions identified by the Secretariat. However, some B2-category grants may be recommended for discontinuation, as has occurred with three grants thus far (to be discussed later). Category C grants are recommended for discontinuation of funding.

**22.** In addition to performance measurement, other information recorded on the Grant Score Cards concerns contextual issues related to program and financial performance. Grant management and governance are also reviewed. Data analysis for the study compared performance across grants in both fragile and stable states. Structured interviews, guided by a questionnaire, were conducted separately with the Fund Portfolio Managers responsible for the relevant grants in order to gain further insights into the contextual issues surrounding each grant. The study also reviewed relevant mission reports by FPMs.

**23.** The limited time available did not permit interviews with Principal Recipients and sub-recipients, Local Fund Agents, and representatives of the Country Coordinating Mechanisms with in-depth review of all relevant documentation prior to preparation of this report. This will be done later to consolidate the initial findings.

A clinican reads an HIV-positive test result at a public hospital. Global Fund grants for HIV/AIDS support testing, treatment and prevention activities.

KEY FINDINGS

## GLOBAL FUND INVESTMENT IN FRAGILE STATES

**24.** Over the first four rounds of funding, 123 (41 percent) of the total of 316 grants allocated globally were to countries defined as fragile states. Forty-five of the 46 fragile states listed in Appendix 1 received at least one grant. The only exception was the Republic of Congo, which has yet to receive a grant from the Global Fund. The 123 grants represent a commitment by the Global Fund Board to finance interventions in the fragile states of US$ 1.1 billion over two years, and approval for a ceiling of US$ 3.0 billion over the five-year lifespan of the grants. These allocations to fragile states account for 35 percent of the total resources awarded by the Global Fund in Rounds 1 to 4 (see Figure 1a). This is remarkable, especially when compared to the recent trend in bilateral assistance as shown in Figure 1b. In 2001, fragile states, which constitute the bottom 40 percent of countries on the CPIA score (quintiles 4 and 5), received only 14 percent of bilateral aid, whereas the top three quintiles (quintiles 1, 2 and 3) received 83 percent of all bilateral aid, or nearly six times as much as the fragile states (1).

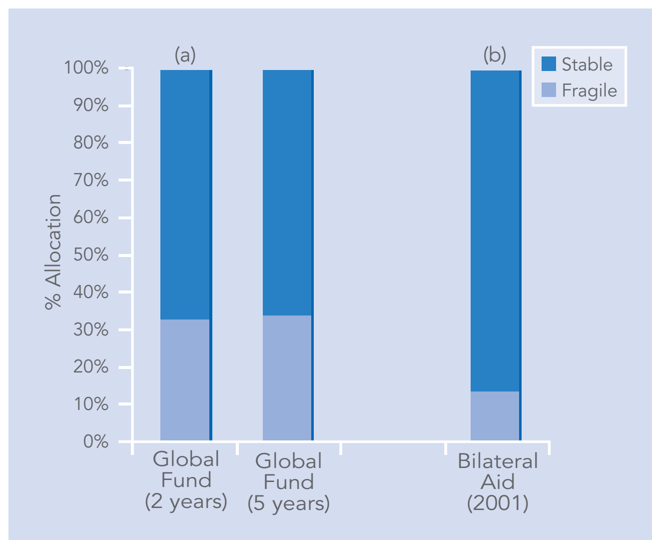


Figure 1: Allocation according to fragility status (a) Global Fund resources and as compared to (b) overall bilateral aid for 2001

**25.** The proposals submitted to the Global Fund are country-driven, based on gaps in a country's national strategic frameworks to fight one or more of the three diseases. The Global Fund does not set specific allocations to individual countries in advance.

**26.** The study examined whether grants to fragile states were any different in size to those of stable states. As shown in Figure 2, below, the study concludes that there is no difference in size of grants with respect to fragile states as compared to stable states. The distribution is more or less identical. Furthermore, grant size did not seem to influence overall grant performance. Grants of less than US$ 10 million performed just as well as those above US$ 10 million over the two-year funding period.

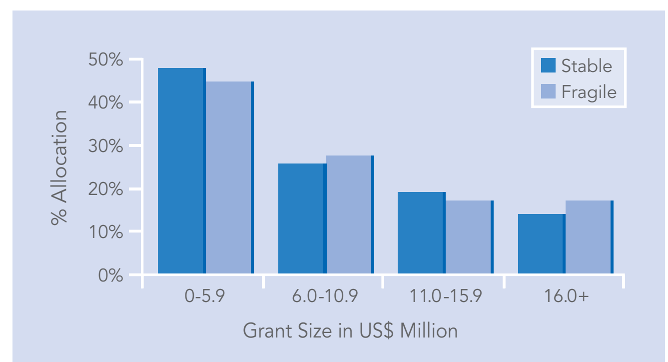


Figure 2: Size of grants to fragile states as compared to grants to stable states

## GRANT PERFORMANCE IN FRAGILE STATES

**27.** Owing to the general lack of capacity, combined with political instability, low absorptive capacity, and other aspects of state fragility, fragile states would not be expected to do as well as stable states. Performance of grants in fragile states was examined through an evaluation of Phase 2 assessment scores for 19 grants compared with the scores for the 55 grants implemented in stable states. The results are given in Figures 3a and 3b, below.

**28.** Figure 3a shows the distribution of grants by performance category for all the four ratings (A, B1, B2, and C). Whereas grants in the stable states more frequently scored in the A category, fragile states tended to score a higher proportion of their grants in category B1 as compared to grants in stable states.

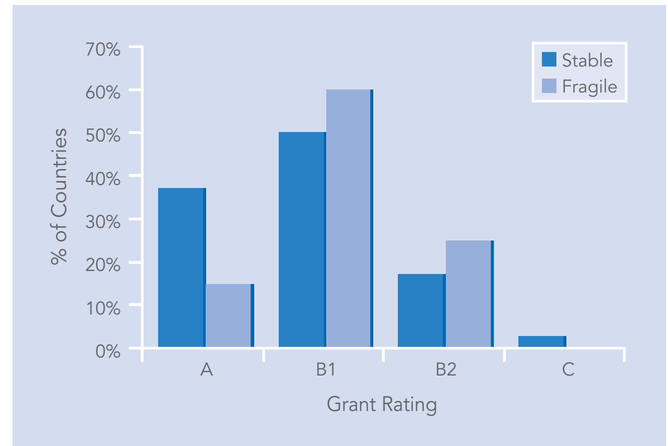


Figure 3a: Performance of grants in fragile states vs. stable states for all performance ratings

**29.** Two grants among those implemented in the stable states scored a C. Funding for one of these grants was discontinued by the Board due to this unsatisfactory performance. The other is still under evaluation by the Board. In addition, two other grants in the stable states scored a borderline B2; a Board decision on the continuation of funding is still pending in these two cases.

30. Since categories A and B1 are both measures of satisfactory performance, the two categories are combined in the analysis given in Figure 3b, below, while categories B2 and C are given separately, as they both reflect less-than-satisfactory performance. The results show that 75 percent of the grants in fragile states scored either A or B1, as compared to 81 percent of the stable states grants which scored in the same categories. When we look at the grants graded together as "satisfactory", we find that there is little difference in performance between those of fragile states and those of other countries. This is probably the most unexpected finding of this preliminary study.

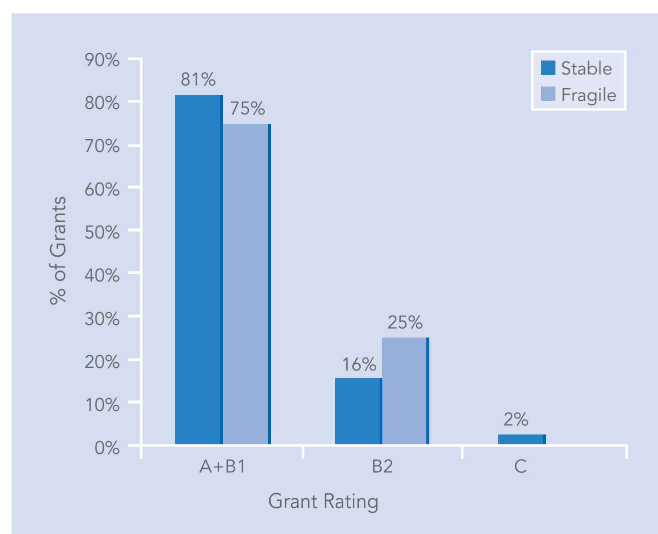


Figure 3b: Performance of grants in fragile states vs. stable states (combining categories A and B1)

## PRINCIPAL RECIPIENTS IN FRAGILE STATES

31. One of the determinants of state fragility is the low capacity of state organs to manage public resources. The expectation would therefore be that civil society, private sector, or the UNDP, which has a standing arrangement with the Global Fund to act as "Principal Recipient of last resort", would more frequently take the role of PR in fragile states as compared to stable states.

32. The results shown in Figures 4a and 4b show otherwise. For the grants in fragile states, public sector agencies, mostly Ministries of Health, were the predominant PR, accounting for 74 percent of the grants in fragile states (whereas they only comprise 53 percent of PRs in stable states). The UNDP as PR accounted for about 20 percent of grants in both fragile and stable states. In stable states there tends to be higher involvement of private sector and civil society organizations serving as PR (29 percent). However, in the fragile states, there was only one private sector PR. Again, it is unwise to draw strong conclusions at this stage, due to the small sample size involved, but the figures do suggest the ability of the public sector to carry out programs of substantial scale in some fragile states.

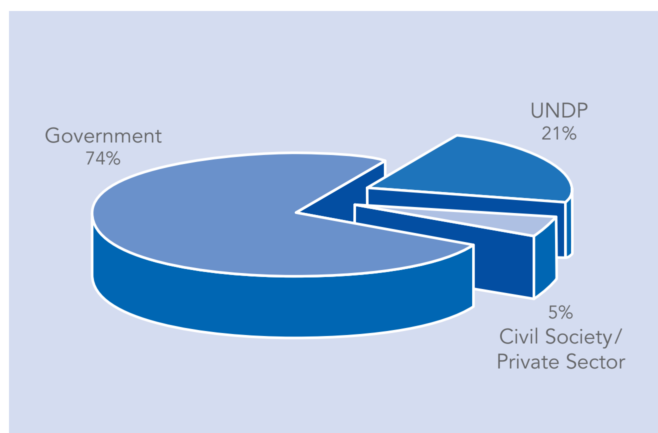


Figure 4a: Type of Principal Recipient in fragile states

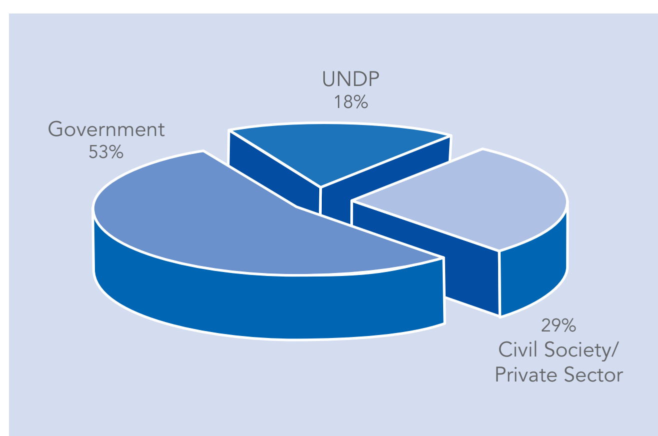


Figure 4b: Type of Principal Recipient in stable states

**33.** A further question was whether government agencies in fragile states would perform well as Principal Recipients, since capacity to manage public resources is one of the determinants of state fragility and a major concern of donors. Overall, 14 of the 19 grants in fragile states were managed by government PRs. Based on Phase 2 performance scores, all 14 of these grants scored a B2 and above; there was not a single grant scored C. Of the 14 grants managed by government PRs, nine (64 percent) scored A or B1. However, the sample size is still small.

**34.** In comparison, grants in the stable states showed little difference in performance whether they were managed by a governmental PR or by another type of organization. Of the 55 grants analyzed, 26 are managed by government PRs, and of these 85 percent (22 grants) scored in the A and B1 categories. Of the 29 non-governmental PRs, 79 percent, or 23 grants, scored equally as high.

## PERFORMANCE BY DISEASE IN FRAGILE STATES

**35.** Interventions relating to the three diseases (malaria, tuberculosis and HIV/AIDS) are organized differently and are supported by different partnerships, both at the global and at the country level. Of the three, TB is probably best organized, with clear control strategies and a global, strong and well-organized Stop TB Partnership that supports national TB control programs. In the case of HIV/AIDS, the interventions are less defined and some lack universal agreement. The interest is also much wider, attracting a wider spectrum of implementers which is both a blessing and a challenge to coordinate. Malaria lies somewhere in between.

**36.** The study examined whether grants for the different disease components performed differently. All other factors being equal, the TB grants performed exceptionally well. TB grants in the fragile states all scored A or B1; no grant scored B2 or C (see Figure 5a). The malaria and HIV/AIDS grants scored well, but did not achieve the same level of quality, in that there were some which fell into the B2 category. The results given in Figure 5b reveal the tendency for TB grants to also perform well in stable states. Of the 10 TB grants in stable states, nine were either category A or B1, with only one grant in category B2.

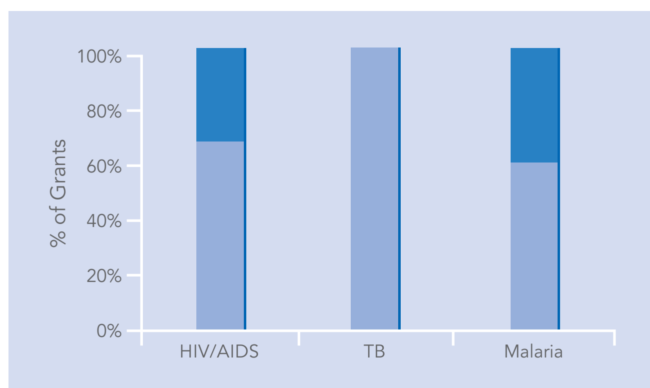


Figure 5a: Grant performance by disease component in fragile states

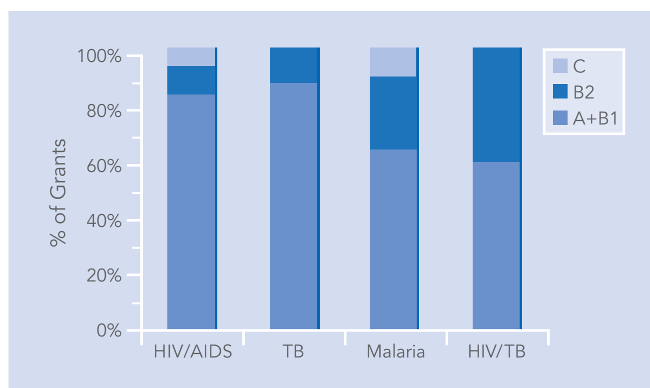


Figure 5b: Grant performance by disease component in stable states

With Global fund support, Niger plans to intensify prevention and treatment efforts for HIV/AIDS and sexually transmitted infections in order to reach at least 90 percent of the population by 2006.

# CONTEXTUAL ISSUES: NAVIGATING STATE FRAGILITY

CONTEXTUAL ISSUES: NAVIGATING STATE FRAGILITY

**37.** To implement grants in fragile states is to navigate the issues that form the essence of state fragility. Understanding the environment in which the grants were implemented is essential for re-positioning donor aid to these states. As a tool for better understanding these issues, the Grant Score Cards for all 19 grants implemented in fragile states were reviewed for further insights into factors that may have led to the better-than-expected performance of these grants. The areas examined included the role of the CCM in overseeing grant implementation; the role of the PR in managing activities and reporting requirements for sub-recipients; the rate of timely disbursements to sub-recipients; oversight by the PR over financial and programmatic activities of sub-recipients; input by technical partners; and the role of the LFA in facilitating the process. This part of the study is not yet completed, but some observations are given below.

**38.** A well-performing grant was more likely to have a proactive CCM which met regularly with the PR and sub-recipients to review progress. These grants also evidenced frequent communication with the PR and sub-recipients and with the Fund Portfolio Manager at the Global Fund Secretariat. Site visits by the PR and CCM to encourage implementation and to verify data, such as observed in the multi-country Western Pacific malaria grant, appears to be a critical factor. The PR, in the example of the Western Pacific malaria grant just noted, was proactive in collecting data from sub-recipients and undertook numerous site visits, taking a hands-on approach to managing and monitoring the implementation of this grant.

**39.** Creativity and initiative on the part of both the CCM and PR were also important. For example, in Burundi, the CCM and the PR introduced a policy whereby Global Fund resources would be used to procure artemisinin-based combination therapy (ACT) for first-line treatment, while funds from other donors such as the World Bank and UNICEF would be used to buy second-line drugs such as quinine. The PR then took the initiative to reallocate the savings realized from the procurement of second-line drugs to the procurement of ACT and bed nets. The CCM also decided, on its own, to expand its composition, bringing in more civil society representatives including organizations of people living with the diseases. At the time of the writing of this report, plans were underway to expand the representation of bilateral and multilateral agencies as well.

**40.** Coordination of partnerships at the country level has proven to be critical. Since the signing of its HIV/AIDS grant, several other donors in Burundi have started to contribute to the government's national strategy. The CCM has encompassed these other development partners and has coordinated the efforts of these partners into a coherent national disease strategy and plan of action. Recognizing the benefits accrued from a coordinated partnership for HIV/AIDS, the Minister of Public Health, who is the PR, has embarked on fostering better coordination among donors and technical partners implementing the malaria program as well.

**41.** Recognizing and facilitating participation by civil society, the private sector and faith-based organizations is important for increasing absorptive capacity and for scaling up interventions. Public/private partnerships are seen as critical for changing the paradigm of development aid and for mobilizing local resources to respond to the three pandemics, and the Global Fund encourages such partnerships through its funding model. Most of the grants in fragile states have embraced this concept and have actively expanded the number of sub-recipients considerably beyond the traditional public sector execution. The HIV/AIDS grant in Cambodia, for example, has 13 sub-recipients while the Ethiopia tuberculosis grant has nine. The Burundi HIV/AIDS grant had the highest number of sub-recipients, totaling 18.

**42.** Performance-based funding seems to prod the actors at the country level into action, perhaps stemming from fear of loss of grants and the political and public repercussions arising from such a loss. In Ethiopia, for instance, the PR took considerable time to understand the realities of performance-based funding, and this led to a failure to appreciate the importance of timely and accurate reporting. However, between June and September 2004, the PR realized that the program was slipping. A greater sense of urgency evolved, pushing them to achieve program goals. Reporting drastically improved and a high-level (ministerial) commitment emerged for working together to make the program succeed. Political commitment was also evident in other states and at both political and program levels.

**43.** Delayed disbursement - both in terms of delayed disbursement from the Global Fund Secretariat to the PR, and by the PR to the implementers/sub-recipients - was a major factor in poorly-performing grants. The most frequent causes for delayed disbursement to the PR was related to cumbersome procurement assessments of the PR by the Global Fund and delayed procurement of drugs and other health products due to bureaucratic processes at country level. At the PR level, frequent causes cited for delayed disbursements revolved around reporting issues with sub-recipients.

Sudan's estimated 7.5 million cases of malaria per year result in approximately 35,000 deaths annually. The Global Fund has approved US$ 27 million for two grants to combat malaria in Sudan.

In Mali, 80-90 percent of children under five carry the Plasmodium parasite in the rainy season. With Global Fund resources, the Ministry of Health and its partners aim to ensure that nearly half a million Malian women and children will sleep under insecticide-treated bed nets by the end of the grant's first two years.

# CONCLUSION

**44.** The Global Fund is investing substantially in fragile states. Approximately one-third of all the resources allocated globally in Rounds 1-4 have gone to fragile states. This applies to both the two-year commitments and the five-year grant period. This is principally because of the Global Fund's mandate that prioritizes flow of its resources to low-income countries with high disease burden, regardless of government structure, donor history or any other factors. This level of investment is a significant departure from current practice of the bilateral donor agencies, which have tended to avoid investments in fragile states or to limit those investments to merely short-term humanitarian responses.

**45.** Second, the evidence from the 19 grants so far analyzed suggests that the grants in fragile states are performing well. This is entirely unexpected, in particular because the majority of the Principal Recipients in these countries are government ministries. It is also interesting to note that grants managed by government PRs performed similarly to those managed by non-government PRs, although the grant number here is too small to draw any reliable conclusions.

**46.** The findings suggest that the Global Fund's performance-based funding model is flexible enough to work in fragile states, and that it is building capacity as grants are being implemented with input by technical partners. Thus, weak government structures can actually be strengthened directly by this model, enabling government PRs to manage the grants well and to share resources with non-government sub-recipients as long as there is a strong political will for change and a commitment to achieving results. This underscores the importance of country leadership and country ownership in creating change and in providing a strong basis for sustainability, as compared to direct implementation by external agencies (13, 14). If the results hold true as more grants are assessed and are included in the ongoing analysis, the Global Fund may offer a unique, performance-based model within which other donors can engage with fragile states, in health and other sectors.

# APPENDIX 1: LIST OF FRAGILE STATES[1]

| | | | |
|---|---|---|---|
| 1. | Afghanistan | 24. | Indonesia |
| 2. | Angola | 25. | Kenya |
| 3. | Azerbaijan | 26. | Kiribati |
| 4. | Burma | 27. | Lao, PDR |
| 5. | Burundi | 28. | Liberia |
| 6. | Cambodia | 29. | Mali |
| 7. | Cameroon | 30. | Nepal |
| 8. | Central African Republic | 31. | Niger |
| 9. | Chad | 32. | Nigeria |
| 10. | Comoros | 33. | Papua New Guinea |
| 11. | Congo, Democratic Republic | 34. | Sao Tome & Principe |
| 12. | Congo, Republic of | 35. | Sierra Leone |
| 13. | Cote d'Ivoire | 36. | Solomon Islands |
| 14. | Djibouti | 37. | Somalia |
| 15. | Dominica | 38. | Sudan |
| 16. | Eritrea | 39. | Tajikistan |
| 17. | Ethiopia | 40. | Timor Leste |
| 18. | Gambia, The | 41. | Togo |
| 19. | Georgia | 42. | Tonga |
| 20. | Guinea | 43. | Uzbekistan |
| 21. | Guinea Bissau | 44. | Vanuatu |
| 22. | Guyana | 45. | Yemen, Republic of |
| 23. | Haiti | 46. | Zimbabwe |

[1] *As defined by the World Bank and the UK's Department of International Development (see Introduction on p.9)*

# APPENDIX 2: GRANTS ASSESSED FOR PHASE 2 FUNDING THROUGH JULY 2005

## A. Grants implemented in stable states

| Grant Number | Disease Component | Principal Recipient | Country | Grant size in US$ | Performance Rating |
|---|---|---|---|---|---|
| ARG-102-G01-H-00 | HIV/AIDS | UNDP | Argentina | 12177200 | A |
| ARM-202-G01-H-00 | HIV/AIDS | Private sector | Armenia | 3166641 | A |
| BEN-102-G01-M-00 | Malaria | UNDP | Benin | 2973150 | B1 |
| BEN-202-G02-T-00 | Tuberculosis | UNDP | Benin | 2173404 | B1 |
| BEN-202-G03-H-00 | HIV/AIDS | UNDP | Benin | 11348000 | B1 |
| CHL-102-G01-H-00 | HIV/AIDS | Private Sector: | Chile | 38059416 | B1 |
| CHN-102-G01-T-00 | Tuberculosis | Government: other | China | 48070000 | A |
| CHN-102-G02-M-00 | Malaria | Government: Other | China | 6406659 | B1 |
| COR-202-G01-H-00 | HIV/AIDS | Government: Other | Costa Rica | 2279501 | B2 |
| CUB-202-G01-H-00 | HIV/AIDS | UNDP | Cuba | 11465129 | A |
| EST-202-G01-H-00 | HIV/AIDS | Ministry of Health | Estonia | 3908952 | B1 |
| GHN-102-G01-H-00 | HIV/AIDS | Ministry of Health | Ghana | 14170222 | B1 |
| GHN-102-G02-T-00 | Tuberculosis | Ministry of Health | Ghana | 5687055 | B1 |
| GHN-202-G03-M-00 | Malaria | Ministry of Health | Ghana | 4596111 | A |
| HND-102-G01-H-00 | HIV/AIDS | UNDP | Honduras | 12583466 | B2 |
| HND-102-G02-T-00 | Tuberculosis | UNDP | Honduras | 6597014 | B2 |
| HND-102-G03-M-00 | Malaria | UNDP | Honduras | 7204140 | B2 |
| IDA-102-G01-T-00 | Tuberculosis | Government: Other | India | 8655033 | A |
| JOR-202-G01-H-00 | HIV/AIDS | Ministry of Health | Jordan | 1778600 | A |
| MAF-202-G01-M-00 | Malaria | Civil Society | Multi-country Africa | 7090318 | A |
| MDG-102-G01-M-00 | Malaria | Civil Society | Madagascar | 2000063 | B1 |
| MDG-202-G02-H-00 | HIV/AIDS | Civil Society | Madagascar | 747199 | A |
| MDG-202-G03-H-00 | HIV/AIDS | Civil Society | Madagascar | 3032048 | B1 |
| MOL-102-G01-C-00 | HIV/TB | Ministry of Health | Moldova | 11719047 | A |
| MON-102-G01-T-00 | Tuberculosis | Ministry of Health | Mongolia | 1730000 | A |
| MON-202-G02-H-00 | HIV/AIDS | Ministry of Health | Mongolia | 2997103 | A |
| MOR-102-G01-H-00 | HIV/AIDS | Ministry of Health | Morocco | 9238754 | A |
| PAN-102-G01-T-00 | Tuberculosis | UNDP | Panama | 570000 | A |
| PHL-202-G01-M-00 | Malaria | Private Sector | Philippines | 7244762 | B1 |
| PHL-202-G02-T-00 | Tuberculosis | Private Sector | Philippines | 3434487 | A |
| RWN-102-G01-C-00 | HIV/TB | Ministry of Health | Rwanda | 8409268 | A |
| SAF-102-G02-C-00 | HIV/TB | Ministry of Finance | South Africa | 12000000 | B2 |
| SER-102-G01-H-00 | HIV/AIDS | Private Sector | Serbia & Montenegro | 2718714 | B1 |
| SLV-202-G01-H-00 | HIV/AIDS | UNDP | El Salvador | 12856729 | B1 |
| SNG-102-G01-H-00 | HIV/AIDS | Government: Other | Senegal | 6000000 | C |
| SNG-102-G02-M-00 | Malaria | Ministry of Health | Senegal | 4285714 | C |
| SWZ-202-G01-H-00 | HIV/AIDS | Government: Other | Swaziland | 29633300 | B1 |
| SWZ-202-G02-M-00 | Malaria | Government: Other | Swaziland | 978000 | B2 |
| TNZ-102-G01-M-00 | Malaria | Ministry of Health | Tanzania | 8790612 | B2 |
| UGD-102-G01-H-00 | HIV/AIDS | Ministry of Finance | Uganda | 36314892 | B2 |
| UKR-102-G04-H-00 | HIV/AIDS | Civil Society | Ukraine | 23354116 | B1 |
| ZAM-102-G01-H-00 | HIV/AIDS | Ministry of Health | Zambia | 21214271 | B1 |
| ZAM-102-G02-M-00 | Malaria | Ministry of Health | Zambia | 17039200 | B1 |
| ZAM-102-G03-T-00 | Tuberculosis | Ministry of Health | Zambia | 12447294 | B1 |
| ZAM-102-G04-H-00 | HIV/AIDS | Faith Based Organization | Zambia | 6614958 | A |
| ZAM-102-G05-M-00 | Malaria | Faith Based Organization | Zambia | 852600 | B1 |
| ZAM-102-G06-T-00 | Tuberculosis | Faith Based Organization | Zambia | 2307962 | A |
| ZAM-102-G08-H-00 | HIV/AIDS | Civil Society | Zambia | 8073013 | B1 |
| ZAN-102-G01-M-00 | Malaria | Ministry of Health | Tanzania | 781220 | B1 |
| ZAN-202-G02-H-00 | HIV/AIDS | Government: Other | Tanzania | 1116000 | B1 |
| HRV-202-G01-H-00 | HIV./AIDS | Ministry of Health | Croatia | 3,363,974 | B1 |
| WRL-102-G01-H-00 | HIV./AIDS | World Lutheran Federation | Multi-country | 485,000 | B1 |
| KAZ-202-G01-H-00 | HIV./AIDS | Other government ministry | Kazakhstan | 6,502,000 | B1 |
| SRL-102-G03-T-00 | Tuberculosis | Ministry of Health | Sri Lanka | 2,384,980 | B1 |
| THA-202-G03-H-00 | HIV./AIDS | Civil society | Thailand | 5,993,913 | B1 |

## B. Grants implemented in fragile states

| Grant Number | Disease Component | Principal Recipient | Country | Grant size in US$ | Performance Rating |
|---|---|---|---|---|---|
| BRN-102-G01-H-00 | HIV/AIDS | Other Government ministry | Burundi | 4877000 | B1 |
| BRN-202-G02-M-00 | Malaria | Ministry of Health | Burundi | 13792126 | B1 |
| CAF-202-G01-H-00 | HIV/AIDS | UNDP | Central Africa Republic | 8198921 | B1 |
| CAM-102-G01-H-00 | HIV/AIDS | Ministry of Health | Cambodia | 11242538 | B1 |
| ETH-102-G01-T-00 | Tuberculosis | Ministry of Health | Ethiopia | 10962600 | B1 |
| ETH-202-G02-M-00 | Malaria | Ministry of Health | Ethiopia | 37915011 | B2 |
| HTI-102-G01-H-00 | HIV/AIDS | Private Sector | Haiti | 24603680 | A |
| HTI-102-G02-H-00 | HIV/AIDS | UNDP | Haiti | 6754697 | B1 |
| IND-102-G01-T-00 | Tuberculosis | Ministry of Health | Indonesia | 21612265 | B1 |
| IND-102-G03-H-00 | HIV/AIDS | Ministry of Health | Indonesia | 6924971 | B2 |
| LAO-102-G01-H-00 | HIV/AIDS | Ministry of Health | Lao PDR | 3407664 | B2 |
| LAO-102-G02-M-00 | Malaria | Ministry of Health | Lao PDR | 12709087 | B2 |
| LAO-202-G03-T-00 | Tuberculosis | Ministry of Health | Lao PDR | 1524338 | A |
| MWP-202-G01-H-00 | HIV/AIDS | Other government ministry | Multi-country Western Pacific | 5163925 | B2 |
| MWP-202-G02-M-00 | Malaria | Other Government ministry | Multi-country Western Pacific | 4530300 | B1 |
| MWP-202-G03-T-00 | Tuberculosis | Other government ministry | Multi-country Western Pacific | 2738806 | B1 |
| TAJ-102-G01-H-00 | HIV/AIDS | UNDP | Tajikistan | 2425245 | A |
| TMP-202-G01-M-00 | Malaria | Ministry of Health | Timor Leste | 2300744 | B1 |
| ZAR-202-G01-T-00 | Tuberculosis | UNDP | Congo, Democratic Republic of | 6408741 | B1 |

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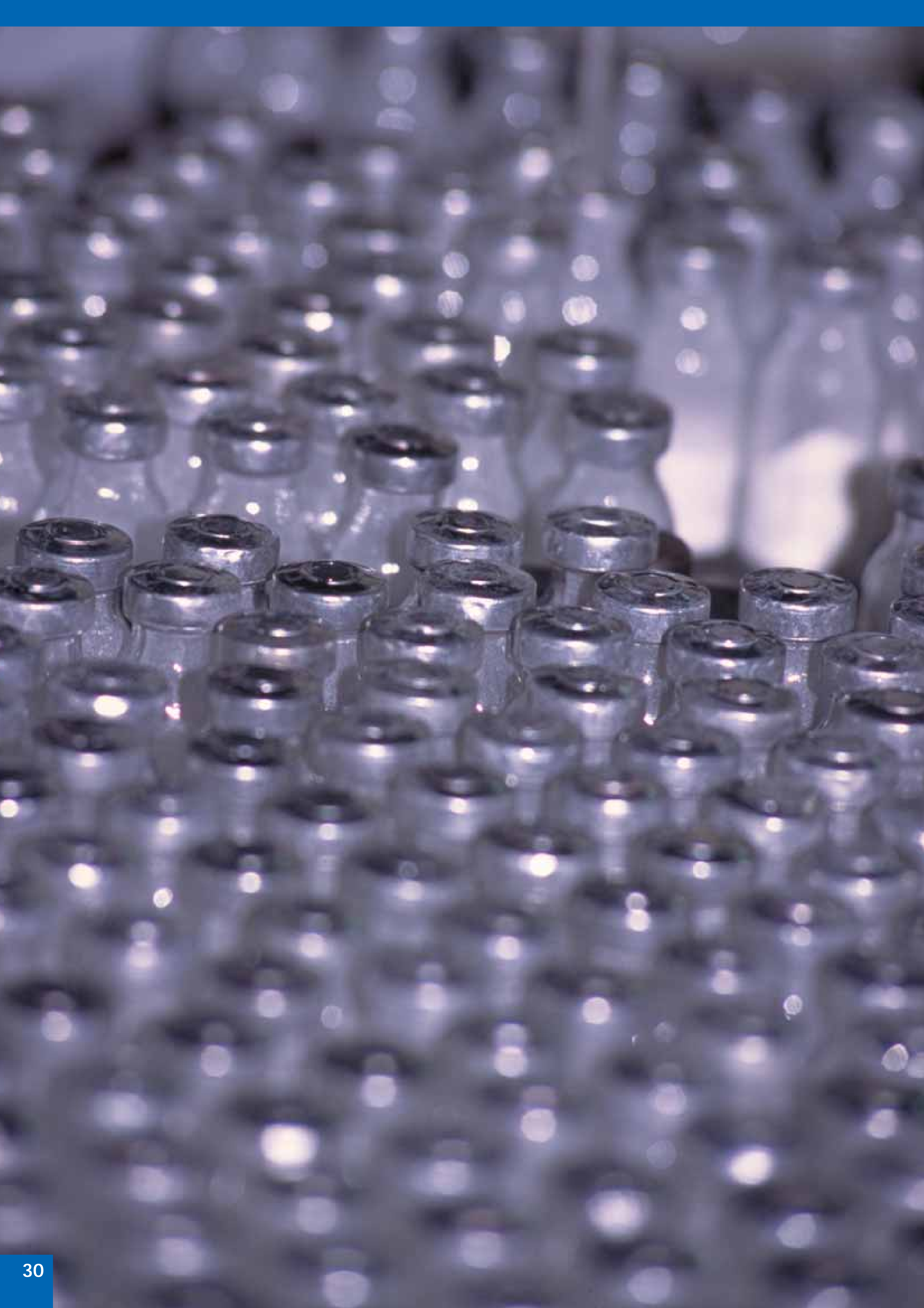

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