The Global Fund to Fight AIDS, Tuberculosis and Malaria
Fifth Board Meeting
Geneva, 5 - 6 June 2003

GF/B5/9

REPORT OF THE PORTFOLIO MANAGEMENT AND PROCUREMENT COMMITTEE (PMPC)

Outline: This paper presents the results of the deliberations of the PMPC. It contains four Annexes, which outline the issues addressed and presents recommendations for consideration by the Board.

Summary of Decision Points:

1. The Board is requested to **approve:**

   a. The list of persons selected for the TRP by the PMPC and the Executive Director (as in Annex 2)
   b. The launch of the TRP renewal process for 2004, on the basis of the recommendations and lessons learned.

2. The Board is requested to **approve** the Eligibility Criteria for the fourth and subsequent rounds of applications to the Global Fund as presented in Part 3. Lists of countries covered by Recommended Eligibility Criteria are available in Annexes 3.1 to 3.4.

3. The Board is requested to endorse recommendations related to procurement of Diagnostics and other Non-Pharmaceutical products and Quality and Monitoring Processes. The Board is also requested to acknowledge the different operational issues surrounding In Kind Donations (see Part 4).

4. The Board is requested to take note of work and discussions on principles of additionality as well as assistance needed to ensure that Neediest and Poorest countries receive funding from the Global Fund.

Part 1: Background

1. The Portfolio Management and Procurement Committee met on the 13th and 14th of May, 2003, in Geneva (Annex 1 details the list of participants) to discuss decision points on:

- TRP renewal
- Eligibility
- Diagnostics and other Non-Pharmaceuticals
- In Kind Donations
- Product Quality Monitoring

2. This report outlines the issues debated and highlights decision points that arose from the discussion. Where applicable, the text references an annex, which provides more information on the topic and explains the rational behind the recommendation emerging from the committee.

3. The committee also had a discussion on a report prepared by WHO/UNAIDS on the neediest and poorest countries.

Part 2: TRP Renewal

1. At its Fourth Board Meeting in January, 2003, the Global Fund Board asked the PMPC to renew and appoint new TRP members for the third round of proposals. The pre-selection panel, which consisted of representatives from WHO, UNAIDS, World Bank, and PMPC, met on the12 May, 2003 to produce a short list of TRP candidates for PMPC review. The work of the pre-selection panel was based on the initial screening of CVs by Health Systems Resource Centre (HSRC), the firm contracted for this purpose.

2. The PMPC met to finalize the shortlist on May 13, 2003. While the process was not perfect, the panel was confident that there was a sufficient number of qualified candidates to meet the current needs for TRP renewal. Nevertheless, panel members did not feel the list was extensive enough to sustain a further round of TRP renewal nor to maintain a regional balance, in part due to the short time provided for the exercise. Many of the panel's concerns were also expressed in the consultant's report.

3. The PMPC recommends that the process be improved in the future in a number of ways to fill 8 posts in 2004, although it accepts the process for this year's TRP renewal. Given the concerns about the current process, it is recommended that a new and expanded recruitment process be undertaken for CY04. This process could be used for further renewal of the TRP.

4. The recruitment and screening consultants[1] should be selected and begin work at least six months before the GF board meeting that will approve the TRP membership, probably in January 2004.

5. It was acknowledged that the two-step pre-selection process, which included a pre-screening by the consultancy followed by a short-listing by the Pre-Selection Panel, added value to the work of the PMPC. The ranking produced by the Consultant was generally the basis for further identification of the best candidates. Despite the possible limitations, it was considered that this was probably the best way of reconciling the need for efficiency, effectiveness, fairness and transparency in the entire TRP renewal process.

Terms of Reference for outsourcing

6. The terms of reference for the consultants should be prepared by the GF secretariat and approved by the PMPC and should include, inter alia:

a. A more expanded recruitment process: More variety in placing focused advertisements and a more concerted effort to attract candidates directly and using specialized institutions, and special attention to experts from regions currently underrepresented in the TRP.
b. Better language balance for advertisements, to avoid especially any bias towards Anglophone countries.
c. A clearer and stronger role for involvement in the consultants work by the GF secretariat and the specialized UN agencies.
d. More detailed and firm guidance on selection criteria and the ranking process.
e. The consultant evaluating applications in the panel should have relevant scientific and technical expertise.
f. The experience of the consultants ranking the proposals needs to be reviewed by the secretariat.

Criteria for assessment of candidates

7. Further development and clarity of the selection criteria and application process is needed, specifically:

a. One application form for candidates with detailed instructions on how to complete it.
b. The screening process needs to be expanded beyond the mere collection of CVs in English. This could introduce a bias against

[1] Consideration should be given to reappointing HSRC in June 2003 given the high quality of work done so far under difficult circumstances.

those who may not have prepared a good CV but may have valuable expertise and experience. This could include the use of references.

c. Input on the ability of TRP candidates to perform the full range of activities and to commit themselves to the necessary time commitment.[2]
d. More attention is needed on both scientific and cross-cutting criteria for TRP members.[3]
e. Consideration should be given to defining the disease criteria more precisely, based on the different needs of the three diseases.
f. The criteria should include more specific information to judge experience in reviewing proposals; criteria should be published in a transparent way.
g. Each CV should be assessed by at least two independent assessors within the contracted consultancy

Quality and retention

8. To ensure quality and retention of the TRP, the following actions should be taken.

1. The Secretariat should contact all highly qualified, but not selected applicants to encourage them to remain engaged.
2. TRP Chair and Vice Chair should be consulted to determine specific gaps and needs, in order to better shape the selection criteria.
3. The TRP Chair and Vice chair should monitor and ensure that the TRP is performing well.

Recommendations:

The Board is requested to **approve:**

1. The list of persons selected for the TRP by the PMPC and the Executive Director (as in Annex 2)
2. The launch of the TRP renewal process for 2004, on the basis of the recommendations and lessons learned.

[2] The fee structure for TRP members needs to be reassessed in view of market comparisons.
[3] For cross-cutters, programmatic experience, including familiarity with PRSP and sectoral approaches, procurement, human capacity development, monitoring and evaluation, financial management, experience in public health and health systems, and economics, inter alia, appears to be important.

Part 3: Eligibility criteria

1. At its Fourth meeting, the Board of the Global Fund decided that "poverty and disease-related need (which encompasses both current disease burden and risk of growth) are the criteria that will be used to determine eligibility to apply for financing from the Global Fund." For the Third Round of applications to the Global Fund, countries were grouped into income categories according to the World Bank classification system.

2. All "Low Income" and "Lower-Middle Income" countries were eligible to apply (with "Lower-Middle Income" countries having to meet additional requirements of co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources). "Upper-Middle Income" countries were eligible only if they faced a "very high current disease burden" (and also had to meet the requirements of co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources).

3. For the Fourth and subsequent rounds of Global Fund financing, the Board requested WHO and UNAIDS to examine in more detail how to categorize countries into a matrix based on disease-related need and poverty, with a particular emphasis on how to broaden the criteria for "disease-related need" from a focus solely on current disease burden to one that fully encompassed vulnerability and the risk of growth of an epidemic.

4. The PMPC reviewed and thanked WHO and UNAIDS for the work that they carried out on this topic. Their analysis revealed several difficulties with the matrix approach:
    a. There are no strictly epidemiological rationales for classifying countries into categories such as "highest," "high," "medium," and "low" disease burden.
    b. The inevitable inaccuracies and uncertainties in data necessitate a degree of caution in the use of epidemiological data for eligibility purposes. In some cases, such as when prevalence rates for a number of countries cluster around a particular value, these uncertainties make it difficult to justify a division or fixed cut-off point.
    c. There are no indicators that can accurately and robustly predict a country's vulnerability to a rapidly increasing epidemic.

5. Therefore, WHO and UNAIDS provided recommendations for cut-off points in the "Upper-Middle Income" group of countries based on current disease

burden,[4] but emphasized that they should be understood as options to guide investment decisions. WHO and UNAIDS recommended against using disease-related need to subdivide the "Lower-Middle Income" category of countries (e.g., to determine different co-financing requirements for this group based on disease-related need).

6. In light of this analysis, the PMPC recommends that the Global Fund continue with the general approach adopted at the Fourth Board meeting for the Third Round. There was consensus about the approach to three of the four income categories ("Low," "Lower-Middle," and "High"), about the need to include a list of eligible countries, and about the fact that regional proposals from groupings that include any eligible proposals should be considered as eligible. There was also consensus about the need to further develop operational and transparent definitions of "co-financing," "focusing on poor and vulnerable populations," and "moving over time towards greater reliance on domestic resources."

7. For "Upper-Middle Income" countries, there was no consensus recommendation. The majority preferred that the "Upper-Middle Income" countries would be eligible only if they met additional criteria related to their current disease burden (in addition to the requirement established for the Third Round of applications that these countries demonstrate evidence of co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources). These disease-related criteria were adopted from the recommendations of WHO and UNAIDS.

8. The majority felt that this approach best reflected the Global Fund's mandate to focus on poor and needy countries (particularly in a resource-constrained environment).

9. A minority felt that all "Upper-Middle Income" countries should be eligible to apply (agreeing with the majority that these countries would be eligible only if they demonstrated evidence of co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources). They felt that this approach best reflected the Global Fund's mandate to finance the most technically sound proposals. They noted that these requirements for co-financing, focusing on poor and vulnerable populations, and moving over time towards greater reliance on domestic resources could be stricter than the similar requirements for "Lower-Middle Income," such that the Global Fund might be financing only a small percentage of an application coming from an "Upper-Middle Income" country.

[4] For HIV/AIDS a ratio is proposed that accounts for both disease burden and capacity to fund programs from domestic resources.

Recommendations:

Decision 1

For the Fourth and subsequent rounds of applications to the Global Fund:

a) Countries classified as "Low Income" by the World Bank are fully eligible to apply for support from the Global Fund;
b) Countries classified as "Lower-Middle Income" by the World Bank are eligible to apply for support from the Global Fund but must meet additional requirements, including co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources;
c) Countries classified as "High Income" by the World Bank are not eligible to apply for support from the Global Fund.

The lists of countries covered by a) and b) for the Fourth Round are included in Annexes 3.1 and 3.2, respectively.

Regional proposals that include any eligible countries may submit applications to the Global Fund.

Decision 2, Option One

For the Fourth and subsequent rounds of applications to the Global Fund:

a) Countries classified as "Upper-Middle Income" by the World Bank are eligible to apply for support from the Global Fund only if they face very high current disease burden. This is defined (based on technical input from WHO and UNAIDS) for each disease as follows:
    1. HIV/AIDS: if the country's ratio of adult HIV seroprevalence (as reported by UNAIDS, multiplied by 1000) to GNI per capita (Atlas method, as reported by the World Bank) exceeds 5;
    2. Tuberculosis: if the country is included on the WHO list of 22 high-burden countries, or on the WHO list of the 36 countries that account for 95% of all new TB cases attributable to HIV/AIDS;
    3. Malaria: if the country experiences more than 1 death due to malaria per 1000 people (as reported by WHO).
b) Eligible countries must meet additional requirements, including co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources.

The list of countries covered by a) for the Fourth Round is included in Annex 3.3.

Decision 2, Option Two

For the Fourth and subsequent rounds of applications to the Global Fund:

a) Countries classified as "Upper-Middle Income" by the World Bank are eligible to apply for support from the Global Fund but must meet additional requirements, including co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources.

The list of countries covered by a) for the Fourth Round is included in Annex 3.4.

Part 4: Procurement

At the Fourth Board meeting, the Board approved the PMPC recommendation that the PSM Advisory Panel should consider necessary policies for the Global Fund related to procurement of diagnostics and other products related to the provision of medications. Until such policies are adopted at the Fifth Board meeting, existing national or institutional practices should govern the selection and procurement of such products by Fund grantees. The PSAM Advisory Panel's recommendation, which was endorsed by PMPC is presented as decision points to be approved by the Board (see pages 2-4). In addition to the decision points, the PMPC discussed the following.

1. Quality Monitoring Process :

a. Based on the recommendations of the Procurement Supply Management Advisory Panel and discussions with technical partners, the PMPC concluded that no international system exists to assess National Drug Regulatory Authorities (NDRA) laboratories (or laboratories recognized by the NDRA) for product quality monitoring.

2. In Kind Donations

a. The Board recognizes the potential role of In Kind Donations to significantly expand the impact of the Global Fund to making a significant contribution to resource mobilization efforts by leveraging cash resources. In-kind donations also constitute a significant means through which the private sector may be involved

with the Global Fund and contribute to achieving the public – private partnership principles upon which the Global Fund is based.

b. The Board recognizes the considerable challenges to be confronted in operationalizing In Kind Donations. There are different issues involved in managing In Kind donations in the form of services, non-health products, or health products, particularly pharmaceuticals, at both the global and country level.

Recommendations:

The Committee recommends that the Board:

1. **Approves** the principles for procurement and quality assurance of pharmaceuticals that were adopted during the Third Board meeting of the Global Fund to be applied to Diagnosis and other Non-Pharmaceuticals. Namely, that: Principal Recipient (PR) is responsible for procurement, and is required to conduct competitive purchasing in order to obtain the lowest possible price for products of assured quality.

2. For non-durable products, the same principles as for pharmaceuticals should be followed. The Global Fund is **recommended** to require selection from lists of pre-qualified products, where they exist, OR products accepted by stringent regulatory agencies OR products accepted by national standards.

3. For durable products the lowest possible price should take into account the Total Cost of Ownership (TCO), including the cost of reagents and other consumables as well as costs for annual maintenance.

4. Procurement methods for durable products may include either lease or purchase. The PR must provide a plan for service and maintenance of the products.

5. The Secretariat will work with technical partners such as WHO, UNAIDS and bilateral agencies to ensure availability of information to recipients in regards to quality assurance and procurement systems related to high priority consumables and durables such as condoms, HIV rapid testing kits, HIV CD4 monitoring, bed nets, microscopes etc.

6. The PMPC recommends that for all products, National Drug Regulatory Authorities (NDRA) laboratories or laboratories recognized by the NDRA be used for quality monitoring by the

Principle Receipt. To ensure the respective laboratories have adequate capacity for full pharmacopoeial testing, they must meet one of the following criteria:

- Acceptance for collaboration with WHO pre-qualification project;
- Accredited in accordance with ISO17025 and/or EN45002;
- Accepted by a stringent authority.[5]

7. PMPC, on the basis of input from the Procurement Support Management- Advisory Panel, and working jointly with other Global Fund committees, particularly with Resource Mobilization Committee, shall consider further the different operational issues surrounding In Kind Donations of services, non-health, health products. These general issues include, inter alia

   - Guarding against conflicts of interest
   - Potential legal liabilities
   - Long term sustainability
   - Valuation of contribution

8. On the basis of the work done by the private sector and others, the PMPC will propose strategic options, capturing issues relating to the diversity of products and services, the managerial capacity of the Global Fund Secretariat and Principal Recipients, and the advantages/costs of channeling donations through the Global Fund vis-à-vis other existing mechanisms.

Part 5: Information Points

1. Additionality

a. Based on a brief concept paper prepared by the Secretariat (a copy of the concept paper is in Annex 4), the PMPC held a preliminary discussion on the principle of additionality; the PMPC has asked the Secretariat to work with appropriate institutions to develop the paper further.

[5] For the purposes of this policy a stringent drug regulatory authority is defined as a regulatory authority in one of the 28 countries which is either a Pharmaceutical Inspection Cooperation Scheme and/or International Conference on Harmonization.

b. The PMPC noted the complexity of tracking additionality and agreed with the Secretariat approach of working with partners to identify mechanisms to measure additionality, for discussion at subsequent Board meetings

2. Neediest and poorest countries

a. At its Fourth meeting, the Board of the Global Fund noted with concern that some countries that face high disease burdens and have lower incomes have not received funding in the first two rounds of Global Fund financing.

b. WHO and UNAIDS presented to the PMPC a report on their work supporting applications from a number of these countries (a copy of this report is available from either of the two organizations). The PMPC lauded WHO and UNAIDS for this initiative and urged that they and other partners continue efforts to ensure that needy and poor countries are not systematically excluded from Global Fund financing.

Annex 1

List of participants

COMMITTEE NAME	**PORTFOLIO MANAGEMENT AND PROCUREMENT COMMITTEE. Attendees, Meeting 13-14 May 2003**
CHAIR	**EUROPEAN COMMISION (Dr. Lieve Fransen)**

CONSTITUENCY	**REPRESENTATIVE**			
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	Mrs.	Siân	Hamilton-Rousset	sian.hamilton@theglobalfund .org
	Mr.	Toby	Kasper	toby.kasper@theglobalfund.org

Annex 2.1 PROPOSED TRP MEMBERS

		1st round			2nd round			3rd round			Alternate	
TB	1	Luelmo	M	Argentina				Norval	M	France	Day	Indonesia
	2	Fujiwara	F	USA								
Malaria	1	Miller	F	UK	Majori	M	Italy	Chimumbwa	M	Zambia	Meek	UK
	2							Ettling	F	USA		
HIV/AIDS	1	Kazatchkine	M	France	Himmich	F	Morocco	Godfrey	M	UK	Barcellos	Brazil
	2	Coutinho	M	Uganda				Solomon	F	India	Kerouedan	France
	3	Malionowska-Sempruch	F	Poland				Hoos	M	USA	Quinn	USA
											Koulla	Cameroon
Cross cutting	1	Griekspoor	M	Netherlands	Broomberg	M	S Africa	Phoolcharoen	M	Thailand	Clark	UK
	2	Gordon	F	Guyana	Skolnik	M	USA	Standing	F	UK	Jankauskiene	Lithuania
	3							Hsu	F	USA		
	4							Munar	M	Colombia		
	5							Denolf	M	Belgium		
	6							Peters	M	Canada		
	7							Shretta	F	Kenya		

Note: To ensure continuity of the TRP, the Board decided some of the current TRP members should continue in the new TRP. The names shown in the Round I and II columns are from the existing TRP. These members have agreed to continue. The Third Round column indicates the names of the proposed new members.

Annex 2.2

Distribution by Country

	1st round	2nd round	3rd round	Alternate
TB	Argentina		France	Indonesia
	USA			
Malaria	UK	Italy	Zambia	UK
			USA	
HIV/AIDS	France	Morocco	UK	Brazil
	Uganda		India	France
	Poland		USA	USA
				Cameroon
Cross cutting	Netherlands	S Africa	Thailand	UK
	Guyana	USA	UK USA	Lithuania
			Colombia	
			Belgium	
			Canada	
			Kenya	

Distribution by Region

N America	6	24%
LAC	3	12%
EUR	9	36%
AFR	4	16%
EMR	1	4%
WPR	0	0%
SEAR	2	8%
Total	25	100%

Distribution by Gender

Male	15	60%
Female	10	40%
Total	25	100%

Annex 3.1
Countries classified as Low Income by the World Bank

Countries are fully eligible to apply for support from the Global Fund

Afghanistan
Angola
Armenia
Azerbaijan
Bangladesh
Benin
Bhutan
Burkina Faso
Burundi
Cambodia
Cameroon
Central African Republic
Chad
Comoros
Congo (Democratic Republic of)
Congo (Republic of)
Cote d'Ivoire
East Timor
Equatorial Guinea
Eritrea
Ethiopia
Gambia, The
Georgia
Ghana
Guinea
Guinea-Bissau
Haiti
India
Indonesia
Kenya
Korea (Democratic Republic of)
Kyrgyzstan
Lao People's Democratic Republic
Lesotho
Liberia
Madagascar
Malawi
Mali
Mauritania
Moldova (Republic of)
Mongolia
Mozambique
Myanmar
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Papua New Guinea
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Solomon Islands
Somalia
Sudan
Tajikistan
Tanzania (United Republic of)
Togo
Uganda
Ukraine
Uzbekistan
Vietnam
Yemen (Republic of)
Zambia
Zimbabwe

Annex 3.2
Countries classified as Lower-Middle Income by the World Bank

Countries are eligible to apply for support from the Global Fund but must meet additional requirements, including co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources

Albania
Algeria
Belarus
Belize
Bolivia
Bosnia and Herzegovina
Bulgaria
Cape Verde
China
Colombia
Cuba
Djibouti
Dominican Republic
Ecuador
Egypt (Arab Republic of)
El Salvador
Fiji
Guatemala
Guyana
Honduras
Iran (Islamic Republic of)
Iraq
Jamaica
Jordan
Kazakhstan
Kiribati
Macedonia (The Former Yugoslav Republic of)
Maldives
Marshall Islands
Micronesia (Federated States of)
Morocco
Namibia
Paraguay
Peru
Philippines
Romania
Russian Federation
Saint Vincent and the Grenadines
Samoa
South Africa
Sri Lanka
Suriname
Swaziland
Syrian Arab Republic
Thailand
Tonga
Tunisia
Turkey
Turkmenistan
Vanuatu
West Bank and Gaza
Yugoslavia

Option One

Annex 3.3
Countries classified as Upper-Middle Income by the World Bank but eligible by virtue of very high current disease burden

Countries are eligible only for the component listed
Countries are eligible to apply for support from the Global Fund but must meet additional requirements, including co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources

HIV/AIDS:

Botswana

Tuberculosis:

Botswana
Brazil

Malaria:

Botswana
Gabon

Option Two

Annex 3.4
Countries classified as Upper-Middle Income by the World Bank

Countries are eligible to apply for support from the Global Fund but must meet additional requirements, including co-financing, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources

Antigua and Barbuda
Argentina
Barbados
Botswana
Brazil
Chile
Costa Rica
Croatia
Czech Republic
Dominica
Estonia
Gabon
Grenada
Hungary
Latvia
Lebanon
Libya
Lithuania
Malaysia
Malta
Mauritius
Mayotte
Mexico
Oman
Palau
Panama
Poland
Saudi Arabia
Seychelles
Slovak Republic
St. Kitts and Nevis
St. Lucia
Trinidad and Tobago
Uruguay
Venezuela

Annex 4

Additionality in the Global Fund: A Concept Paper for the Portfolio Management and Procurement Committee[6]

Additionality of Global Fund resources: Rationale and definition

The Global Fund was set up out of the recognition that there is a considerable gap between the resources currently available for the fight against AIDS, tuberculosis, and malaria, and the sums needed to halt these diseases. The existing commitments from both developed and developing countries are insufficient to reverse the spread of these epidemics, and without substantial additional funds the lives of millions of people globally will be endangered. Further, there is an emerging consensus internationally that the control of infectious diseases is a global public good which has been inadequately financed, and which requires significant new resources.

The concept of *additionality* – that resources raised must be supplemental to existing resource streams – is thus fundamental to the Global Fund, and as such is featured prominently in all key Global Fund policy statements, such as the Framework Agreement. For the Global Fund to fulfill its mandate to make a sustainable and significant contribution to the reduction of infections, illness and death caused by HIV/AIDS tuberculosis and malaria in countries in need, it must mobilize new resources for these three diseases and illustrate that these additional resources have had an impact. If funds are not additional but rather simply diverted from the current commitments of multilateral, bilateral, or national programs into Global Fund coffers, or if funds did not measurably mitigate the impact caused by HIV/AIDS, TB and malaria, then the initiative would have failed. The Global Fund's monitoring and evaluation procedures and results-based disbursement system will illustrate the impact of the funded activities on the HIV/AIDS, TB and malaria epidemics. The challenge remains to prove the additionality of the resources that contributed to those impacts.

Despite complexities in measuring and operationalizing additionality as described below, the Global Fund tentatively considers funds to be additional if total domestic and external expenditures are at least equal to the planned domestic and external financial commitments for the same year. Recipient countries must continue to take a leadership role – both

[6] This concept paper will be updated taking into account PMPC committee members' input from previous meetings and in conjunction with an appropriate institution.

politically and financially – in the fight against AIDS, tuberculosis, and malaria. The availability of Global Fund resources should not diminish commitments made to increase health sector spending (e.g., at the Abuja Summit) and otherwise scale up the responses to AIDS, tuberculosis and malaria. Financing from donor countries and agencies must be additional both at the national and at the global levels. Thus it would be inappropriate for resources pledged either as part of existing bilateral commitments to recipient countries or to international initiatives or organizations to be rerouted to the Global Fund. Natural fluctuations in the balance between domestic and external funding in a given country, however, have the potential to make insisting on additionailty of both domestic and external resources difficult .

This insistence on the need for new resources is supportive of and indeed related to a broader recognition that international development assistance must be dramatically scaled up, as articulated at, for example, the International Conference on Financing for Development in Monterrey, Mexico in March 2002.

The additionality of Global Fund resources in practice

The additionality of Global Fund resources is first addressed in the proposal recommendation phase. CCMs are asked to provide data on existing and future disease-specific resources flows and indicate how the Global Fund financing would supplement these current and future commitments. For Round 3 this information is to be presented in a table that requires the applicant to indicate the value of itemized funds available, the request from Global Fund and the remaining unmet need, which sum up to equal the total resources needed for each disease (see Annex B). The Technical Review Panel considers this information in taking a decision to recommend proposals for approval.

Once a proposal has been approved, additionality is addressed in the grant negotiations with Principal Recipients. At a minimum, this encompasses discussions of the principles, but can also include collection of relevant data to allow the tracking of additionality and the development of plans to measure additionality. The grant agreement signed between the Global Fund and the Principal Recipient typically includes the following language on additionality:

> "In accordance with the criteria governing the selection and award of this Grant, the Global Fund has awarded the Grant to the Principal Recipient on the condition that the Grant is in addition to the normal and expected resources that the Host Country usually receives or budgets from external or domestic sources. In the event such other resources are reduced to an extent that it appears, in the sole judgment of the Global Fund, that the Grant is being used to substitute for such other resources, the Global Fund may terminate this Agreement in whole or in part under Article 21 of this Agreement."

Resource flows will continue to be tracked over the lifecycle of each program through annual reports. Before a second disbursement is made after the first two years, programs will have to demonstrate sustained domestic and external financial commitments to each disease or explain any significant changes in or discrepancies between planned and actual expenditures.

Difficulties in measuring additionality in resource flows

While important, the *ex ante* commitments described above are unlikely to ensure additionality. However, tracking additionality has considerable complexities. Some of the problems of measuring additionality are intrinsic, while others result from the generally weak public expenditure management in the countries that receive the bulk of financing from the Global Fund. We have identified the following difficulties in measuring additionality:

1. The multisectoral nature of Global Fund financing. HIV/AIDS grants often fund programs in health, education, agriculture, youth, and gender that are implemented by both public and private actors. Thus disease-specific resource flows must be tracked through multiple government ministries and sectors of the economy.. Share of expenditure on these diseases in education, agriculture, and other non-health sectors is typically small, and is often not available as a discrete budget item.[7]
2. The definitions of domestic and external financing. Disagreements may arise over the definitions of domestic and external assistance. For example, some countries consider loans as domestic commitments (in light of the fact that they must be repaid, presumably with domestic resources), while others treat them as external financing.

3. The weakness of the expenditure tracking systems necessary to show additionality. Recent IMF-World Bank research found that of 24 highly-indebted poor countries studied (18 of which have been approved for Global Fund financing), none could be classified as requiring little or no upgrading in their public expenditure management systems to be able to track poverty-reducing public spending; 9 required some upgrading and 15 required substantial upgrading.

4. The wide gap between budgets and actual expenditure present in many developing countries reduces the usefulness of relying on published budget figures. Even in well-functioning economies, audited expenditure reports are typically not available for at least six months after the close of a fiscal year.

[7] There has been some progress in developing national accounts for AIDS expenditures, particularly in Latin America, but comprehensive databases of expenditure by disease rather than by sector are rare, particularly in Africa.

This means that in many countries a single year's audited data might not be available before the conclusion of a two year grant.

Arguments against additionality

There are several arguments that have been raised against the principle of additionality. The first relates to macroeconomic stability, particularly the concern that large inflows of foreign exchange may cause an appreciation of the currency in the recipient country, damaging exports. There has been a renewed interest in this so-called "Dutch Disease" effect in the wake of the possibility of significant increases in development assistance. Most analysts (e.g., from DFID, the World Bank, and the IMF) agree that any deleterious appreciation in the real exchange rate related to a shift towards consumption of non-tradable goods and services engendered by increased development assistance can be offset – particularly in the medium-term – through a combination of improved productivity from investment in social capital development and of judicious use of monetary policy. Further, the composition of expenditure can have a considerable effect on the exchange rate: if a high proportion of Global Fund financing is used to purchase imports (e.g., antiretroviral or artemisinin-containing therapy), the exchange rate appreciation will be blunted.

Nonetheless, concerns about the short-term economic impacts of large grants that are in addition to other inflows of foreign exchange may have a dampening effect on the size and/or frequency of applications to the Global Fund (although these decisions will not be apparent to the Global Fund, as they should take place at the CCM before an application is submitted).

A second argument against additionality relates to its impact on the integrity of the budgeting process. If a country's budgeting process is well functioning, it should produce an equitable and efficient allocation of resources among the various competing budgetary priorities. If the Global Fund insists that its resources must be additional to the current resource flows, by definition the delicate balance agreed upon in the budgetary process is upset and skewed in favor of expenditure on AIDS, tuberculosis, and malaria.

This negative impact is compounded by the relatively short time horizon of Global Fund grants, as this reduces their predictability and therefore exacerbates planning dilemmas.[8]

[8] The Global Fund's results-based disbursement strategy should partially mitigate this, as this approach to conditionality is more predictable than most others, as the targets against which monies will be disbursed are chosen by the recipient rather than the donor and so axiomatically are benchmarks that should be readily achievable.