Summary Report of the Technical Evaluation Reference Group (TERG) of the Global Fund

Sixth Meeting

Geneva, Switzerland 15-16 March, 2007

1.0 Introduction

This document reports on the Sixth TERG Meeting, which took place from 15-16 March 2007 in Geneva, Switzerland at the Global Fund premises. It provides a summary of key issues discussed and the TERG's recommendations. The agenda for the meeting and participant list are attached as Annex A. The TERG meeting focused principally on the selection of countries for study under the Five Year Evaluation and reviewed implementation plans for the three main study areas. The TERG also received a presentation on the preliminary LFA evaluation report from the consultants who conducted the study, and made arrangements for a full technical review of this report. The TERG also reviewed and discussed a proposal for rotation of TERG membership and received an update on the Global Fund's data quality audit implementation strategy. Overall meeting objectives were as follows:

1. Selection of countries for Five-Year Evaluation Study Areas 2 & 3
2. Review Study Area 1 & 2 implementation plan and timeline
3. Review draft report of the Local Fund Agent Evaluation
4. Review Five-Year Evaluation workplan, timeline and deliverables & plans for next TERG meeting
5. Review plans for rotating TERG membership
6. Review Data Quality Analysis implementation strategy

2.0 Global Fund Progress Update

2.1 Background

The Secretariat presented key findings of the Global Fund 2007 'Partners in Impact Results Report'.

2.2 Discussion & Recommendations

The TERG commended the Secretariat for the important report which summarizes areas of success, but also highlights challenges for the Global Fund and areas for improvement. TERG felt that the success of the Global Fund is now widely recognized and TERG members suggested that further description of the potential areas of improvement would be particularly useful in discussions with the Board and Board Committees.

As the Report is valuable to wider audiences, TERG members recommended wide dissemination to both global and country partners, in particular in the "South". The TERG recommended that in addition to the report, summary presentations with speakers notes be made available widely as part of a proactive communications strategy.

The TERG recommended that production of such a major report should be sufficient once a year. The timing of such reports should be coordinated to the extent possible with those of other major partners, taking into account special events related to the Global Fund, such as Board meetings and Replenishment conferences.

The TERG also encourages the Global Fund to continue its major contributions to greater harmonization of reporting.

3.0 Selection of countries for the Five-Year Evaluation

3.1 Background

The Global Fund Five-Year Evaluation is designed to conduct evaluations in 20 countries to assess the collective impact of Global Fund and other contributors on the burden of the three diseases (Study Area 3 Impact Evaluation) and to conduct studies in 16 countries to assess the partner environment and determinants of grant success (Study Area 2).

In November 2006, the TERG presented to the Board a set of qualitative and quantitative criteria that would identify a shortlist of countries most appropriate to participate in the impact evaluation. These criteria and screening processes are described in detail in the document shared with the TERG, 'Country Selection for Study Areas 3' (attached as Annex B). As a result of applying the criteria to all 113 countries with an active Global Fund grant, a set of 35 countries was short listed as the pool of countries for potential inclusion in either Study Areas 2 or 3. While respecting these criteria, the final selection of countries is ultimately a purposive sample.

In December 2006, based on the shortlist of countries, the TERG selected a set of 12 countries to participate in the 'Partners in Impact Forum'. The Forum was a major catalyst for countries to make substantial preparations for implementing a large-scale impact evaluation. All countries, except China, who declined to participate, had prepared for the Forum an inventory of available data necessary for impact measurement, and identified major gaps in data availability and data quality. All countries also prepared a presentation that summarized their relative strengths and weaknesses vis-à-vis conducting an impact evaluation. Countries were able to consult with the Contractors in defining concrete steps towards implementing evaluation activities.

3.2 Discussion & Recommendations

Taking into account the country presentations and discussions with countries at the Forum, The TERG finalized the selection of countries for inclusion in the Five-Year Evaluation.

- Impact evaluation (Study Area 3) work will be conducted in a total of 20 countries, of which 8 will undergo additional efforts to fill existing data gaps. Supplemental data collection efforts may also be supported in other countries selected for impact evaluation if additional resources are leveraged.
- Partnership evaluation (Study Area 2) work will be conducted in a total of 16 countries, of which 11 are also selected for the impact evaluation. An additional five countries with overall weak or 'mixed' grant performance are included under Study Area 2 to ensure that the evaluation also provides information concerning difficulties in Global Fund grant making.

The final list of 25 countries is attached as Annex C.

4.0 Five-Year Evaluation: Implementation of Study Area 1 & 2

4.1 Background

In evaluating the Global Fund model, Study Area 1 examines the efficiency and effectiveness of the various organizational structures of the Global Fund, and the Fund's interaction with countries. In Study Area 2, the evaluation examines the benefits, drawbacks and intricacies of the Fund's inherent reliance on partners for successful grant implementation.

4.2 Discussion & Recommendations

Study Area 1 and 2:

With regard to setting Study Area 1 priorities, the TERG noted that evaluation of the governance function is a priority to be be addressed at the upcoming Board retreat. The draft inception report for Study Areas 1 & 2, due 20 April, will come with a Conceptual framework for governance evaluation: this will allow a short review period for the TERG prior to the 15th Board meeting and the Board retreat session on the evaluation of the Global Fund Governance function.

The TERG agreed to hold a teleconference to discuss the Inception Report prior to the Board Retreat.

The TERG expressed concerns that work needs to start immediately to prepare a further developed analytical framework for Study Areas 1 and 2: The TERG recommended that the contractor invests in capacity to build this framework which needs to recognize and address the special features of the Global Fund model and system.

The TERG discussed a number of issues regarding the focus and challenges of Study Areas 1 and 2. These included issues such as country ownership or the partnership environment, which will require quantitative as well as qualitative measures.

The TERG noted that the timeline for Study Area 2 has been delayed by one month due to delays in contract signing, which will require some adaptation of the timing of the early deliverables. The TERG recommended that the assessment of the 16 countries for Study Area 2 be conducted in two phases to provide important learning opportunities through implementation. The first phase will include visits to an initial set of countries (8-10 countries, to be defined in the inception report). Experience gained in these countries will allow refinement of methods and questions, feeding into the final synthesis and overall evaluation report. The second phase will see the second part of country visits and delivery of final results prior to the Board Meeting in April 2008. The TERG stipulated that results from the initial should be incorporated into the SA2 draft report due August 2007.

The TERG did not recommend that the consultants hold a high-level consultative meeting to canvass stakeholder opinion as these types of meetings were already held on the same topic during the conduct of the stakeholder assessment in 2006.

5.0 Evaluation of the Local Fund Agent System

5.1 Background

Based on findings from the 360° stakeholder survey results and discussions at the Partnership Forum, the TERG had requested an evaluation of the Local Fund Agent system. This evaluation is an integral part of the overall Five-Year Evaluation. However, due to the Global Fund's need to compete a tender for LFA services in 2007 and the urgent need for information on LFA performance, the TERG evaluation was initiated in 2006 outside of the process for the core elements Five-Year Evaluation.

Under TERG guidance, the Euro Health Group was selected to conduct this evaluation. The evaluation was launched in December 2006. The Euro Health Group team of consultants delivered their preliminary report at the TERG meeting and presented early recommendations for TERG discussion.

5.2 Discussion & Recommendations

The TERG welcomed the presentation provided by the Euro Health Group evaluation team. As an overall comment, TERG members noted that the recommendations found in the Final Draft Report are numerous (fifteen in total), lacking in clarity and without a clear sense of priority. The TERG requested that the recommendations be condensed and presented in clear and simple language. TERG members questioned the evaluation team on the rationale of their overall findings with a notable focus on the overall suitability of the model. TERG members also focused on the characteristics associated with sound and productive relationships between LFAs and Principal Recipients. Finally TERG and the Euro Health Group evaluation team discussed the balance of skill sets required to perform the LFA function. The TERG arranged a teleconference to discuss their comments on the preliminary LFA evaluation report. That tele-conference was to be held on March 23rd.

6.0 Global Fund Five Year Evaluation Workplan & Timeline

6.1 Background

The TERG reviewed the workplan and timeline for Five-Year Evaluation implementation and agreed to specific dates and opportunities for TERG involvement and input. The TERG confirmed the division of members into subgroups to take primary responsibility for overseeing the various study areas, but emphasized that all interim and final evaluation reports and other such communications should be shared with the full TERG for review and comment.

6.2 Discussion & Recommendations

TERG members committed to ensure proactive TERG involvement in activities related to the Five-Year Evaluation and requested that the Secretariat facilitate TERG participatory activity during the implementation of 5YE to the greatest extent possible**.** Based on the positive experience with previous TERG subgroups, TERG members committed to forming working groups to follow planning and implementation of the Five-Year Evaluation as follows:

- **Study Area 1 & 2:** R. Korte, R. Leke, J. Pedraza, D. Barr, L. Peschi, J. Broekmans, P. De Lay.
- **Study Area 3:** R. Korte, P. De Lay, E. Massiah, B. Ul Haq, S. Bertozzi, J. Broekmans and B. Nahlen.

The TERG emphasized that the contractor should ensure a clear focus on capacity building in the conduct of evaluations under Study Area 3 and noted that a capacity-building plan is part of the first deliverable that will be reviewed and approved by the TERG. The TERG noted that building or strengthening systems will be a challenge given the short timeframe but that dormant capacity at the country level should be mobilized by the contractor and in-country Impact Evaluation Task Force.

The TERG also reiterated the paradigm of 'country ownership' in particular for Study area 3, and emphasized that it is critical for the contractor to implement this pillar of the Five-Year Evaluation. Among other activities, the TERG requires the contractor to (1) involve in-country Impact Evaluation Task Forces in the design and supervision of the Impact evaluation work plan; (2) ensure to the greatest extent possible the alignment of the Five-Year Evaluation effort with each of the national M&E plans; (3) prioritize the use of in-country resources in the implementation of the Five-Year Evaluation; and (4) ensure effective feedback sessions to in-country stakeholders.

For each contract, the TERG agreed on the need to have a clear and agreed-upon monitoring plan. The Secretariat will prepare and share such plans as soon as possible with the TERG's input and clearance.

The TERG also reiterated previous discussions in which it had been decided that the Five-Year Evaluation management team would be protected from being drawn into the overall activities of the Global Fund Secretariat. The TERG emphasized the team should fully support the TERG oversight of the Five-Year Evaluation and should report proactively and regularly on progress and issues encountered in the implementation of the Five-Year Evaluation.

7.0 TERG Member Rotation

7.1 Background

Since its first meeting in September 2004, the TERG has benefited from the active participation and dedicated support of 9 appointed members and 4 ex-officio members, representing the broad range of disciplines required for monitoring and evaluation of the Global Fund. The Terms of Reference (TOR) of the TERG stipulate:

- Para 9. Members of the TERG shall normally serve for a period of three years, and shall be eligible to serve not more than two consecutive terms.
- Para 10. After the first full term of a member, the rotation of members shall be such that approximately one third of the membership is changed every year.

TERG member Ties Boerma has recently asked to be recused from TERG membership, as he represents WHO as part of the consortium that won the tender on Study Area 3 of the Five-Year Evaluation. The TERG needed to decide whether it should seek a new member for TERG, or whether the membership of Ties Boerma should be set out for the time of his active involvement in the consortium implementing the Five-Year Evaluation. TERG member Etsuko Kita has also expressed a wish to step down from the TERG due to competing demands. The procedure to recruit new members would be the same as that employed to identify and appoint the initial group of TERG members. Legal counsel was present at the meeting to inform the discussion.

7.2 Discussion & recommendations

The TERG considered these issues and the process for selection of new TERG members, and made the following recommendations:

- As the Global Fund is at a critical stage in the launch of the Five-Year Evaluation, the TERG recommended that currently-active members be retained for the next 18 months, and that the two vacant seats be filled.
- For similar reasons, the TERG recommended that the present TERG Chair and Vice-Chair retain their positions for the duration of the Five-Year Evaluation.
- The TERG requested the Secretariat to develop operational procedures for TERG membership rotation after this point. Based on the advice from Legal Council it was decided that these operational procedures would not be included in the TOR as such, but would be instead combined in a specific set of TERG Operating Procedures which would be agreed by the TERG with the advice of Legal Council. This will allow more flexibility for further development of TERG procedures if and as appropriate.

- The TERG also decided to initiate the process of filling the two vacant seats previously held by Ties Boerma and Etsuko Kita. Legal Council confirmed that this should follow the process described in the TERG TOR for new appointments of TERG members.

- The TERG discussed the fact that its current Terms of Reference do not allow for involvement of the TERG in the selection process of new members, which appears to be an oversight. Thus the TERG recommended that a draft decision point be put before to the PSC and Board to revise the TOR to accommodate the TERG Chair on the TERG selection committee. The draft decision point was presented by the TERG Chair to the PSC and will be presented to the April 2007 Board meeting for decision (last slide of the presentation to PSC, attached).
- The TERG also recommended that the Secretariat develop an analysis of the TERG's existing expertise and demographic characteristics (e.g., geographic and gender representation) that could guide the Board and selection committee in the nomination and selection of new members.
- TERG members recommended the development of methods to evaluate performance of members and requested that the Secretariat propose draft criteria for discussion at the next TERG meeting.

8.0 Data Quality Audit Implementation Strategy

8.1 Background

The DQA implementation strategy was presented to the TERG for information and discussion. The objective of the Data Quality Audit (DQA) Tool is to verify the quality of programmatic performance data reported to the Global Fund. The Global Fund Board requested the Secretariat to develop this methodology as part of its accountability framework. Data quality assessments will need a high level of independence including an independent assessment of the quality of the regular LFA verification work.

The DQA Tool was developed jointly with PEPFAR, USAID, WHO and MEASURE Evaluation from April to November 2006. It was pilot tested in Tanzania in November 2006 and in February 2007 the Global Fund and WHO held a multi-partner workshop to *(1)* review, improve and validate the DQA Methodology and *(2)* discuss the use of the DQA Tool by different Partners (including WHO, RBM, UNAIDS, Stop TB and HMN).

TERG was reminded that data quality efforts are of interest to all partners and that harmonized approaches to design and implementation will benefit all partners. However, the Global Fund has a clear and specific need for data quality assessments.

8.2 Discussion & Recommendations

The TERG discussed the content of the DQA implementation strategy and gave valuable input on the vision and plan to roll out the tool. The TERG requested that the Secretariat develop a clear strategy.

9.0 Additional recommendations

The TERG emphasized its desire for proactive and engaged involvement in the implementation of the Five-Year Evaluation and suggested TERG member participation in country missions and country Impact Evaluation Task Force meetings where possible.
The TERG also suggested mechanisms to improve TERG-Secretariat communications, including more frequent consultations, especially by teleconference.

The TERG required adequate time to ensure proper oversight of the Five-Year Evaluation, and thus expects all reports requiring inputs or guidance from the TERG to be shared with TERG members at least 7 days before the comments are due.

10.0 Next meeting

The 7th TERG meeting was tentatively agreed for 26-27 June, 2007 in Geneva, Switzerland. These dates will need to be confirmed as timelines for implementation of the Five-Year Evaluation are finalized with the Contractors. The Secretariat will communicate this confirmed timeline as early as possible. The 8th TERG meeting is provisionally scheduled for 5-7 September, 2007, and will also be held in Geneva. The TERG will continue to review evaluation products between meetings, and provide these to the PSC as they become available.

ANNEX A

MEETING AGENDA & PARTICIPANTS LIST

AGENDA – 6th TERG MEETING

		Thursday 15th March **Venue: Prevention Square, The Global Fund**	
	08.00 – 09.00	**TERG retreat breakfast – Prevention Square**	
1	**09.00 – 10.00**	**Introduction & Global Fund progress update** - Review agenda, meeting objectives - Secretariat update on Global Fund progress Chair for morning session: R. Korte	R. Korte Secretariat
2	**10.00 – 12.30** Inclusive of coffee break	**Selection of countries for Study Areas 2 & 3** - Review major outcomes of the PIF - Discussion and recommendations - Finalize decisions	R. Korte Secretariat
	12.30 – 14.00	**Lunch**	
3	**14.00 – 15.30**	**Review Study Area 1 & 2 implementation plans** - Review timeline and work method including planning for inception report and Board retreat Chair for afternoon session: Rose Leke	Secretariat
4	**15.30 – 17.30** Inclusive of coffee break	**Review draft report of the LFA Evaluation** - Presentation from consultants - Euro Health Group - Discussion and recommendations	EHG Secretariat
5	**17.30 – 18.30**	**Drafting of Day One recommendations**	TERG focal points Secretariat
	19.00	**Dinner**	

		Friday 16th March Venue: Prevention Square, The Global Fund	
6	**08.30 – 08.45**	**Summary of Day One discussions and TERG recommendations** - Identify items requiring further clarification Chair for morning session: David Barr	Secretariat
7	**08.45 – 09.30**	**Review Five-Year Evaluation workplan, timeline & plans for next TERG meeting**	Secretariat
8	**10.45 – 11.30**	**Review proposal for rotating TERG membership** - Discussion and recommendations	Secretariat
	10.30 – 10.45	**Coffee**	
9	**11.30 – 12.30**	**Review Data Quality Audit implementation strategy** - Presentation of DQA tool and strategy for roll-out - Discussion and recommendations	Secretariat
	12.30 – 14.00	**Lunch**	
	14:00	**Closing**	

List of Participants – 6th TERG Meeting, 15-16 March, 2007

TERG members	Title	Address	Telephone	E–Mail
BARR David	Senior Philanthropic Advisor Tides Foundation	193, Second Avenue No. 5 New York, N.Y. 10003 USA	+1 646 602 0027	d.barr@earthlink.net
KORTE Rolf	Honorary Professor Faculty of Medicine Justus-Liebig University, Giessen, Germany Senior Health Policy Advisor, GTZ, Germany	Ziegelhuette 30 61476 Kronberg Germany	+49 175 433 4018	rolf.korte@swiftkenya.com
LEKE Rose	Professor of Immunology and Parasitology	Faculty of Medicine and Biomedical Sciences P. O. Box 3851 University of Yaounde Cameroon	+237 223 44 51	roleleke@yahoo.com
MASSIAH Ernest	Senior Social Development Specialist	Inter. American Development Bank 13+ New York Avenue NW Washington, DC 2+57 USA	+1 202 623 3816	ernestm@iadb.org
PESCHI Loretta	Co-ordinator of the Italian NGOs Network for the Global Action against AIDS	Via Pegasus 1 I – 00060 Castelnuovo di Porto (Roma) Italy	+39 347 703 41 55	peschilo@alice.it
Ex officio Members	**Title**	**Address**	**Telephone**	**E–Mail**
BROEKMANS Jaap F.	Former Executive Director	KNCV Tuberculosis Foundation P.O.Box 146, 2501 CC The Hague, Netherlands	+31 70 416 72 27 (secr.) +31 70 416 72 22 (general)	broekmansJ@KNCVTBC.nl
DE LAY Paul	Director, Monitoring & Evaluation UNAIDS	UNAIDS Secretariat 20, avenue Appia CH-1211 Geneva 27 Switzerland	+41 22 791 3666	delayp@unaids.org
NAHLEN Bernard	Deputy Coordinator President's Malaria Initiative	USAID Room 3.6-18 RRB Washington, DC 20523	+1 202 712 5915	bnahlen@usaid.gov

Additional Participants	Title	Address	Telephone	E–Mail
BOERMA Ties	Director Measurement and Health Information Systems	World Health Organization 20, avenue Appia CH-1211 Geneva 27	+41 22 791 1481	boermat@who.int
CAMMACK Tim	Consultant	Euro Health Group Tinghojvej 77, 2860 Soborg Denmark	+ 45 39 69 68 88	timcammack@mweb.co.za
EZEH Alex	Executive Director African Population & Health Research Center	Shelter Afrique Centre PO Box 10787, 00100 GPO Nairobi, Kenya	+254 20 272 0400	aezeh@aphrc.org
RICHTER Kerry	Consultant	Euro Health Group Tinghojvej 77, 2860 Soborg Denmark	+ 45 39 69 68 88	
SARRIOT Eric	Consultant	Macro International Inc. c/o ANERA PO Box 19982, Jerusalem Israel	+972 54 214 7389	mailto:EricSarriot@gmail.com
VAESSEN Martin	Sr. Vice President Project Director DHS	Macro International 11785 Beltsville Drive, Suite 300 Calverton MD 20705, U.S.A	+1 301 572 0899	Martin.T.Vaessen@orcmacro.com
ZULU Eliya Msiyaphazi	Deputy Director African Population and Health Research Center	2nd Floor, Longonot Road, Upper Hill, PO Box 10787, 00100 Nairobi, Kenya	+254 20 272 0400	ezulu@aphrc.org

GF Secretariat	Title	Address	Telephone	E–Mail
SCHWARTLANDER Bernhard	Director Performance Evaluation & Policy	The Global Fund 8, Chemin de Blandonnet 1214 Vernier	+41 22 791 17 80	Bernhard.Schwartlander@theglobalfund.org
LOW–BEER Daniel	Deputy Director Performance Evaluation & Policy		+41 22 791 19 29	Daniel.Low–Beer@theglobalfund.org
XUEREF Serge	Manager Evaluation & Scientific Policy		+41 22 791 8208	Serge.Xueref@theglobalfund.org
PLOWMAN Beth Anne	Senior Evaluation Officer Evaluation & Scientific Policy		+41 22 791 1747	Beth.Plowman@theglobalfund.org
GREENWELL Karen Fern	Senior Evaluation Officer Evaluation & Scientific Policy		+41 22 791 1700	Karen.Greenwell@theglobalfund.org
LANG Alexandra	Evaluation Officer Evaluation & Scientific Policy		+41 22 791 5920	Alex.Lang@theglobalfund.org

ANNEX B

COUNTRY SELECTION PROCESS

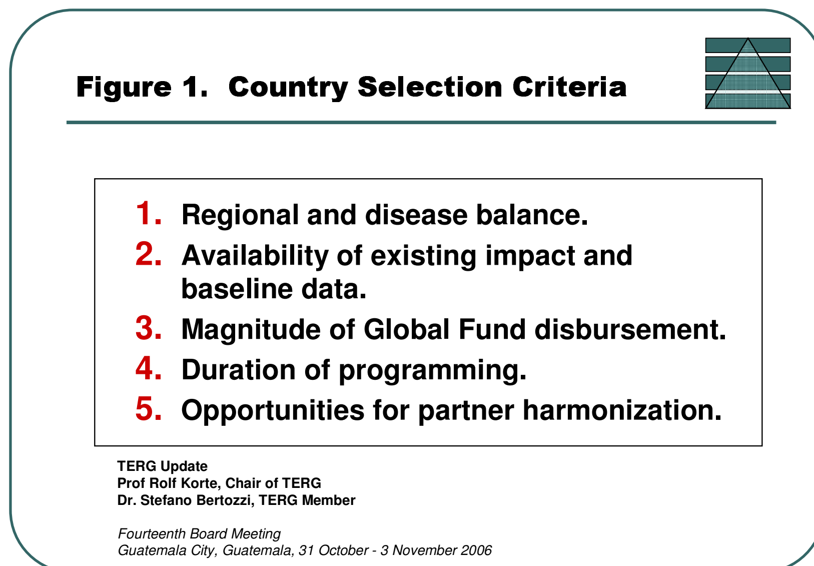
THE GLOBAL FUND FIVE-YEAR EVALUATION

COUNTRY SELECTION FOR STUDY AREAS 3 (IMPACT) AND 2

I. PURPOSE

The Global Fund Five-Year Evaluation (5YE) was designed to include an evaluation of disease impact (Study Area 3) in a total of 20 countries, including 8 'Comprehensive Evaluation Countries' (CECs) and 12 'Secondary Evaluation Countries' (SACs). At the Fourteenth Board Meeting of the Global Fund, the Technical Evaluation Reference Group of the Global Fund (TERG) set forth 5 criteria to drive the process of selecting countries for impact evaluation (Figure 1).

This paper describes the operationalization and application of these criteria and the resulting selection by TERG of 12 CECs, and a proposed selection of 8 SACs to participate in the Global Fund Five-Year Impact Evaluation. In addition, a provisional selection is proposed of 16 countries for Study Area 2 (Global Fund partner environment and grant performance), which was in part based on the same selection process and criteria.



II. DESIRED REGIONAL DISTRIBUTION OF COUNTRIES

The desired regional distribution of impact evaluation countries was decided prior to applying the country selection criteria, with the aim to mirror the regional distribution in Global Fund grant commitments, and to ensure that the impact evaluation takes place in a wide variety of contexts.

The 20 countries will be distributed proportional to grant disbursements to regions. Figure 2 shows the distribution of Global Fund grant disbursements over the 8 global Fund regions, as

of December 2006. It is of note that grant *commitments*, over the full 3-5 year lifecycle of approved grants, for grants from rounds 1-5 show an almost identical regional distribution (not shown). Figure 3 shows the corresponding distribution of 20 target countries over the 8 Global Fund regions.

Just over half of all grant disbursements (55%) have been to sub-Saharan Africa, and therefore just over half of the 20 countries (11 of 20 countries) will also be selected from these regions: 5 from East Africa, 3 from Southern Africa and 3 from West and Central Africa (Figure 3). For the remaining regions, the distribution of disbursements suggest 3 countries in East Asia and the Pacific (15% of total disbursements); 2 countries each from Eastern Europe & Central Asia and from Latin American & the Caribbean (which each account for 10% of total disbursements); and 1 country each from North Africa & the Middle East and from South Asia (which each have received about 5% of cumulative disbursements).

Figure 2. Dispersion of GF disbursements (mln US$), by region (Dec. 2006)

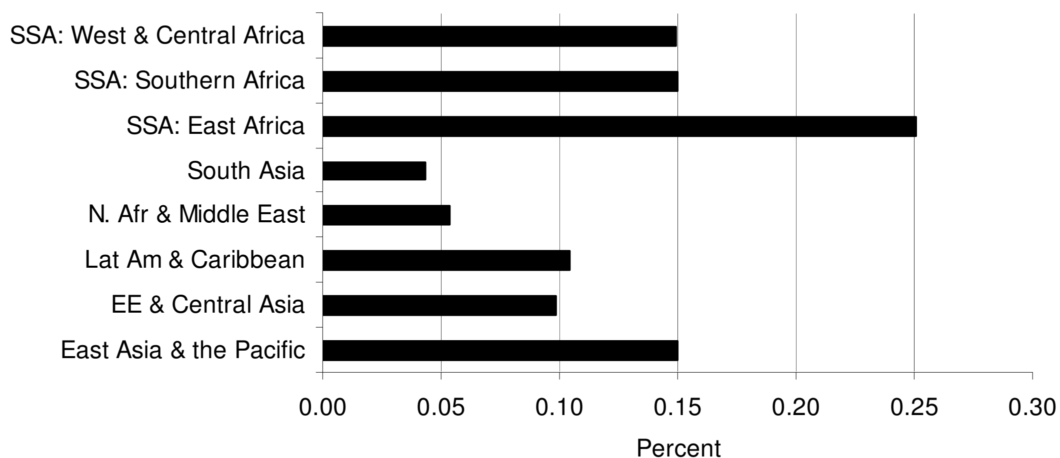


Figure 3. Desired distribution of 20 impact evaluation countries according to distribution of grant disbursements

Region	*Cumulative grant disbursements (December 2006)*	*Corresponding distribution of 20 countries for impact evaluation*
East Asia & the Pacific	15%	3
Eastern Europe & Central Asia	10%	2
Latin America & Caribbean	10%	2
North Africa & Middle-East	5 %	1
South Asia	4 %	1
Sub-Saharan Africa: East Africa	25 %	5
Sub-Saharan Africa: Southern Africa	15 %	3
Sub-Saharan Africa: West & Central Africa	15 %	3
TOTAL	**100%**	**20**

III. COUNTRY SELECTION PROCESS

A total of 113 countries which have at least one active Global Fund grant from rounds 1 to 5, as of December 2006, were eligible for selection.

In summary, the selection process entailed, first, the screening of the 113 countries based on 4 initial selection criteria (minimum country size, minimum 2 diseases with grants, minimum grant duration, minimum total disbursements). Secondly, countries that 'qualified' according to these four screens were ranked, within geographical region, by level of disease burden and grant cumulative disbursements – where the countries ranking highest in terms of disease burden, and as secondary criterion grant magnitude, were considered to be the most logical candidates.

The third step consisted of proposing this ranked list to country and regional experts within and outside the Global Fund, to take into account their estimation of the partner environment and preparedness and capacity for impact evaluation for the countries within each region. This expert input resulted in selecting-out, from the top-listed number of countries within each regional quotum, certain countries ranking high in disease burden and, as secondary criterion, grant amount, and selecting-in several lower-burden / lower grant amount countries that were judged particularly suitable in view of an advanced state of preparedness and capacity for impact evaluation.

Fourth, from the thus obtained shortlist of (32) countries, TERG pre-selected CECs and is in the process of selecting SACs, with further input from country experts in partner organizations. For CECs, countries with highest burden and highest-grant amounts were prioritized, provided they were judged acceptable in terms of quality of routine data collection and M&E, and again country capacity and readiness for impact evaluation, taking account also of the strength of the national partnership system. For SACs, countries with relatively good baseline (survey and financial) data were prioritized. Also priority was given to countries able to participate to both Study area 3 and Study area 2, as complete case studies will be valuable to learn lessons from such comprehensive evaluations.

The same 32 countries were finally reviewed to select 16 candidates for Study Area 2, seeking a balance between well-performing and less well performing recipients, according to average grant Phase 2 ratings.

These steps are described in detail below.

Step 1. Initial screening (result: 56 QUALIFYING countries)

Four initial screens were applied to the pool of 113 recipient countries from Global Fund Rounds 1-5, to immediately exclude countries which would be of lesser interest:

1. "Minimum population size" excluding countries with population size, as of 2006, in the lowest decile (<1.42 million).
2. "Minimum 2 diseases with grants" excluding countries receiving GF grant/s for only one disease.
3. "Minimum grant duration" excluding countries that received their first grant disbursement later than July 2004.
4. "Minimum grant amount" excluding countries with cumulative grant disbursement amounts in the lowest two deciles (<US$ 5.0 million), as of December 2006.

This screening resulted in the exclusion of 57 countries (Figure 4), leaving a total of 56 'qualifying' countries with relatively more significant population size, mix of diseases with Global Fund grants in terms of diseases, duration of funding and disbursement amount.

Figure 4. Initial country screening and number of excluded countries

Criterion	Countries excluded, out of 113 recipients*
"Minimum population size"	14
"Minimum 2 diseases with grants"	29
"Minimum grant duration"	35
"Minimum grant amount"	23
Total excluded	57
Total qualifying	56

Note: screening criteria are not mutually exclusive. A country may be excluded for not meeting any one or more of the criteria.

Step 2. Ranking by disease burden and grant magnitude

(result: WITHIN-REGION RANKS among qualifying countries)

Within each region, the qualifying countries were ranked by level of disease burden and grant financial amount.

A. Disease burden. Disease burden was operationalized by using one key indicator for each disease: adult HIV prevalence rate (2005 estimates), tuberculosis disease incidence rate (2004 estimates) and malaria mortality rate (2005 estimates). For the purpose of obtaining one overall, cross-disease score for each country, country scores for each disease indicator were categorized into quartiles. For each country, quartile scores for the diseases for which it has/had Global Fund grants, were averaged (so that, for example, the level of malaria burden would not factor in for countries with no malaria grant).

B. Grant amount. Two indicators of Global Fund grant amount were considered: 1) total disbursements from all grants in a country, up to December 2006, *per capita*; and 2) total disbursements as proportion of the total national health expenditure in 2003 (the most recent expenditure data available). Country values for both indicators were grouped into terciles, and, for each country, summed.

The disease burden score (range 1-4) and grant amount score (range 2-6) were then each standardized on a scale of 1-10. Within each region, the countries ranking highest in terms of disease burden, and, among countries with the same disease burden rank, as secondary criterion grant amount, were considered to be the most logical candidates.

Step 3. Appraisal of country capacity and partnerships

(result: 32 SHORTLISTED countries)

The third step consisted of proposing the ranked lists of countries within each region, to country and regional experts within and outside the Global Fund. Outside to the Global Fund, comments were seek from WHO, Office of the Global AIDS Coordinator (OGAC), Worldbank, UNAIDS and other stakeholders (bilateral donors) to take into account their estimation of the:

1) preparedness of national partners (including Government and CCM/PR) and capacity of the country to implement, in collaboration with the cross-country coordinating body contracted by the TERG/Secretariat, the impact evaluation activities and to achieve the objectives of the impact evaluation; and

2) strength and support of the network of partners in each country (e.g., international programmes of HIV/AIDS, tuberculosis and malaria control and/or financial support).

The strength of the partnership network was furthermore assessed by scoring the presence of PEPFAR, World Bank Malaria booster programme, World Bank Multi-country programme on AIDS (MAP) USA President's Malaria Initiative and WHO/Stop TB in each country. As of December 2006, 15 countries were supported by PEPFAR, 9 by the World Bank Malaria booster programme, 30 by MAP, 16 by PMI and 22 (high-burden countries) by WHO/Stop TB.

This expert input resulted in selecting-out, from the top-listed countries within each regional quotum (Figure 3), certain countries ranking high in disease burden and, secondarily, grant amount, while selecting-in several lower-ranking countries that were judged particularly suitable in view of an advanced state of preparedness and capacity for impact evaluation. The result was a shortlist of 32 countries, most of which were still among the highest ranked within their region in terms disease of burden and, secondarily, grant amount.

Step 4. Further country-expert input and appraisal of data availability

(result: 12 candidate-CECs & 8 additional SACs)

From countries on this shortlist, the TERG provisionally selected 12 of them to be invited to be candidate CECs: countries with highest burden and highest grant amounts were prioritized, provided they were judged acceptable in terms of quality of routine data collection and country capacity and readiness for impact evaluation, considering also the national partnership system.

For SACs, for which the impact evaluation would involve no or only limited primary data collection, countries were sought with relatively good baseline data. To judge this, a data availability score was constructed for each country, comprising of:

- The number of population-based (household or target-population) surveys, conducted between 2000 and 2007 (according to plannings of summer 2006), which measured indicators of the three diseases and/or the coverage of relevant interventions:
    - for HIV/AIDS: Demographic and Health Surveys (DHS)[1], Multiple Indicator Cluster Surveys (MICS)[2], AIDS Indicator Surveys (AIS), Behavioral Surveillance Survey (BSS) and Sexual Behavior Surveys (SBS);
    - for TB: Prevalence surveys and tuberculin surveys recorded in the WHO/STB database;
    - for Malaria: DHS, MICS, Netmark survey, Malaria Indicator survey, WHO/Headquarters' World Health Surveys, AIDS indicator survey and surveys conducted in conjunction with Expanded Programme of Immunization (EPI) campaigns or surveillance[3].
- Existence of national health accounts (NHA) with sub-account components for the three diseases[4].
- Existence of relevant health facility surveys (Service availability and provision assessments, Service Availability Mapping, facility censuses, etc.).

---

[1] ORC Macro - MEASURE *DHS+*. Demographic and Health Surveys (DHS): ORC Macro, Calverton, MD, USA http://www.measuredhs.com/

[2] UNICEF, http://www.childinfo.org/MICS2/MICSCTY/MICScntry2.htm

[3] Source: Household Survey Status in Africa south of the Sahara; as of May 4 2005 http://www.rollbackmalaria.org/partnership/wg/wg_monitoring/docs/HHsurvey_schedule.xls

[4] http://www.who.int/nha/en/

A country's overall household survey score was constructed as the average number of population-based surveys for the diseases with grants (e.g., not counting number of TB surveys for countries with no TB grants). The overall data availability score weighted the existence of NHAs twice compared to the other two data types, to appraise the importance of NHAs as the only means to identify the financial share of Global Fund (and other partners' and programmes') in total national health expenditures.

Step 5. Appraisal of grant performance (result: provisional proposal 16 countries for SA-2)

TERG then reviewed the same shortlist of 32 countries to select 16 candidates for Study Area 2, seeking a balance between well-performing and less well performing recipients. Grant performance was based on the average of all grant Phase 2 ratings within each country; as all countries on the shortlist had, as of December 2006, completed at least 1 Phase 2 review (range 1-7). To this end, Phase 2 ratings of A, B1, B2 and C were quantified as scores 1,2,3, and 4; countries with an average Phase 2 score of less than 1.8 were categorized as well-performing, countries with an average score of 1.8-2.5 as medium-performing and countries with an average score of above 2.5 as poor performing. In this way, 6 well-performing, 6 medium-performing and 4 poor-performing countries were selected for Study Area 2.

Step 6 / Next steps

Under a recently signed Memorandum of Understanding (MOU) with the GF**,** UNAIDS has agreed to facilitate, the fast-tracking of impact evaluation activities by bringing together all relevant country-level partners involved in HIV, TB and malaria in the 12 CEC candidate countries. In particular, UNAIDS will support the establishment of country level Impact Evaluation Task Forces, and will facilitate the development of country impact evaluation implementation plans with gap analyses. It is expected that bilateral and multilateral partners, in addition to local stakeholders including governments, CCM/PR, civil society representatives, local universities and more will be involved in these intensive in-country efforts.

Representatives of the 12 CEC candidates will be invited to a '*Partners in Impact' Forum* in Geneva, 26-28 February 2007, to strengthen country impact evaluation plans and activities based on sharing of experiences between countries and on partners' technical expertise.

Immediately following the Forum, TERG will select the final list of 8 CECs, based on the quality of presented country impact evaluation plans, and reviewing existing criteria such as geographical distribution and grant performance. The 4 remaining CECs candidates will be invited to participate in the impact evaluation as SACs.

IV. RESULTING SELECTION OF CECS CANDIDATES AND PROPOSAL FOR SECS

This section describes and explains TERG's selection of 12 CEC candidates – of which 8 will ultimately become CECs and 4 SACs – and a proposal for 8 additional SACs. The selections are compared with the burden & grant amount ranks of these countries among all qualifying countries within their region.

In the East Asia and Pacific region, China was selected as CEC candidate despite its low ranking on disease burden and grant amount. This is because China's large national population, the denominator for both disease burden indicators and for disbursements *per capita*, masks the significant absolute disease burden and grant amount in the country (for example, 15% of worldwide incident TB cases are in China according to 2004 estimates). Regions of China with relatively higher disease burden and investments will be selected to evaluate impact. Furthermore, China has shown a high level of preparedness and capacity to partake in the evaluation. Highest-burden high-grant Papua New Guinea was judged poorly in terms of preparedness, capacity and a supportive environment, and so was not selected.

As a SAC, Viet Nam could be selected over Thailand, in view of high burden, good data availability and positive opinion among regional experts, compared to (second choice) Thailand.

In Eastern Europe and Central Asia, Moldova was selected as CEC candidate as it ranked highest in disease burden and secondarily grant amount. Russia, ranking equally high in terms of disease burden, was not selected, because of low grant amount criteria and data availability. Furthermore, experience in country indicates that it would not be an efficient or even welcoming place to conduct an evaluation. Kyrgyzstan would be a logical SAC candidate, more so than slightly higher-burden Georgia and Romania because of better data availability.

In the Latin America and Caribbean region, Haiti and Peru, the two qualifying highest-burden countries, were selected as CEC candidate. It is proposed to not select any SACs in this region, so as not to over-represent the region compared to its share in total disbursements (Figure 3).

In South Asia, India was selected as CEC candidate, over Nepal which had similar disease burden, but less data available and less support from stakeholders within and outside the Global Fund. In addition, although the standardized grant amount score was higher for Nepal, India would score higher in terms of grant amount if this were calculated against populations of certain high-burden, programme-targeted states – which are the unique focus of the Global Fund supported control programmes and which will also be the focus of the 5YE – instead of the national population. Bangladesh, with similarly high burden, could be selected as SAC.

From the Global Fund region North Africa and the Middle East, none of the four qualifying countries were selected as CEC candidate, or are proposed as SAC. This is because the two highest ranking countries, Mali and Chad, are (per UN-designation) located in West Africa, where Burkina and Ghana were already appointed CAC candidate and Senegal is proposed as SAC. The two remaining countries, Somalia and Yemen, were not selected because Somalia lacks published data on total health expenditures and Yemen suffers from a lack of baseline data for the 3 diseases.

In sub-Saharan Africa almost all countries rank very high in terms of disease burden, grant amount and data availability. In these regions, constituting 11 or 12 of the total 20 countries to participate in the evaluation, there are still several countries to be selected. In these regions, expert judgement on country preparedness, capacity played a comparatively large role in the selection. A balance was furthermore sought between countries with strong presence of international financing and technical partners, and countries with a weaker partnership network. In East Africa, highest-burden Tanzania became CEC candidate, instead of Uganda which met less support from country experts. Ethiopia was selected as a second CECs, over higher-burden Burundi and Kenya, because of comparably favorable expert opinions on country readiness, capacity and availability of baseline data. Kenya and Rwanda, with comparatively good data availability, are proposed as SACs.

From Southern Africa, Zambia and Malawi were selected as CEC candidate. South Africa and Lesotho, with equally high burden, were not, due to less favorable judgment on country readiness and capacity for impact evaluation. Mozambique (if not Benin) might be selected as SAC.

From Western & Central Africa, Burkina Faso and Ghana were selected as CEC candidate, mainly because of favorable judgement on country readiness and capacity compared to some higher-burden countries. Highest-burden Nigeria, and Senegal, and perhaps Benin (if not Mozambique), are potential SACs.

IV. LIMITATIONS IN THE SELECTION PROCESS

Several limitations are acknowledged in the selection process. Most important, the selection of countries is a purposeful (i.e. convenience) sample rather than a probabilistic sample, and

therefore the sample cannot be assumed to be representative of the total of countries with active Global Fund grants. While regional balance was ensured by selecting the number of countries for each region in proportion to the regions' shares in disbursement, TERG purposefully selected as CECs countries where expected total health impact would be relatively important and likely to be measurable, by excluding countries with short grant duration, relatively low Global Fund disbursements and/or only one type of disease grant. This choice also reflects the aim to learn 'best evaluation practices' from successful case studies within CECs, and to build the desired 'model platform' for impact evaluation that can subsequently be applied in other countries.

The definitions of disease burden, grant amount and data availability scores were kept simplistic, and may in some cases have led to unintended, arbitrary rank orders. Notably, grant amount was scored on a *per capita* basis compared to national population sizes (and national health expenditures), whereas in certain countries, notably some very large ones where disease burden and Global Fund-supported programmes are largely limited to sub-areas of the country. When instead expressing grant disbursements per person with HIV or tuberculosis and per person living in a malaria transmission risk area, the larger countries China, Indonesia and Russia get higher grant amount scores, although the scores for India, Ethiopia and Nigeria would decrease.

Second, the data availability score did not take into account the (varying) quality, coverage and completeness of vital registration in qualifying countries, a potentially important data source for mortality impact, for lack of complete, standardized statistics about vital registration systems for the total set of qualifying countries.

As a third example, the scoring of disease burden and grant amount into quartiles and tertiles, respectively, ignored variation and precision in available data and estimates. This may have biased the ranking between countries in the same quartile for burden but differing tertiles of grant amounts.

A final limitation is that the important judgments and knowledge on country preparedness and capacity to undertake impact evaluation from country-experts within the Global Fund and among external Stakeholders on Impact, were seriously taken into account at several stages of the selection process, but not documented in detail.

Candidate Countries for Study Areas 3 (CECs & SACs) and 2

For calculations & complete background data see worksheet 'All 113 c'ies, subselect 56 & 32'

Data reflect situation of December 2006

GF Region (& desired no. of c'ies for SA3, to achieve regional distribution proportional to disbursements)	**Country**	**GF cumulative disbursements (US $)** HIV/AIDS	TB	Malaria	**QUALIFY** (pre-screen, from 113 to 56 countries)	**Standardized scorings** **Disease burden quartiles (Range 1-10)**	Grant finance amount (Range 1-10)	Data availability (Range 1-6)	Secretariat Judgements of suitability for 5YE - among 56 qualifying c'ies Operations	Perfo. Evaluation & Policy	Grant Performance (av. Phase 2 rating)	International partners	**Study Area 3** **12 candidate Comprehensive Evaluation countries (CECs)**	**Proposed 8 (additional) Secondary Analysis countries (SACs)**	**Study Area 2** **Proposed 16 countries, by level of grant performance** Good perf.	Medium perf.	Poor perf.
E. Asia & Pacific (3)	Cambodia	35,821,348	5,139,871	11,191,835	YES	8	10	2.7	Good	Good	Medium	5	x			x	
E. Asia & Pacific (3)	Vietnam	8,694,722	2,500,000	12,355,174	YES	5	1	5.0	Good	Neutral	Medium	1,5		x			
E. Asia & Pacific (3)	Indonesia	20,874,406	38,429,197	15,410,639	YES	4	1	2.0	Good	Neutral	Medium	5					
E. Asia & Pacific (3)	China	56,008,431	58,114,728	13,295,197	YES	2	1	2.3	Good	Good	Good	5	x		x		
EE & Central Asia (2)	Ukraine	51,834,560	-	-	NO: HIV grant	7	6	4.0	Poor		Medium	-					
EE & Central Asia (2)	Moldova	4,553,971	4,553,971	-	YES	6	6	0.5	Good	Neutral	Good	-	x		x		
EE & Central Asia (2)	Georgia	5,270,905	1,339,913	806,300	YES	3	6	0.7	Good	Neutral	Medium	-					
EE & Central Asia (2)	Kyrgyzstan	7,454,538	1,466,311	933,345	YES	2	6	2.0	Good	Neutral	Medium	-		x		x	
L A & Carib (2)	Haiti	52,170,677	6,871,331	6,544,146	YES	7	10	1.3	Good	Neutral	Good	1	x		x		
L A & Carib (2)	Peru	19,333,815	24,626,409	-	YES	6	6	3.0	Good	Good	Medium	-	x			x	
L A & Carib (2)	Dominican Republic	13,853,287	1,683,124	-	YES	6	3	3.0	Good	Neutral	Good	-					
L A & Carib (2)	Honduras	20,934,987	5,070,310	5,542,598	YES	5	8	1.0	Neutral	Neutral	Poor	-					
N. Afr & Mid-East (1)	Yemen	3,378,501	2,309,685	5,278,128	YES	5	3	0.0	Good	Neutral	Poor	-					x
South Asia (1)	Nepal	3,194,329	1,442,630	1,673,683	YES	4	3	1.3	Good	Neutral	Medium	-					
South Asia (1)	India (one state)	22,327,050	17,977,450	13,419,026	YES	4	1	4.7	Good	Good	Medium	5	x				
South Asia (1)	Bangladesh	8,287,114	22,767,367	-	YES	4	1	4.0	Good	Neutral	Good	5		x	x		
SSA: East (5)	Tanzania (& Zanzibar)	59,675,677	1	49,527,765	YES	10	10	5.3	Good	Good	Medium	1,2,3,5	x			x	
SSA: East (5)	Uganda	33,657,270	4,599,506	52,204,485	YES	10	10	3.3	Neutral	Neutral	Poor	1,2,3,5					
SSA: East (5)	Burundi	13,516,474	1,368,790	16,568,331	YES	9	10	1.0	Good	Neutral	Medium	3					
SSA: East (5)	Kenya	29,326,570	5,968,645	56,829,416	YES	9	10	3.0	Neutral	Neutral	Poor	1,2,3,5		x			x
SSA: East (5)	Ethiopia	95,415,280	15,327,331	107,989,811	YES	8	10	5.7	Neutral	Good	Medium	1,2,3,4,5	x				
SSA: East (5)	Rwanda	40,737,695	20,202,699	49,049,296	YES	8	10	4.7	Good	Neutral	Good	1,2,3		x			
SSA: Southern (3)	Malawi	64,297,184	-	6,363,507	YES	10	10	4.0	Good	Good	Medium	2,3,4	x			x	
SSA: Southern (3)	Zambia	68,954,692	19,479,427	31,358,089	YES	10	10	6.0	Good	Good	Good	1,2,3,4	x		x		
SSA: Southern (3)	Lesotho	12,542,234	1,654,010	-	YES	10	10	1.0	Neutral	Neutral	Poor	-					
SSA: Southern (3)	Mozambique	20,522,476	7,215,542	6,653,718	YES	9	8	2.0	Neutral	Neutral	Medium	1,2,3,5		*x?*			*x?*
SSA: West & Central (3)	DR Congo	30,142,942	12,327,396	22,748,859	YES	10	10	2.3	Poor	Neutral	Medium	3,4,5					
SSA: West & Central (3)	Nigeria	20,534,904	-	27,743,554	YES	10	3	5.5	Good	Neutral	Poor	1,3,4,5		x		x	
SSA: West & Central (3)	Burkina Faso	9,611,923	5,599,615	7,119,071	YES	8	6	3.7	Neutral	Neutral	Good	3,4	x				
SSA: West & Central (3)	Benin	16,729,577	3,095,159	4,338,728	YES	7	10	3.3	Neutral	Neutral	Medium	2,3,4		*x?*			*x?*
SSA: West & Central (3)	Ghana	20,066,182	11,318,383	23,469,067	YES	7	8	2.7	Good	Good	Good	2,3	x		x		
SSA: West & Central (3)	Senegal	8,987,935	-	16,143,961	YES	6	6	2.5	Good	Neutral	Poor	2,3,4		x			x
TOTAL	**32**												**12**	**8**	**6**	**6**	**4**

Legend

10 = highest t 10 = highest (6 = best data availability
1 = lowest bu 1 = lowest (rel 1 = least data availability

Good = averag 1=PEPFAR
Medium = avera 2=President's Malaria Initiative
Poor = averag 3=Worldbank Multicountry AIDS Programme
4=Worldbankk Malaria Booster Programme
5=StopTB 'high-burden' country

To complement 4 SACs from the 12 candidate CECs which will not become CECs.

ANNEX C

Countries selected for participation in Five-Year Evaluation

Cluster	Country	Health Impact Evaluation Studies (SA3)	Partnership Studies (SA2)
Eastern Europe & Central Asia	Kyrgyzstan		
	Moldova		
Latin America & Caribbean	Haiti[1]		
	Honduras		
	Peru[1]		
North Africa & Middle East	Yemen		
East Asia & Pacific	Cambodia[1]		
	Vietnam		
South Asia	India		
	Nepal		
SSA: West & Central	Benin		
	Burkina Faso[1]		
	DRC		
	Ghana		
	Nigeria		
SSA: East	Burundi		
	Ethiopia[1]		
	Kenya		
	Rwanda		
	Tanzania[1]		
	Uganda		
SSA: Southern	Malawi[1]		
	Mozambique		
	South Africa		
	Zambia[1]		
TOTAL	**25**	**20**	**16**

[1] Supplementary data collection